PUBLIC PACKET

OREGON BOARD OF DENTISTRY

BOARD MEETING
OCTOBER 21, 2016

STANDARD PROTOCOLS FOR GENERAL CONSENT ORDERS

CIVIL PENALTIES

Licensee shall pay a $____ civil penalty in the form of a cashier's, bank, or official check, made payable to the Oregon Board of Dentistry and delivered to the Board offices within 30 days of the effective date of the Order.

> **NOTE:** The Board will allow licensed dentists a 30-day payment period for each civil penalty increment of $2,500
>
> **NOTE:** The Board will allow licensed dental hygienists a 30-day payment period of each civil penalty increment of $500

RESTITUTION PAYMENTS

Licensee shall pay $___ in restitution in the form of a cashier's, bank, or official check made payable to patient __ and delivered to the Board offices within 30 days of the effective date of the Order.

> **NOTE:** The Board will allow licensed dentists a 30-day payment period for each restitution increment of $2,500

REIMBURSEMENT PAYMENTS

Licensee shall provide the Board with documentation verifying reimbursement payment made to ___, the patient's insurance carrier, within 30 days of the effective date of the Order.

> **NOTE:** The Board will allow licensed dentists a 30-day payment period for each reimbursement increment of $2,500

CONTINUING EDUCATION – BOARD ORDERED

Licensee shall successfully complete ___ hours of ___ (OPTIONS: Board pre-approved, hands-on, mentored), continuing education in the area of ___ within ___ (OPTIONS: years, months) of the effective date of this Order, unless the Board grants an extension, and advises the Licensee in writing. This ordered continuing education is in addition to the continuing education required for the licensure period ___ (OPTIONS: April 1, XXX to March 31, XXX OR October 1, XXX to September 30, XXX). As soon as possible after completion of a Board ordered course, Licensee shall submit documentation to the Board verifying completion of the course.

COMMUNITY SERVICE

Licensee shall provide ___ hours of Board approved community service within ___ (OPTIONS: years, months) of the effective date of this Order, unless the Board grants an extension, and advises the Licensee in writing. The community service shall be pro bono, and shall involve the Licensee providing direct dental care to patients. Licensee shall submit documentation verifying completion of the community service within the specified time allowed for the community service.

FALSE CERTIFICATION OF CONTINUING EDUCATION

Licensee shall be reprimanded, pay a $____ ($2,000 for dentists OR $1,000 for dental hygienists) civil penalty, complete ten hours of community service within 60 days and complete the balance of the ___ (40 OR 24) hours of continuing education for the licensure period (4/1/-- to 3/31/-- OR 10/1/-- to 9/30/--), within 60 days of the effective date of this Order. As soon as possible following completion of the continuing education the Licensee shall provide the Board with documentation certifying the completion.

WORKING WITHOUT A CURRENT LICENSE

Licensee shall pay a $___ civil penalty in the form of a cashier's, bank, or official check, made payable to the Oregon Board of Dentistry and delivered to the Board offices within 30 days of the effective date of the Order.

> **NOTE:** A licensed dentist, who worked any number of days without a license will be issued a Notice of Proposed Disciplinary Action and offered a Consent Order incorporating a reprimand and a $5,000 civil penalty.

> **NOTE:** A licensed dental hygienist who worked any number of days without a current license, will be issued a Notice of Proposed Disciplinary Action and offered a Consent Order incorporating a reprimand and civil penalty of $2,500.

ALLOWING A PERSON TO PERFORM DUTIES FOR WHICH THE PERSON IS NOT LICENSED OR CERTIFIED

Licensee shall pay a $___ civil penalty in the form of a cashier's, bank, or official check, made payable to the Oregon Board of Dentistry and delivered to the Board offices within 30 days of the effective date of the Order, unless the Board grants an extension, and advises the Licensee in writing.

NOTE: The Licensee will be charged $2,000 for the first offense and $4,000 for the second, and each subsequent offense.

FAILURE TO CONDUCT WEEKLY BIOLOGICAL TESTING OF STERILIZATION DEVICES

Licensee shall pay a $ ____ civil penalty in the form of a cashier's, bank, or official check made payable to the Oregon Board of Dentistry and delivered to the Board offices within _____ days of the effective date of the Order, complete ____ hours of Board approved community service within _____ (months, year) of the effective date of the Order, and, for a period of one year of the effective date of the Order, submit, by the fifteenth of each month, the results of the previous month's weekly biological monitoring testing of sterilization devices.

NOTE: Failure to do biological monitoring testing one to five times within a calendar year will result in a Letter of Concern.

NOTE: Failure to do biological monitoring testing six to ten times within a calendar year will result in the issuance of a Notice of Proposed Disciplinary Action and an offer of a Consent Order incorporating a reprimand.

NOTE: Failure to do biological monitoring testing 11 to 20 times within a calendar year will result in the issuance of a Notice and an offer of a Consent Order incorporating a reprimand, a $3,000 civil penalty to be paid within 60 days, 20 hours of Board approved community service to be completed within six months, and monthly submission of spore testing results for a period of one year from the effective date of the Order.

NOTE: Failure to do biological monitoring testing more than 20 times within a calendar year will result in the issuance of a Notice and an offer of a Consent Order incorporating a reprimand, a $6,000 civil penalty to be paid within 90 days, 40 hours of Board approved community service to be completed within one year, and monthly submission of spore testing results for a period of one year from the effective date of the Order.

STANDARD PROTOCOLS FOR CONSENT ORDERS SPECIFICALLY RELATED TO ALCOHOL ABUSE

ALCOHOL

Licensee shall, for an indefinite length of time, be subject to the following conditions of this Consent Order:

Licensee shall not apply for relief from these conditions within five years of the effective date of the Order, and then must do so in writing.

Licensee shall not use alcohol, controlled drugs, or mood altering substances at any place or time unless prescribed by a licensed practitioner for a bona fide medical condition and upon prior notice to the Board and care providers, except that prior notice to the Board and care providers shall not be required in the case of a bona fide medical emergency.

Licensee shall undergo an evaluation by a Board approved addictionologist or treatment center within 30 days of the effective date of the Order and make the written evaluation and treatment recommendations available to the Board.

Licensee shall adhere to, participate in, and complete all aspects of any and all residential care programs, continuing care programs and recovery treatment plans recommended by Board approved care providers and arrange for a written copy of all plans, programs, and contracts to be provided to the Board within 30 days of the effective date of this Order.

Licensee shall advise the Board, in writing, of any change or alteration to any residential care programs, continuing care programs, and recovery treatment plans 14 days before the change goes into effect.

Licensee shall instruct all health care providers participating in the residential, continuing care, and recovery programs to respond promptly to any Oregon Board of Dentistry inquiry concerning Licensee's compliance with the treatment plan and to immediately report to the Board, any positive test results or any substantial failure to fully participate in the programs by the Licensee. Licensee shall instruct the foregoing professionals to make written quarterly reports to the Board of Licensee's progress and compliance with the treatment programs.

Licensee shall waive any privilege with respect to any physical, psychiatric, or psychological evaluation or treatment in favor of the Board for the purposes of determining compliance with this Order, or the need to modify this Order, and shall execute any waiver or release upon request of the Board.

Licensee shall submit to a Board approved, random, supervised, urinalysis testing program, at Licensee's expense, with the frequency of the testing to be determined by the Board, but initially at a minimum of 24 random tests per year. Licensee shall arrange for the results of all tests, both positive and negative, to be provided promptly to the Board.

Licensee shall advise the Board, within 72 hours, of any alcohol, illegal or prescription drug, or mind altering substance related relapse, any positive urinalysis test result, or any substantial failure to participate in any recommended recovery program.

Licensee shall personally appear before the Board, or its designated representative(s), at a frequency to be determined by the Board, but initially at a frequency of three times per year.

Licensee shall, within three days, report the arrest for any misdemeanor or felony and, within three days, report the conviction for any misdemeanor or felony.

Licensee shall assure that, at all times, the Board has the most current addresses and telephone numbers for residences and offices.

STANDARD PROTOCOLS FOR CONSENT ORDERS SPECIFICALLY RELATED TO SUBSTANCE ABUSE

DRUGS

Licensee shall, for an indefinite length of time, be subject to the following conditions of this Consent Order:

Licensee shall not apply for relief from these conditions within five years of the effective date of the Order and then must do so in writing.

Licensee shall not use controlled drugs or mind altering substances at any place or time unless prescribed by a licensed practitioner for a bona fide medical condition and upon prior notice to the Board and care providers, except that prior notice to the Board and care providers shall not be required in the case of a bona fide medical emergency.

NOTE: It may be appropriate to add “alcohol” to this condition.

Licensee shall undergo an evaluation by a Board approved addictionologist or treatment center within 30 days of the effective date of the Order and make the written evaluation and treatment recommendations available to the Board.

License shall adhere to, participate in, and complete all aspects of any and all residential care programs, continuing care programs and recovery treatment plans recommended by Board approved care providers and arrange for a written copy of all plans, programs, and contracts to be provided to the Board within 30 days of the effective date of the Order.

Licensee shall advise the Board, in writing, of any change or alteration to any residential care programs, continuing care programs, and recovery treatment plans 14 days before the change goes into effect.

Licensee shall instruct all health care providers participating in the residential, continuing care, and recovery programs to respond promptly to any Oregon Board of Dentistry inquiry concerning Licensee’s compliance with the treatment plan and to immediately report to the Board, any positive test results or any substantial failure to fully participate in the programs by the Licensee. Licensee shall instruct the foregoing professionals to make written quarterly reports to the Board of Licensee’s progress and compliance with the treatment programs.

Licensee shall waive any privilege with respect to any physical, psychiatric, or psychological evaluation or treatment in favor of the Board for the purposes of determining compliance with this Order, or the need to modify this Order and shall execute any waiver or release upon request of the Board.

Licensee shall submit to a Board approved, random, supervised, urinalysis testing program, at Licensee's expense, with the frequency of the testing to be determined by the Board, but initially at a minimum of 24 random tests per year. Licensee shall arrange for the results of all tests, both positive and negative, to be provided to the Board.

Licensee shall advise the Board, within 72 hours, of any drug related relapse, any positive urinalysis test result, or any substantial failure to participate in any recommended recovery program.

Licensee shall personally appear before the Board, or its designated representative(s), at a frequency to be determined by the Board, but initially at a frequency of three times per year.

IF APPROPRIATE –

Licensee will not order or dispense any controlled substance, nor shall Licensee store any controlled substance in his/her office.

Licensee shall immediately begin using pre-numbered triplicate prescription pads for prescribing controlled substances. Said prescription pads will be provided to the Licensee, at his/her expense, by the Board. Said prescriptions shall be used in their numeric order. Prior to the 15th day of each month, Licensee shall submit to the Board office, one copy of each triplicate prescription used during the previous month. The second copy to the triplicate set shall be maintained in the file of the patient for whom the prescription was written. In the event of a telephone prescription, Licensee shall submit two copies of the prescription to the Board monthly. In the event any prescription is not used, Licensee shall mark all three copies void and submit them to the Board monthly.

Licensee shall maintain a dental practice environment in which nitrous oxide is not present or available for any purpose, or establish a Board approved plan to assure that Licensee does not have singular access to nitrous oxide. The Board must approve the proposed plan before implementation.

Licensee shall immediately surrender his/her Drug Enforcement Administration Registration.

STANDARD PROTOCOLS FORCONSENT ORDERS SPECIFICALLY RELATED TO SEXUAL VIOLATIONS

SEX RELATED VIOLATIONS

Licensee shall, for an indefinite length of time, be subject to the following conditions of this Consent Order:

Licensee shall not apply for relief from these conditions within five years of the effective date of the Order, and then must do so in writing.

Licensee shall undergo an assessment by a Board approved evaluator, within 30 days of the effective date of the Order, and make the written evaluation and treatment recommendations available to the Board.

Licensee shall adhere to, participate in, and complete all aspects of any and all residential care programs, continuing care programs and recovery treatment plans recommended by Board approved care providers and arrange for a written copy of all plans, programs, and contracts to be provided to the Board within 30 days of the effective date of the Order.

Licensee shall advise the Board, in writing, of any change or alteration to any residential care programs, continuing care programs, and recovery treatment plans 14 days before the change goes into effect.

Licensee shall instruct all health care providers participating in the residential, continuing care, and recovery programs to respond promptly to any Oregon Board of Dentistry inquiry concerning Licensee's compliance with the treatment plan and to immediately report to the Board, any substantial failure to fully participate in the programs by the Licensee. Licensee shall instruct the foregoing professionals to make written quarterly reports to the Board of Licensee's progress and compliance with the treatment programs.

Licensee shall waive any privilege with respect to any physical, psychiatric, or psychological evaluation or treatment in favor of the Board for the purposes of determining compliance with this Order, or the need to modify this Order, and shall execute any waiver or release upon request of the Board.

Licensee shall submit to a polygraph examination or plethysmograph examination, at Licensee's expense, at the direction of the Board or a counseling provider.

Licensee shall advise the Board, within 72 hours, of any substantial failure to participate in any recommended recovery program.

Licensee shall personally appear before the Board, or its designated representative(s), at a frequency to be determined by the Board, but initially at a frequency of three times per year.

IF APPROPRIATE –

Require Licensee to advise his/her dental staff or his/her employer of the terms of the Consent Order at least on an annual basis. Licensee shall provide the Board with documentation attesting that each dental staff member or employer reviewed the Consent Order. In the case of a Licensee adding a new employee, the Licensee shall advise the individual of the terms of the Consent Order on the first day of employment and shall provide the Board with documentation attesting to that advice.

STANDARD PROTOCOLS FOR CONSENT ORDERS REQUIRING CLOSE SUPERVISION

CLOSE SUPERVISION

a. For a period of at least six months, Licensee shall only practice dentistry in Oregon under the close supervision of a Board approved, Oregon licensed dentist (Supervisor), in order to demonstrate that clinical skills meet the standard of care. Periods of time Licensee does not practice dentistry as a dentist in Oregon, shall not apply to reduction of the (six) month requirement

b. Licensee will submit the names of any other supervising dentists for Board approval. Licensee will immediately advise the Board of any change in supervising dentists.

c. Licensee shall only treat patients when another Board approved Supervisor is physically in the office and shall not be solely responsible for emergent care.

d. The Supervisor will review and co-sign Licensee's treatment plans, treatment notes, and prescription orders.

e. Licensee will maintain a log of procedures performed by Licensee. The log will include the patient's name, the date of treatment, and a brief description of the procedure. The Supervisor will review and co-sign the log. Prior to the 15th of each month, Licensee will submit the log of the previous month's treatments to the Board.

f. For a period of two weeks, or longer if deemed necessary by the Supervisor, the Supervisor will examine the appropriate stages of dental work performed by Licensee in order to determine clinical competence.

g. After two weeks, and for each month thereafter for a period of six months, the Supervisor will submit a written report to the Board describing Licensee's level of clinical competence. At the end of six months, the Supervisor, will submit a written report attesting to the level of Licensee's competency to practice dentistry in Oregon.

h. At the end of the restricted license period, the Board will re-evaluate the status of Licensee's dental license. At that time, the Board may extend the restricted license period, lift the license restrictions, or take other appropriate action.

STANDARD PROTOCOLS – DEFINITIONS

Group practice: On 10/10/08, the Board defined “group practice” as two or more Oregon licensed dentists, one of which may be a respondent, practicing in the same business entity and in the same physical location.

When ordering a licensee to practice only in a group practice, add the caveat, “**Periods of time Licensee is not practicing dentistry as a dentist in Oregon, shall not apply to reduction of the (five year) requirement.**

STANDARD PROTOCOLS – PARAGRAPHS

WHEREAS, based on the results of an investigation, the Board has filed a Notice of Proposed Disciplinary Action, dated XXX, and hereby incorporated by reference; and

APPROVAL OF MINUTES

OREGON BOARD OF DENTISTRY
MINUTES
August 19, 2016

MEMBERS PRESENT: Julie Ann Smith, D.D.S., M.D., M.C.R., President
Todd Beck, D.M.D., Vice President
Amy B. Fine, D.M.D.
Alton Harvey Sr.
Jose Javier, D.D.S.
Yadira Martinez, R.D.H.
James Morris
Alicia Riedman, R.D.H.
Brandon Schwindt, D.M.D.
Gary Underhill, D.M.D.

STAFF PRESENT: Stephen Prisby, Executive Director
Paul Kleinstub, D.D.S., M.S., Dental Director/Chief Investigator
Daryll Ross, Investigator (portion of meeting)
Harvey Wayson, Investigator (portion of meeting)
Daniel Blickenstaff, D.D.S., Investigator (portion of meeting)
Michelle Lawrence, D.M.D., Consultant (portion of meeting)
Teresa Haynes, Acting Office Manager (portion of meeting)
Haley Huntington, Office Specialist (portion of meeting)

ALSO PRESENT: Lori Lindley, Sr. Assistant Attorney General

VISITORS PRESENT: Lynn Ironside, R.D.H., ODHA; Kyle Johnstone, ODHA; Conor McNulty, ODA; Mary Harrison, ODAA; Ken Yates, ODA; Phillip T. Marucha, D.M.D., OHSU; Sean Benson, D.D.S., OHSU; Pamela Lynch, R.D.H, EPDH; Denise Fjordbeck, Dept. of Justice; Harold Hickock; Adele Montgomery; Tom Riedman; Caroline Maier, R.D.H.; James Brown; Thomas Haymore, D.M.D.

Call to Order: The meeting was called to order by the President at 7:32 a.m. at the Board office; 1500 SW 1st Ave., Suite 770, Portland, Oregon.

NEW BUSINESS

MINUTES

Dr. Fine moved and Mr. Harvey seconded that the minutes of the June 17, 2016 Board meeting be approved as amended. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

Dr. Javier moved and Dr. Fine seconded that the minutes of the July 13, 2016 Special Teleconference Board meeting be approved as presented. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

ASSOCIATION REPORTS

Oregon Dental Association
Conor McNulty, ODA Executive Director, introduced Ken Yates, ODA, Director of Government Affairs. Mr. McNulty reported positive progress with workforce discussions and the pilot program process. Mr. McNulty also reported on Water Treatment Notice by municipalities and the ODA's support of public process regarding the 90 day notice of addition or deletion to fluoride in the water system that will be entering into the legislative session.

Oregon Dental Hygienists' Association
Ms. Ironside reported that the Annual ODHA Conference will be taking place November 11-13, 2016 and introduced Kyle Johnstone, ODHA. Mr. Johnstone reported that the ODHA will be providing training for registered dental hygienists to work with older patients more effectively and that the ODHA is working to expand dental healthcare practices to underserved populations in Oregon.

Oregon Dental Assistants Association
Ms. Harrison reported that the ODAA and DANB are providing a scholarship for ODAA members looking to expand their certificate.

COMMITTEE AND LIAISON REPORTS

WREB Liaison Report
Ms. Martinez reported that she attended the Dental Examiner Review Board (DERB) meeting and that there were not any major changes in WREB examinations. Dr. Fine reported that WREB passed a rule that will not allow anyone that holds a place of leadership, such as a committee member, to also hold a place of leadership within a different testing organization. Dr. Fine stated that a WREB Operative Committee meeting will be held in October.

AADB Liaison Report
Dr. Beck reported that he has been assigned to a taskforce for a dental compact that includes Oregon looking to adjoin multiple states under common licensure regulations to increase portability of licensees. Dr. Beck also stated that the next meeting will be held October 18-19 and that more information will be available after he attends the meeting.

ADEX Liaison Report
Dr. Fine reported that she attended their annual meeting in Chicago, Illinois and a Patient-Centered Curriculum Integrated Format has been implemented in regard to patient involvement in exams. This format allows for a student exam to occur during a regular school day, ensuring that the patient is a patient of record.

CDCA Liason Report
Dr. Fine reported that the CDCA is looking to combine the two annual meetings into one annual meeting.

Committee Meetings
Rules Oversight Committee recommends the following rules be moved to a public rulemaking hearing on October 20, 2016:

OAR 818-001-0082 – Access to Public Records

(1) Public records not exempt from disclosure may be inspected during office hours at the Board office upon reasonable notice.
(2) Copies of public records not exempt from disclosure may be purchased **upon receipt of a written request**. The Board may withhold copies of public records until the requestor pays for the copies.
(3) The Board establishes the following fees:
(a) $25 per hour for the time required to locate and remove non-public records or for filling special requests;
(b) Up to ten (10) pages at no cost; more than 10 pages, $0.50 for each page plus postage necessary to mail the copies;
(c) $0.10 per name and address for computer-generated lists on paper or labels; $0.20 per name and address for computer-generated lists on paper or labels sorted by specific zip code;
(d) Data files on diskette or CD:
(A) All Licensed Dentists -- $50;
(B) All Licensed Dental Hygienists -- $50;
(C) All Licensees -- $100.
(e) $60 per year for copies of minutes of all Board and committee meetings;
(f) Written verification of licensure -- $2.50 per name; and
(g) Certificate of Standing -- $20.

Stat. Auth.: ORS 183, 192, 670 & 679
Stats. Implemented: ORS 192.420, 192.430 & 192.440
Hist.: DE 11-1984, f. & ef. 5-17-84; DE 1-1988, f. 12-28-88, cert. ef. 2-1-89, DE 1-1989, f. 1-27-89, cert. ef. 2-1-89; Renumbered from 818-001-0080; DE 1-1990, f. 3-19-90, cert. ef. 4-2-90; DE 1-1991(Temp), f. 8-5-91, cert. ef. 8-15-91; DE 2-1991, f. & cert. ef. 12-31-91; OBD 3-1999, f. 6-25-99, cert. ef. 7-1-99

Dr. Schwindt moved and Dr. Fine seconded that the Board move OAR 818-001-0082 – Access to Public Records as presented to a public rulemaking hearing on October 20, 2016. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

OAR 818-001-0083 – Relief from Public Disclosure

Upon the receipt of a written request of an individual who has been disciplined by the Oregon Board of Dentistry, the Board shall remove from its website, and other publicly accessible print and electronic publications under the Board's control, all information related to disciplining the individual under ORS 679.140 and any findings and conclusions made by the Board during the disciplinary proceeding, if:
(1) The request is made 10 years or more after the date on which any disciplinary sanction ended;
(2) The individual was not disciplined for financially or physically harming a patient as determined by the Board;
(3) The individual informed the Board of the matter for which the individual was disciplined before the Board received information about the matter or otherwise had knowledge of the matter;

(4) The individual making the request, if the individual is or was a licensee, has not been subjected to other disciplinary action by the Board following the imposition of the disciplinary sanction; and
(5) The individual fully complied with all disciplinary sanctions imposed by the Board.

Dr. Schwindt moved and Dr. Fine seconded that the Board move OAR 818-001-0083 – Relief from Public Disclosure as presented to a public rulemaking hearing on October 20, 2016. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

OAR 818-001-0087 – Fees

(1) The Board adopts the following fees:
(a) Biennial License Fees:
(A) Dental —$390;
(B) Dental — retired — $0;
(C) Dental Faculty — $335;
(D) Volunteer Dentist — $0;
(E) Dental Hygiene —$230;
(F) Dental Hygiene — retired — $0;
(G) Volunteer Dental Hygienist — $0.
(b) Biennial Permits, Endorsements or Certificates:
(A) Nitrous Oxide Permit — $40;
(B) Minimal Sedation Permit — $75;
(C) Moderate Sedation Permit — $75;
(D) Deep Sedation Permit — $75;
(E) General Anesthesia Permit — $140;
(F) Radiology — $75;
(G) Expanded Function Dental Assistant — $50;
(H) Expanded Function Orthodontic Assistant — $50;
(I) Instructor Permits — $40;
(J) Dental Hygiene Restorative Functions Endorsement — $50;
(K) Restorative Functions Dental Assistant — $50;
(L) Anesthesia Dental Assistant — $50;
(M) Dental Hygiene, Expanded Practice Permit — $75;
(N) Non-Resident Dental ~~Permit~~ **Background Check** - $100.00;
(c) Applications for Licensure:
(A) Dental — General and Specialty — $345;
(B) Dental Faculty — $305;
(C) Dental Hygiene — $180;
(D) Licensure Without Further Examination — Dental and Dental Hygiene — $790.
(d) Examinations:
(A) Jurisprudence — $0;
~~(B) Dental Specialty:~~
~~(i) If only one candidate applies for the exam, a fee of $2,000.00 will be required at the time of application; and~~
~~(ii) If two candidates apply for the exam, a fee of $1,000.00 will be required at the time of application; and~~
~~(iii) If three or more candidates apply for the exam, a fee of $750.00 will be required at the time~~

~~of application.~~
(e) Duplicate Wall Certificates — $50.
(2) Fees must be paid at the time of application and are not refundable.
(3) The Board shall not refund moneys under $5.01 received in excess of amounts due or to which the Board has no legal interest unless the person who made the payment or the person's legal representative requests a refund in writing within one year of payment to the Board.

Stat. Auth.: ORS 679 & 680
Stats. Implemented: ORS 293.445, 679.060, 679.115, 679.120, 679.250, 680.050, 680.075, 680.200 & 680.205
Hist.: DE 6-1985(Temp), f. & ef. 9-20-85; DE 3-1986, f. & ef. 3-31-86; DE 1-1987, f. & ef. 10-7-87; DE 1-1988, f. 12-28-88, cert. ef. 2-1-89, corrected by DE 1-1989, f. 1-27-89, cert. ef. 2-1-89; Renumbered from 818-001-0085; DE 2-1989(Temp), f. & cert. ef. 11-30-89; DE 1-1990, f. 3-19-90, cert. ef. 4-2-90; DE 1-1991(Temp), f. 8-5-91, cert. ef. 8-15-91; DE 2-1991, f. & cert. ef. 12-31-91; DE 1-1992(Temp), f. & cert. ef. 6-24-92; DE 2-1993, f. & cert. ef. 7-13-93; OBD 1-1998, f. & cert. ef. 6-8-98; OBD 3-1999, f. 6-25-99, cert. ef. 7-1-99; Administrative correction, 8-2-99; OBD 5-2000, f. 6-22-00, cert. ef. 7-1-00; OBD 8-2001, f. & cert. ef. 1-8-01; OBD 2-2005, f. 1-31-05, cert. ef. 2-1-05; OBD 2-2007, f. 4-26-07, cert. ef. 5-1-07; OBD 3-2007, f. & cert. ef. 11-30-07; OBD 1-2009(Temp), f. 6-11-09, cert. e. 7-1-09 thru 11-1-09; OBD 2-2009, f. 10-21-09, cert. ef. 11-1-09; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 3-2011(Temp), f. 6-30-11, cert. ef. 7-1-11 thru 12-27-11; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 1-2012, f. & cert. ef. 1-27-12; OBD 1-2013, f. 5-15-13, cert. ef. 7-1-13; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14; OBD 2-2015(Temp), f. & cert. ef. 6-26-15 thru 12-22-15; OBD 3-2015, f. 9-8-15, cert. ef. 10-1-15

Dr. Schwindt moved and Dr. Beck seconded that the Board move OAR 818-001-0087 Fees as presented to a public rulemaking hearing on October 20, 2016. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

OAR 818-012-0005 – Scope of Practice

(1) No dentist may perform any of the procedures listed below:
(a) Rhinoplasty;
(b) Blepharoplasty;
(c) Rhydidectomy;
(d) Submental liposuction;
(e) Laser resurfacing;
(f) Browlift, either open or endoscopic technique;
(g) Platysmal muscle plication;
(h) Otoplasty;
(i) Dermabrasion;
~~(j) Lip augmentation;~~
(j) ~~(k)~~ Hair transplantation, not as an isolated procedure for male pattern baldness; and
(k) ~~(l)~~ Harvesting bone extra orally for dental procedures, including oral and maxillofacial procedures.
(2) Unless the dentist:
(a) Has successfully completed a residency in Oral and Maxillofacial Surgery accredited by the American Dental Association, Commission on Dental Accreditation (CODA), ~~and~~
~~(b) Has successfully completed a clinical fellowship, of at least one continuous year in duration,~~

~~in esthetic (cosmetic) surgery recognized by the American Association of Oral and Maxillofacial Surgeons or by the American Dental Association Commission on Dental Accreditation~~**,** or
(b) ~~(c)~~ Holds privileges either:
(A) Issued by a credentialing committee of a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to perform these procedures in a hospital setting; or
(B) Issued by a credentialing committee for an ambulatory surgical center licensed by the State of Oregon and accredited by either the JCAHO or the Accreditation Association for Ambulatory Health Care (AAAHC).
(3) A dentist may utilize Botulinum Toxin Type A **and dermal fillers** to treat a condition that is within the scope of the practice of dentistry after completing a minimum of ~~16~~ **20** hours in a hands on clinical course(s)**, which includes both Botulimum Toxin Type A and dermal fillers, and** ~~in which~~ the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP).
Stat. Auth.: ORS 679 & 680
Stats. Implemented: ORS 679.010(2), 679.140(1)(c), 679.140(2), 679.170(6) & 680.100
Hist.: OBD 6-2001, f. & cert. ef. 1-8-01; OBD 1-2013, f. 5-15-13, cert. ef. 7-1-13; OBD 3-2013, f. 10-24-13, cert. ef. 1-1-14; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-1

Dr. Schwindt moved and Dr. Beck seconded that the Board move OAR 818-012-0005 – Scope of Practice as amended to a public rulemaking hearing on October 20, 2016. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

OAR 818-012-0010 – Unacceptable Patient Care

The Board finds, using the criteria set forth in ORS 679. 140(4), that a licensee engages in or permits the performance of unacceptable patient care if the licensee does or permits any person to:
(1) Provide treatment which exposes a patient to risk of harm when equivalent or better treatment with less risk to the patient is available.
(2) Fail to seek consultation whenever the welfare of a patient would be safeguarded or advanced by having recourse to those who have special skills, knowledge and experience; provided, however, that it is not a violation of this section to omit to seek consultation if other competent licensees in the same locality and in similar circumstances would not have sought such consultation.
(3) Fail to provide or arrange for emergency treatment for a patient currently receiving treatment.
(4) Fail to exercise supervision required by the Dental Practice Act over any person or permit any person to perform duties for which the person is not licensed or certified.
(5) Render services which the licensee is not licensed to provide.
(6) Fail to comply with ORS 453.605 to 453.755 or rules adopted pursuant thereto relating to the use of x-ray machines.
(7) Fail to maintain patient records in accordance with OAR 818-012-0070.
(8) Fail to provide goods or services in a reasonable period of time which are due to a patient pursuant to a contract with the patient or a third party.
(9) Attempt to perform procedures which the licensee is not capable of performing due to physical or mental disability.

(10) Perform any procedure for which the patient or patient's guardian has not previously given informed consent provided, however, that in an emergency situation, if the patient is a minor whose guardian is unavailable or the patient is unable to respond, a licensee may render treatment in a reasonable manner according to community standards.
(11) Use the behavior management technique of Hand Over Mouth (HOM) without first obtaining informed consent for the use of the technique.
(12) Use the behavior management technique of Hand Over Mouth Airway Restriction (HOMAR) on any patient.
(13) Fail to determine and document a dental justification prior to ordering a Cone Beam CT series with field greater than 10x10 cm for patients under 20 years of age where pathology, anatomical variation or potential treatment complications would not be otherwise visible with a Full Mouth Series, Panoramic or Cephalometric radiographs.
(14) Fail to advise a patient of any treatment complications or treatment outcomes.

Stat. Auth.: ORS 679 & ORS 680
Stats. Implemented: ORS 679.140(1)(e), ORS 679.140(4) & ORS 680.100
Hist.: DE 6, f. 8-9-63, ef. 9-11-63; DE 14, f. 1-20-72, ef. 2-10-72; DE 5-1980, f. & ef. 12-26-80; DE 2-1982, f. & ef. 3-19-82; DE 5-1982, f. & ef. 5-26-82; DE 9-1984, f. & ef. 5-17-84; Renumbered from 818-010-0080; DE 3-1986, f. & ef. 3-31-86; DE 1-1988, f. 12-28-88, cert. ef. 2-1-89, DE 1-1989, f. 1-27-89, cert. ef. 2-1-89; Renumbered from 818-011-0020; DE 2-1997, f. & cert. ef. 2-20-97; DE 3-1997, f. & cert. ef. 8-27-97; OBD 7-2001, f. & cert. ef. 1-8-01

Dr. Schwindt moved and Dr. Underhill seconded that the Board move OAR 818-012-0010 – Unacceptable Patient Care as presented to a public rulemaking hearing on October 20, 2016. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

OAR 818-012-0030 – Unprofessional Conduct

~~The Board finds that in addition to the conduct set forth in ORS 679.140(2), a licensee engages in unprofessional conduct if the licensee does or permits any person to:~~ **The Board finds that in addition to the conduct set forth in ORS 679.140(2), unprofessional conduct includes, but is not limited to, the following in which a licensee does or knowingly permits any person to:**
(1) Attempt to obtain a fee by fraud**,** or misrepresentation.
(2) Obtain~~ing~~ a fee by fraud**,** or misrepresentation.
(a) A licensee obtains a fee by fraud if the licensee ~~obtains a fee by~~ knowingly mak~~ing~~**es,** or permit~~ting~~**s** any person to make**,** a material, false statement intending that a recipient**,** who is unaware of the truth**,** rely upon the statement.
(b) A licensee obtains a fee by misrepresentation if the licensee obtains a fee through making or permitting any person to make a material, false statement.
(c) Giving cash discounts and not disclosing them to third party payers is not fraud or misrepresentation.
(3) Offer rebates, split fees, or commissions for services rendered to a patient to any person other than a partner, employee, or employer.
(4) Accept rebates, split fees, or commissions for services rendered to a patient from any person other than a partner, employee, or employer.
(5) Initiate, or engage in, with a patient, any behavior with sexual connotations. The behavior can include but is not limited to, inappropriate physical touching; kissing of a sexual nature;

gestures or expressions, any of which are sexualized or sexually demeaning to a patient; inappropriate procedures, including, but not limited to, disrobing and draping practices that reflect a lack of respect for the patient's privacy; or initiating inappropriate communication, verbal or written, including, but not limited to, references to a patient's body or clothing that are sexualized or sexually demeaning to a patient; and inappropriate comments or queries about the professional's or patient's sexual orientation, sexual performance, sexual fantasies, sexual problems, or sexual preferences.
(6) Engage in an unlawful trade practice as defined in ORS 646.605 to 646.608.
(7) Fail to present a treatment plan with estimated costs to a patient upon request of the patient or to a patient's guardian upon request of the patient's guardian.
(8) Misrepresent any facts to a patient concerning treatment or fees.
(9)(a) Fail to provide a patient or patient's guardian within 14 days of written request:
(A) Legible copies of records; and
(B) Duplicates of study models**,** ~~and~~radiographs **of the same quality as the originals, and** photographs ~~or legible copies thereof~~ if the**y** ~~radiographs, photographs or study models~~ have been paid for.
(b) The dentist may require the patient or guardian to pay in advance a fee reasonably calculated to cover the costs of making the copies or duplicates. The dentist may charge a fee not to exceed $30 for copying 10 or fewer pages of written material and no more than $0.50 per page for pages 11 through 50 and no more than $0.25 for each additional page (including records copied from microfilm), plus any postage costs to mail copies requested and actual costs of preparing an explanation or summary of information, if requested. The actual cost of duplicating ~~x-rays~~ **radiographs** may also be charged to the patient. Patient records or summaries may not be withheld from the patient because of any prior unpaid bills, except as provided in (9)(a)(B) of this rule.
(10) Fail to identify to a patient, patient's guardian, or the Board the name of an employee, employer, contractor, or agent who renders services.
(11) Use prescription forms pre-printed with any Drug Enforcement Administration number, name of controlled substances, or facsimile of a signature.
(12) Use a rubber stamp or like device to reproduce a signature on a prescription form or sign a blank prescription form.
(13) Order drugs listed on Schedule II of the Drug Abuse Prevention and Control Act, 21 U.S.C. Sec. 812, for office use on a prescription form.
(14) Violate any Federal or State law regarding controlled substances.
(15) Becomes addicted to, or dependent upon, or abuses alcohol, illegal or controlled drugs, or mind altering substances**, or practice with an untreated substance use disorder diagnosis that renders the licensee unable to safely conduct the practice of dentistry or dental hygiene.**
(16) Practice dentistry or dental hygiene in a dental office or clinic not owned by an Oregon licensed dentist(s), except for an entity described under ORS 679.020(3) and dental hygienists practicing pursuant to ORS 680.205(1)(2).
(17) Make an agreement with a patient or person, or any person or entity representing patients or persons, or provide any form of consideration that would prohibit, restrict, discourage or otherwise limit a person's ability to file a complaint with the Oregon Board of Dentistry; to truthfully and fully answer any questions posed by an agent or representative of the Board; or to participate as a witness in a Board proceeding.
(18) Fail to maintain at a minimum a current BLS for Healthcare Providers certificate or its equivalent. (Effective January 2015).
(19) Conduct unbecoming a licensee or detrimental to the best interests of the public,

including conduct contrary to the recognized standards of ethics of the licensee's profession or conduct that endangers the health, safety or welfare of a patient or the public.
(20) Knowingly deceiving or attempting to deceive the Board, an employee of the Board, or an agent of the Board in any application or renewal, or in reference to any matter under investigation by the Board. This includes but is not limited to the omission, alteration or destruction of any record in order to obstruct or delay an investigation by the Board, or to omit, alter or falsify any information in patient or business records.
(21) Knowingly practicing with a physical or mental impairment that renders the Licensee unable to safely conduct the practice of dentistry or dental hygiene.
(22) Take any action which could reasonably be interpreted to constitute harassment or retaliation towards a person whom the licensee believes to be a complainant or witness.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 679 & 680
Stats. Implemented: ORS 679.140(1)(c), 679.140(2), 679.170(6) & 680.100
Hist.: DE 6, f. 8-9-63, ef. 9-11-63; DE 14, f. 1-20-72, ef. 2-10-72; DE 5-1980, f. & ef. 12-26-80; DE 2-1982, f. & ef. 3-19-82; DE 5-1982, f. & ef. 5-26-82; DE 9-1984, f. & ef. 5-17-84; Renumbered from 818-010-0080; DE 3-1986, f. & ef. 3-31-86; DE 1-1988, f. 12-28-88, cert. ef. 2-1-89; DE 1-1989, f. 1-27-89, cert. ef. 2-1-89; Renumbered from 818-011-0020; DE 1-1990, f. 3-19-90, cert. ef. 4-2-90; DE 2-1997, f. & cert. ef. 2-20-97; OBD 3-1999, f. 6-25-99, cert. ef. 7-1-99; OBD 1-2006, f. 3-17-06, cert. ef. 4-1-06; OBD 1-2007, f. & cert. ef. 3-1-07; OBD 3-2007, f. & cert. ef. 11-30-07; OBD 1-2008, f. 11-10-08, cert. ef. 12-1-08; OBD 2-2009, f. 10-21-09, cert. ef. 11-1-09; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14; OBD 3-2015, f. 9-8-15, cert. ef. 10-1-15

Dr. Schwindt moved and Dr. Underhill seconded that the Board move OAR 818012-0030 – Unprofessional Conduct as presented to a public rulemaking hearing on October 20, 2016. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

OAR 818-012-0032 – Diagnostic Records

1) Licensees shall provide duplicates of physical diagnostic records that have been paid for to patient or patient's guardian within 14 days of written request.
(A) Physical records include silver emulsion radiographs, physical study models, paper charting and chart notes.
(B) Licensees may require the patient or patient's guardian to pay in advance the fee reasonably calculated to cover costs of making the copies or duplicates.
(i) Licensee may charge a fee not to exceed $30 for copying 10 or fewer pages of written material and no more than $0.50 per page for 11-50 and no more than $0.25 for each additional page, including cost of microfilm plus any postage costs to mail copies requested and actual costs of preparing an explanation or summary of information, if requested. The actual costs of duplicating radiographs may also be charged to the patient.
2) Licensees shall provide duplicates of digital patient records within 5 clinical days of written request by the patient or patient's guardian.

A) Digital records include any patient diagnostic image, study model, test result or chart record in digital form.
B) Licensees may require the patient or patient's guardian to pay for the typical retail cost of the digital storage device, such as a CD, thumb drive, or DVD as well as associated postage.
C) Licensees shall not charge any patient or patient's guardian to transmit requested digital records over email if total records do not exceed 25 Mb.
D) A clinical day is defined as a day during which the dental clinic treated scheduled patients.
E) Licensees may charge up to $5 for duplication of digital records up to 25Mb and up to $30 for more than 25Mb.
F) Any transmission of patient records shall be in compliance with the Health Insurance Portability and Accountability Act (HIPAA Act) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act).
G) Duplicated digital records shall be of the same quality as the original digital file.
3) If a records summary is requested by patient or patient's guardian, the actual cost of creating this summary and its transmittal may be billed to the patient or patient's guardian.

Dr. Schwindt moved and Dr. Beck seconded that the Board move OAR 818-012-0032 – Diagnostic Records as amended to a public rulemaking hearing on October 20, 2016. The motion passed with Dr. Smith, Dr. Beck, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye. Dr. Fine voted no.

OAR 818-012-0040 – Infection Control Guidelines

In determining what constitutes unacceptable patient care with respect to infection control, the Board may consider current infection control guidelines such as those of the Centers for Disease Control and Prevention and the American Dental Association.
(1) Additionally, licensees must comply with the following requirements:
(**a**) (~~1~~)Disposable gloves shall be worn whenever placing fingers into the mouth of a patient or when handling blood or saliva contaminated instruments or equipment. Appropriate hand hygiene shall be performed prior to gloving.
(**b**) (~~2~~)Masks and protective eyewear or chin-length shields shall be worn by licensees and other dental care workers when spattering of blood or other body fluids is likely.
(**c**)(~~3~~) Between each patient use, instruments or other equipment that come in contact with body fluids shall be sterilized.
(**d**) (~~4~~)Environmental surfaces that are contaminated by blood or saliva shall be disinfected with a chemical germicide which is mycobactericidal at use.
(**e**)(~~5~~) Impervious backed paper, aluminum foil, or plastic wrap may be used to cover surfaces that may be contaminated by blood or saliva and are difficult or impossible to disinfect. The cover shall be replaced between patients.
(**f**) (~~6~~)All contaminated wastes and sharps shall be disposed of according to any governmental requirements.
(2) Dentists must comply with the requirement that heat sterilizing devices shall be tested for proper function by means of a biological monitoring system that indicates micro-organisms kill each calendar week in which scheduled patients are treated. Testing results shall be retained by the **dentist** ~~licensee~~ for the current calendar year and the two preceding calendar years.

Stat. Auth.: ORS 679.120, 679.250(7), **679.535,** 680.075 & 680.150
Stats. Implemented: ORS 679.140, 679.140(4) & 680.100
Hist.: DE 1-1988, f. 12-28-88, cert. ef. 2-1-89; DE 1-1989, f. 1-27-89, cert. ef. 2-1-89; DE 2-1992, f. & cert. ef. 6-24-92; OBD 1-2004, f. 5-27-04, cert. ef. 6-1-04; OBD 1-2008, f. 11-10-08, cert. ef. 12-1-08; OBD 3-2013, f. 10-24-13, cert. ef. 1-1-14; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14

Dr. Schwindt moved and Dr. Morris seconded that the Board move OAR 818-012-0040 – Infection Control as presented to a public rulemaking hearing on October 20, 2016. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

OAR 818-012-0060 – Failure to Cooperate with Board

(1) No licensee shall:
(~~1~~**a**) Fail to report to the Board violations of the Dental Practice Act.
(~~2~~**b**) Use threats or harassment to delay or obstruct any person in providing evidence in any investigation, contested case, or other legal action instituted by the Board.
(~~3~~**c**) Discharge an employee based primarily on the employee's attempt to comply with or aid in the compliance with the Dental Practice Act.
(~~4~~**d**) Use threats or harassment to obstruct or delay the Board in carrying out its functions under the Dental Practice Act.
(~~5~~**e**) Deceive or attempt to deceive the Board with respect to any matter under investigation including altering or destroying any records.
(~~6~~**f**) Make an untrue statement on any document, letter, or application submitted to the Board.
(~~7~~**g**) Fail to temporarily surrender custody of original patient records to the Board when the Board makes a written request for the records. For purposes of this rule, the term records includes, but is not limited to, the jacket, treatment charts, models, radiographs, photographs, health histories, billing documents, correspondence and memoranda.
(h) Fail to attend a Board requested investigative interview or failure to fully cooperate in any way with an ongoing Board investigation.
(2) No ~~person~~ **applicant** shall:
(~~8~~**a**) Deceive or attempt to deceive the Board with respect to any matter under investigation including altering or destroying any records.
(~~9~~**b**) Make an untrue statement on any document, letter, or application submitted to the Board.
(c) Fail to fully cooperate with the Board during the course of an investigation, including but not limited to, waiver of confidentiality privileges, except attorney-client privilege.

Stat. Auth.: ORS 679 & 680
Stats. Implemented: ORS 679.060(4), 679.170(5), 679.250(8), 679.290, 679.310(1), 680.050(4) & 680.100
Hist.: DE 9-1984, f. & ef. 5-17-84; DE 1-1988, f. 12-28-88, cert. ef. 2-1-89; DE 1-1989, f. -27-89, cert. ef. 2-1-89; Renumbered from 818-011-0050; DE 2-1997, f. & cert. ef. 2-20-97; OBD 1-2008, f. 11-10-08, cert. ef. 12-1-08

Dr. Schwindt moved and Dr. Underhill seconded that the Board move OAR 818-012-0060 – Failure to Cooperate with Board as presented to a public rulemaking hearing on October 20, 2016. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, and Dr. Underhill voting aye.

OAR 818-012-0070 – Patient Records

(1) Each licensee shall have prepared and maintained an accurate record for each person receiving dental services, regardless of whether any fee is charged. The record shall contain the name of the licensee rendering the service and include:
(a) Name and address and, if a minor, name of guardian;
(b) Date description of examination and diagnosis;
(c) An entry that informed consent has been obtained and the date the informed consent was obtained. Documentation may be in the form of an acronym such as "PARQ" (Procedure, Alternatives, Risks and Questions) or "SOAP" (Subjective Objective Assessment Plan) or their equivalent.
(d) Date and description of treatment or services rendered;
(e) Date ~~and~~**,** description **and documentation of informing the patient** of treatment complications **or treatment outcomes**;
(f) Date and description of all radiographs, study models, and periodontal charting;
(g) Health history; and
(h) Date, name of, quantity of, and strength of all drugs dispensed, administered, or prescribed.
(2) Each ~~dentist~~ **licensee** shall have prepared and maintained an accurate record of all charges and payments for services including source of payments.
(3) Each ~~dentist~~ **licensee** shall maintain patient records and radiographs for at least seven years from the date of last entry unless:
(a) The patient requests the records, radiographs, and models be transferred to another ~~dentist~~ **licensee** who shall maintain the records and radiographs;
(b) The ~~dentist~~ **licensee** gives the records, radiographs, or models to the patient; or
(c) The ~~dentist~~ **licensee** transfers the ~~dentist's~~ **licensee's** practice to another ~~dentist~~ **licensee** who shall maintain the records and radiographs.
(4) When changing practice locations, closing a practice location or retiring, each licensee must retain patient records for the required amount of time or transfer the custody of patient records to another licensee licensed and practicing dentistry in Oregon. Transfer of patient records pursuant to this section of this rule must be reported to the Board in writing within 14 days of transfer, but not later than the effective date of the change in practice location, closure of the practice location or retirement. Failure to transfer the custody of patient records as required in this rule is unprofessional conduct.
(5) Upon the death or permanent disability of a licensee, the administrator, executor, personal representative, guardian, conservator or receiver of the former licensee must notify the Board in writing of the management arrangement for the custody and transfer of patient records. This individual must ensure the security of and access to patient records by the patient or other authorized party, and must report arrangements for permanent custody of patient records to the Board in writing within 90 days of the death of the licensee.

Stat. Auth.: ORS 679
Stats. Implemented: ORS 679.140(1)(e) & ORS 679.140(4)
Hist.: DE 9-1984, f. & ef. 5-17-84; DE 1-1988, f. 12-28-88, cert. ef. 2-1-89, DE 1-1989, f. 1-27-90, cert. ef. 2-1-90; Renumbered from 818-011-0060; DE 1-1990, f. 3-19-90, cert. ef. 4-2-90; OBD 7-2001, f. & cert. ef. 1-8-01

Dr. Schwindt moved and Dr. Underhill seconded that the Board move OAR 818-012-0070 – Patient Records as presented to a public rulemaking hearing on October 20, 2016. The motion

passed with Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

OAR 818-021-0011 – Application for License to Practice Dentistry Without Further Examination

(1) The Oregon Board of Dentistry may grant a license without further examination to a dentist who holds a license to practice dentistry in another state or states if the dentist meets the requirements set forth in ORS 679.060 and 679.065 and submits to the Board satisfactory evidence of:
(a) Having graduated from a school of dentistry accredited by the Commission on Dental Accreditation of the American Dental Association; or
(b) Having graduated from a dental school located outside the United States or Canada, completion of a predoctoral dental education program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association or completion of a postdoctoral General Dentistry Residency program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association, and proficiency in the English language; and
(c) Having passed the dental clinical examination conducted by a regional testing agency or by a state dental licensing authority; and
(d) Holding an active license to practice dentistry, without restrictions, in any state; including documentation from the state dental board(s) or equivalent authority, that the applicant was issued a license to practice dentistry, without restrictions, and whether or not the licensee is, or has been, the subject of any final or pending disciplinary action; and
(e) Having conducted licensed clinical practice in Oregon, other states or in the Armed Forces of the United States, the United States Public Health Service or the United States Department of Veterans Affairs for a minimum of 3,500 hours in the five years immediately ~~prior~~ **preceding** ~~to~~ application. **Having conducted licensed clinical practice in Oregon for a minimum of 3,500 hours in the five years immediately prior to application for licensed dentists employed by a dental education program, CODA accredited dental school, with documentation from the dean or appropriate administration of the institution regarding length and terms of employment, the applicant's duties and responsibilities, the actual hours involved in teaching clinical dentistry, and any adverse actions or restrictions**; and
(f) Having completed 40 hours of continuing education in accordance with the Board's continuing education requirements contained in these rules within the two years immediately preceding application.
(2) Applicants must pass the Board's Jurisprudence Examination.
(3) A dental license granted under this rule will be the same as the license held in another state; i.e., if the dentist holds a general dentistry license, the Oregon Board will issue a general (unlimited) dentistry license. If the dentist holds a license limited to the practice of a specialty, the Oregon Board will issue a license limited to the practice of that specialty. If the dentist holds more than one license, the Oregon Board will issue a dental license which is least restrictive.

Stat. Auth.: ORS 679
Stats. Implemented: ORS 679.060, 679.065, 679.070, 679.080 & 679.090
Hist.: OBD 4-1999, f. 6-25-99, cert. ef. 7-1-99; OBD 4-2001, f. & cert. ef. 1-8-01; OBD 12-2001(Temp), f. & cert. ef. 1-9-01 thru 7-7-01; OBD 14-2001(Temp), f. 8-2-01, cert. ef. 8-15-01 thru 2-10-02; OBD 15-2001, f. 12-7-01, cert. ef. 1-1-02; OBD 1-2002(Temp), f. & cert. ef. 7-17-02 thru 1-12-03; Administrative correction 4-16-03; OBD 1-2003, f. & cert. ef. 4-18-03; OBD 1-

2004, f. 5-27-04, cert. ef. 6-1-04; OBD 3-2004, f. 11-23-04 cert. ef. 12-1-04; OBD 1-2006, f. 3-17-06, cert. ef. 4-1-06

Ms. Riedman moved and Mr. Morris seconded that the Board move OAR 818-021-0011 – Application for License to Practice Dentistry Without Further Examination as amended to a public rulemaking hearing on October 20, 2016. The motion passed Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, and Dr. Underhill voting aye.

OAR 818-021-0025 – Application for License to Practice Dental Hygiene without Further Examination

(1) The Oregon Board of Dentistry may grant a license without further examination to a dental hygienist who holds a license to practice dental hygiene in another state or states if the dental hygienist meets the requirements set forth in ORS 680.040 and 680.050 and submits to the Board satisfactory evidence of:
(a) Having graduated from a dental hygiene program accredited by the Commission on Dental Accreditation of the American Dental Association; or
(b) Having graduated from a dental hygiene program located outside the United States or Canada, completion of not less than one year in a program accredited by the Commission on Dental Accreditation of the American Dental Association, and proficiency in the English language; and
(c) ~~Evidence of~~ ~~h~~**Having** passed the clinical dental hygiene examination conducted by a regional testing agency or by a state dental or dental hygiene licensing authority; and
(d) Holding an active license to practice dental hygiene, without restrictions, in any state; including documentation from the state dental board(s) or equivalent authority, that the applicant was issued a license to practice dental hygiene, without restrictions, and whether or not the licensee is, or has been, the subject of any final or pending disciplinary action; and
(e) Having conducted licensed clinical practice in Oregon, in other states or in the Armed Forces of the United States, the United States Public Health Service, the United States Department of Veterans Affairs~~, or teaching all disciplines of clinical dental hygiene at a dental hygiene education program accredited by the Commission on Dental Accreditation of the American Dental Association~~ for a minimum of 3,500 hours in the five years immediately preceding application. **Having conducted licensed clinical practice in Oregon for a minimum of 3,500 hours in the five years immediately prior to application, f**~~F~~or **licensed** dental hygienists employed by a dental hygiene program, **CODA accredited, with** documentation from the dean or appropriate administration of the institution regarding length and terms of employment, the applicant's duties and responsibilities, the actual hours involved in teaching ~~all disciplines of~~ clinical dental hygiene, and any adverse actions or restrictions; and
(f) Having completed 24 hours of continuing education in accordance with the Board's continuing education requirements contained in these rules within the two years immediately preceding application.
(2) Applicants must pass the Board's Jurisprudence Examination.

Stat. Auth.: ORS 680
Stats. Implemented: ORS 680.040, 680.050, 680.060, 680.070 & 680.072
Hist.: OBD 4-1999, f. 6-25-99, cert. ef. 7-1-99; OBD 4-2001, f. & cert. ef. 1-8-01; OBD 12-2001(Temp), f. & cert. ef. 1-9-01 thru 7-7-01; OBD 14-2001(Temp), f. 8-2-01, cert. ef. 8-15-01 thru 2-10-02; OBD 15-2001, f. 12-7-01, cert. ef. 1-1-02; OBD 1-2002(Temp), f. & cert. ef. 7-17-02 thru 1-12-03; Administrative correction 4-16-03; OBD 1-2003, f. & cert. ef. 4-18-03; OBD 1-

2004, f. 5-27-04, cert. ef. 6-1-04; OBD 3-2004, f. 11-23-04 cert. ef. 12-1-04; OBD 1-2006, f. 3-17-06, cert. ef. 4-1-06; OBD 2-2009, f. 10-21-09, cert. ef. 11-1-09; OBD 4-2011, f. & cert. ef. 11-15-11

Ms. Riedman moved and Mr. Morris seconded that the Board move OAR 818-021-0025 – Application for License to Practice Dental Hygiene Without Further Examination as amended to a public rulemaking hearing on October 20, 2016. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

OAR 818-035-0040 – Expanded Functions for Dental Hygienists

(1) Upon completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course of instruction approved by the Board, a dental hygienist who completes a Board approved application shall be issued an endorsement to administer local anesthetic agents and local anesthetic reversal agents under the general supervision of a licensed dentist. Local anesthetic reversal agents shall not be used on children less than 6 years of age or weighing less than 33 pounds.
(2) Upon completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course of instruction approved by the Board, a dental hygienist may administer nitrous oxide under the indirect supervision of a licensed dentist in accordance with the Board's rules regarding anesthesia.
(3) Upon completion of a course of instruction approved by the Oregon Health Authority, Public Health Division, a dental hygienist may purchase Epinephrine and administer Epinephrine in an emergency.

Stat. Auth.: ORS 679 & 680
Stats. Implemented: ORS 679.025(2)(j) & 679.250(7)
Hist.: DE 5-1984, f. & ef. 5-17-84; DE 3-1986, f. & ef. 3-31-86; DE 2-1992, f. & cert. ef. 6-24-92; OBD 3-1998, f. & cert. ef. 7-13-98; OBD 7-1999, f. 6-25-99, cert. ef. 7-1-99; OBD 8-1999, f. 8-10-99, cert. ef. 1-1-00; OBD 15-2001, f. 12-7-01, cert. ef. 1-1-02; OBD 2-2007, f. 4-26-07, cert. ef. 5-1-07; OBD 3-2007, f. & cert. ef. 11-30-07; OBD 1-2008, f. 11-10-08, cert. ef. 12-1-08; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14

Dr. Schwindt moved and Dr. Javier seconded that the Board move OAR 818-035-0040 – Expanded Functions for Dental Hygienists as presented to a public rulemaking hearing on October 20, 2016. The motion passed Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

OAR 818-042-0020 – Dentist and Dental Hygienist Responsibility

(1) A dentist is responsible for assuring that a dental assistant has been properly trained, has demonstrated proficiency, and is supervised in all the duties the assistant performs in the dental office. Unless otherwise specified, dental assistants shall work under indirect supervision in the dental office.
(2) A dental hygienist who works under general supervision may supervise ~~a~~ dental assistant**s** in the dental office if the dental assistant**s** ~~is~~ **are** rendering assistance to the dental hygienist in providing dental hygiene services and the dentist is not in the office to provide indirect supervision. A dental hygienist with an Expanded Practice Permit may hire and supervise ~~a~~

dental assistant**s** who will render assistance to the dental hygienist in providing dental hygiene services.
(3) The supervising dentist or dental hygienist is responsible for assuring that all required licenses, permits or certificates are current and posted in a conspicuous place.
(4) Dental assistants who are in compliance with written training and screening protocols adopted by the Board may perform oral health screenings under general supervision.

Stat. Auth.: ORS 679 & 680
Stats. Implemented: ORS 679.025(2)(j) & 679.250(7)
Hist.: OBD 9-1999, f. 8-10-99, cert. ef. 1-1-00; OBD 1-2004, f. 5-27-04, cert. ef. 6-1-04; OBD 2-2012, f. 6-14-12, cert. ef. 7-1-12

Dr. Schwindt moved and Dr. Underhill seconded that the Board move OAR 818-042-0020 – Dentist and Dental Hygienist Responsibility as presented to a public rulemaking hearing on October 20, 2016. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

OAR 818-042-0050 – Taking of X- Rays - Exposing of Radiographs

(1) A dentist may authorize the following persons to place films, adjust equipment preparatory to exposing films, and expose the films under general supervision:
(a) A dental assistant certified by the Board in radiologic proficiency; or
(b) A radiologic technologist licensed by the Oregon Board of Medical Imaging and certified by the Oregon Board of Dentistry (OBD) who has completed ten (10) clock hours in a Board approved dental radiology course and submitted a satisfactory full mouth series of radiographs to the OBD.
(2) A dentist or dental hygienist may authorize a dental assistant who has completed a course of instruction approved by the Oregon Board of Dentistry, and who has passed the written Dental Radiation Health and Safety Examination administered by the Dental Assisting National Board, or comparable exam administered by any other testing entity authorized by the Board, or other comparable requirements approved by the Oregon Board of Dentistry to place films, adjust equipment preparatory to exposing films, and expose the films under the indirect supervision of a dentist, dental hygienist, or dental assistant who holds an Oregon Radiologic Proficiency Certificate. The dental assistant must successfully complete the clinical examination within six months of the dentist **or dental hygienist** authorizing the assistant to take radiographs.

Stat. Auth.: ORS 679
Stats. Implemented: ORS 679.025(2)(j) & 679.250(7)
Hist.: OBD 9-1999, f. 8-10-99, cert. ef. 1-1-00; OBD 2-2003, f. 7-14-03 cert. ef. 7-18-03; OBD 4-2004, f.11-23-04 cert. ef. 12-1-04; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14;OBD 3-2015, f. 9-8-15, cert. ef. 10-1-15

Dr. Schwindt moved and Dr. Javier seconded that the Board move OAR 818-042-0050 – Taking of X-rays -Exposing of Radiographs as presented to a public rulemaking hearing on October 20, 2016. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

OAR 818-042-0070 – Expanded Function Dental Assistants (EFDA)

The following duties are considered Expanded Function Duties and may be performed only after the dental assistant complies with the requirements of 818-042-0080:
(1) Polish the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis to remove stains **providing the patient is checked by a dentist or dental hygienist after the procedure is performed, prior to discharge**;
(2) Remove temporary crowns for final cementation and clean teeth for final cementation;
(3) Preliminarily fit crowns to check contacts or to adjust occlusion outside the mouth;
(4) Place temporary restorative material (i.e., zinc oxide eugenol based material) in teeth providing that the patient is checked by a dentist before and after the procedure is performed;
(5) Place and remove matrix retainers for alloy and composite restorations;
(6) Polish amalgam or composite surfaces with a slow speed hand piece;
(7) Remove excess supragingival cement from crowns, bridges, bands or brackets with hand instruments providing that the patient is checked by a dentist after the procedure is performed;
(8) Fabricate temporary crowns, and temporarily cement the temporary crown. The cemented crown must be examined and approved by the dentist prior to the patient being released;
(9) Under general supervision, when the dentist is not available and the patient is in discomfort, an EFDA may recement a temporary crown or recement a permanent crown with temporary cement for a patient of record providing that the patient is rescheduled for follow-up care by a licensed dentist as soon as is reasonably appropriate; and
(10) Perform all aspects of teeth whitening procedures.

Stat. Auth.: ORS 679 & 680
Stats. Implemented: ORS 679.020, 679.025 & 679.250
Hist.: OBD 9-1999, f. 8-10-99, cert. ef. 1-1-00; OBD 1-2004, f. 5-27-04, cert. ef. 6-1-04; OBD 3-2005, f. 10-26-05, cert. ef. 11-1-05; OBD 2-2009, f. 10-21-09, cert. ef. 11-1-09; OBD 3-2015, f. 9-8-15, cert. ef. 10-1-15

Dr. Schwindt moved and Dr. Underhill seconded that the Board move OAR 818-042-0070 – Expanded Function Dental Assistants (EFDA) as presented to a public rulemaking hearing on October 20, 2016. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

OAR 818-042-0112 – Expanded Function Preventive Dental Assistants (EFPDA)

The following duties are considered Expanded Function Preventive Duties and may be performed only after the dental assistant complies with the requirements of 818-042-0113:
(1) Polish the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis to remove stains providing the patient is checked by a dentist or dental hygienist after the procedure is performed, prior to discharge.

Dr. Schwindt moved and Dr. Javier seconded that the Board move OAR 818-042-0112 – Expanded Function Preventive Dental Assistants (EFPDA) as presented to a public rulemaking hearing on October 20, 2016. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

OAR 818-042-0113 – Certification – Expanded Function Preventive Dental Assistants (EFPDA)

The Board may certify a dental assistant as an expanded function preventive dental assistant:
(1) By credential in accordance with OAR 818-042-0120, or
(2) If the assistant submits a completed application, pays the fee and provides evidence of;
(a) Certification of Radiologic Proficiency (OAR 818-042-0060); and satisfactory completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association; or
(b) Certification of Radiologic Proficiency (OAR 818-042-0060); and passage of the Oregon Basic or Certified Preventive Functions Dental Assistant (CPFDA) examination, and the Expanded Function Dental Assistant examination, or equivalent successor examinations, administered by the Dental Assisting National Board, Inc. (DANB), or any other testing entity authorized by the Board; and certification by an Oregon licensed dentist that the applicant has successfully polished the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis to remove stains on six patients.

Dr. Schwindt moved and Dr. Javier seconded that the Board move OAR 818-042-0113 – Certification – Expanded Function Preventive Dental Assistants (EFPDA) as presented to a public rulemaking hearing on October 20, 2016. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

OAR 818-042-0120 – Certification by Credential

(1) Dental Assistants who wish to be certified by the Board in Radiologic Proficiency or as Expanded Function Dental Assistants, ~~or as~~ Expanded Function Orthodontic Dental Assistants**, or as Expanded Function Preventive Dental Assistants** shall:
(a) Be certified by another state in the functions for which application is made. The training and certification requirements of the state in which the dental assistant is certified must be substantially similar to Oregon's requirements; or
(b) Have worked for at least 1,000 hours in the past two years in a dental office where such employment involved to a significant extent the functions for which certification is sought; and
(c) Shall be evaluated by a licensed dentist, using a Board approved checklist, to assure that the assistant is competent in the expanded functions.
(2) Applicants applying for certification by credential in Radiologic Proficiency must obtain certification from the Oregon Health Authority, Center for Health Protection, Radiation Protection Services, of having successfully completed training equivalent to that required by OAR 333-106-0055 or approved by the Oregon Board of Dentistry.

Stat. Auth.: ORS 679
Stats. Implemented: ORS 679.020, 679.025 & 679.250
Hist.: OBD 9-1999, f. 8-10-99, cert. ef. 1-1-00; OBD 2-2003, f. 7-14-03 cert. ef. 7-18-03; OBD 4-2004, f. 11-23-04 cert. ef. 12-1-04; OBD 3-2005, f. 10-26-05, cert. ef. 11-1-05; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14

Dr. Schwindt moved and Dr. Beck seconded that the Board move OAR 818-042-0120 –

Certification by Credential as presented to a public rulemaking hearing on October 20, 2016. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

OAR 818-026-0010 Definitions
As used in these rules:

(1) "Anesthesia Monitor" means a person trained in monitoring patients under sedation and capable of assisting with procedures, problems and emergency incidents that may occur as a result of the sedation or secondary to an unexpected medical complication.
(2) "Anxiolysis" means the diminution or elimination of anxiety.
(3) “General Anesthesia” means a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.
(4) “Deep Sedation” means a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.
(5) “Moderate Sedation” means a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.
(6) “Minimal Sedation” means minimally depressed level of consciousness, produced by **non-intravenous pharmacological methods**, ~~**an enteral drug**~~, that retains the patient’s ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. When the intent is minimal sedation for adults, the appropriate initial dosing of a single **non-intravenous pharmacological method** ~~**enteral drug**~~ is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use. Nitrous oxide/oxygen may be used in combination with a single **non-intravenous pharmacological method** ~~**enteral drug**~~ in minimal sedation.
(7) “Nitrous Oxide Sedation” means an induced, controlled state of minimal sedation, produced solely by the inhalation of a combination of nitrous oxide and oxygen in which the patient retains the ability to independently and continuously maintain an airway and to respond purposefully to physical stimulation and to verbal command.
(8) “Maximum recommended dose” (MRD) means ~~**maximum Food and Drug Administration-recommended dose of a drug, as printed in Food and Drug Administration-Approved labeling for unmonitored dose**~~ **maximum Food and Drug Administration (FDA) recommended dose of a drug, as printed in FDA approved labeling for unmonitored home use.**
(9) “Incremental Dosing” means during minimal sedation, administration of multiple doses of a drug until a desired effect is reached, but not to exceed the maximum recommended dose (MRD).
(10) “Supplemental Dosing” means during minimal sedation, supplemental dosing is a single additional dose of the initial drug that is necessary for prolonged procedures. The supplemental dose should not exceed one-half of the initial dose and should not be

administered until the dentist has determined the clinical half-life of the initial dosing has passed. The total aggregate dose must not exceed 1.5x the MRD on the day of treatment.
(11) "Enteral Route" means administration of medication via the gastrointestinal tract. Administration by mouth, sublingual (dissolving under the tongue), intranasal and rectal administration are included.
(12) "Parenteral Route" means administration of medication via a route other than enteral. Administration by intravenous, intramuscular, and subcutaneous routes are included.

Stat. Auth.: ORS 679
Stats. Implemented: ORS 679.250(7) & 679.250(10)
Hist.: OBD 2-1998, f. 7-13-98, cert. ef. 10-1-98; OBD 6-1999, f. 6-25-99, cert. ef. 7-1-99; OBD 3-2003, f. 9-15-03, cert. ef. 10-1-03; OBD 1-2005, f. 1-28-05, cert. ef. 2-1-05; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10

Dr. Smith moved and Dr. Schwindt seconded that the Board refer OAR 818-026-0010 – Definitions back to the Anesthesia Committee for further review. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye. Dr. Schwindt voted no.

OAR 818-026-0030 Requirement for Anesthesia Permit, Standards and Qualifications of an Anesthesia Monitor

(1) A permit holder who administers sedation shall assure that drugs, drug dosages, and/or techniques used to produce sedation shall carry a margin of safety wide enough to prevent unintended deeper levels of sedation.
(2) No licensee shall induce central nervous system sedation or general anesthesia without first having obtained a permit under these rules for the level of anesthesia being induced.
(3) A licensee may be granted a permit to administer sedation or general anesthesia with documentation of training/education and/or competency in the permit category for which the licensee is applying by any one the following:
(a) Initial training/education in the permit category for which the applicant is applying shall be completed no more than two years immediately prior to application for sedation or general anesthesia permit; or
(b) If greater than two years but less than five years since completion of initial training/education, an applicant must document completion of all continuing education that would have been required for that anesthesia/permit category during that five year period following initial training; or
(c) If greater than two years but less than five years since completion of initial training/education, immediately prior to application for sedation or general anesthesia permit, current competency or experience must be documented by completion of a comprehensive review course approved by the Board in the permit category to which the applicant is applying and must consist of at least one-half (50%) of the hours required by rule for Nitrous Oxide, Minimal Sedation, Moderate Sedation and General Anesthesia Permits. Deep Sedation and General Anesthesia Permits will require at least 120 hours of general anesthesia training.
(d) An applicant for sedation or general anesthesia permit whose completion of initial training/education is greater than five years immediately prior to application, may be granted a sedation or general anesthesia permit by submitting documentation of the requested permit level from another state or jurisdiction where the applicant is also licensed to practice dentistry

or dental hygiene, and provides documentation of the completion of at least 25 cases in the requested level of sedation or general anesthesia in the 12 months immediately preceding application; or
(e) Demonstration of current competency to the satisfaction of the Board that the applicant possesses adequate sedation or general anesthesia skill to safely deliver sedation or general anesthesia services to the public.
(4) Persons serving as anesthesia monitors in a dental office shall maintain current certification in Health Care Provider Basic Life Support (BLS)/Cardio Pulmonary Resuscitation (CPR) training, or its equivalent, shall be trained in monitoring patient vital signs, and be competent in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. (The term "competent" as used in these rules means displaying special skill or knowledge derived from training and experience.)
~~(5) A licensee holding an anesthesia permit shall at all times hold a current Health Care Provider BLS/CPR level certificate or its equivalent, or a current Advanced Cardiac Life Support (ACLS) Certificate or Pediatric Advanced Life Support (PALS) Certificate, whichever is appropriate for the patient being sedated.~~
(**5) A licensee holding a nitrous or minimal sedation permit, shall at all times maintain a current BLS for Health Care Providers certificate or its equivalent.**
(6) A licensee holding an anesthesia permit for moderate sedation, deep sedation or general anesthesia at all times maintains a current BLS for Health Care Providers certificate or its equivalent, and a current Advanced Cardiac Life Support (ACLS) Certificate or Pediatric Advanced Life Support (PALS) Certificate, whichever is appropriate for the patient being sedated. If a licensee permit holder sedates only patients under the age of 12, only PALS is required. If a licensee permit holder sedates only patients age 12 and older, only ACLS is required. If a licensee permit holder sedates patients younger than 12 years of age as well as older than 12 years of age, both ACLS and PALS are required. For licensees with a moderate sedation permit only, successful completion of the American Dental Association's course *"Recognition and Management of Complications during Minimal and Moderate Sedation"* at least every two years may be substituted for ACLS, but not for PALS.
(a) Advanced Cardiac Life Support (ACLS) and or Pediatric Advanced Life Support (PALS) do not serve as a substitute for Health Care Provider Basic Life Support (BLS).
(7)~~(6)~~ When a dentist utilizes a single dose oral agent to achieve anxiolysis only, no anesthesia permit is required.
(8)~~(7)~~ The applicant for an anesthesia permit must pay the appropriate permit fee, submit a completed Board-approved application and consent to an office evaluation.
(9)~~(8)~~ Permits shall be issued to coincide with the applicant's licensing period.

Stat. Auth.: ORS 679 & 680
Stats. Implemented: ORS 679.250
Hist.: OBD 2-1998, f. 7-13-98, cert. ef. 10-1-98; OBD 3-2003, f. 9-15-03, cert. ef. 10-1-03; OBD 1-2005, f. 1-28-05, cert. ef. 2-1-05; OBD 2-2005, f. 1-31-05, cert. ef. 2-1-05; OBD 3-2005, f. 10-26-05, cert. ef. 11-1-05; OBD 1-2008, f. 11-10-08, cert. ef. 12-1-08; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 2-2012, f. 6-14-12, cert. ef. 7-1-12

Dr. Smith moved and Dr. Schwindt seconded that the Board move OAR 818-026-0030 - Requirement for Anesthesia Permit, Standards and Qualifications of an Anesthesia Monitor as amended to a public rulemaking hearing on October 20, 2016. The motion passed with Dr.

Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

OAR 818-026-0050 Minimal Sedation Permit

Minimal sedation and nitrous oxide sedation.
(1) The Board shall issue a Minimal Sedation Permit to an applicant who:
(a) Is a licensed dentist in Oregon;
(b) Maintains a current BLS for Healthcare Providers certificate or its equivalent; and
(c) Completion of a comprehensive training program consisting of at least 16 hours of training and satisfies the requirements of the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students (2007) at the time training was commenced or postgraduate instruction was completed, or the equivalent of that required in graduate training programs, in sedation, recognition and management of complications and emergency care; or
(d) In lieu of these requirements, the Board may accept equivalent training or experience in minimal sedation anesthesia.
(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedures and during recovery:
(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;
(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;
(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;
(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;
(e) An oxygen delivery system with adequate full facemask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;
(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;
(g) Sphygmomanometer, stethoscope, pulse oximeter, and/or automatic blood pressure cuff; and
(h) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives and anticonvulsants.
(3) Before inducing minimal sedation, a dentist **permit holder** who induces minimal sedation shall:
(a) Evaluate the patient;
(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian;
(c) Certify that the patient is an appropriate candidate for minimal sedation; and
(d) Obtain written informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient's record.
(4) No permit holder shall have more than one person under minimal sedation at the same time.

(5) While the patient is being treated under minimal sedation, an anesthesia monitor shall be present in the room in addition to the treatment provider. The anesthesia monitor may be the dental assistant. After training, a dental assistant, when directed by a dentist **permit holder**, may administer oral sedative agents or anxiolysis agents calculated and dispensed by a dentist **permit holder** under the direct supervision of a dentist **permit holder**.
(6) A patient under minimal sedation shall be visually monitored at all times, including recovery phase. The dentist **permit holder** or anesthesia monitor shall monitor and record the patient's condition.
(7) The patient shall be monitored as follows:
(a) Color of mucosa, skin or blood must be evaluated continually. Patients must have continuous monitoring using pulse oximetry. The patient's response to verbal stimuli, blood pressure, heart rate, and respiration shall be monitored and documented if they can reasonably be obtained.
(b) A discharge entry shall be made by the dentist **permit holder** in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.
(8) The dentist **permit holder** shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:
(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;
(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;
(c) The patient can talk and respond coherently to verbal questioning;
(d) The patient can sit up unaided;
(e) The patient can ambulate with minimal assistance; and
(f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.
(g) A dentist **permit holder** shall not release a patient who has undergone minimal sedation except to the care of a responsible third party.
(9) Permit renewal. In order to renew a Minimal Sedation Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent. In addition, Minimal Sedation Permit holders must also complete four (4) hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current BLS for Healthcare Providers certificate, or its equivalent, may not be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

Stat. Auth.: ORS 679
Stats. Implemented: ORS 679.250(7) & 679.250(10)
Hist.: OBD 6-1999, f. 6-25-99, cert. ef. 7-1-99; Administrative correction 8-12-99; OBD 3-2003, f. 9-15-03, cert. ef. 10-1-03; OBD 1-2005, f. 1-28-05, cert. ef. 2-1-05; OBD 2-2005, f. 1-31-05, cert. ef. 2-1-05; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14; OBD 4-2015, f. 9-8-15, cert. ef. 1-1-16

Dr. Smith moved and Dr. Underhill seconded that the Board move OAR 818-026-0050 – Minimal Sedation Permit as presented to a public rulemaking hearing on October 20, 2016. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Ms. Riedman and Dr. Underhill voting aye.

OAR 818-026-0060 Moderate Sedation Permit

Moderate sedation, minimal sedation, and nitrous oxide sedation.
(1) The Board shall issue or renew a Moderate Sedation Permit to an applicant who:
(a) Is a licensed dentist in Oregon;
(b) In addition to a current BLS for Healthcare Providers certificate or its equivalent, either maintains a current Advanced Cardiac Life Support (ACLS) certificate and/or a Pediatric Advanced Life Support (PALS) certificate, whichever is appropriate for the patient being sedated. ~~Successful completion of a board approved course on minimal/moderate sedation at least every two years may be substituted for ACLS, but not for PALS;~~ and
(c) Satisfies one of the following criteria:
(A) Completion of a comprehensive training program in enteral and/or parenteral sedation that satisfies the requirements described in Part V of the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students (2007) at the time training was commenced.
(i) Enteral Moderate Sedation requires a minimum of 24 hours of instruction plus management of at least 10 dental patient experiences by the enteral and/or enteral-nitrous oxide/oxygen route.
(ii) Parenteral Moderate Sedation requires a minimum of 60 hours of instruction plus management of at least 20 dental patients by the intravenous route.
(B) Completion of an ADA accredited postdoctoral training program (e.g., general practice residency) which affords comprehensive and appropriate training necessary to administer and manage parenteral sedation, commensurate with these Guidelines.
(C) In lieu of these requirements, the Board may accept equivalent training or experience in moderate sedation anesthesia.
(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedures and during recovery:
(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;
(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;
(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;
(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;
(e) An oxygen delivery system with adequate full face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;
(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;
(g) A recovery area that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area can be the operating room;
(h) Sphygmomanometer, precordial/pretracheal stethoscope, capnograph, pulse oximeter, oral and nasopharyngeal airways, larynageal mask airways, intravenous fluid administration equipment, automated external defibrillator (AED); and

(i) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives and anticonvulsants.
(3) No permit holder shall have more than one person under moderate sedation, minimal sedation, or nitrous oxide sedation at the same time.
(4) During the administration of moderate sedation, and at all times while the patient is under moderate sedation, an anesthesia monitor, and one other person holding a current BLS for Healthcare Providers certificate or its equivalent, shall be present in the operatory, in addition to the dentist **permit holder** performing the dental procedures.
(5) Before inducing moderate sedation, a dentist **permit holder** who induces moderate sedation shall:
(a) Evaluate the patient and document, using the American Society of Anesthesiologists Patient Physical Status Classifications, that the patient is an appropriate candidate for moderate sedation;
(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian; and
(c) Obtain written informed consent from the patient or patient's guardian for the anesthesia.
(6) A patient under moderate sedation shall be visually monitored at all times, including the recovery phase. The dentist **permit holder** or anesthesia monitor shall monitor and record the patient's condition.
(7) The patient shall be monitored as follows:

(a) Patients must have continuous monitoring using pulse oximetry, and End-tidal CO2 monitors. Patients with cardiovascular disease shall have continuous electrocardiograph (ECG) monitoring. The patient's blood pressure, heart rate, and respiration shall be recorded at regular intervals but at least every 15 minutes, and these recordings shall be documented in the patient record. The record must also include documentation of preoperative and postoperative vital signs, all medications administered with dosages, time intervals and route of administration. If this information cannot be obtained, the reasons shall be documented in the patient's record. A patient under moderate sedation shall be continuously monitored and shall not be left alone while under sedation;
(b) During the recovery phase, the patient must be monitored by an individual trained to monitor patients recovering from moderate sedation.
(8) A dentist **permit holder** shall not release a patient who has undergone moderate sedation except to the care of a responsible third party.
(a) When a reversal agent is administered, the dentist **permit holder** shall document justification for its use and how the recovery plan was altered.
(9) The dentist **permit holder** shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:
(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;
(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;
(c) The patient can talk and respond coherently to verbal questioning; (d) The patient can sit up unaided;
(e) The patient can ambulate with minimal assistance; and
(f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.
(10) A discharge entry shall be made by the dentist **permit holder** in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.

(11) After adequate training, an assistant, when directed by a dentist **permit holder**, may dispense oral medications that have been prepared by the dentist permit holder for oral administration to a patient under direct supervision. **Pursuant to OAR 818-042-0115 a Certified Anesthesia Dental Assistant, when directed by a dentist permit holder, may** introduce additional anesthetic agents into an infusion line under the direct ~~visual~~ supervision of a dentist **permit holder**.
(12) Permit renewal. In order to renew a Moderate Sedation Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent; a current Advanced Cardiac Life Support (ACLS) certificate and/or a current Pediatric Advanced Life Support (PALS) certificate; Successful completion of a board approved course on minimal/moderate sedation at least every two years may be substituted for ACLS, but not for PALS; and must complete 14 hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current ACLS or PALS certification or successful completion of the American Dental Association's course "Recognition and Management of Complications during Minimal and Moderate Sedation" may be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021- 0060.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 679
Stats. Implemented: ORS 679.250(7) & 679.250(10)
Hist.: OBD 2-1998, f. 7-13-98, cert. ef. 10-1-98; OBD 1-1999, f. 2-26-99, cert. ef. 3-1-99; OBD 6-1999, f. 6-25-99, cert. ef. 7-1-99; Administrative correction 8-12-99; OBD 2-2000(Temp), f. 5-22-00, cert. ef. 5-22-00 thru 11-18-00; OBD 2-2001, f. & cert. ef. 1-8-01; OBD 3-2003, f. 9-15-03, cert. ef. 10-1-03; OBD 1-2005, f. 1-28-05, cert. ef. 2-1-05; OBD 2-2005, f. 1-31-05, cert. ef. 2-1-05; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 2-2011(Temp), f. 5-9-11, cert. ef. 6-1-11 thru1-27-11; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 1-2013, f. 5-15-13, cert. ef. 7-1-13; OBD 3-2013, f. 10-24-13, cert. ef. 1-1-14; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14; OBD 4-2015, f. 9-8-15, cert. ef. 1-1-16

Dr. Smith moved and Dr. Schwindt seconded that the Board move OAR 818-026-0060 – Moderate Sedation Permit as amended to a public rulemaking hearing on October 20, 2016. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Ms. Riedman and Dr. Underhill voting aye.

OAR 818-026-0065 Deep Sedation

Deep sedation, moderate sedation, minimal sedation, and nitrous oxide sedation.
(1) The Board shall issue a Deep Sedation Permit to a licensee who holds a Class 3 Permit on or before July 1, 2010 who:
(a) Is a licensed dentist in Oregon; and
(b) In addition to a current BLS for Healthcare Providers certificate or its equivalent, maintains a current Advanced Cardiac Life Support (ACLS) certificate and/or a Pediatric Advanced Life Support (PALS) certificate, whichever is appropriate for the patient being sedated.
(2) The following facilities, equipment and drugs shall be on site and available for immediate

use during the procedures and during recovery:
(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;
(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;
(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;
(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;
(e) An oxygen delivery system with adequate full face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;
(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;
(g) A recovery area that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area can be the operating room;
(h) Sphygmomanometer, precordial/pretracheal stethoscope, capnograph, pulse oximeter, electrocardiograph monitor (ECG), automated external defibrillator (AED), oral and nasopharyngeal airways, laryngeal mask airways, intravenous fluid administration equipment; and
(i) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives and anticonvulsants.
(3) No permit holder shall have more than one person under deep sedation, moderate sedation, minimal sedation, or nitrous oxide sedation at the same time.
(4) During the administration of deep sedation, and at all times while the patient is under deep sedation, an anesthesia monitor, and one other person holding a current BLS for Healthcare Providers certificate or its equivalent, shall be present in the operatory, in addition to the dentist **permit holder** performing the dental procedures.
(5) Before inducing deep sedation, a dentist **permit holder** who induces deep sedation shall:
(a) Evaluate the patient and document, using the American Society of Anesthesiologists Patient Physical Status Classifications, that the patient is an appropriate candidate for deep sedation;
(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian; and
(c) Obtain written informed consent from the patient or patient's guardian for the anesthesia.
(6) A patient under deep sedation shall be visually monitored at all times, including the recovery phase. The dentist **permit holder** or anesthesia monitor shall monitor and record the patient's condition.
(7) The patient shall be monitored as follows:
(a) Patients must have continuous monitoring using pulse oximetry, electrocardiograph monitors (ECG) and End-tidal CO2 monitors. The patient's heart rhythm shall be continuously monitored and the patient’s blood pressure, heart rate, and respiration shall be recorded at regular intervals but at least every 5 minutes, and these recordings shall be documented in the patient record. The record must also include documentation of preoperative and postoperative vital signs, all medications administered with dosages, time intervals and route of administration. If this information cannot be obtained, the reasons shall be documented in the

patient's record. A patient under deep sedation shall be continuously monitored;
(b) Once sedated, a patient shall remain in the operatory for the duration of treatment until criteria for transportation to recovery have been met.
(c) During the recovery phase, the patient must be monitored by an individual trained to monitor patients recovering from deep sedation.
(8) A dentist **permit holder** shall not release a patient who has undergone deep sedation except to the care of a responsible third party. When a reversal agent is administered, the dentist **permit holder** shall document justification for its use and how the recovery plan was altered.
(9) The dentist **permit holder** shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:
(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;
(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;
(c) The patient can talk and respond coherently to verbal questioning;
(d) The patient can sit up unaided;
(e) The patient can ambulate with minimal assistance; and
(f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.
(10) A discharge entry shall be made by the dentist **permit holder** in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.
(11) ~~After adequate training, an~~ **Pursuant to OAR 818-042-0115 a Certified Anesthesia Dental A**~~a~~ssistant, when directed by a dentist **permit holder**, may administer oral sedative agents calculated by a dentist **permit holder** or introduce additional anesthetic agents into an infusion line under the direct visual supervision of a dentist
(12) Permit renewal. In order to renew a Deep Sedation Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent; a current Advanced Cardiac Life Support (ACLS) certificate and/or a current Pediatric Advanced Life Support (PALS) certificate; and must complete 14 hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current ACLS and/or PALS certificates may be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

Dr. Smith moved and Dr. Underhill seconded that the Board move OAR 818-026-0065 – Deep Sedation as presented to a public rulemaking hearing on October 20, 2016. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Ms. Riedman and Dr. Underhill voting aye.

OAR 818-026-0070 General Anesthesia Permit

General anesthesia, deep sedation, moderate sedation, minimal sedation and nitrous oxide sedation.
(1) The Board shall issue a General Anesthesia Permit to an applicant who:
(a) Is a licensed dentist in Oregon;
(b) In addition to a current BLS for Healthcare Providers certificate or its equivalent, maintains

a current Advanced Cardiac Life Support (ACLS) certificate and/or a Pediatric Advanced Life Support (PALS) certificate, whichever is appropriate for the patient being sedated, and
(c) Satisfies one of the following criteria:
(A) Completion of an advanced training program in anesthesia and related subjects beyond the undergraduate dental curriculum that satisfies the requirements described in the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students (2007) consisting of a minimum of 2 years of a postgraduate anesthesia residency at the time training was commenced.
(B) Completion of any ADA accredited postdoctoral training program, including but not limited to Oral and Maxillofacial Surgery, which affords comprehensive and appropriate training necessary to administer and manage general anesthesia, commensurate with these Guidelines.
(C) In lieu of these requirements, the Board may accept equivalent training or experience in general anesthesia.
(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedure and during recovery:
(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least three individuals to freely move about the patient;
(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;
(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;
(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;
(e) An oxygen delivery system with adequate full face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;
(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;
(g) A recovery area that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area can be the operating room;
(h) Sphygmomanometer, precordial/pretracheal stethoscope, capnograph, pulse oximeter, electrocardiograph monitor (ECG), automated external defibrillator (AED), oral and nasopharyngeal airways, laryngeal mask airways, intravenous fluid administration equipment; and
(i) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, intravenous medications for treatment of cardiac arrest, narcotic antagonist, antihistaminic, antiarrhythmics, antihypertensives and anticonvulsants.
(3) No permit holder shall have more than one person under general anesthesia, deep sedation, moderate sedation, minimal sedation or nitrous oxide sedation at the same time.
(4) During the administration of deep sedation or general anesthesia, and at all times while the patient is under deep sedation or general anesthesia, an anesthesia monitor, and one other person holding a current BLS for Healthcare Providers certificate or its equivalent, shall be present in the operatory in addition to the dentist **permit holder** performing the dental procedures.
(5) Before inducing deep sedation or general anesthesia the dentist **permit holder** who

induces deep sedation or general anesthesia shall:
(a) Evaluate the patient and document, using the American Society of Anesthesiologists Patient Physical Status Classifications, that the patient is an appropriate candidate for general anesthesia or deep sedation;
(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian; and
(c) Obtain written informed consent from the patient or patient's guardian for the anesthesia.
(6) A patient under deep sedation or general anesthesia shall be visually monitored at all times, including recovery phase. A dentist **permit holder** who induces deep sedation or general anesthesia or anesthesia monitor trained in monitoring patients under deep sedation or general anesthesia shall monitor and record the patient's condition on a contemporaneous record.
(7) The patient shall be monitored as follows:
(a) Patients must have continuous monitoring of their heart rate, heart rhythm, oxygen saturation levels and respiration using pulse oximetry, electrocardiograph monitors (ECG) and End-tidal CO2 monitors. The patient's blood pressure, heart rate and oxygen saturation shall be assessed every five minutes, and shall be contemporaneously documented in the patient record. The record must also include documentation of preoperative and postoperative vital signs, all medications administered with dosages, time intervals and route of administration. The person administering the anesthesia and the person monitoring the patient may not leave the patient while the patient is under deep sedation or general anesthesia;
(b) Once sedated, a patient shall remain in the operatory for the duration of treatment until criteria for transportation to recovery have been met.
(c) During the recovery phase, the patient must be monitored, including the use of pulse oximetry, by an individual trained to monitor patients recovering from general anesthesia.
(8) A dentist **permit holder** shall not release a patient who has undergone deep sedation or general anesthesia except to the care of a responsible third party. When a reversal agent is administered, the dentist **permit holder** shall document justification for its use and how the recovery plan was altered.
(9) The dentist **permit holder** shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:
(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;
(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;
(c) The patient can talk and respond coherently to verbal questioning;
(d) The patient can sit up unaided;
(e) The patient can ambulate with minimal assistance; and
(f) The patient does not have nausea or vomiting and has minimal dizziness.
(10) A discharge entry shall be made in the patient's record by the dentist **permit holder** indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.
(11) ~~After adequate training, an~~ **Pursuant to OAR 818-042-0115 a Certified Anesthesia Dental A**~~a~~ssistant, when directed by a dentist **permit holder**, may introduce additional anesthetic agents to an infusion line under the direct visual supervision of a dentist **permit holder**.
(12) Permit renewal. In order to renew a General Anesthesia Permit, the permit holder must

provide documentation of a current BLS for Healthcare Providers certificate or its equivalent; a current Advanced Cardiac Life Support (ACLS) certificate and/or a current Pediatric Advanced Life Support (PALS) certificate; and must complete 14 hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current ACLS and/or PALS certificates may be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 679
Stats. Implemented: ORS 679.250(7) & 679.250(10)
Hist.: OBD 2-1998, f. 7-13-98, cert. ef. 10-1-98; OBD 6-1999, f. 6-25-99, cert. ef. 7-1-99; Administrative correction 8-12-99; OBD 2-2000(Temp), f. 5-22-00, cert. ef. 5-22-00 thru 11-18-00; Administrative correction 6-21-01; OBD 3-2003, f. 9-15-03, cert. ef. 10-1-03; OBD 1-2005, f.1-28-05, cert. ef. 2-1-05; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 2-2011(Temp), f. 5-9-11, cert. ef. 6-1-11 thru 1-27-11; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 1-2013, f. 5-15-13, cert. ef. 7-1-13; OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14; OBD 4-2015, f. 9-8-15, cert. ef. 1-1-16

Dr. Smith moved and Dr. Schwindt seconded that the Board move OAR 818-026-0070 – General Anesthesia Permit as presented to a public rulemaking hearing on October 20, 2016. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Ms. Riedman and Dr. Underhill voting aye.

OAR 818-026-0080 Standards Applicable When a Dentist Performs Dental Procedures and a Qualified Provider Induces Anesthesia

(1) A dentist who does not hold an anesthesia permit may perform dental procedures on a patient who receives anesthesia induced by a physician anesthesiologist licensed by the Oregon Board of Medical Examiners, another Oregon licensed dentist holding an appropriate anesthesia permit, or a Certified Registered Nurse Anesthetist (CRNA) licensed by the Oregon Board of Nursing.
(2) A dentist who does not hold a Nitrous Oxide Permit for nitrous oxide sedation may perform dental procedures on a patient who receives nitrous oxide induced by an Oregon licensed dental hygienist holding a Nitrous Oxide Permit.
(3) A dentist who performs dental procedures on a patient who receives anesthesia induced by a physician anesthesiologist, another dentist holding an anesthesia permit, a CRNA, or a dental hygienist who induces nitrous oxide sedation, shall maintain a current BLS for Healthcare Providers certificate, or its equivalent, and have the same personnel, facilities, equipment and drugs available during the procedure and during recovery as required of a dentist who has a permit for the level of anesthesia being provided.
(4) A dentist, a dental hygienist or an Expanded Function Dental Assistant (EFDA) who performs procedures on a patient who is receiving anesthesia induced by a physician anesthesiologist, another dentist holding an anesthesia permit or a CRNA shall not schedule or treat patients for non emergent care during the period of time of the sedation procedure.
(5) Once anesthetized, a patient shall remain in the operatory for the duration of treatment until

criteria for transportation to recovery have been met.
(6) The qualified anesthesia provider who induces **moderate sedation, deep sedation or general** anesthesia shall monitor the patient's condition until the patient is discharged and record the patient's condition at discharge in the patient's dental record as required by the rules applicable to the level of anesthesia being induced. The anesthesia record shall be maintained in the patient's dental record and is the responsibility of the dentist who is performing the dental procedures.
(7) A dentist who intends to use the services of a qualified anesthesia provider as described in section 1 above, shall notify the Board in writing of his/her intent. Such notification need only be submitted once every licensing period.

Stat. Auth.: ORS 679

Stats. Implemented: ORS 679.250(7) & (10)

Hist.: OBD 2-1998, f. 7-13-98, cert. ef. 10-1-98; OBD 3-2003, f. 9-15-03, cert. ef. 10-1-03; OBD 1-2005, f. 1-28-05, cert. ef. 2-1-05; OBD 1-2006, f. 3-17-06, cert. ef. 4-1-06; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 3-2015, f. 9-8-15, cert. ef. 10-1-15

Dr. Smith moved and Dr. Underhill seconded that the Board move OAR 818-026-0080 – Standards Applicable When a Dentist Performs Dental Procedures and a Qualified Provider Induces Anesthesia as presented to a public rulemaking hearing on October 20, 2016. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Ms. Riedman and Dr. Underhill voting aye.

818-026-0110 - **Office Evaluations**

(1) By obtaining an anesthesia permit or by using the services of a physician anesthesiologist, CRNA, an Oregon licensed dental hygienist **permit holder** or another dentist **permit holder** to administer anesthesia, a licensee consents to in-office evaluations by the Oregon Board of Dentistry, to assess competence in central nervous system anesthesia and to determine compliance with rules of the Board.

(2) The in-office evaluation may include, but is not limited to:

(a) Observation of one or more cases of anesthesia to determine the appropriateness of technique and adequacy of patient evaluation and care;

(b) Inspection of facilities, equipment, drugs and records; and

(c) Confirmation that personnel are adequately trained, hold a current BLS for Healthcare Providers certificate, or its equivalent, and are competent to respond to reasonable emergencies that may occur during the administration of anesthesia or during the recovery period.

(3) The evaluation shall be performed by a team appointed by the Board and shall include:

(a) A permit holder who has the same type of license as the licensee to be evaluated and who holds a current anesthesia permit in the same class or in a higher class than that held by the licensee being evaluated.

(b) A member of the Board's Anesthesia Committee; and

(c) Any licensed dentist, deemed appropriate by the Board President, may serve as team leader and shall be responsible for organizing and conducting the evaluation and reporting to the Board.

(4) The Board shall give written notice of its intent to conduct an office evaluation to the licensee to be evaluated. Licensee shall cooperate with the evaluation team leader in scheduling the

evaluation which shall be held no sooner than 30 days after the date of the notice or later than 90 days after the date of the notice.

Stat. Auth.: ORS 679 & 680
Stats. Implemented: ORS 679.250(7) & (10)
Hist.: OBD 2-1998, f. 7-13-98, cert. ef. 10-1-98; OBD 3-2003, f. 9-15-03, cert. ef. 10-1-03; OBD 1-2005, f. 1-28-05, cert. ef. 2-1-05; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 4-2015, f. 9-8-15, cert. ef. 1-1-16

Dr. Smith moved and Dr. Underhill seconded that the Board move OAR 818-026-0110 – Office Evaluations as presented to a public rulemaking hearing on October 20, 2016. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Ms. Riedman and Dr. Underhill voting aye.

OAR 818-042-0115 Expanded Functions – Certified Anesthesia Dental Assistant

(1) A dentist holding the appropriate anesthesia permit may verbally authorize a Certified Anesthesia Dental Assistant**, who possesses a Certified Anesthesia Dental Assistant certificate from the Oregon Board of Dentistry** to:
(a) Administer medications into an existing intravenous (IV) line of a patient under sedation or anesthesia under direct visual supervision.
(b) Administer emergency medications to a patient in order to assist the licensee in an emergent situation under direct visual supervision.
(2) A dentist holding the appropriate anesthesia permit may verbally authorize a Certified Anesthesia Dental Assistant to dispense to a patient, oral medications that have been prepared by the dentist and given to the anesthesia dental assistant by the supervising dentist for oral administration to a patient under Indirect Supervision.
Stat. Auth.: ORS 679
Stats. Implemented: ORS 679.020(1), 679.025(1) & 679.250(7)
Hist.: OBD 1-2001, f. & cert. ef. 1-8-01; OBD 1-2006, f. 3-17-06, cert. ef. 4-1-06

Dr. Smith moved and Dr. Underhill seconded that the Board move OAR 818-042-0115 – Expanded Functions – Certified Anesthesia Dental Assistant as presented to a public rulemaking hearing on October 20, 2016. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Ms. Riedman and Dr. Underhill voting aye.

EXECUTIVE DIRECTOR'S REPORT

Board Member & Staff Updates
Mr. Prisby reported that Dr. Jose Javier completed his required new Board member training and orientation. He also reported that the OBD hired Haley Huntington as the new Office Specialist in June. Haley is a graduate of Oregon State University with a Bachelor's of Science in Human Services and Family Sciences. In her free time she helps operate a Red Angus cattle ranch with her family outside of Molalla. He stated that the staff and he appreciate her excellent communication skills, computer skills, positive attitude and punctuality.

Budget Status Report
Mr. Prisby presented the latest budget report from July 1, 2015 through June 30, 2016, which is halfway through the budget. It shows revenue of $1,728,977.10 and expenditures of $1,358,932.23. Board members were asked if they had any questions regarding the budget.

OBD 2017-19 Agency Request Budget & Affirmative Action Guidelines
Mr. Prisby reported that he submitted the Agency Request Budget to DAS-CFO on August 1st. Agencies with 10 or fewer full time employees will provide a streamlined Affirmative Action Plan to the Governor's Office by September 16th. Mr. Prisby has a meeting with Nakeia Daniels, the Governor's Affirmative Action Manager, on August 26th. Mr. Prisby stated that he will incorporate her suggestions and feedback into the new plan and email it to the Board members when it is drafted, before the due date, for the Board to review.

Customer Service Survey Report
Mr. Prisby went over the attached chart showing the OBD Legislatively Mandated Customer Service Survey Results from July 1, 2015 – June 30, 2016.The results of the survey show that the OBD continues to receive positive ratings from the majority of those that submit a survey.

Board and Staff Speaking Engagements
Dr. Paul Kleinstub, Dental Director/Chief Investigator made a presentation on "Record Keeping" and "Updates from the OBD" to Advantage Dental at Eagle Crest in Redmond on Friday, July 29.

Mr. Prisby attended the Oregon Oral Health Coalition's Advocacy Summit in Lake Oswego on Tuesday, August 9.

Agency Head Financial Transaction Report July 1, 2015 – June 30, 2016
Mr. Prisby stated that Board policy requires that at least annually, the entire Board review agency head financial transactions and that acceptance of the report be placed in the minutes.
Dr. Underhill moved and Ms. Martinez seconded that the Board accept the Agency Head Financial Transaction Report as presented**.** The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

Board Best Practices Self- Assessment
Mr. Prisby asked the Board to complete the attached Best Practices Self-Assessment so that it can be included as part of the 2016 Performance Measures Report. He will provide the OBD's annual progress report at the next Board meeting which will incorporate the Self-Assessment results.

The Board discussed the Self-Assessment.

Dr. Smith moved and Dr. Fine seconded that the Board approve the 2016 Best Practices Self-Assessment as presented. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

HPSP - Year 6 Report & Survey Results
Mr. Prisby stated that he and Mr. Wayson attended a Statement of Work meeting on August 21st with representatives from the Medical, Nursing & Pharmacy Boards to review contractor requirements and duties relating to the administration of the HPSP transitioning from OHA in July 2017. Board members were asked if they had any questions regarding the transition or information presented.

TriMet Contract
Mr. Prisby asked that the Board ratify entering into a contract with TRIMET for the Universal Pass Program which will allow the OBD to provide transportation passes for employees that are eligible to receive such passes for transportation to and from work. Dr. Smith moved and Dr. Fine seconded that Mr. Prisby ratify the contract as presented with TRIMET for the Universal Pass Program. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

OBD 2017-2020 Strategic Plan Draft Document
Mr. Prisby reported that the Board & Staff held a strategic planning session April 22-23, 2016 and that the Board last undertook strategic planning in 2007. He also stated that the information was distilled into the attached 2017-2020 Strategic Plan, which also updated the Board's mission "to promote high quality oral healthcare in the State of Oregon by equitably regulating dental professionals." Mr. Prisby asked the Board to approve and ratify the final draft of the Board's Strategic Plan. Dr. Smith moved and Dr. Beck seconded that the Board approve the OBD 2017-2020 Strategic Plan Draft as presented. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

Dental Assisting National Board (DANB)
Mr. Prisby provided an update regarding the transition to dental assistant certifications being processed by DANB on behalf of the OBD, which went into effect July 1st. The administrative staff and Mr. Prisby connected with DANB officials on a conference call on August 9th to review the transition and Mr. Prisby provided a report on the meeting to the Board.

Citizen Advocacy Center (CAC)
Mr. Prisby stated that on Saturday, September 17, 2016, and Sunday, September 18, 2016, the Citizen Advocacy Center (CAC) will co-sponsor a national conference with the theme "Modernizing the Regulatory Framework for Telehealth". He reported that The OBD is co-sponsoring the event with other Oregon health regulatory licensing agencies; a preliminary meeting program is included.

Newsletter
Mr. Prisby reported that the last newsletter was published in December. Mr. Prisby anticipates the next edition going out later in the year, which will incorporate the Board's Strategic Plan, new rule changes, and other important news and updates relevant to our Licensees. Articles from our new President Dr. Julie Ann Smith, former board member Dr. Jonna Hongo and a new board member biography of Dr. Jose Javier already have space reserved in the next newsletter.

UNFINISHED BUSINESS and RULES

OAR 818-005 and OAR 818-021-0026 Criminal Background Check Rules have been updated

as required by HB 3168 (2013) and HB 2250 (2015) to be consistent with the DAS statewide rules. Dr. Smith moved and Mr. Harvey seconded that the Board move OAR 818-005 and OAR 818-021-0026 - Criminal Background Check rules as presented to a public rule making hearing on October 20, 2016. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

CRIMINAL RECORDS CHECK AND FITNESS DETERMINATION RULES
~~818-005-0000~~
~~Definitions~~
~~As used in OAR Chapter 818, Division 005, unless the context of the rule requires otherwise, the following definitions apply:~~
~~(1) Conviction: A final judgment on a verdict or finding of guilty, a plea of guilty, a plea of nolo contendere (no contest); or any determination of guilt entered by a court of law against an employee applicant/employee in a criminal case, unless that judgment has been reversed or set aside by a subsequent court decision.~~
~~(2) Criminal Offender Information: Records and related data as to physical description and vital statistics; fingerprints received and compiled by the Oregon State Police, Bureau of Criminal Identification, for purposes of identifying criminal offenders and alleged offenders; and records of arrests and the nature and disposition of criminal charges, including sentencing, confinement, parole, and release.~~
~~(3) Crime Relevant to a Fitness Determination: A crime listed or described in OAR 818-005-0020.~~
~~(4) Criminal Records Check: One or more of the following processes used to check the criminal history of an employee applicant/employee:~~
~~(a) A name-based check of criminal offender information conducted through use of the Law Enforcement Data System (LEDS) maintained by the Oregon State Police, in accordance with the rules adopted and procedures established by the Oregon State Police (LEDS Criminal Records Check);~~
~~(b) A check of Oregon criminal offender information through fingerprint identification, conducted by the Oregon State Police at the Board's request (Oregon Criminal Records Check); or~~
~~(c) A nationwide check of federal criminal offender information through fingerprint identification, conducted by the Oregon State Police through the Federal Bureau of Investigation at the Board's request (Nationwide Criminal Records Check).~~
~~(5) Denied: A fitness determination by the Board pursuant to a final fitness determination under OAR 818-005-0025 that the subject individual is not fit to be an employee, volunteer, contractor, or vendor in a position covered by OAR 818-005-0025.~~
~~(6) False Statement: In association with an activity governed by these rules, an employee applicant/ employee either:~~
~~(a) Provided the Board with materially false information about the employee applicant's/employee's criminal history, such as, but not limited to, materially false information about employee applicant/employee or conviction record; or~~
~~(b) Failed to provide to the Board information material to determining employee applicant's/employee's criminal history.~~
~~(7) Fitness Determination: A determination made by the Board pursuant to the process established in OAR 818-005-0025 that an employee applicant/ employee is or is not fit to be a Board employee, volunteer, contractor, or vendor.~~
~~(8) Employee applicant/employee: An individual identified in OAR 818-005-0025 as someone from whom the Board may require a criminal records check.~~

~~Stat. Auth: ORS 181.534, 676.303 & 679.253~~
~~Stats. Implemented: ORS 676.303 & 181.534~~
~~Hist.: OBD 4-2011, f & cert. ef. 11-15-11~~

~~818-005-0005~~
~~Employee Applicant/Employee~~
~~The Board may require an Employee Applicant/Employee to complete a criminal records check pursuant to these rules if the person:~~
~~(1)(a) Is employed by or applying for employment with the Board; or~~
~~(b) Provides services or seeks to provide services to the Board as a volunteer, contractor, or vendor; and~~
~~(2) Is, or will be, working or providing services in a position in which the person:~~
~~(a) Provides information technology services and has control over, or access to, information technology systems that would allow the person to harm the information technology systems or the information contained in the systems; or~~
~~(b) Accesses information, that state or federal laws, rules or regulations prohibit disclosing or define as confidential.~~

~~Stat. Auth: ORS 181.534, 676.303 & 679.253~~
~~Stats. Implemented: ORS 676.303 & 181.534~~
~~Hist.: OBD 4-2011, f & cert. ef. 11-15-11~~

~~818-005-0011~~
~~Criminal Records Check Required~~
~~The Board may conduct, or request the Oregon State Police to conduct, a criminal records check when:~~
~~(1) An individual meets the definition of an employee applicant/employee; or~~
~~(2) Required by federal law or regulation, by state or administrative rule, or by contract or written agreement with the Board.~~

~~Stat. Auth: ORS 181.534, 676.303 & 679.253~~
~~Stats. Implemented: ORS 676.303 & 181.534~~
~~Hist.: OBD 4-2011, f & cert. ef. 11-15-11~~

~~818-005-0015~~
~~Criminal Records Check Process~~
~~(1) Disclosure of Information by employee applicant/employee.~~
~~(a) Preliminary to a criminal records check, an employee applicant/employee shall complete and sign the Oregon Board of Dentistry Criminal Records Request form and, if requested by the Board, a fingerprint card within three business days of having received the card. The Oregon Board of Dentistry Criminal Records Request form shall require the following information: name, birth date, Social Security Number, driver's license or identification card number, prior residency in other states, and any other identifying information deemed necessary by the Board. The Oregon Board of Dentistry Criminal Records Request form may also require details concerning any circumstance listed in OAR 818-005-0020(1).~~
~~**Note**: The Board may extend the deadline for good cause.~~
~~(b) The Board may require additional information from the employee applicant/employee as necessary to complete the criminal records check and fitness determination, such as, but not limited to, proof of identity; or additional criminal, judicial, or other background information.~~

~~(2) When the Board determines under OAR 818-005-0005 that a criminal records check is required, the Board may request or conduct a LEDS Criminal Records Check, an Oregon Criminal Records Check, a Nationwide Criminal Records Check, or any combination thereof.~~

~~Stat. Auth: ORS 181.534, 676.303 & 679.253~~
~~Stats. Implemented: ORS 676.303 & 181.534~~
~~Hist.: OBD 4-2011, f & cert. ef. 11-15-11~~

~~818-005-0021~~
~~Potentially Disqualifying Crimes~~
~~(1) Crimes Relevant to a Fitness Determination:~~
~~(a) All felonies;~~
~~(b) All misdemeanors;~~
~~(c) Any Federal crime, United States Military crime or international crime.~~
~~(2) Evaluation Based on Oregon and Other Laws. An authorized designee shall evaluate a crime on the basis of Oregon laws and, if applicable, Federal laws or the laws of any other jurisdiction in which a criminal records check indicates an employee applicant/employee may have committed a crime, as those laws are in effect at the time of the fitness determination.~~
~~(3) Expunged Juvenile Record. Under no circumstances shall an employee applicant/employee subject individual be denied under these rules on the basis of the existence or contents of a juvenile record that has been expunged pursuant to ORS 419A.260 and 419A.262.~~

~~Stat. Auth: ORS 181.534, 676.303 & 679.253~~
~~Stats. Implemented: ORS 676.303 & 181.534~~
~~Hist.: OBD 4-2011, f & cert. ef. 11-15-11~~

~~818-005-0025~~
~~Final Fitness Determination~~
~~(1) If the Board elects to conduct a criminal records check, the Board shall make a fitness determination about an employee applicant/employee based on information provided by the employee applicant/employee under OAR 818-005-0005, the criminal records check(s) conducted, and any materially false statements made by the employee applicant/employee.~~
~~(2) In making a fitness determination about an employee applicant/employee, the Board shall also consider the factors in subsections (a), (b), and (c) below in relation to information provided by the employee applicant/employee under OAR 818-005-0015, any LEDS report or criminal offender information obtained through a criminal records check, and other information known by the Board. To assist in considering these factors, the Board may obtain any other information deemed relevant, from the employee applicant/employee or any other credible source, including law enforcement and criminal justice agencies or courts within or outside of Oregon. To acquire other criminal offender information from the employee applicant/employee, the Board may request to meet with the employee applicant/employee and may request to receive written materials or authorization to obtain other relevant information, from employee applicant/employee. The employee applicant/employee shall meet with the Board when requested and provide additional information or authorization within a reasonable period of time, as arranged with the Board. The Board's final fitness determination regarding an employee applicant/employee will include considerations of:~~
~~(a) Potentially disqualifying crimes or conditions and any mitigating circumstances including, but not limited to:~~
~~(A) False Statement. Any materially false statements made by the employee~~

~~applicant/employee to the Board;~~
~~(B) Sex Offender. The employee applicant/employee is registered, or is required to register, as a sex offender in Oregon or any other jurisdiction;~~
~~(C) Warrants. An outstanding warrant against the employee applicant/employee for any crime in any jurisdiction;~~
~~(D) Deferred Sentence, Diversion Program, Parole or Probation. The employee applicant/employee has a deferred sentence, conditional discharge, is participating in a diversion program, or has not completed a required diversion program or any condition of post-prison supervision, parole or probation, for any potentially disqualifying crime;~~
~~(E) Parole or Probation Violation. A post-prison supervision, parole or probation violation for any potentially disqualifying crime; or~~
~~(F) Unresolved Arrests, Charges or Indictments. An unresolved arrest, charge, or a pending indictment, for a potentially disqualifying crime.~~
~~(b) Evaluating any potentially disqualifying crime or condition identified in this subsection (a), the department shall consider:~~
~~(A) The nature of the crime;~~
~~(B) The facts that support the conviction or pending indictment or that indicate the making of a false statement;~~
~~(C) The relevancy, if any, of the crime or the false statement to the specific requirements of the employee applicant's/employee's present or proposed position, services, or employment.~~
~~(c) Intervening circumstances, when applicable, relevant to the responsibilities of the employment or services, including, but not limited to:~~
~~(A) The passage of time since the commission or alleged commission of a crime identified under subsection (a);~~
~~(B) The age of the employee applicant/employee at the time of the commission or alleged commission of a crime identified under subsection (a);~~
~~(C) The likelihood of a repetition of offenses or of the commission of another crime;~~
~~(D) The subsequent commission of another crime;~~
~~(E) Whether a conviction identified under subsection (a) has been set aside and the legal effect of setting aside the conviction; and~~
~~(F) A recommendation of an employer.~~
~~(3) If an employee applicant/employee refuses to consent to a criminal records check, including fingerprint identification, the Board shall deny the employment of the employee applicant/employee or deny any applicable position or authority to provide services. A person may not appeal any determination made based on a refusal to consent.~~
~~(4) If an employee applicant/employee is denied as not fit, the subject individual may not be employed by the Board, or provide services as a volunteer, contractor, or vendor.~~
~~(5) A final fitness determination is a final order of the Board unless the affected employee applicant/employee appeals by requesting either a contested case hearing as provided by OAR 818-005-0035.~~
~~(6) The Board shall inform the employee applicant/employee who has been determined not to be fit on the basis of a criminal records check, via courier, or registered or certified mail to the most current address provided by the employee applicant/employee, of such disqualification.~~

~~Stat. Auth: ORS 181.534, 676.303 & 679.253~~
~~Stats. Implemented: ORS 676.303 & 181.534~~
~~Hist.: OBD 4-2011, f & cert. ef. 11-15-11~~

~~818-005-0030~~

~~Incomplete Fitness Determination~~
~~(1) The Board will close a fitness determination as incomplete when:~~
~~(a) Circumstances change so that a person no longer meets the definition of an "employee applicant/employee" under OAR 818-005-0005;~~
~~(b) The employee applicant/employee does not provide materials or information under OAR 818-015-0015(1)(a) within the time frames established under that rule;~~
~~(c) The Board cannot locate or contact the employee applicant/employee;~~
~~(d) The Board applicant/employee fails or refuses to cooperate with the Board's attempts to acquire other relevant information under OAR 818-005-0015(1)(b);~~
~~(e) The Board determines that the employee applicant/employee is not eligible or not qualified for the position for a reason unrelated to the fitness determination process; or~~
~~(f) The position is no longer open.~~
~~(2) An employee applicant/employee does not have a right to a contested case hearing under OAR 818-005-0035(2).~~

~~Stat. Auth: ORS 181.534, 676.303 & 679.253~~
~~Stats. Implemented: ORS 676.303 & 181.534~~
~~Hist.: OBD 4-2011, f & cert. ef. 11-15-11~~

~~818-005-0035~~
~~Contesting a Fitness Determination~~
~~(1) This rule sets forth a contested case hearing process by which a subject individual may appeal a fitness determination made under OAR 818-005-0025 that he or she is fit or not fit to be a Board employee, volunteer, contractor, or vendor.~~
~~(2) The Attorney General's Model Rules of Procedure, OAR 137-003-0001 through 137-003-0092, apply unless the Board refers the matter to the Office of Administrative Hearings to assign an Administrative Law Judge. If the Board refers the matter to the Office of Administrative Hearings, 137-003-0501 through 137-003-0700 shall apply.~~
~~(3) Process.~~
~~(a) To request a contested case hearing, the employee applicant/employee or the employee applicant/employee individual's legal representative must submit a written request to the Executive Director of the Board. To be timely, the request must be received by the Executive Director of the Board within 21 business days of the postmark of the fitness determination notification letter.~~
~~(b) A contested case hearing shall be conducted by an Administrative Law Judge appointed by the Office of Administrative Hearings once a timely request has been received by the Board as outlined in section (3)(a).~~
~~(4) The Administrative Law Judge will establish the time and place of the hearing. Notice of the hearing shall be served on the Board or designee and participants at least ten working days in advance of the hearing date.~~
~~(5) No Public Attendance. Contested case hearings on fitness determinations are closed to non-participants.~~
~~(6) A fitness determination made under OAR 818-005-0025 becomes final when:~~
~~(a) A timely request for hearing is not filed; or~~
~~(b) A party withdraws a hearing request, notifies the Board or the Administrative Law Judge that the party will not appear, or fails to appear for the hearing.~~
~~(7) The Administrative Law Judge will issue a proposed order following a hearing. Exceptions, if any, must be received by the Board within 10 working days after the service of the proposed order.~~

~~(8) An employee applicant/employee currently employed by the Board who is denied as unfit pursuant to a final fitness determination may appeal the fitness determination either under the contested case process made available by this rule or through a process available under applicable personnel rules, policies and collective bargaining agreements. An employee applicant's/employee's decision to appeal a fitness determination through applicable personnel rules, policies, and collective bargaining agreements is an election of remedies as to the rights of the individual with respect to the fitness determination and is a waiver of the contested case process made available by this rule.~~
~~(9) The only remedy that may be awarded is a determination that the employee applicant/employee is fit or not fit. Under no circumstances shall the Board be required to place an employee applicant/employee in any position, nor shall the Board be required to accept services or enter into a contractual agreement with a employee applicant/employee.~~
~~(10) An employee applicant/employee may not use the appeals process established by this rule to challenge the accuracy or completeness of information provided by the Oregon State Police, the Federal Bureau of Investigation, or agencies reporting information to the Oregon State Police or the Federal Bureau of Investigation. To challenge the accuracy or completeness of information identified in this section (10), a employee applicant/employee may use any process made available by the agency that provided the information.~~
~~(11) Appealing a fitness determination, challenging criminal offender information with the agency that provided the information, or requesting a new criminal records check and re-evaluation of the original fitness determination will not delay or postpone the Board's hiring process or employment decisions.~~
~~(12) Alternative Process. An employee currently employed by the Board may choose to appeal a fitness determination either under the process made available by this rule or through a process made available by applicable personnel rules, policies and collective bargaining provision. A subject individual's decision to appeal a fitness determination through applicable personnel rules, polices and collective bargaining provisions is an election of remedies as to the rights of the individual with respect to the fitness determination and is a waiver of the contested case process made available by this rule.~~
~~(13) The only remedy that may be awarded is a determination that the employee is fit or not fit. Under no circumstances shall the Board be required to place an employee in any position, or shall the Board be required to accept services or enter into a contractual agreement with an employee.~~

Stat. Auth: ORS 181.534, 676.303 & 679.253
Stats. Implemented: ORS 676.303 & 181.534
Hist.: OBD 4-2011, f & cert. ef. 11-15-11

818-005-0040
Agency Representation
(1) Subject to the approval of the Attorney General, an officer or employee of the Board, designated by the Executive Director, is authorized to appear on behalf of the Board in contested case hearings conducted pursuant to these rules.
(2) Board officers, employees, or other authorized personnel may not present legal argument as defined under OAR 137-003-0008 on behalf of the Board in contested case hearings conducted pursuant to these rules.
(3) When the Board determines it is necessary to consult with the Attorney General's office, the Administrative Law Judge will provide a reasonable period of time for a Board's representative to consult with the Attorney General's office and to obtain either written or oral legal argument or

advice, if necessary.

Stat. Auth: ORS 181.534, 676.303 & 679.253
Stats. Implemented: ORS 676.303 & 181.534
Hist.: OBD 4-2011, f & cert. ef. 11-15-11

~~**818-005-0045**~~
~~**Record Keeping, Confidentiality**~~
~~Any information obtained in the criminal records check is confidential. The Board must restrict the dissemination of information obtained in the criminal records check. Only those persons, as identified by the Board, with a demonstrated and legitimate need to know the information, may have access to criminal records check records.~~

~~Stat. Auth.: ORS 181.534, 676.303 & 679.253~~
~~Stats. Implemented: ORS 676.303 & 181.534~~
~~Hist.: OBD 4-2011, f & cert. ef. 11-15-11~~

818-021-0026
State and Nationwide Criminal Background Checks, Fitness Determinations
(1) The Board requires fingerprints of all applicants for a dental or dental hygiene license to determine the fitness of an applicant. **The purpose of this rule is to provide for the reasonable screening of dental and dental hygiene applicants and licensees in order to determine if they have a history of criminal behavior such that they are not fit to be granted or hold a license that is issued by the Board.**~~These will be provided on prescribed forms provided by the Board. Fingerprints may be obtained at a law enforcement office or at a private service. The Board will submit fingerprints to the Oregon State Police for checks against state and national data sources. Any original fingerprint cards will subsequently be destroyed by the Oregon State Police.~~
(2)~~(2)~~ These rules are to be applied when evaluating the criminal history of all licensees and applicants for a dental or dental hygiene license and for conducting fitness determinations **consistent with the outcomes provided in OAR 125-007-0260.**
~~based upon such history. The fact that the applicant has cleared the criminal history check does not guarantee the granting of a license.~~
~~(3) Except as otherwise provided in section (1) in making the fitness determination the Board shall consider:~~
(3) Criminal records checks and fitness determinations are conducted according to ORS 181A.170 to 181A.215, ORS 670.280 and OAR 125-007-0200 to 127-007-0310.
(a) The Board will request the Oregon Department of State Police to conduct a state and nationwide criminal records check. Any original fingerprint cards will subsequently be destroyed.
(b) All background checks must include available state and national data, unless obtaining one or the other is an acceptable alternative.
(c) The applicant or licensee must disclose all arrests, charges, and convictions regardless of the outcome or date of occurrence. Disclosure includes but is not limited to military, juvenile, expunged, dismissed or set aside criminal records.
(4) If the applicant or licensee has potentially disqualifying criminal offender information, the Board will consider the following factors in making a fitness determination:
(a) The nature of the crime;
(b) The facts that support the conviction or pending indictment or that indicates the making

of the false statement;

(c) The relevancy, if any, of the crime or the false statement to the specific requirements of the subject individual's present or proposed position, services, employment, license, or permit; and

(d) Intervening circumstances relevant to the responsibilities and circumstances of the position, services, employment, license, or permit. Intervening circumstances include but are not limited to:

(A) The passage of time since the commission of the crime;

(B) The age of the subject individual at the time of the crime;

(C) The likelihood of a repetition of offenses or of the commission of another crime:

(D) The subsequent commission of another relevant crime;

(E) Whether the conviction was set aside and the legal effect of setting aside the conviction; and

(F) A recommendation of an employer.

(e) Any false statements or omissions made by the applicant or licensee; and

(f) Any other pertinent information obtained as part of an investigation.

(5) The Board will make a fitness determination consistent with the outcomes provided in OAR 125-007-0260.

(a) A fitness determination approval does not guarantee the granting or renewal of a license.

(b) An incomplete fitness determination results if the applicant or licensee refuses to consent to the criminal history check, refuses to be fingerprinted or respond to written correspondence, or discontinues the criminal records process for any reason. Incomplete fitness determinations may not be appealed.

(6)~~(4)~~ The Board may require fingerprints of any licensed Oregon dentist or dental hygienist, who is the subject of a complaint or investigation for the purpose of requesting a state or nationwide criminal records background check.

(7)~~(5)~~ All background checks shall be requested to include available state and national data, unless obtaining one or the other is an acceptable alternative.

(8)~~(6)~~ Additional information required. In order to conduct the Oregon and National Criminal History Check and fitness determination, the Board may require additional information from the licensee/applicant as necessary, such but not limited to, proof of identity; residential history; names used while living at each residence; or additional criminal, judicial or other background information.

(9)~~(7)~~ Criminal offender information is confidential. Dissemination of information received ~~under HB 2157~~ **may be disseminated** ~~is~~ only to people with a demonstrated and legitimate need to know the information. The information is part of the investigation of an applicant or licensee and as such is confidential pursuant to ORS 676.175(1).

(10)~~(8)~~ The Board will permit the individual for whom a fingerprint-based criminal records check was conducted, to inspect the individual's own state and national criminal offender records and, if requested by the individual, provide the individual with a copy of the individual's own state and national criminal offender records.

(11)~~(9)~~ The Board shall determine whether an individual is fit to be granted a license or permit, based on **fitness determinations**~~the criminal records background check~~, on any false statements made by the individual regarding criminal history of the individual, or any refusal to submit or consent to a criminal records check including fingerprint identification, and any other pertinent information obtained as a part of an investigation. If an individual is determined to be unfit, then the individual may not be granted a license or permit. The Board may make fitness determinations conditional upon applicant's acceptance of probation, conditions, or limitations, or other restrictions upon licensure.

~~(10) The Board may consider any conviction of any violation of the law for which the court could impose a punishment and in compliance with ORS 670.280. The Board may also consider any arrests and court records that may be indicative of a person's inability to perform as a licensee with care and safety to the public.~~
(12)~~(11) If an~~ **An** applicant or licensee **may appeal a final fitness determination pursuant to OAR 125-007-0300.** ~~is determined not to be fit for a license or permit, they are entitled to a contested case process pursuant to ORS 183.414 -183.470.~~ Challenges to the accuracy of completeness of **criminal history** information **must be made in accordance with OAR 125-007-0030(7).** ~~provided by the Oregon State Police, Federal Bureau of Investigation and agencies reporting information must be made through the Oregon State Police, Federal Bureau of Investigation, or reporting agency and not through the contested case process pursuant to ORS 183.~~
~~(12) If the applicant discontinues the application process or fails to cooperate with the criminal history check process, then the application is considered incomplete.~~

Stat. Auth.: ORS 679 & 680, 181A.195, 181A215, 676.303
Stats. Implemented: ORS 181A.195, 181A.215, 676.303, 183, 670.280, 679.060, 679.115, 679.140, 679.160, 680.050, 680.082 & 680.100
Hist.: OBD 1-2006, f. 3-17-06, cert. ef. 4-1-06; OBD 4-2011, f & cert. ef. 11-15-11

818-005-0050 - Criminal Records Check for Employees, Volunteers and Applicants
(1) The Board may require a criminal records check and fitness determination for Board employees, volunteers or applicants for employment with the Board.
(2) Criminal records checks and fitness determinations are conducted pursuant to ORS 181A.170 to 181A.215 and OAR 125-007-0200 to 125-007-0310.
(a) To complete the criminal records check and fitness determination, the Board may require additional information from the employee, volunteer or applicant, such as, but not limited to, proof of identity or additional criminal, judicial or other background information.
(b) If the employee, volunteer or applicant has potentially disqualifying criminal offender information, the Board will consider factors listed in ORS 181A.195 before making a fitness determination.
(c) An approved fitness determination does not guarantee employment.
(d) An incomplete fitness determination does not entitle the employee, volunteer or applicant the right to appeal under OAR 125-007-0300.
(3) Pursuant to ORS 181A.195, ORS 676.175, and OAR 125-007-0310, information obtained in the criminal records check is confidential and will not be disseminated by the Board except to persons with a demonstrated and legitimate need to know the information.
(4) The Board may charge a fee to the employee, volunteer or applicant for the criminal records check. The fee will not exceed the fee charged the Board by the OSP and the FBI to obtain such information.

Stat. Auth.: ORS 181A.195, 676.303
Stats. Implemented: ORS 181A.170, 181A.195, 181A215, 676.175, 676.303, 679.250

Dr. Smith moved and Dr. Fine seconded to hold a public rulemaking hearing on October 20, 2016 at 7 p.m. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

CORRESPONDENCE

Oregon Society of Oral and Maxillofacial Surgeons

Dr. Brett Ueeck is requesting that the Oregon Society of Oral and Maxillofacial Surgeons be recognized as a dental organization so that they can sponsor visiting fellows that rotate through Head and Neck Institute's training program. The Board directed staff to send Dr. Ueeck a letter stating that it does not interpret that ORS 679.040(1) would allow the Oregon Society of Oral and Maxillofacial Surgeons' sponsorship of the Head and Neck Institute's training program to qualify for a resident to obtain a nonresident permit.

Dr. Michelle Aldrich and Dr. Kimberly Ross

Dr. Michelle Aldrich and Dr. Kimberly Ross are requesting that the Board either remove from its website that if a licensee has the comment "Please contact the Board office" under Board Action, or post the document(s) on the website so individuals can see the information, and not have to contact the Board for it.

Dr. Schwindt moved and Dr. Beck seconded that the Board refer Drs. Aldrich and Ross' letter and concerns to the Enforcement and Discipline Committee for review and discussion. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

Dr. Magda D'Angelis-Morris

Dr. Magda D'Angelis-Morris is requesting that the Board consider removing the clinical component (full mouth series) of the Oregon Radiologic Proficiency examination.

Dr. Beck moved and Dr. Schwindt seconded that the Board refer Dr. D'Angleis-Morris letter and concerns to the Licensing, Standards and Competency Committee for review and discussion. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

Dr. William Grieve

Dr. William Grieve submitted information to the Board regarding Smile Direct Club which allows individuals to order online invisible aligners without first being examined by a dentist. Dr. Grieve is requesting the Board take action.

The Board directed Ms. Lindley to look into and research the business.

OTHER BUSINESS

Articles and News of Interest (no action necessary)

- Wall Street Journal – "Occupational Licensing Doesn't Seem to Restrict Nurses' Mobility"
- OROHC Newsletter
- HPSP June 2016 Newsletter
- HPSP July/August 2016 Newsletter
- CDC Guidelines for Prescribing Opioids for Chronic Pain

EXECUTIVE SESSION: The Board entered into Executive Session pursuant to ORS 192.606 (1)(f), (h) and (k); ORS 676.165; ORS 676.175 (1), and ORS 679.320 to review records exempt from public disclosure, to review confidential investigatory materials and investigatory information, and to consult with counsel.

PERSONAL APPEARANCES AND COMPLIANCE ISSUES
Licensees appeared pursuant to their Consent Orders in case numbers **2008-0013, 2013-0097, 2013-0119** and **2014-0094**

LICENSING ISSUES

OPEN SESSION: The Board returned to Open Session.

Dr.Schwindt left the meeting.

Specialty Examinations
Dr. Javier moved and Dr. Underhill seconded that the Board approve the examiners as presented. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, and Dr. Underhill voting aye.

Dr. Javier moved and Dr. Underhill seconded that the Board allow the Executive Director and the president of the Board to approve specialty examiners for any other specialty examination that may need to be administered prior to the October 21, 2016 Board Meeting. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

Dr. Stavropoulos – Request for the Board to consider allowing her to demonstrate competency to qualify for General Anesthesia Permit

Dr. Fine moved and Dr. Beck seconded that the Board issue Dr. Stavropoulos a moderate sedation permit and grant Dr. Stavropoulos a General Anesthesia Permit after successful completion of 25 General Anesthesia cases under the direct supervision of either Dr. Pamela Hughes, or Dr. Mark Engelstad. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, Dr. Schwindt and Dr. Underhill voting aye.

Dr. Brady – Request to reinstate General Anesthesia Permit
Mr. Morris moved and Mr. Harvey seconded that the Board send licensee a letter denying the reinstatement of his general anesthesia permit. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, and Dr. Underhill voting aye.

CONSENT AGENDA

2017-0014, 2017-0005, 2016-0102, 2017-0001, 2016-0220, 2016-0205, 2016-0207, 2016-0156 and **2016-0206** Dr. Beck moved and Dr. Underhill seconded that the above referenced cases be closed with a finding of No Violation of the Dental Practice Act per the staff's recommendations. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

COMPLETED CASES

2016-0103, 2016-0067, 2015-0214, 2016-0057, 2016-0093, 2016-0021, 2016-0020, 2016-0081, 2016-0063, 2016-0024, 2016-0068, 2016-0099, 2017-0010, 2016-0108 and **2016-0201** Dr. Beck moved and Dr. Underhill seconded that the Board close the matter with No Further Action per the staff's recommendation. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

2016-0056
Mr. Morris moved and Dr. Underhill seconded that the Board close the matter with a Letter of Concern addressing the issue of ensuring that prior to providing treatment, the patient, the patient records and the pathology that is being treated are all accurately identified and verified. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

BARRETT, RICHARD P., D.M.D. 2016-0051
Mr. Morris moved and Dr. Underhill seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand; a civil penalty of $3,000.00 to be paid within 60 days, complete 20 hours of Board approved community service within 6 months, and monthly submission of spore testing results for a period of one year from the effective date of the Order. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

2016-0058
Ms. Riedman moved and Dr. Underhill seconded that the Board close the matter with a Letter of Concern addressing the issue of ensuring that medications administered to a patient are documented in the patient record and that when dental pathology is evident on a radiograph, the pathology is documented in the patient records. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

BETTIS, WILLIAM D., D.M.D. 2015-0229
Mr. Harvey moved and Dr. Javier seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand; a civil penalty of $2,000.00, and completion of 2 hours of Infection Control continuing education for the licensure period 4/1/2014 – 3/31/2016 within 3 months of the effective date of the order, and issue an Order of Examination whereby the Licensee will undergo a neuro-psychiatric evaluation to be issued within 30 days only if Licensee does not agree to the examination without an Order. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

2016-0060
Ms. Martinez moved and Mr. Harvey seconded that the Board close the matter with a **STRONGLY** worded Letter of Concern reminding Licensee to assure that he clearly documents the flow rate of the nitrous oxide that is administered to his patients and that the appropriate consents are signed and that patients are fully recovered before discharge. The motion passed

with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

2016-0072
Dr. Underhill moved and Dr. Javier seconded that the Board close the matter with a **STRONGLY** worded Letter of Concern suggesting some continuing education in pre-op assessment and diagnosis of third molar extractions, and also suggest continuing education on post surgical management of third molar extraction complications and to ensure proper documentation is in place. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

2015-0235
Dr. Javier moved and Ms. Martinez seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that he has isolated the tooth with a rubber dam before using endodontic hand files in the patient's mouth. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

2016-0030
Dr. Fine moved and Mr. Morris seconded that the Board, with regard to Respondents 1 and 2, close the matter with Letters of Concern reminding Licensees to assure that all instruments that they use are sterilized in autoclaves that are being spore tested on a weekly basis. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman, and Dr. Underhill voting aye.

2016-0007
Mr. Morris moved and Dr. Underhill seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that all of his autoclaves are tested with a biological testing device on a weekly basis. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye. Dr. Schwindt previously recused himself, but was not present for voting or discussion.

EDWARDS, JAMES., D.D.S. 2016-0164
Ms. Riedman moved and Dr. Javier seconded that the Board close the matter with respect to Respondent #1 with a Letter of Concern reminding Licensee to assure that the instruments he is using are being sterilized in an autoclave that is being spore tested on a weekly basis, and in respect to Respondent #2 to issue a Notice of Proposed Disciplinary Action and to offer Licensee a Consent Order incorporating a reprimand for failure to do biological monitoring testing 9 times in the calendar year 2015, and to complete 3 hours of Board approved continuing education on record keeping within 60 days of the effective date of the order. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

EDWARDS, JAMES., D.D.S. 2016-0150
Mr. Harvey moved and Dr. Fine seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent order incorporating a reprimand, a civil penalty of $5,000.00, a refund to patient DF of $1,310.00, and a refund to patient KK of $1,941.00.The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

2016-0048
Ms. Martinez moved and Dr. Underhill seconded that the Board close the matter with a Letter of Concern reminding licensee that when using small instruments a throat drape or ligature is used. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

GAFFANEY, MICHELLE L., R.D.H. 2016-0098
Ms. Martinez moved and Dr. Javier seconded that the Board issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order in which the Licensee would agree to be reprimanded, or in lieu of the disciplinary action, allow the Licensee to retire her dental hygiene license. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

GIBSON, REX S., D.D.S. 2016-0037
Dr. Javier moved and Dr. Underhill seconded that the Board issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order in which the Licensee would agree to be reprimanded, pay a $6,000.00 civil penalty within 90 days of the effective date of the Order, complete 40 hours of Board approved community service within one year, and monthly submission of spore testing results for a period of one year from the effective date of the Order. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

2016-0091
Dr. Fine moved and Ms. Martinez seconded that the Board close the matter with a **STRONGLY** worded Letter of Concern addressing the issue of ensuring that adequate radiographs are taken and reviewed prior to the extraction of teeth. The motion passed with Dr. Smith, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye. Dr. Beck recused himself.

2015-0201
Mr. Morris moved and Dr. Underhill seconded that the Board close the matter with a Letter of Concern addressing the issue of ensuring that when acute symptoms arise during treatment, all possibilities are explored when attempting to diagnose the source of the symptoms. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

2016-0075
Mr. Morris moved and Dr. Underhill seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that all radiographs taken are documented in the patient's chart notes. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

2015-0221
Dr. Fine moved and Dr. Javier seconded to close the matter with No Further Action. The motion passed with Dr. Smith, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye. Dr. Beck recused himself. Dr. Schwindt previously recused himself, but was not present for voting or discussion.
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2016-0071
Ms. Riedman moved and Dr. Underhill seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that his autoclave is spore tested on a weekly basis, to assure that he has a current periapical radiograph of the treated tooth when placing a crown on a tooth, and to document all pathology that he sees on a radiograph, even if it is asymptomatic. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

HOWERTON, DAVID W., D.M.D. 2016-0049
Mr. Harvey moved and Dr. Underhill seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand and a $5,000.00 civil penalty; completion of three hours of Board approved continuing education in record keeping within six months; and successfully pass the Board's jurisprudence exam. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

2016-0073
Ms. Martinez moved and Dr. Underhill seconded that the Board close the matter with a **STRONGLY** worded Letter of Concern addressing the issue of ensuring that a diagnosis is documented in the patient records to justify prescribing medication and that current BLS/CPR certification is maintained. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

2016-0001
Dr. Underhill moved and Dr. Javier seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that instruments that he uses have been sterilized in an autoclave that is being spore tested on a weekly basis. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

HAYMORE, THOMAS L., D.M.D. 2015-0200, **2015-0222, 2015-0223, 2015-0056**
Ms. Riedman moved and Mr. Morris seconded that the Board with regard to Respondent #1 close the matter with No Further Action; for Respondent #2, in the matter of case 2015-0200, move to combine with case 2015-0222 and case 2015-0223, and combine these violations with those of 2015-0056 and issue an Amended Notice of Proposed Disciplinary Action and offer Licensee a re-worded Consent Order incorporating a reprimand, a $10,000.00 civil penalty, surrender of his Minimal Sedation Permit, agree to not apply for any level of sedation permit, and a one year suspension of his dental license with six months of the suspension stayed. The motion passed with Dr. Smith, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye. Dr. Beck recused himself. Dr. Schwindt previously recused himself, but was not present for voting or discussion.

2016-0040
Dr. Javier moved and Mr. Harvey seconded that the Board close the matter with a **STRONGLY** worded Letter of Concern addressing the issue of ensuring that when the Board requests records and information, the requested material is provided in a timely manner, and that prior to providing treatment, a diagnosis is documented to justify providing the treatment. The motion

passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

KORANDO, CHARLES W., D.D.S. 2016-0042
Dr. Fine moved and Ms. Martinez seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand, a $3,000.00 civil penalty to be paid within 60 days, 20 hours of Board approved community service to be completed within six months, and monthly submission of spore testing results for a period of one year from the effective date of the Order. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

2016-0003
Mr. Morris moved and Dr. Javier seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that all autoclaves in his office are spore tested all weeks that patients are scheduled. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

McCLURE, WILLIAM C., D.D.S. 2016-0053
Mr. Morris moved and Dr. Javier seconded that the Board issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order in which the Licensee would agree to be reprimanded, pay $280.00 in restitution in the form of a cashier's, bank, or official check made payable to patient WS, pay a $1,000.00 civil penalty per Board protocols, and complete three hours of Board approved continuing education in the area of record keeping within six months of the effective date of the Order. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

MILLARD, ROBERT B., D.D.S. 2016-0132 & 2016-0175
Ms. Riedman moved and Dr. Underhill seconded that the Board combine 2016-0132 with 2016-0175 and to issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand; a civil penalty of $7,500.00; a refund to patient AA of $2,205.00; a refund to patient GS of $376.00, and that he take a 20 hour Board approved hands-on CE course on restorative dentistry within six months of the effective date of the Order. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

2016-0113
Mr. Harvey moved and Ms. Riedman seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that a periodontal diagnosis is documented for all hygiene appointments. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

MUELLER, FREDERICK A., D.M.D. 2016-0209
Ms. Martinez moved and Dr. Javier seconded that the Board issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order in which the Licensee would agree to be reprimanded and pay a $1,000.00 civil penalty. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

NEWKIRK, ANTHONY J., D.M.D. 2016-0018
Dr. Underhill moved and Dr. Javier seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand, and a $1,000.00 civil penalty. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

2015-0232
Dr. Javier moved and Dr. Beck seconded that the Board close the matter with a Letter of Concern regarding proper documentation of type and strength of anesthetic used and complete documentation of prescriptions written. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

2016-0014
Dr. Fine moved and Ms. Martinez seconded that the Board close the matter with a Letter of Concern addressing the issues of ensuring that a diagnosis is documented prior to proving dental treatment and that all medications administered to a patient are documented in the patient record. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

2016-0046
Mr. Morris moved and Dr. Underhill seconded that the Board close the matter with a Letter of Concern addressing the issue of ensuring that when informed consent is obtained prior to administering nitrous oxide, it is documented in the patient records, and that when the taking of vital signs is not possible, that information is documented in the patient records. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

2016-0027
Mr. Morris moved and Dr. Javier seconded that the Board close the matter with a Letter of Concern addressing the issue of ensuring that dental records are maintained as dictated by the Board's rules and that prior to providing treatment, a diagnosis is documented to justify the treatment. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

PHAM, BAO V., D.M.D. 2016-0062
Ms. Riedman moved and Dr. Underhill seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent order incorporating a reprimand; a civil penalty of $3,000.00 to be paid within 60 days, 20 hours of Board approved community service to be completed within six months, and monthly submission of spore testing results for a period of one year from the effective date of the Order. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

2016-0173
Mr. Harvey moved and Ms. Riedman seconded that the Board close the matter with a **STRONGLY** worded Letter of Concern reminding Licensee to assure that she tests the autoclaves in her office on a weekly basis with a biologic spore strip, and that when working with charting templates, that she customize them to fit the unique needs for documenting each

different appointment. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

2016-0023
Ms. Martinez moved and Dr. Underhill seconded that the Board close the matter with a Letter of Concern addressing the issue of ensuring that EFDAs are limited to providing services allowed by the Board's rules. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

2016-0213
Dr. Underhill moved and Dr. Javier seconded that the Board close the matter with a Letter of Concern advising provider to develop an organized system for tracking spore testing data in all clinics. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

SNYDER, JOHN J., D.M.D. 2016-0191
Dr. Javier moved and Dr. Underhill seconded that the Board issue a proposed Notice of Disciplinary Action and offer the Licensee a Consent Order incorporating a reprimand, a civil penalty of $6,000.00 to be paid within 90 days, 40 hours of Board approved community service to be completed within one year, and monthly submission of spore testing results for a period of one year from the effective date of the Order. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

2015-0141
Dr. Fine moved and Dr. Underhill seconded that the Board close the matter with a Letter of Concern, reminding Licensee to assure that he documents all treatments and medicaments, and to get esthetic approval of a denture prior to final processing. The motion passed with Dr. Smith, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye. Dr. Beck recused himself.

2015-0216
Mr. Morris moved and Dr. Underhill seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that all medicaments used are documented in the patient chart notes, and that all sterilizers are tested with a biological monitoring system on a weekly basis. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

SURFACE, RYAN J., D.M.D. 2016-0011
Ms. Riedman moved and Mr. Harvey seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand; a civil penalty of $2,000.00, completion of ten hours of community service within 60 days, and complete the balance of 3 hours continuing education for the licensure period (4/1/2013 – 3/31/2015), within 60 days of the effective date of this order. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

2016-0052

Mr. Harvey moved and Dr. Beck seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that PARQ or its equivalent is documented and that all treatment is thoroughly documented. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

VAN de GRAAFF, WAYNE K., D.D.S. 2015-0206
Ms. Martinez moved and Dr. Underhill seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand, a civil penalty of $3,000.00, 20 hours of Board approved community service and monthly submission of spore testing results for a period of one year from the effective date of the Order. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

PREVIOUS CASES REQUIRING BOARD ACTION

GARNACHE, MONICA A., D.M.D. 2016-0146
Dr. Underhill moved and Dr. Beck seconded that the Board deny Licensee's proposed resolution and affirm the Board's action of 6/17/16. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

KEILMAN, MARK N., D.D.S. 2015-0208
Dr. Javier moved and Mr. Harvey seconded that the Board accept the proposed wording and offer Licensee a re-worded Consent Order incorporating a reprimand; a $3,000.00 civil penalty; completion of 48 hours of a Board approved continuing education in endodontics within six months; and application through the OAGD for entry into the Board's Mentor program with emphasis on endodontics. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

KIM, SEAN S., D.M.D. 2014-0087 & 2015-0227
Dr. Fine moved and Dr. Javier seconded that the Board offer Licensee a re-worded Consent Order incorporating a reprimand; a $5,000.00 civil penalty; a $1,870.67 reimbursement to Met Life for patient RS, a $1,940.00 refund to patient RS; a $2,712.00 refund to patient SB; successful completion of the courses "Making Endodontics Fun, Predictable, and Profitable" and "Restorative Dentistry 2 – Fixed Prosthodontics" within the next six months; submission of ten completed cases to the Board in the first year after completion of the Board ordered courses, and the next two cases where the patient's Vertical Dimension of Occlusion (VDO) has been altered. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

MATSUDA, MELVIN., D.D.S. 2014-0227
Mr. Morris moved and Ms. Riedman seconded that the Board decline the Licensee's offer and affirmed the Board's action of 10/30/2015. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye. Dr. Schwindt previously recused himself, but was not present for voting or discussion.

2015-0014
Ms. Riedman moved and Mr. Harvey seconded that the Board issue an Order of Dismissal dismissing the Notice of Proposed Disciplinary Action, dated 11/10/15 and closing the matter with a Letter of Concern reminding Licensee to assure the testing of his sterilization devices was completed on a weekly basis. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

NILES, DAVID G., D.D.S. 2015-0169
Mr. Harvey moved and Ms. Riedman seconded that the Board issue an Order of Dismissal dismissing the Final Default Order, effective 6/17/16, and accept Licensee's offer of a Consent Order incorporating a reprimand. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

WEINBERG, SUSAN K., D.M.D. 2015-0187
Ms. Martinez moved and Dr. Underhill seconded that the Board accept Licensee's offer of a Consent Order incorporating a reprimand, three hours of continuing education in record keeping, and Licensee may provide fixed prosthodontics treatment only under the direct supervision of a Board approved mentor until Licensee completes Board approved hands-on continuing education in fixed prosthodontic procedures and demonstrates to a Board approved mentor the ability to provide acceptable fixed prosthetics, except that Licensee may place no more than two crowns per patient appointment without direct supervision. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

ZAVARI, BITA, D.M.D. 2015-0170
Dr. Underhill moved and Dr. Javier seconded that the Board deny Licensee's proposed resolution and affirm the Board's decision of 6/17/16. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

HAYMORE, THOMAS L. D.M.D., 2008-0013
Dr. Fine moved Dr. Javier seconded that the Board deny Licensee's request to be released from his second amended consent order. The motion passed with Dr. Smith, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye. Dr. Beck recused himself. Dr. Schwindt previously recused himself, but was not present for voting or discussion.

LICENSURE AND EXAMINATION

Ratification of Licenses Issued
Ms. Riedman moved, and Dr. Beck seconded, that licenses issued be ratified as published. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

DENTAL HYGIENISTS

H7201	SHANNON MC GLADREY, R.D.H.	6/6/2016
H7202	GENAVIEVE MARIE CLEM, R.D.H.	6/6/2016
H7203	SARAH MARIE MAXEY, R.D.H.	6/6/2016
H7204	ERIN LYNN BURDICK, R.D.H.	6/6/2016
H7205	KATHERINE N GREEN, R.D.H.	6/8/2016
H7206	ISABELLA CUERO-SHELDON, R.D.H.	6/8/2016
H7207	ASHTON N BRITTON, R.D.H.	6/8/2016
H7208	CARLY JEAN BULL, R.D.H.	6/8/2016
H7209	KILI ANN BRUNDRIDGE, R.D.H.	6/16/2016
H7210	KAILYN RENEE SANDERS, R.D.H.	6/17/2016
H7211	KEALA MAE-MARIE BINGHAM, R.D.H.	6/17/2016
H7212	JACLYN M HARDY, R.D.H.	6/17/2016
H7213	MARINA RUCHIN, R.D.H.	6/23/2016
H7214	KYLEE TORRICO, R.D.H.	6/23/2016
H7215	LINDSAY MAUREEN CERA, R.D.H.	6/24/2016
H7216	KATIE-LYNN R GOODWIN, R.D.H.	6/28/2016
H7217	BRIDGET LEE FLYNN, R.D.H.	6/28/2016
H7218	ANIELA SAGE KLINEFELTER, R.D.H.	6/28/2016
H7219	AUBREY MARIE MARTINI, R.D.H.	6/28/2016
H7220	EMILY GILBERT, R.D.H.	6/28/2016
H7221	KATIE A ORLANDO, R.D.H.	6/28/2016
H7222	AMY M WERNER, R.D.H.	6/28/2016
H7223	BRITTANY A LINDGREN, R.D.H.	7/6/2016
H7224	BREANNA JOY WOLF, R.D.H.	7/6/2016
H7225	KAYLA N PARKS, R.D.H.	7/6/2016
H7226	CARA L NUNEMAKER, R.D.H.	7/6/2016
H7227	KATI MARIE HALL, R.D.H.	7/6/2016
H7228	JENNIFER KAY HOWARD, R.D.H.	7/6/2016
H7229	TAMMY L WALKER, R.D.H.	7/6/2016
H7230	COURTNEY R ORTH, R.D.H.	7/6/2016
H7231	JOURDAN LEANN BURKLUND, R.D.H.	7/14/2016
H7232	TAYLOR DENAE LOTT, R.D.H.	7/14/2016
H7233	MELODY NICOLE FERZACCA, R.D.H.	7/14/2016
H7234	MADISON ALEXANDRA SWINN, R.D.H.	7/14/2016
H7235	ALLISON RENAE HANCOCK, R.D.H.	7/14/2016
H7236	PRESLIE SOPHIE BECK, R.D.H.	7/14/2016
H7237	DEVIN ELISE ENDICOTT, R.D.H.	7/14/2016
H7238	CLAUDIA M ESCOBAR, R.D.H.	7/14/2016
H7239	TAYLOR CHRISTINE SJELIN, R.D.H.	7/21/2016
H7240	ALEXA K CASTLE, R.D.H.	7/21/2016
H7241	TAREN KATRINA LARSEN, R.D.H.	7/21/2016
H7242	HEATHER LYNN THOMAS, R.D.H.	7/21/2016
H7243	MACKENZIE TINGLE, R.D.H.	7/21/2016
H7244	AUBREY LAREE WASSOUF, R.D.H.	7/21/2016

H7245	DANIELLE MARIE BASS, R.D.H.	7/21/2016
H7246	THELMA RENEE SCHNEIDER, R.D.H.	7/21/2016
H7247	CHRISTINA DIANE KYLE, R.D.H.	7/21/2016
H7248	MICHELLE LOUISE EDWARDS, R.D.H.	7/21/2016
H7249	KAITLYN E EMARD, R.D.H.	7/21/2016
H7250	PAMELA S LINEGAR, R.D.H.	7/21/2016
H7251	CATHERINE UYEN TRAN, R.D.H.	7/21/2016
H7252	ANNE MARIE HETHORN, R.D.H.	7/21/2016
H7253	MARIAH GODINEZ, R.D.H.	7/21/2016
H7254	BRIDGET ELISABETH SCHNEIDER, R.D.H.	7/21/2016
H7255	SARAH NICOLE ARNSBERG, R.D.H.	7/21/2016
H7256	EMILIE MAE KEIMIG, R.D.H.	7/21/2016
H7257	CHELSIE R VANDEHEY, R.D.H.	7/21/2016
H7258	HOLLY LYN ANDYKE, R.D.H.	7/21/2016
H7259	DUSTY J LAWELLIN-MENDOZA, R.D.H.	7/26/2016
H7260	JAMIE LYNN HAMILTON, R.D.H.	7/26/2016
H7261	PULAUD MEHR, R.D.H.	7/26/2016
H7262	ANGELA MARIE PECHMANN, R.D.H.	7/26/2016
H7263	JOSEPHINE CHRISTENSEN, R.D.H.	7/26/2016
H7264	CHERYL A SELLARS, R.D.H.	7/26/2016
H7265	TAMIKA M JEFFERSON, R.D.H.	7/26/2016
H7266	RACHAEL POTTER, R.D.H.	7/26/2016
H7267	PAYTEN KAE WISNIEWSKI, R.D.H.	7/26/2016
H7268	MICAELA NICOLE DUDLEY, R.D.H.	7/26/2016
H7269	HEATHER RENEE MILLER, R.D.H.	7/26/2016
H7270	SAMANTHA DAWN DAVIS, R.D.H.	7/28/2016
H7271	CHELSEA ANNE LITTON, R.D.H.	7/28/2016
H7272	CEVINAH CHOTARD ZUÑIGA-WEST, R.D.H.	7/28/2016
H7273	SHARON A FOUGHT, R.D.H.	8/5/2016
H7274	SARAH BERNADETTE TYLER, R.D.H.	8/5/2016
H7275	ASHLEY MIKEL DOUGHERTY, R.D.H.	8/5/2016
H7276	CHRISTINA MARIE FRISCIA-DREIER, R.D.H.	8/5/2016
H7277	EMMY X H LI, R.D.H.	8/5/2016
H7278	JORDYN LEE MAIN, R.D.H.	8/5/2016
H7279	RACHEL ELIZABETH COWGER, R.D.H.	8/8/2016
H7280	RACHEL GAIL NICHOLS, R.D.H.	8/8/2016

DENTISTS

D10449	MARY FRANCES STAVROPOULOS, D.D.S.	6/6/2016
D10450	BENJAMIN D JAMES, D.D.S.	6/8/2016
D10451	BRANDON ALDEN SNOW, D.M.D.	6/8/2016
D10452	JAMES KOLBY ROBINSON, D.M.D.	6/8/2016
D10453	LAUREN NGA-LING HUM, D.M.D.	6/8/2016
D10454	SCOTT MITCHELL ROOKER, D.D.S.	6/8/2016
D10455	LAWRENCE M EBEL, D.M.D.	6/15/2016
D10456	ERIC MICHAEL PETERS, D.M.D.	6/16/2016
D10457	DANIEL WARNOCK, D.D.S.	6/16/2016

D10458	CAROLINE ZELLER, D.D.S.	6/17/2016
D10459	MERAT BERNIE OSTOVAR, D.M.D.	6/17/2016
D10460	NATHAN SCOTT RISLEY, D.M.D.	6/17/2016
D10461	ROLAND H NOMIE, D.M.D.	6/17/2016
D10462	LANCE L BERGESON, D.M.D.	6/17/2016
D10463	DEVIN R NELSON, D.M.D.	6/17/2016
D10464	SPENCER NATHAN BURNHAM, D.M.D.	6/17/2016
D10465	JOHN NEIL DELLA CROCE, D.M.D.	6/20/2016
D10466	TYLER S BRADSTREET, D.M.D.	6/20/2016
D10467	KARL SHUAI SHAO, D.M.D.	6/20/2016
D10468	KEITH L ARGRAVES,	6/20/2016
D10469	TAYLOR C BENNION, D.M.D.	6/20/2016
D10470	JENNIFER HONG NGUYEN, D.M.D.	6/20/2016
D10471	KIRANDEEP K BRAR, D.M.D.	6/20/2016
D10472	MATTHEW R ERICKSON, D.M.D.	6/20/2016
D10473	CATHERINE BOM KIM, D.M.D.	6/21/2016
D10474	KRISTIN ELIZABETH MOTSCHALL, D.D.S.	6/21/2016
D10475	SARAH JEAN ERMOSHKIN, D.D.S.	6/21/2016
D10476	AMARDEEP BAINS, D.M.D.	6/23/2016
D10477	JARED M YOUNG, D.M.D.	6/23/2016
D10478	SUKHMANPREET KAUR SIDHU, D.M.D.	6/23/2016
D10479	ALEXANDER RUDNITSKI, D.M.D.	6/24/2016
D10480	MATT ANDERSON, D.D.S.	6/24/2016
D10481	STACY LEIGH GRIFFITH, D.D.S.	6/24/2016
D10482	JACOB C BURRY, D.D.S.	7/6/2016
D10483	IKE H RAHIMI, D.M.D.	7/6/2016
D10484	AUDREY MICHELLE MIKKELSON, D.M.D.	7/6/2016
D10485	YVONNE YANG, D.D.S.	7/14/2016
D10486	KAYLA MARIE WALTERS, D.M.D.	7/14/2016
D10487	KARAN JOHNSON REPLOGLE, D.D.S.	7/14/2016
D10488	GABRIELLE LYNN SCHAEFER WEISHOFF, D.M.D.	7/14/2016
D10489	ELIJAH JED VOLVOVIC, D.M.D.	7/14/2016
D10490	LINDSAY K TAIRA, D.M.D.	7/14/2016
D10491	THANH-TRUC THI NGUYEN, D.M.D.	7/14/2016
D10492	JOHN MICHAEL B DURO, D.M.D.	7/14/2016
D10493	JIYUNG KANG, D.M.D.	7/14/2016
D10494	BRADLEY S MC GOWAN, D.M.D.	7/14/2016
D10495	DARYL M KHAW, D.M.D.	7/14/2016
D10496	CASEY DILLON NORLIN, D.M.D.	7/14/2016
D10497	SETH E HINCKLEY, D.M.D.	7/14/2016
D10498	CRYSTAL M KELSO, D.M.D.	7/14/2016
D10499	ALEXANDRIA E JOHNSON, D.M.D.	7/14/2016
D10500	ESTRELLITA GITZEN RAMIREZ, D.M.D.	7/14/2016
D10501	RYAN M LEININGER, D.M.D.	7/14/2016
D10502	NATHAN E BUSHMAN, D.D.S.	7/21/2016
D10503	JOSHUA TOD HARDIN, D.M.D.	7/21/2016
D10504	MICHAEL LEE MC CUNNIFF, D.D.S.	7/21/2016
D10505	JENNIFER LEE ROSALES, D.M.D.	7/21/2016

D10506	EMILY FERN GAUNT, D.M.D.	7/21/2016
D10507	ERIN KATHLEEN JOHNSON, D.D.S.	7/21/2016
D10508	HEATHER MARIE MANKA, D.M.D.	7/21/2016
D10509	KENNETH GREGORY DOWNING, D.M.D.	7/21/2016
D10510	ANDREW JON CEFALO, D.M.D.	7/21/2016
D10511	LISA YANTI ANDERSON-PIETZ, D.M.D.	7/21/2016
D10512	NAVID KALANTARPOUR, D.D.S.	7/26/2016
D10513	BERMEN BARK-HUNG WONG, D.D.S.	7/26/2016
D10514	CHRISTOPHER ALLEN PRIMLEY, D.M.D.	7/26/2016
D10515	ALLISON LEE OETH, D.D.S.	7/26/2016
D10516	KEITH MICHAEL HERKERT, D.M.D.	7/26/2016
D10517	KIRAN MISTRY, D.D.S.	7/26/2016
D10518	MICHAEL CHARLES KIM, D.M.D.	7/26/2016
D10519	ALEXANDER SONESSON, D.M.D.	7/26/2016
D10520	STEVEN PHILIP HACKMYER, D.D.S.	7/26/2016
D10521	NICHOLAS S STEBBINS, D.M.D.	7/28/2016
D10522	BENJAMIN WADE HASLAM, D.M.D.	7/28/2016
D10523	MIRA KHAROTI DELLA CROCE, D.M.D.	8/5/2016
D10524	MICHAEL J PURCELL, D.D.S.	8/5/2016
D10525	ERIK SEAN SWANSON, D.M.D.	8/5/2016
D10526	KEDY SHEN, D.M.D.	8/5/2016
D10527	JONATHAN JAMES JELMINI, D.D.S.	8/5/2016
D10528	ERICA D CROSTA, D.M.D.	8/5/2016
D10529	DOMINIQUE J MEDINA, D.D.S.	8/5/2016
D10530	SOROUSH AMALI, D.M.D.	8/5/2016
D10531	JOHN MARK WAITE, D.M.D.	8/5/2016
D10532	MICHELLE GARNACHE, D.M.D.	8/5/2016
D10533	CHAD W ACHATZ, D.M.D.	8/5/2016

EXECUTIVE SESSION: The Board entered into Executive Session pursuant to ORS 192.660(2)(i), to conduct the annual review and performance evaluation of the Executive Director. No final action will be taken in Executive Session.

OPEN SESSION: The Board returned to Open Session.

Dr. Beck moved and Mr. Morris seconded that the Board rate Mr. Prisby as Outstanding on his performance evaluation. The motion passed with Dr. Smith, Dr. Beck, Dr. Fine, Mr. Harvey, Dr. Javier, Ms. Martinez, Mr. Morris, Ms. Riedman and Dr. Underhill voting aye.

Announcement

No announcements

DRAFT

ADJOURNMENT

The meeting was adjourned at 4:20 p.m. Dr. Smith stated that the next Board meeting would take place October 21, 2016.

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Julie Ann Smith, D.D.S., M.D., M.C.R.
President

DRAFT

ASSOCIATION REPORTS

Nothing to report under this tab

COMMITTEE REPORTS

ADEX
AMERICAN BOARD OF DENTAL EXAMINERS, INC.

Stanwood Kanna, D.D.S., President
William Pappas, D.D.S., Vice-President
Jeffery Hartsog, D.M.D., Secretary
Conrad McVea, III, D.D.S., Treasurer
Bruce Barrette, D.D.S., Past President

Highlights of the 12th Annual American Board of Dental Examiners, Inc. (ADEX) House of Representatives
August 7, 2016
Rosemont, IL

The following are highlights of the 12th Annual ADEX House of Representatives:

There were 50 out of 58 Jurisdiction, District Hygiene and District Consumer Representatives present.

2016 – 2017 Officers were elected: Dr. Stanwood Kanna, HI, President; Dr. William Pappas, NV, Vice-President; Dr. Jeffery Hartsog, MS, Secretary; Dr. Conrad "Chip" McVea, III, LA, Treasurer. Dr. Bruce Barrette, WI, remains as Immediate Past President.

District 5 elected Dr. Eleanore Awadalla, OH, to the ADEX Board of Directors.

District 8 re-elected Dr. David Perkins, CT, to the ADEX Board of Directors.

District 9 elected Dr. Russell Chin, RI, to the ADEX Board of Directors.

District 10 elected Dr. Mina Paul, MA, to the ADEX Board of Directors.

ADEX Board of Directors

- Framework for a major review on the ADEX Bylaws announced.
- ADEX Strategic Plan reviewed.

Changes to the ADEX Dental Examination:

- Scoring – No changes.
- Endodontics
  - Increased the allowable size of the posterior access opening for 2017.
  - Approved new prototype Acadental molar for use in examination starting in 2018 or later depending on its availability.
- Periodontics – No changes. The committee is working on developing a prototype patient-based periodontics exam that test for the critical aspects of the National Occupational Analysis (NOA).
- Restorative
  - Approved the indirect pulp cap protocol beginning in 2017.
  - In 2018 there will be one posterior composite restoration.
- Prosthodontics – No change to current exam. Committee finalized new proposed criteria.

P.O. Box 50718 • Mesa, AZ 85208
Telephone (503) 724-1104
ADEXOFFICE@aol.com
www.adexexams.org

Changes to the ADEX Dental Hygiene Examination:

- The 2017 scoring changes will undergo an equating study before they are implemented.
- The Case Selection will consist of one primary quadrant with 6 natural teeth and 2 posterior teeth in a secondary quadrant all of which the candidate may utilize to select surfaces.
- The 2018 examination will be stopped after pre-treatment if it is determined that an adequate number of points to pass the examination has not been accrued to have a chance to pass.
- A process for the submission of a second Case Selection is being investigated for implementation in 2018.

ADEX House of Representatives:

- Approved the Dental and Dental Hygiene Examinations as recommended by the Examination Committees and the Board of Directors.

Presentations to the House of Representatives:

Dr. Joseph Gambacorta, Asst. Dean of Clinical Affairs, Univ. of Buffalo - School of Dental Medicine

"The Role of the Patient Centered CIF in a National Exam for Dentistry."

Dr. David Perkins, Chairman, The Commission on Dental Competency (CDCA)

"ADA Licensure Task Force – The Dental Examinations Are Not the Same."

****

13th Annual ADEX House of Representatives Meeting is scheduled on Sunday, August 13, 2017, Doubletree Hotel, Rosemont, IL.

AMERICAN BOARD OF DENTAL EXAMINERS, INC.

Stanwood Kanna, D.D.S., President
William Pappas, D.D.S., Vice-President
Jeffery Hartsog, D.M.D., Secretary
Conrad McVea, III, D.D.S., Treasurer
Bruce Barrette, D.D.S., Past President

September 26, 2016

ADEX Member States:

Great and wonderful news today. The Governor of California has just signed Bill 2331 into law. It is official. ADEX has gone through the most challenging aspect of its acceptance into the state of California.

This Bill now states that State of California accepts the ADEX Dental Examination but it is contingent upon an Occupational analysis to be conducted by the State of California. We are in the immediate process of moving that aspect through. ADEX is confident that the exam and its formats will go through this process with no problems.

I would like to take this time to thank all the leadership of ADEX, the members of the Executive Committee, Board of Directors, Dental Exam Committee and the ADEX Member States for their hard work in moving this process through. We have all done a great job. The goal is not reached yet, but we are a large step closer. The possibilities are now open for tremendous movement towards a uniform national exam.

Congratulations to all! Now we must take this momentum and make plans and push hard for our goal.

Thank you, Mahalo,

Stanwood H. Kanna
President

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www.adexexams.org

CDCA

September 2016

Quarterly Newsletter

Volume 5

Governor Jerry Brown Signs California Bill to Designate the ADEX Exam for Dental Licensure Pathway

On September 24, 2016, California Governor Jerry Brown signed state bill 2331 which allows for the inclusion of the ADEX dental exam as an approved pathway for initial licensure in California. A Standards Compliance and Certification Review of the ADEX Dental examination must now be conducted by the Office of Professional Examination Services who will deliver their review to the Dental Board of California. This procedural process is likely to take several months.

Two New CDCA Member States

The CDCA Board of Directors was thrilled to welcome two new CDCA member states this summer; Missouri and Utah. With now 27 member jurisdictions, the CDCA continues to grow and benefit from the rich experiences and knowledge that each new member board brings. We are excited to include both Missouri's and Utah's dental board members in all of our activities and events at January's Annual Meeting.

2016 Educators Conference Recap and Feedback

Dental and dental hygiene educators from schools that host CDCA administered ADEX exams across the U.S. met for the 2016 Educators Conference in Maryland this past June 16th and 17th. Educators networked with CDCA Steering Committee members, member state board leadership, PCCIF exam chiefs and the CDCA Board of Directors while attending both group and dental/dental hygiene track based sessions. The conference included educator panels such as "Educator's Perspective on the Patient Centered CIF Exam" and a dental hygiene panel on "Why are some Mock Boards more successful than others?". Post event survey feedback indicated that panels allowed for open dialogue between schools and were well received by educators.

Below are just a couple of comments we received in the Educators Conference post-event survey:

"We will conduct the first CDCA/ADEX "exam" at our facility. This conference has been informative, lessened anxiety and has proven to be a great venue for networking. The best part was "mock board" session. We will use some of the ideas presented in this portion of the conference."

"Exactly what I was hoping to take away from! The conference gave me the tool to (1). Assess our school performance on the ADEX CDCA exam, compared to national result; (2). Confirm that our school is on the right track without preparation of our students for success; and (3). Implement additional steps in our preparation to ensure even better success. Thank you."

Ms. Patricia Connolly-Atkins leads the afternoon dental hygiene panel, "The ADEX Dental Hygiene Exam"

Educators from 6 participating PCCIF schools shared an educator's perspective of the PCCIF.

Class of 2016 Candidate Survey Feedback

The CDCA surveyed all 2016 dental and dental hygiene candidates from all exam sites after their examinations to ask about their experiences with the CDCA throughout the exam process. 1,164 dental candidates and 898 dental hygiene candidates from all exam sites participated. Feedback helped identify areas to improve and projects have been started around candidate manuals, DSE images as well as CFE consistency.

Reminder: CDCA Annual Meeting This January 12th-14th

Next year's meeting will take place on January 12-14, 2017 and will be held once again at Disney's Yacht and Beach Club Resorts in Orlando, FL. Invitations to the CDCA Annual Meeting will be sent out to all Active (Voting) Members of the CDCA, as well as to Consultant Members who serve on the CDCA Standing Committees or who are Chief Examiners, Dental Captains, or Data System Managers in early October. Please be sure to register as soon as you receive your invitation and we look forward to a great meeting.

CDCA Educators Conference is moving!

The 2017 Educator's Conference will be held in conjunction with the CDCA Annual Meeting in January, in Orlando, Florida, at Disney's Yacht and Beach Club Resorts on January 13-14, 2017. The schools have been notified of this change of date and venue and registration begins in October.

Nominations open for 2017 Guy Shampaine Award

The CDCA is excited to open nominations for the 2017 Guy Shampaine Award! The Guy Shampaine Award annually recognizes a CDCA member whose outstanding efforts on behalf of the CDCA embody our values of service, dedication, and integrity. This award was created in 2016 in honor of Dr. Guy Shampaine, whose many contributions include significant service as a CDCA dental examination chief, and outstanding leadership service to the CDCA Board of Directors, culminating with four years as its Chairman from 2011-2015.

ALL CDCA members, including consultants, are eligible. However, CDCA Board Members are not eligible for the Guy Shampaine Award and you may not nominate yourself.

Please click here for more information and to fill out a nomination form. All nominations must be submitted by October 28, 2016, via the online form.

Dental Examiner Standardization and Calibration Improvement Initiative

In collaboration with ADEX and CITA, the CDCA is actively working to enhance dental examiner standardization (training) and calibration both online and onsite. As part of this initiative, all active CDCA dentists were surveyed on their experience and feedback over the last 18 months with the current standardization and calibration process. Thank you to the 242 dental examiners that participated in the survey. This feedback was very helpful and will be incorporated into adjustments for the 2017 exam season. A similar survey for dental hygiene examiners will be emailed to CDCA members in October.

PCCIF Successfully Implemented at 7 Schools for the Class of 2016 - Preparations for 2017

With overall positive feedback received from class of 2016 participating schools, 13 dental schools have requested CDCA to offer the Patient Centered Curriculum Integrated Format (PCCIF) exam to their class of 2017. Based on learning in 2016, CDCA will be making enhancements to its computer systems at central office and on site to help facilitate the administration of future PCCIF exams based on feedback we received from members, candidates, and school faculty.

All Dental Hygiene Sites Successfully Transitioned to Electronic Tablet Scoring

The CDCA successfully implemented electronic scoring at all spring dental hygiene exam sites. Most candidates are now able to receive their scores within 24 hours of their exam. Examiners reported appreciation for the efficiency of the new electronic process. Thank you for everyone's efforts to help take bubble sheets out of the CDCA vocabulary. Also, based on examiner feedback during 2016, many new enhancements and features are being added to the electronic grading system in 2017!

NEW - CDCA Community Snapshots "Snaps"

The CDCA would like to offer space in our quarterly newsletters for photos of our members out at exam sites as a new ongoing piece. If you have any photos of team dinners, team outings, etc. you would like to submit to the member Community Snapshots "Snaps" Section of the newsletter, please send them with a brief description to Brittany Verner, our Public Affairs and Special Projects Leader, at bverner@cdcaexams.org.

The June 28th New Hampshire Technical Institute dental hygiene crew enjoying some delicious seafood.

Why travel alone, when you can fly together as a team?!

CDCA Highlighted in the Evolution of Dentistry in Jamaica

The 25 minute video includes a segment on the CDCA's role (minutes 17:50 to 19:50). To download the video, click on this link.

Meet the CDCA Team: Hannah Vannoy

Meet the CDCA's first full-time remote employee: Hannah Vannoy. From her home in Savannah, GA, she supports CDCA's service mission as the Associate Director of Application Development and Technical Services.

Focusing on the development of various software systems, both current and new, Hannah's efforts are centered on finding holes in processes and then finding ways to fill them. With more than 10 years of experience in dental licensure administration, she brings a depth of knowledge as she approaches developing training protocols that will help the CDCA exam teams while onsite as well as systems that the central office uses to

communicate with examiners and candidates.

Apart from the regular trips up to the central office, Hannah most appreciates the “solving puzzles” aspect of her role, and she enjoys being able to contribute to the day-to-day goals of the team. Though she may be hundreds of miles from the central office, she can reach out to any of her fellow team members at a moment’s notice.

When not working on projects to support the CDCA, Hannah serves in the military with the Georgia Army National Guard. While her army experience over the past five years is rooted in Signal support functions, she is now learning how signal and cyber functions affect her battalion’s field artillery missions and the soldiers she leads.

Hannah is excited to be a part of the CDCA staff, and you will see her at many of the exams in 2017. Along with Michael Zeder, Director of Testing Operations and Technical Services, she will be on call to answer your technical questions that may arise while you’re on site at an exam.

If you need to reach out to her, her email is hvannoy@cdcaexams.org, and her phone number is 443-270-3081.

CDCA By the Numbers: Dental and Dental Hygiene Clinical Year-to-Date Stats

5,721 Dental Candidates Tested

4,201 Dental Hygiene Candidates Tested

69 Dental Auxiliary Candidates Tested

6 New Exam Sites Added

117 Different Dental and Dental Hygiene Exam Sites Visited

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You're invited to...

The 2017 CDCA Annual Meeting

Thursday, January 12 to Saturday, January 14, 2017

Disney's Yacht & Beach Club Resorts
Orlando, Florida

Dear Stephen Prisby,

We are pleased to inform you that the CDCA's 2017 Annual Meeting will be held on January 12-14, 2017 (Thursday-Saturday), at Disney's Yacht & Beach Club Resorts in Orlando, Florida. We have included some quick links for you to the right of this invitation to help you navigate the registration process as well as answer questions regarding arrival/departure dates, transportation, hotels, reimbursement information and other important meeting arrangements. This invitation and meeting resource materials are being sent to all Active (Voting) Members of the CDCA, as well as to Consultant Members who serve on the CDCA Standing Committees or who are Chief Examiners, Dental Captains, Data System Managers or those who have joined the CDCA this year.

This year's program includes additional opportunities for training and several adjustments to the placement of our traditional sessions in order to improve the meeting flow and dialogue for attendees. This year's Zegarelli Lecture will be an engaging and practical presentation focused on bridging generations within educational and exam environments today by generational expert Phil Gwoke of BridgeWorks.

On Thursday, January 12, the conference will start with Dental and Dental Hygiene Chiefs, Dental Captains, and Data Systems Managers training, as well as the New Member Orientation and State Board President/Vice President Forum. Most functions will begin in the morning.

On Friday, January 13, the morning will begin with Committee Meetings, and feature the Zegarelli Lecture and Town Hall. A Disney-led Spouse/Guest Tour will be available starting at 7:45 am. Following lunch, Business Session I will commence, which will include the CDCA member service awards (a listing of the recipients is included with the linked materials). The State Caucus meetings will be held immediately after Business Session I. The evening will conclude with our VIP Reception for all Annual Meeting attendees and educators from CDCA/ADEX exam participating schools from across the U.S.

On Saturday, January 14, the morning begins with elections and the

Quick Links:

Event RSVP

Book Your Hotel Stay

Preliminary Agenda

Attendee Info Resource

Service Awards

Magical Express Information

Setup Your MagicBand

Map of Disney's Yacht and Beach Club Resorts

Guest/Spouse Tour Information

If you have any questions or need more information, please contact:

Jack Feldesman, Director of Finance and Administration, jfeldesman@cdcaexams.org, 443-270-3075

Shannon Dadurka, Event Logistics Specialist, sdadurka@cdcaexams.org, 443-270-3086

Steering Committee meeting and concludes with Business Session II and any election runoffs. Adjournment is at 11:30am, allowing attendees time to return home the same day.

Please let us know if you will be able to join us this year by clicking on the "RSVP Now" button to the right. While registering online for the Annual Meeting, you will also be able to reserve your hotel room at Disney's Yacht & Beach Club Resorts.

RSVP Now

Should you wish to extend your stay, feel free to take advantage of the special CDCA room block rate of $211 (plus 12.5% tax) per night between Saturday, January 7, 2017 and Tuesday, January 17, 2017 (subject to availability).

On behalf of the Board of Directors, we thank you for your interest and hope to see you in January!

Sincerely,

Dave Perkins, DMD
Chairman

Alexander Vandiver, MBA
Chief Executive Officer

Jack Feldesman, MBA
Director of Finance and Administration

Preliminary Agenda:

THURSDAY, JANUARY 12, 2017

Registration 7:00am-6:00pm
Dental Chiefs Training 8:30am-11:30am
Dental Hygiene Chiefs and DSMs Training 9:00am-11:30am
New Member Orientation Session I 9:00am-11:30am
Lunch: New Members/Board of Directors/Dental and Dental Hygiene Chiefs and DSMs 11:30am-12:30pm
Dental Captains Training 12:30pm-3:00pm
New Member Orientation Session II 12:30pm-2:30pm
Dental Chiefs, Dental Hygiene Chiefs, Assignment Committee and Board of Directors Roundtable 3:00pm-4:30pm
State Board President/Vice President Forum 4:30pm-6:30pm

FRIDAY, JANUARY 13, 2017

Registration 7:00am-6:00pm
Optional Guest/Spouse Tour 7:45am-2:00pm
Optional Examiner Scoring Tablet Workshop 8:00am-9:00am
Optional Understanding Your Grading Statistics Report Workshop 8:00am-9:00am
Committee Meetings 8:00am-9:00am

Zegarelli Lecture 9:00am-11:00am
Town Hall 11:00am-12:30pm
Lunch 12:30pm-1:30pm
Business Session I 1:30pm-4:00pm
State Caucuses 4:00pm-5:30pm
VIP Reception 7:30pm-10:00pm

SATURDAY, JANUARY 14, 2017

Registration 6:30am-12:00pm
Buffet Breakfast 7:00am-9:15am
Elections 7:30am-9:15am
Active (Voting) Members Only 7:30am-9:15am
Steering Committee 8:00am-9:30am
Business Session II and Elections Runoff 9:30am-11:30am
Adjournment 11:30am

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EXECUTIVE DIRECTOR'S REPORT

EXECUTIVE DIRECTOR'S REPORT
October 21, 2016

Board Member & Staff Updates

The following Board members are eligible for reappointment to the Board this spring: Dr. Beck, Ms. Riedman and Mr. Morris. I hope they are interested in continuing to serve on the Board and I recommended their continued service and my support to the governor's office. I will coordinate with them their timely submission of required interest forms to the governor's office. The Board will have a vacancy when Dr. Schwindt's second term of service ends in the spring as well.

OBD Budget Status Report

Attached is the latest budget report for the 2015 - 2017 Biennium. This report, which is from July 1, 2015 through August 31, 2016, shows revenue of $2,096,152.16 and expenditures of $1,579,373.86. If Board members have questions on this budget report format, please feel free to ask me. Our proposed 2017-19 Agency Budget has been reviewed by DAS and I will have an update on their feedback at the meeting. **Attachment #1**

Customer Service Survey

Attached are the legislatively mandated survey results from July 1, 2016 – August 31, 2016, Comments received will be available for the Board to review at the meeting. The results of the survey show that the OBD continues to receive positive ratings from the majority of those that submit a survey. **Attachment #2**

Board and Staff Speaking Engagements

I gave a "Board Updates" presentation on September 21, 2016 to the Multnomah Dental Society at the OHSU School of Dentistry in Portland.

I gave a "Board Updates" presentation on October 7, 2016 to the Oregon Dental Association's House of Delegates in Portland.

AADA and AADB Annual Meetings

I will report to the Board on the American Association of Dental Administrators and the American Association of Dental Boards Annual Meetings which were scheduled October 16 - 19, 2016 in Denver, Colorado.

National Practitioners Data Bank (NPDB) Report

Attached is the result of the NPDB's compliance review for reporting disciplinary actions between January 1, 2013 and December 31, 2014. The NPDB congratulates all of the state boards that achieved the "compliant status by August 1, 2016. The NPDB would like to thank all of the state boards for their hard work in meeting NPDB reporting requirements.
Attachment #3

Executive Order 16-06- Public Records

Attached are Executive Order 16-06 and the OBD's revised Agency Records Request Policy. State agencies were directed by Governor Brown through this Executive Order to work through DAS and the Secretary of State's State Archivist, to implement model public records management policies. I am asking the Board to review and approve the new Agency Records Requests Policy, #834-413-010. **Attachment #4 ACTION REQUESTED**

Executive Order 16-13- Unifying Cyber Security in Oregon
Attached is an email from Governor Kate Brown to all agency directors and Executive Order 16-13 announcing her order to unify cyber security in Oregon.
Attachment #5

2016 Annual Performance Report
Attached is the OBD's Annual Performance Progress Report along with the Board's Self-Assessment results.
Attachment #6

Dental Hygiene Renewal
The second renewal of the 2015-17 Biennium finished Sept 30th.

- 1906 Renewals mailed – July 16, 2016
- 1696 Renewed
- 163 Expired (92 out-of-state, 71 in Oregon)
- 47 Retired

Expanded Practice Dental Hygienists- Report
The OBD is required to report on the reimbursement of services provided by expanded practice dental hygienists per ORS 680.210 Compilation of data on expanded practice dental hygienists; reports by health insurers; report to legislature; rules. The information was sent to the legislators in September.
Attachment #7

Letter to Legislators & 2017-2020 Strategic Plan
The strategic plan was posted on the OBD website and an email blast sent to all Licensees informing them of the plan as well. A letter was sent to all legislators and shared with Governor Brown updating them on the plan and recent Board activities.
Attachment #8

Draft 2017 Legislation - Pain Management
Attached is draft legislation revising pain management education requirements for Licensees from Sarah Lochner, Legislative Coordinator for Behavioral Health Programs + Health Policy and Analytics, External Relations.
Attachment #9

Citizen Advocacy Center (CAC) Annual Meeting & Telehealth information
The CAC's annual meeting was held September 18 & 19 in Portland. The OBD was one of the sponsors and I attended along with other stakeholders to identify and discuss ways in which the health professional regulatory system can facilitate the use of telehealth technologies.
Attachment #10

Newsletter
The next newsletter is being assembled and it should be completed and distributed before the December Board Meeting. Thank you to our Office Specialist, Haley Huntington and our editor, Dr. Fine for keeping this project on track.

Appn Year 2017

BOARD OF DENTISTRY
Fund 3400 BOARD OF DENTISTRY
For the Month of AUGUST 2016

REVENUES

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
0505	FINES AND FORFEITS	78,100.00	0.00	78,100.00	75,000.00	-3,100.00
0975	OTHER REVENUE	28,401.78	1,084.57	29,486.35	55,001.00	25,514.65
0205	OTHER BUSINESS LICENSES	1,702,165.00	259,881.00	1,962,046.00	3,141,259.00	1,179,213.00
0410	CHARGES FOR SERVICES	12,617.50	2,824.50	15,442.00	17,200.00	1,758.00
0210	OTHER NONBUSINESS LICENSES AND FEES	3,700.00	650.00	4,350.00	16,000.00	11,650.00
0605	INTEREST AND INVESTMENTS	6,024.57	703.24	6,727.81	8,000.00	1,272.19
		1,831,008.85	**265,143.31**	**2,096,152.16**	**3,312,460.00**	**1,216,307.84**

TRANSFER OUT

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
2443	TRANSFER OUT TO OREGON HEALTH AUTHORITY	74,605.00	5,670.00	80,275.00	216,000.00	135,725.00
		74,605.00	**5,670.00**	**80,275.00**	**216,000.00**	**135,725.00**

PERSONAL SERVICES

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
3110	CLASS/UNCLASS SALARY & PER DIEM	511,498.60	49,384.05	560,882.65	1,142,595.00	581,712.35
3160	TEMPORARY APPOINTMENTS	5,501.13	0.00	5,501.13	3,920.00	-1,581.13
3170	OVERTIME PAYMENTS	4,612.53	427.32	5,039.85	3,771.00	-1,268.85
3180	SHIFT DIFFERENTIAL	88.13	1.50	89.63	0.00	-89.63
3190	ALL OTHER DIFFERENTIAL	1,010.84	335.40	1,346.24	35,483.00	34,136.76
3220	PUBLIC EMPLOYES' RETIREMENT SYSTEM	73,909.42	6,674.12	80,583.54	175,030.00	94,446.46
3210	ERB ASSESSMENT	132.48	11.52	144.00	352.00	208.00
3260	MASS TRANSIT	2,950.19	258.87	3,209.06	6,881.00	3,671.94
3221	PENSION BOND CONTRIBUTION	26,635.34	2,424.61	29,059.95	67,003.00	37,943.05
3230	SOCIAL SECURITY TAX	39,808.60	3,799.54	43,608.14	90,716.00	47,107.86
3240	UNEMPLOYMENT ASSESSMENT	0.00	0.00	0.00	0.00	0.00
3250	WORKERS' COMPENSATION ASSESSMENT	251.13	24.41	275.54	552.00	276.46
3270	FLEXIBLE BENEFITS	115,232.08	9,006.68	124,238.76	240,768.00	116,529.24
		781,630.47	**72,348.02**	**853,978.49**	**1,767,071.00**	**913,092.51**

SERVICES and SUPPLIES

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
4275	PUBLICITY & PUBLICATIONS	6,080.09	482.97	6,563.06	13,800.00	7,236.94
4150	EMPLOYEE TRAINING	21,995.31	892.56	22,887.87	68,577.04	45,689.17
4250	DATA PROCESSING	3,783.69	259.00	4,042.69	6,412.00	2,369.31

Attachment #1

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
4200	TELECOMM/TECH SVC AND SUPPLIES	10,614.75	158.96	10,773.71	23,155.99	12,382.28
4715	IT EXPENDABLE PROPERTY	2,110.32	0.00	2,110.32	5,421.00	3,310.68
4175	OFFICE EXPENSES	54,923.03	1,382.75	56,305.78	84,561.00	28,255.22
4400	DUES AND SUBSCRIPTIONS	9,482.95	0.00	9,482.95	1,043.96	-8,438.99
4575	AGENCY PROGRAM RELATED SVCS & SUPP	50,310.13	3,201.40	53,511.53	165,516.01	112,004.48
4225	STATE GOVERNMENT SERVICE CHARGES	19,709.79	1,764.15	21,473.94	40,831.99	19,358.05
4650	OTHER SERVICES AND SUPPLIES	57,618.45	7,130.27	64,748.72	71,185.81	6,437.09
4315	IT PROFESSIONAL SERVICES	14,850.00	0.00	14,850.00	52,460.00	37,610.00
4300	PROFESSIONAL SERVICES	133,736.19	5,687.50	139,423.69	125,917.20	-13,506.49
4325	ATTORNEY GENERAL LEGAL FEES	120,203.60	8,167.50	128,371.10	224,149.00	95,777.90
4100	INSTATE TRAVEL	18,162.54	3,030.31	21,192.85	49,208.00	28,015.15
4125	OUT-OF-STATE TRAVEL	0.00	0.00	0.00	0.00	0.00
4425	FACILITIES RENT & TAXES	83,872.92	6,660.24	90,533.16	154,455.00	63,921.84
4375	EMPLOYEE RECRUITMENT AND DEVELOPMENT	0.00	0.00	0.00	655.00	655.00
4700	EXPENDABLE PROPERTY $250-$5000	0.00	0.00	0.00	5,421.00	5,421.00
4475	FACILITIES MAINTENANCE	0.00	0.00	0.00	542.00	542.00
		607,453.76	**38,817.61**	**646,271.37**	**1,093,312.00**	**447,040.63**

SPECIAL PAYMENTS

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
6443	DIST TO OREGON HEALTH AUTHORITY	79,124.00	0.00	79,124.00	185,128.00	106,004.00
		79,124.00	**0.00**	**79,124.00**	**185,128.00**	**106,004.00**

		3400		
		Monthly Activity	Biennium Activity	Financial Plan
REVENUES	REVENUE	265,143.31	2,096,152.16	3,312,460.00
	Total	265,143.31	2,096,152.16	3,312,460.00
EXPENDITURES	PERSONAL SERVICES	72,348.02	853,978.49	1,767,071.00
	SERVICES AND SUPPLIES	38,817.61	646,271.37	1,093,312.00
	SPECIAL PAYMENTS	0	79,124	185,128.00
	Total	111,165.63	1,579,373.86	3,045,511.00
TRANSFER OUT	TRANSFER OUT	5,670	80,275	216,000.00
	Total	5,670	80,275	216,000.00

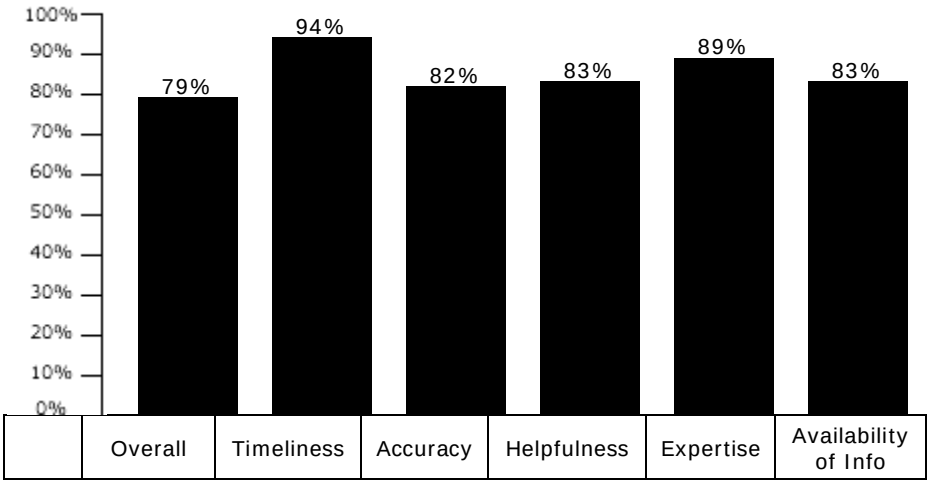
Survey Reports

OBD

Showing Data for: OBD Time Period: August 2016 Change View

Number of Responses: 20

Percent Rating Service Good or Excellent



Rating Totals By Question

Question	Don't Know	Poor	Fair	Good	Excellent
Q1	2	0	1	6	11
Q2	3	0	3	4	10
Q3	2	0	3	4	11
Q4	2	0	2	4	12
Q5	2	0	3	4	11
Q6	1	0	4	5	10

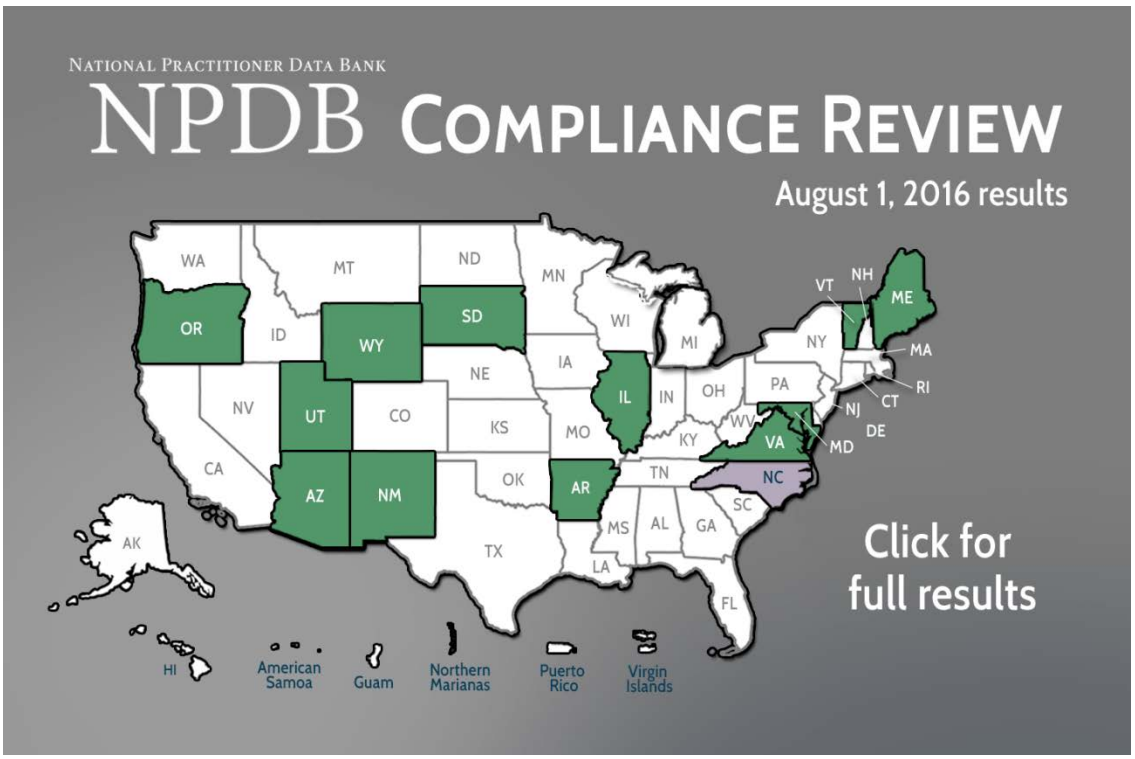
Question #1: TIMELINESS: How would you rate the timeliness of services provided by the Oregon Board of Dentistry?
Question #2: ACCURACY: How do you rate the ability of the Oregon Board of Dentistry to provide services correctly the first time?
Question #3: HELPFULNESS: How do you rate the helpfulness of the Oregon Board of Dentistry employees?
Question #4: EXPERTISE: How do you rate the knowledge and expertise of the Oregon Board of Dentistry employees?
Question #5: AVAILABILITY OF INFORMATION: How do you rate the availability of information at the Oregon Board of Dentistry?
Question #6: OVERALL SERVICE: How do you rate the overall quality of service provided by the Oregon Board of Dentistry

U.S. Department of Health & Human Services

NPDB NATIONAL PRACTITIONER DATA BANK

Dear State Board/Agent,

The National Practitioner Data Bank (NPDB) is pleased to provide the results of our compliance review, which examined the reporting compliance for disciplinary actions taken between January 1, 2013 and December 31, 2014 for the following states: **Arizona, Arkansas, Illinois, Maine, Maryland, New Mexico, North Carolina, Oregon, South Dakota, Utah, Vermont, Virginia,** and **Wyoming**. The results are presented for each state, board, and profession. An explanation of the compliance status definitions is available on the NPDB website.



The NPDB congratulates all of the state boards that achieved the “compliant” status by August 1, 2016. The NPDB would like to thank all of the state boards for their hard work in meeting NPDB reporting requirements. We continue to work with state boards that need assistance with meeting federal reporting requirements. Please send inquiries to DPDBcompliance@hrsa.gov.

Thank you,

The National Practitioner Data Bank

The NPDB sends correspondence to registered NPDB users to keep them informed of NPDB practices and system updates. If you are no longer associated with the organization that the NPDB sends messages to, please contact the Data Bank administrator with the organization to delete your account. If you do not know who the Data Bank administrator is for the organization, please contact the NPDB.

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NATIONAL PRACTITIONER DATA BANK

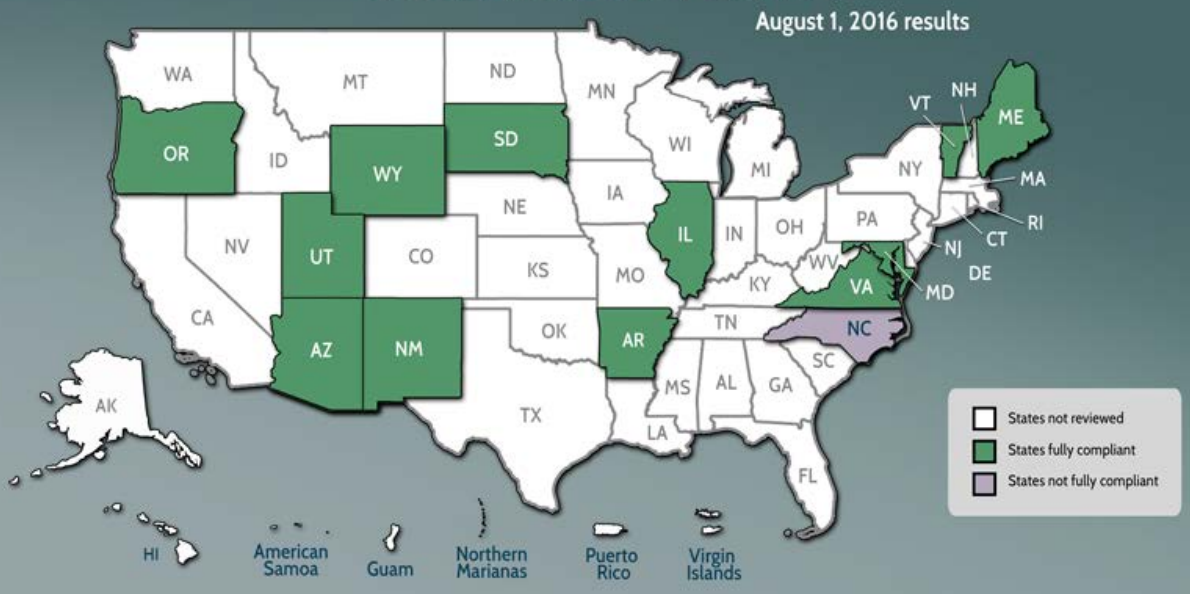
NPDB COMPLIANCE REVIEW

This August 2016 review examined state licensing and certification board adverse actions taken between January 2013 and December 2014.

- All states and territories are reviewed every two years.
- The professions reviewed include those most queried in the NPDB, plus a random sample.
- The review compares adverse actions taken by state licensing and certification boards to actual reports submitted to the NPDB.
- This effort ensures all actions reportable by federal law are correctly reported.

COMPLIANCE BY STATE

August 1, 2016 results



Compliance by State Board, Profession

August 1, 2016 results

NORTH CAROLINA

NC State Board Of Examiners For NHA	Health Care Facility Administrator	Compliant
NC State Hearing Aid Dealers and Fitters Board	Hearing Aid (or Instrument) Specialist, Dealer, Dispenser or Fitt...	Compliant
North Carolina Board of Examiners for Speech and Language Pathology and Audiology	Audiologist	Compliant
	Speech/Language Pathologist	Compliant
North Carolina Board of Nursing	Advanced Practice Nurse	Compliant
	Licensed Practical or Vocational Nurse	Compliant
	Registered Nurse	Compliant
North Carolina Board of Pharmacy	Pharmacy Intern	Compliant
North Carolina Marriage and Family Therapy Licensure Board	Licensed Marriage and Family Therapist Associate	Non-Compliant
	Marriage and Family Therapist	Non-Compliant
North Carolina Medical Board	Osteopathic Physician (DO)	Compliant
	Physician (MD)	Compliant
	Physician Assistant	Compliant
North Carolina Psychology Board	Psychological Assistant, Associate, Examiner	Compliant
	Psychologist	Compliant
North Carolina Social Work Certification & Licensure	Social Worker	Compliant
North Carolina State Board of Dental Examiners	Dental Hygienist	Compliant
	Dentist	Compliant
North Carolina State Board of Opticians	Licensed Optician	Compliant

Compliant | Working Toward Compliance | Non-Compliant

For additional information on the status assigned, visit:
www.npdb.hrsa.gov/compliance

ARIZONA

Arizona Acupuncture Board Of Examiners	Acupuncturist	Compliant
Arizona Board of Behavioral Health Examiners	Social Worker	Compliant
Arizona Board of Chiropractic Examiners	Chiropractor	Compliant
Arizona Board of Osteopathic Examiners in Medicine and Surgery	Osteopathic Physician (DO)	Compliant
Arizona Medical Board	Physician (MD)	Compliant
	Physician Assistant	Compliant
Arizona State Board of Dental Examiners	Dental Hygienist	Compliant
	Dentist	Compliant
Arizona State Board of Nursing	Advanced Practice Nurse	Compliant
	Certified Nurse Aide	Compliant
	Registered Nurse	Compliant
Arizona State Board of Optometry	Optometrist	Compliant
Department of Health Services, Division of Licensing Services, Bureau of Emergency Medical Services & Trauma System	EMT, Paramedic	Compliant
	Speech/Language Pathologist	Compliant

ARKANSAS

Arkansas Board of Podiatric Medicine	Podiatrist	Compliant
Arkansas Psychology Board	Psychologist	Compliant
	School Psychologist	Compliant
Arkansas Social Work Licensing Board	Social Worker	Compliant
Arkansas State Board of Dental Examiners	Dentist	Compliant
Arkansas State Board of Dispensing Opticians	Dispensing Optician	Compliant
Arkansas State Board of Examiners Counselors	Dance Therapist	Compliant
	Recreation Therapist	Compliant
Arkansas State Board of Nursing	Advanced Practice Nurse	Compliant
	Registered Nurse	Compliant
Arkansas State Board of Optometry	Optometrist	Compliant
Arkansas State Medical Board	Osteopathic Physician (DO)	Compliant
	Physician (MD)	Compliant
	Physician Assistant	Compliant
	Respiratory Therapy Technician	Compliant
State Board of Examiners of Alcoholism & Drug Abuse Counselors	Alcohol and Drug Abuse Counselor	Compliant

ILLINOIS

Illinois Department of Financial and Professional Regulation Division of Professional Regulation	Advanced Practice Nurse	Compliant
	Dentist	Compliant
	Nutritionist	Compliant
	Osteopathic Physician (DO)	Compliant
	Perfusionist	Compliant
	Physical Therapist	Compliant
	Physician (MD)	Compliant
	Physician Assistant	Compliant
	Professional Counselor	Compliant
	Registered Nurse	Compliant
	Sex Offender Counselor	Compliant
	Social Worker	Compliant

MAINE

Maine Board of Dental Examiners	Dentist	Compliant
Maine Board of Licensure in Medicine	Physician (MD)	Compliant
	Physician Assistant	Compliant
Maine Board of Osteopathic Licensure	Osteopathic Physician (DO)	Compliant
Maine State Board of Nursing	Advanced Practice Nurse	Compliant
	Registered Nurse	Compliant
Office of Licensing & Registration	Addictions Counselor	Compliant
	Audiologist	Compliant
	Dietitian	Compliant
	Health Care Facility Administrator	Compliant
	Pharmacist	Compliant
	Professional Counselor	Compliant
	Social Worker	Compliant
	Speech/Language Pathologist	Compliant

MARYLAND

Maryland Board of Nursing	Advanced Practice Nurse	Compliant
	Registered Nurse	Compliant
Maryland Board of Physical Therapy	Physical Therapy Assistant	Compliant
Maryland Board of Physicians	Osteopathic Physician (DO)	Compliant
	Physician (MD)	Compliant
	Physician Assistant	Compliant
Maryland Board of Professional Counselors and Therapists	Addictions Counselor	Compliant
Maryland Department of Health And Mental Hygiene	Social Worker	Compliant
Maryland State Board of Dental Examiners	Dentist	Compliant
MIEMSS	EMT	Compliant
	EMT, Paramedic	Compliant

NEW MEXICO

New Mexico Board of Dental Health Care	Dental Hygienist	Compliant
	Dentist	Compliant
New Mexico Board of Examiners for Occupational Therapy	Occupational Therapy Assistant	Compliant
New Mexico Board of Nursing	Advanced Practice Nurse	Compliant
	Registered Nurse	Compliant
New Mexico Board of Podiatry	Podiatrist	Compliant
New Mexico Board of Social Work Examiners	Social Worker	Compliant
New Mexico Environment Dept - Radiation Control Bureau	Radiation Therapy Technologist	Compliant
New Mexico Massage Therapy Board	Massage Therapist	Compliant
New Mexico Medical Board	Physician (MD)	Compliant
	Physician Assistant	Compliant
New Mexico Nursing Home Administrators B	Health Care Facility Administrator	Compliant
New Mexico Regulation & Licensing Department, Board of Osteopathic Medica...	Osteopathic Physician (DO)	Compliant
New Mexico Respiratory Care Advisory Board	Respiratory Therapy Technician	Compliant

OREGON

Oregon Board of Dentistry	Dentist
Oregon Board of Radiologic Technology	Radiation Therapy Technologist
Oregon Health Licensing Agency	Hearing Aid (or Instrument) Specialist, Dealer, Dispenser or Fitt.
	Nutritionist
Oregon Medical Board	Osteopathic Physician (DO)
	Physician (MD)
	Physician Assistant
Oregon State Board of Licensed Social Workers	Social Worker
Oregon State Board of Nursing	Advanced Practice Nurse
	Certified or Qualified Medication Aide
	Registered Nurse

SOUTH DAKOTA

South Dakota Board of Counselor Examiners	Marriage and Family Therapist
South Dakota Board of Medical & Osteopathic Examiners	Osteopathic Physician (DO)
	Physician (MD)
	Physician Assistant
South Dakota Board of Nursing	Advanced Practice Nurse
	Certified or Qualified Medication Aide
	Registered Nurse
South Dakota Board of Pharmacy	Pharmacy Intern
South Dakota Board of Social Work Examiners	Social Worker
South Dakota Certification Board for Drug and Alcohol Professionals	Addictions Counselor
South Dakota State Board of Dentistry	Dentist

UTAH

Utah Board of Nursing	Advanced Practice Nurse
	Registered Nurse
Utah Division of Occupational and Professional Licensing	Dentist
	Health Care Facility Administrator
	Music Therapist
	Osteopathic Physician (DO)
	Physical Therapist
	Physical Therapy Assistant
	Physician (MD)
	Physician Assistant
	Radiation Therapy Technologist
	Social Worker

VERMONT

Vermont Department of Health, Board of Medical Practice	Physician (MD)
	Physician Assistant
Vermont Office of Professional Regulation	Advanced Practice Nurse
	Certified Nurse Aide
	Dental Hygienist
	Dentist
	Dietitian
	Osteopathic Physician (DO)
	Registered Nurse
	Respiratory Therapy Technician
	School Psychologist
	Social Worker

VIRGINIA

Virginia Department of Health Professions	Advanced Practice Nurse
	Dentist
	Health Care Facility Administrator
	Midwife, Lay (Non-Nurse)
	Occupational Therapy Assistant
	Osteopathic Physician (DO)
	Physical Therapy Assistant
	Physician (MD)
	Physician Assistant
	Radiologic Technologist
	Registered Nurse
	Respiratory Therapist
	Social Worker
	Speech/Language Pathologist

WYOMING

Wyoming Board of Dental Examiners	Dentist
Wyoming Board of Medicine	Osteopathic Physician (DO)
	Physician (MD)
	Physician Assistant
Wyoming Board of Occupational Therapy	Occupational Therapist
Wyoming Mental Health Professions Licensing Board	Social Worker
Wyoming State Board of Nursing	Advanced Practice Nurse
	Registered Nurse

Compliance

Data by State: Oregon

Reporting Compliance Status by State
Reporting Compliance Status by Profession

Reporting Compliance Status by State | Background

Overall Data

Download: XLS CSV

Profession	Project	Current Status	First Reviewed	Last Reviewed
Acupuncturist	Entity Attestation	Attested	06/19/2015	06/19/2015
Athletic Trainer	Entity Attestation	Attested	05/29/2015	05/29/2015
Audiologist	Entity Attestation	Attested	10/16/2015	10/16/2015
Behavior Analysis	Entity Attestation	Attested	05/29/2015	05/29/2015
+ Behavioral Health - Marriage and Family Therapists				
+ Behavioral Health - Other Behavioral Health Related Professions				
+ Behavioral Health - Professional Counselors				
Certified Nurse Aide/Certified Nursing Assistant	Entity Attestation	Attested	03/30/2015	03/30/2015
Certified or Qualified Medication Aide	Comparison Project	Compliant	07/01/2016	07/01/2016
Chiropractic Assistant	Entity Attestation	Attested	07/27/2016	07/27/2016
Chiropractor	Entity Attestation	Attested	07/27/2016	07/27/2016
− Dentistry				
Dental Hygienist	Entity Attestation	Attested	06/04/2015	06/04/2015
Dentist	Comparison Project	Compliant	04/01/2011	07/01/2016
Denturist	Entity Attestation	Attested	05/29/2015	05/29/2015
Dietitian	Entity Attestation	Attested	05/29/2015	05/29/2015
EMT, Basic	Entity Attestation	Attested	12/22/2015	12/22/2015

EMT, Intermediate/Critical Care	Entity Attestation	Attested	12/22/2015	12/22/2015
EMT, Paramedic	Entity Attestation	Attested	12/22/2015	12/22/2015
Emergency Medical Responder/First Responder	Entity Attestation	Attested	02/19/2014	02/19/2014
Environmental Health Specialist	Entity Attestation	Attested	05/29/2015	05/29/2015
⊞ Eye and Vision Service Practitioner				
Health Care Facility Administrator	Entity Attestation	Attested	05/29/2015	05/29/2015
Hearing Aid (or Instrument) Specialist, Dealer, Dispenser or Fitter	Comparison Project	Compliant	07/01/2010	07/29/2016
Limited X-Ray Machine Operator (LXMO)	Entity Attestation	Attested	05/06/2015	05/06/2015
Massage Therapist	Entity Attestation	Attested	05/01/2015	05/01/2015
Midwife, Lay (Non-Nurse)	Entity Attestation	Attested	05/29/2015	05/29/2015
Mri Technologist	Entity Attestation	Attested	05/06/2015	05/06/2015
Nuclear Medicine Technologist	Entity Attestation	Attested	05/06/2015	05/06/2015
Nurse Aide/Nursing Assistant	Entity Attestation	Attested	03/30/2015	03/30/2015
⊞ Nursing Related Professions				
Nutritionist	Comparison Project	Compliant	07/11/2016	07/11/2016
Occupational Therapist	Entity Attestation	Attested	02/18/2016	02/18/2016
Occupational Therapy Assistant	Entity Attestation	Attested	02/18/2016	02/18/2016
Osteopathic Physician Resident (DO)	Entity Attestation	Attested	06/19/2015	06/19/2015
⊞ Pharmacy				
⊞ Physical Therapy				
Physician Assistant	Comparison Project	Compliant	07/01/2010	07/11/2016
Physician Resident (MD)	Entity Attestation	Attested	06/19/2015	06/19/2015
⊞ Physicians				
Podiatrist	Entity Attestation	Attested	06/19/2015	06/19/2015
Professional Counselor, Family/Marriage	Entity Attestation	Attested	11/27/2015	11/27/2015
Psychological Assistant, Associate, Examiner	Entity Attestation	Attested	03/28/2016	03/28/2016
Psychologist	Entity Attestation	Attested	03/28/2016	03/28/2016
Radiation Therapy Technologist	Comparison Project	Compliant	07/01/2016	07/01/2016
Radiologic Technician/Technologist	Entity Attestation	Attested	05/06/2015	05/06/2015
Rehabilitation Therapist	Entity Attestation	Attested	06/16/2015	06/16/2015
Respiratory Therapist	Entity Attestation	Attested	05/29/2015	05/29/2015
⊞ Social Worker				
Sonographer	Entity Attestation	Attested	05/06/2015	05/06/2015
Speech-Language Pathology Assistant	Entity Attestation	Could Not Attest	12/09/2013	12/09/2013
Speech/Language Pathologist	Entity Attestation	Attested	10/16/2015	10/16/2015
X-Ray Technician or Operator	Entity Attestation	Attested	05/06/2015	05/06/2015

Attachment #3

***Note**: Data displayed includes only the states/professions reviewed by HRSA. Please note that not all states regulate every profession.*

Compliance

Data by State: Oregon

Reporting Compliance Status by State | Background

Introduction to Compliance

U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA) has undertaken efforts to improve the completeness and accuracy of data reported to the National Practitioner Data Bank (NPDB). The Secretary of HHS is exercising regulatory authority (45 CFR part 60) to publish a report listing government agencies that have failed to meet their NPDB reporting requirements.

For more information about the reporting compliance process and definitions of terms, see About Reporting Compliance.

The tables display the current compliance status for government agencies contacted for the Adverse Action Comparison Project, Never Reported Professions Compliance Effort, and Attestation Project. The tables include only those states and professions that HRSA has reviewed or is currently reviewing. The compliance status listed in the tables is one of eight possible determinations: Compliant, Non-Compliant, Working Toward Compliance, Under Review, Attested, Could Not Attest, Failed to Attest, or Not Reviewed.

For specific NPDB user instructions in completing these processes, please see Compliance Actions.

Oregon
Kate Brown, Governor

Board of Dentistry
1500 SW 1st Ave. Ste 770
Portland, OR 97201-5837
(971) 673-3200
Fax: (971) 673-3202

TO: OBD, Members

FROM: Stephen Prisby
OBD, Executive Director

DATE: October 3, 2016

SUBJECT: Revised Agency Records Request Policy

Attached are Executive Order 16-06 and the OBD's revised Agency Records Request Policy. State agencies were directed by Governor Brown through this Executive Order to work through DAS and the Secretary of State's, State Archivist, to implement model public records management policies.

The OBD's revised Agency Records Requests Policy was approved by the State's Archivist, Mary Beth Herkert on September 30, 2016.

I am asking the Board to review and approve the new Agency Records Requests Policy, #834-413-010.

Office of the Governor
State of Oregon

EXECUTIVE ORDER NO. 16-06

PUBLIC RECORDS

Upon assuming the office of Governor in February 2015, I offered a package of bills to the Legislative Assembly relating to ethics and governmental accountability. A key component of that package was Senate Bill 9, which mandated that an audit be conducted of state agencies' responses to public records requests with respect to issues of cost, timeliness and procedures. The Legislature approved Senate Bill 9 and I signed it into law on June 15, 2015.

The Secretary of State's Audits Division has conducted the audit required by Senate Bill 9, and on November, 2015, released the audit results in a document entitled "State Agencies Respond Well to Routine Public Records Requests, but Struggle with Complex Requests and Emerging Technologies." (The audit and the audit results are hereinafter referred to collectively as the "Audit.") The Audit examined a sampling of large, medium and small agencies and found that for the most part Oregon state agencies handle routine requests well and struggle with complex requests.

The Audit also revealed other issues that affect agencies' ability to respond to requests such as retention policies, changing technologies and fee structures.

The Audit included specific recommendations, including a recommendation that the Oregon Department of Administrative Services ("DAS") create standardized rates for copying and standardized rates for employee labor among state agencies in order to resolve some of the inconsistency in public records requests fees statewide.

The Audit further recommended that DAS be empowered to provide guidance to agencies regarding communication technologies as they relate to public records.

The Audit found, further, that the variation in responses to public records requests is due, at least in part, to a lack of statewide policies and guidelines with regard to record types created by emergent technology, a standardized fee structure, and automated processes and procedures that make records retention arduous and subjective.

It is also clear that as a result of the rise of modern communications technology, the volume of records subject to search and potential legal review significantly impacts the ability for an agency to respond in a timely manner and causes concern and mistrust to grow in the public's view.

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EXECUTIVE ORDER NO. 16-06
PAGE TWO

The purpose of the Government of the State of Oregon is to serve the people of Oregon. State government must therefore be open and transparent. All Oregonians deserve full and complete information regarding the affairs of government and the official acts of those who represent them as public officials and employees.

NOW THEREFORE, IT IS HEREBY DIRECTED AND ORDERED:

1. DAS shall develop and promote model public records management policies, approved by the State Archivist, for use by executive branch agencies no later than June 30, 2016. All state agencies shall comply with ORS 192.018 within 90 days of DAS' promotion of model policies by either adopting the DAS policy or modifying it to meet agency-specific records management needs.

2. DAS shall improve accessibility and government transparency by fully implementing all of the recommendations outlined in the SOS audit, which are incorporated herein. DAS shall work with and report to the Governor's office in the implementation of the audit recommendations. This work shall begin immediately. The recommendations that shall be fully implemented include, but are not limited to:

    a. Streamlining and standardizing state agency processes and procedures regarding responses to public records requests;

    b. Working with state agencies to develop a standard protocol for tracking public records requests, and documentation related to each request;

    c. Developing uniform statewide standards and guidelines on agency fee structures or charging policies; and

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EXECUTIVE ORDER NO. 16-06
PAGE THREE

d. Working with agencies to develop streamlined management processes, administrative rules, and statewide policy guidance regarding internal processes and procedures for records retention and management.

3. This Order shall remain in effect until it is otherwise modified, amended or terminated.

Done at Salem, Oregon, this 20th day of January, 2016.

Kate Brown
GOVERNOR

ATTEST:

Jeanne P. Atkins
SECRETARY OF STATE

OREGON BOARD OF DENTISTRY
POLICY 834-413-010
AGENCY RECORDS REQUESTS

Purpose: To define appropriate circumstances under which Agency records may be made available in compliance with the law.

The Oregon Board of Dentistry handles a great deal of confidential written information about licensees. This information has been defined as subject to multiple safeguards to prevent unauthorized disclosure (see policy 834-413-001, Confidentiality).

Notwithstanding our responsibility to strictly observe confidentiality safeguards, the Agency sometimes receives requests for copies of records pertaining to the disciplinary record of a licensee. The release of such information is in accordance with state and/or federal statutes. Because of the complexity of these laws and the nature of the work that we do, the Executive Director has designated that only the Executive Assistant/Office Manager in concert with the Executive Director may fill such requests, as well as making determinations regarding the billing of fees to recover the Agency's costs of compliance with those requests that are found to have merit. All such requests for Agency records will thus be referred to the Executive Assistant/Office Manager for disposition.

The Oregon Board of Dentistry has adopted DAS Statewide Policy 107-001-020. (See Attached)

DAS DEPARTMENT OF ADMINISTRATIVE SERVICES STATEWIDE POLICY	NUMBER 107-001-020	SUPERSEDES
	EFFECTIVE DATE July 1, 2016	PAGE NUMBER Pages 1 of 11
DIVISION Office of the Chief Operating Officer	REFERENCE/AUTHORITY ORS 192.018, 174.112 Executive Order 16-06	
POLICY OWNER Department of Administrative Services		
SUBJECT Public Records Management	APPROVED SIGNATURE George Naughton, Director *(signature on file with DAS Business Services)*	

PURPOSE

This Policy is intended to support statewide compliance with ORS 192.018 by establishing minimum standards for state agency policies relating to the internal management of public records and providing a Model Public Records Management Policy (Model Policy) for state agency reference and/or adoption.

State agencies may adopt the model policy language provided under each subsection of the **POLICY GUIDELINES** section of this Policy (and attached as EXHIBIT A) or adopt more restrictive policy requirements and practices to meet agency-specific business needs. Agencies may also incorporate by reference any existing internal policies that adequately address the policy areas outlined in the **POLICY GUIDELINES** and required by this Policy.

Agencies are required to seek review and approval from the State Archivist, in accordance with ORS 192.018, prior to adopting an internal public records management policy.

Agencies must review and, if necessary, update their public records management policy at least once per biennium to account for changes in applicable laws, policies and/or changing business needs and ensure ongoing accessibility. All policy amendments must be submitted to the State Archivist for review and approval in accordance with ORS 192.018, prior to adoption.

APPLICABILITY

This Policy applies to all agencies within the Executive Department, as defined in ORS 174.112, excluding the following:

- Secretary of State
- State Treasurer
- The Attorney General, but only with respect to its authority under ORS 182.124 over information systems security in the Department of Justice
- Oregon State Lottery
- State Board of Higher Education or any public university listed in ORS 352.002.

The requirements in this Policy do not supersede, modify or replace the existing legal responsibilities of any state agency. Agencies must continue to meet obligations required by all applicable laws, policies, procedures and standards including without limitation: state and Federal public records laws, privacy laws and regulations, and applicable DAS policies and procedures.

EXCLUSIONS

ORS 192.018 requires every state agency to have a "written policy that sets forth the agency's use, retention and ownership of public records." Therefore, other than the excluded organizations listed above in the **APPLICABILITY** section of this Policy, there are no other exclusions.

EXHIBIT

- **EXHIBIT A: Model Public Records Management Policy**

SPECIAL SITUATIONS

- Retained records may be subject to public disclosure upon request, even if their retention was not required by law. The statutes requiring public disclosure of records apply more broadly than the statutes requiring records to be retained.
- Agencies are not required to create public records that would not otherwise exist.
- Only the official copy of a public record must be retained. Stock of publications are not public records and may be preserved for convenience or destroyed.

GENERAL INFORMATION

The goal of this policy is to ensure public records are managed and maintained appropriately across the enterprise of state government and streamline compliance with ORS 192.018 by requiring agencies to adopt internal public records management policies that address the following components, at a minimum:

I. Public Records Maintenance
II. Roles and Responsibilities
III. Education and Training
IV. Access and Ownership
V. Integrity
VI. Retention Generally
VII. Storage and Retrieval
VIII. Public Records Requests
IX. Disposition and Destruction

COMPLIANCE

Agencies subject to this Policy must achieve compliance with ORS 192.018 within 90 days of the effective date of this Policy.

In addition, agencies will develop and implement internal processes and procedures that support compliance, deter abuse and detect violations.

If an agency's public records management policy, approved and adopted in accordance with this Policy, cannot be feasibly implemented Agencies may submit a written request for assistance to the Secretary of State Archives Division (Archives Division). The request should specify: the policy section(s) and implicated requirements making implementation over-burdensome; and the type of assistance necessary for the agency to achieve compliance with their approved internal public records management policy.

REPORTING

Agencies shall notify DAS – Office of the Chief Operating Officer when the State Archivist has formally approved their public records management policy and the agency is in compliance with ORS 192.018.

DEFINITIONS

"**Cloud-computing**" has the same meaning as defined in the National Institute of Standards and Technology (NIST) Special Publication 800-145 .

"**Custodian**" refers to a public body mandated, directly or indirectly, to create, maintain, care for or control a public record. "Custodian" does not include a public body that has custody of a public record as an agent of another public body that is the custodian, unless the public record is not otherwise available.

"**Instant Messaging**" refers to real-time text communications between or among computers or mobile devices over the Internet or functionally similar communications network.

"**Metadata**" is data that provides information about other data. Metadata assists in resource discovery by allowing resources to be found by relevant criteria, identifying resources, bringing similar resources together, distinguishing dissimilar resources and giving location information.

"**Public Record**" has the meaning established in ORS 192.005. In general it refers to information that is prepared, owned, used or retained by a state agency or political subdivision; relates to an activity, transaction or function of a state agency or political subdivision; and is necessary to satisfy the fiscal, legal, administrative or historical policies, requirements or needs of the state agency or political subdivision.

"**Social Media**" refers to web-based and mobile communication technologies that allow the creation and exchange of user-generated content such as comments or responsive postings. Examples of "social media" as of the time this Policy is adopted include but are not limited to Twitter, Flickr, blogging sites, Facebook, YouTube and Instagram.

"**Text Messaging**" refers to messages exchanged between fixed-line phones or mobile phones and fixed or portable devices over a network. Excluded from the definition of "text messages" are electronic mail ("e-mail") communications, whether such messages are exchanged among or between official State of Oregon e-mail accounts or e-mail accounts maintained by private entities.

"**Unified Communications**" refers to IBM Unified Communications and, more specifically, the packaged services or user-profiles available to agencies (e.g. instant messaging, video conferencing, telephony, call management and call control across multiple systems etc…).

POLICY GUIDELINES

I. PUBLIC RECORDS MAINTENANCE

Agencies shall adopt public records management policies and procedures to ensure public records are maintained and managed in a manner that protects the integrity of each record, without regard to the technology or medium used to create or communicate the record, from the time of creation of a public record to the time of final disposition of the public record as determined by their authorized records retention schedule.

- **Model Policy Language**
  Public records shall be maintained and managed in a manner that protects the integrity of the records within the Oregon Board of Dentistry without regard to the technology or medium used to create or communicate the record, from the time of creation of a public record to the time of final disposition of the public record as determined by their authorized records retention schedule.

II. ROLES AND RESPONSIBILITIES

Agencies shall develop a Records Management Program that includes the program organizational structure, identified roles and associated responsibilities of agency employees necessary to properly manage the agency's public records.

Agencies shall designate an Agency Records Officer in accordance with ORS 192.105 (2)(a) and assign

additional employees, as necessary, to be responsible for working with the Archives Division and State Archivist to carry out the following:

- Regular review of records, regardless of format (electronic, paper, etc…) to determine if records should be retained or destroyed;
- Identify and develop retention schedules for new records series (groups of records);
- Maintain a filing system of the agency's paper and electronic records based on authorized retention schedules. Agency filing systems must include the description and location of public records, including records the agency is required to retain due to litigation (active litigation hold) and/or special audit. Records retained beyond their authorized retention period due to mitigating administrative need must also be accounted for in the filing system. Agencies are required to submit written justification of the mitigating administrative need to the State Archivist for approval.
- Coordinate and track employee completion of public records management training to ensure agency staff understand how to records are properly managed, in compliance with authorized records retention schedules;
- Review and update internal public records management policies and procedures. Obtain State Archivist approval of revisions to the agency public records management policy;
- Develop and implement internal processes and procedures for the transfer, retrieval and destruction of records in accordance with authorized retention periods; and
- Ensure that records are destroyed according to their authorized retention period;
- Document the destruction of public records and retain that documentation according to the authorized records retention schedule found in OAR chapter 166-300.

Agencies must designate one or more employee(s) charged with the management of each responsibility related to public records management outlined above. The organizational structure, designated roles and associated responsibilities within the agency-specific records management program is left to agency discretion based on the agency size and business requirements.

- **Model Policy Language**
  *Oregon law requires agencies to designate an Agency Records Officer "to coordinate its agency's Records Management Program" (ORS 192.105(2)(a)). Oregon Board of Dentistry records officer, will **s**erve as primary liaison with the State Archivist and receive training from the State Archivist in performing their duties.*

  Oregon Board of Dentistry will ensure agency public records are managed in accordance with their authorized records retention schedules, from the time of creation to final disposition, by assigning designated staff/positions with the following responsibilities:

III. EDUCATION AND TRAINING

Agencies are responsible for developing a public records training program for all employees. The agency Records Officer will receive additional training from the State Archivist and will work within the agency to coordinate staff training and awareness. The Archives Division will serve as a resource in agency training development.

Each agency shall implement a training program that includes basic public records training, as a component of new employee orientation training, completed at the time of hiring; and incorporated as part of regular employee training, completed once a biennium. The manner and mechanism through which training is disseminated is left to agency discretion (e.g. iLearn, Secretary of State Archives training, etc…).

- **Model Policy Language**
  Basic public records training will be completed as a component of Oregon Board of Dentistry new employee orientation training; and incorporated as part of regular employee training, completed once a biennium.

Oregon Board of Dentistry will utilize the following training program to provide public records training:

IV. ACCESS AND OWNERSHIP

Without regard to how public records are being stored, agencies must have custody and control over created records and ensure all public records are maintained and accessible for as long as required by their authorized retention schedules or litigation holds.

Agencies shall develop a plan and implement procedures to ensure the on-going accessibility of public records in the event of a disaster. Additionally, agencies shall continuously review the technological advances related to their business practices and the availability of retained records and, migrate public records to keep up with technology and to ensure enduring accessibility.

- **Model Policy Language**
  Without regard to how public records are being stored, Oregon Board of Dentistry will have custody and control over public records. Through on-going review of technological advances, agencies shall ensure all public records are maintained and accessible for as long as required by applicable retention schedules or litigation holds.

  Oregon Board of Dentistry disaster mitigation process are addressed in the Oregon Board of Dentistry disaster preparedness and recovery plan.

V. INTEGRITY

Agencies shall ensure all public records reliably represent information actually used to conduct state business process and shall apply adequate controls to ensure that the integrity of public records can be demonstrated by certified copy or accompanying metadata.

- **Model Policy Language**
  Oregon Board will ensure appropriate access and version controls are applied to all electronically stored records from record creation to final disposition.

  The authenticity of each record can be demonstrated either by certified copy of paper records or via accompanying metadata for all electronic records.

VI. RETENTION GENERALLY

The public records retention practices of agencies shall be in compliance with ORS chapter 192 and OAR chapter 166-300. Records not found on the State Agency General Records Retention Schedule are considered to be program records of the State of Oregon listed under the Agency Special Retention Schedules.

Agencies shall preserve and classify public records in accordance with ORS chapter 192, OAR chapter 166-300 and DAS Statewide Policy 107-004-050 regarding Information Asset Classification.

- **Model Policy Language**
  Oregon Board of Dentistry will preserve and classify public records in accordance with ORS chapter 192, OAR chapter 166-300 and DAS Statewide Policy 107-004-050 regarding Information Asset Classification.

  Oregon Board of Dentistry will work with the Archives Division to establish retention practices to ensure compliance with ORS chapter 192 and OAR chapter 166-300.

  CLOUD-COMPUTING
  Refer to State Cloud Computing Policy (DAS Statewide Policy 107-004-150; 107-004-150 PR).

- **Model Policy Language**
  Oregon Board of Dentistry practices and procedures with respect to public records management in the Cloud will ensure compliance with DAS Statewide Cloud-Computing Policy (DAS Policy 107-004-150; 107-004-150 PR) and OAR chapter 166-300.

EMAIL

Official Email Account:

Official, state-issued email accounts shall be primarily used for communications regarding official state business and virtually all e-mail messages composed or sent using employees' official equipment and/or official e-mail addresses be for primarily business purposes and assumed to be public records.

Personal use of official email accounts shall be limited, and must not: (1) interfere with normal business activities; (2) be associated with any outside for-profit business activity; or (3) otherwise contain any content that would cause embarrassment to the State of Oregon.

Personal Email Accounts:

If personal email accounts must be used, employees must copy their official e-mail accounts on all such outgoing communications, and forward any received messages on which their official e-mail accounts are not copied.

Personal email accounts (addresses) used for communications related to state business may be subject to search and production.

- **Model Policy Language**
  Official Email Accounts
  In most circumstances, emails sent to or from a State employee's official email account will meet the definition of a public record. It is therefore Oregon Board of Dentistry policy that virtually all email messages composed or sent using employees' official equipment and/or official email addresses be for primarily business purposes.

  When the Oregon Board of Dentistry receives a public records request, all official email accounts and systems used for official State business are subject to search and production.

  Personal Email Accounts
  If private email accounts must be used to conduct State business, it is Oregon Board of Dentistry policy that employees copy their official email accounts on all such outgoing communications, and forward any received messages on which their official email accounts are not copied immediately or as soon as practicably possible.

INSTANT MESSAGING

Policy regarding Instant Messages shall be the same as that recited below regarding **TEXT MESSAGING**.

- **Model Policy Language**
  Oregon Board of Dentistry policy regarding Instant Messages shall be the same as that recited below regarding ***TEXT MESSAGING****.*

SOCIAL MEDIA

Agency use of social media must comply with all applicable laws, policies, procedures and standards including without limitation: public records laws, privacy laws and regulations, Statewide and Agency specific IT security policies, internal audit controls, risk management standards, and applicable DAS policies and

procedures.

Agencies will develop a social media plan, including practices and procedures, to address agency use of social media for official state business to establish appropriate protocols for public records posted to, stored on, or generated by use of social media, when records are not documented elsewhere.

Content placed on a social media platform will be an accurate copy of an official record that is retained elsewhere by the agency per the official retention schedule.

Public records generated by use of social media must be accurately captured and retained in compliance with public records laws, authorized records retention schedules as well as other applicable Federal and State rules and policies.

Public records stored on social media must be accessible and retained in accordance with the authorized records retention schedule, as well as other applicable Federal and State rules and policies.

- **Model Policy Language**
  Any content placed on any Social Media platform by shall be an accurate copy of an official record that is retained elsewhere by the Oregon Board of Dentistry per the authorized records retention schedules.

Oregon Board of Dentistry will develop practices and procedures to manage agency use of social media to ensure public records are accurately captured and retained per authorized records retention schedules receive training from the State Archivist in performing this duty.

- *Agency Use Policy*
  - *The Agency does not utilize social media [Facebook, Twitter, Snapchat, etc…]*
- *Records Management Protocols*
  - *Agency Generated*
  - *Use Generated*
  - *Stored/Archived*
- *Site Maintenance and Monitoring Practices*

TEXT MESSAGING

Acceptable Use:

- **Business Communications**
  Agencies may use text messages to communicate information related to official state business, only if the content of the communication is documented elsewhere in an official public record, meaning that the content of the text message communication:
  - Has already been documented in a separate public record; or
  - Necessarily will be documented and retained as a separate public record to comply with applicable laws.

  In the absence of separate documentation, State employees are not to use text messages for official purposes other than routine communications that do not meet the definition of a "public record."

- **Routine Communications**
  Agencies may use text messages for **c**ommunicating factual or logistical information that would not result in the creation of a text message-based public records, meaning text message communications:
  - Regarding scheduling or logistical information; or
  - Providing factual information unrelated to official state business.

Unacceptable Use:

State employees shall avoid communicating official state business or engaging in discussions regarding the

primary business of employee's work over text-message. As noted above, relevant facts pertaining to official state business may be reported only if they are already documented in separate public records or they necessarily will be documented in a separate public record.

If, notwithstanding this Policy, text message is used to communicate information (not otherwise documented) relating to official state business or primary business of the employee's work, such discussion is to be immediately converted and saved in a separate public record format (e.g. by forwarding the relevant text messages to an employee's official e-mail).

State-owned devices with text message capability are always subject to search.

Agency employees' personal electronic devices shall not be used to transmit text messages related to state business. Personal devices used to transmit text messages regarding official state business and/or other substantive information related to employee's work are subject to search.

- **Model Policy Language**

  Acceptable Use:

  Oregon Board of Dentistry employees may use text messaging to communicate factual and logistical information that: is not part of or related to conducting official state business, unless that information has been documented elsewhere; or will be documented and retained as a separate public record according to the agency's authorized records retention schedule.

  In the absence of separate documentation Oregon Board of Dentistry employees are not to use text messages for official purposes other than for routine communications that do not meet the definition of a "public record."

  Examples of Acceptable Uses

  - *Scheduling.*
  - *Requesting a call or email on a matter, without substantive discussion.*
  - *Requesting or offering logistical assistance ("Can you help me get these boxes to the courthouse?")*
  - *Forwarding any person's contact information ("I'm at 503-378-6002.")*
  - *Explaining your current whereabouts, or inquiring about someone else's ("We're at the meeting discussing this morning's announcement. Are you around?")*
  - *Describing facts or events that do not relate to the substance of the Office's work ("Spilled coffee all over myself right before trial!"), or that have been or necessarily will be separately recorded ("Mr. Jones just testified to the committee that our bill would cost taxpayers $3 million.")*
  - *Inquiring about events like those in the previous bullet ("Has Mr. Jones testified in committee yet?")*

  Unacceptable Use:

  Oregon Board of Dentistry employees must avoid communicating official state business or engaging in discussions regarding the primary business of employee's work over text-message.

  As noted above, relevant facts pertaining to official state business may be reported only if they are already documented in separate public records or they necessarily will be documented in a separate public record.

  If, notwithstanding this Policy, text message is used to communicate information (not otherwise documented) relating to official state business or primary business of the employee's work, such

discussion is to be immediately converted and saved in a separate public record format (e.g. by forwarding the relevant text messages to an employee's official e-mail).

Because Oregon Board of Dentistry requires that no text message-based public records be created –or if they are created, that be converted and saved in an alternate format, which would serve as the official copy of the record - Oregon Board of Dentistry will not retain text messages.

Oregon Board of Dentistry employees' personal electronic devices should not be used to transmit text messages related to state business. Personal devices are subject to search if used to transmit text messages regarding official state business and/or information related to employee's work that rises to the level of creating a public record.

UNIFIED COMMUNICATIONS

The State of Oregon has entered into a contract with IBM to offer Unified Communications solutions directly to agencies. Agencies must carefully select a user profile which includes specific packaged services and determine which services should be active for employee use based on the agency-specific business needs.

Certain features offered to agencies, if actively used by agency employees for official state business, will result in the creation of public records. Agencies must develop internal policies and practices to ensure created public records are retained if necessary and otherwise, appropriately managed in accordance with authorized records retention schedules as well as other State and Federal policies and laws.

- **Model Policy Language**
  Oregon Board of Dentistry shall identify public records created by actively using Unified Communications features and ensure those records are appropriately managed in accordance with authorized records retention schedules as well as other applicable State and Federal policies and laws.
  Oregon Board of Dentistry shall implement the following practices and procedures to accurately capture public records created by use of active Unified Communications features receive training from IBM, DAS and/or the State Archivist in performing these duties.

VOICEMAIL

Unless otherwise required, messages on voicemail or other telephone message storage and retrieval system will not be retained.

Email transcription of voicemail messages is a feature of **Unified Communications** solutions referenced in the previous section. Email transcriptions of a voicemail message may be considered a public record subject to retention and must be retained in accordance with authorized records retention schedules.

- **Model Policy Language**
  Unless otherwise required, Oregon Board of Dentistry will not retain messages on voicemail.

  Email transcriptions of voicemails that are determined to be public records will be retained in accordance with authorized records retention schedules and may be subject to public disclosure upon request.

VII. STORAGE AND RETRIEVAL

PAPER RECORDS

Agencies will maintain a filing system of the agency's paper records. The filing system will include location of records, retention periods and procedures for retrieval of agency records.

Agencies may transfer paper records to micrographics or convert paper records to an electronic format for storage using electronic or cloud systems in accordance with the technical and management standards in OAR chapter 166 and DAS Statewide Cloud Policy requirements. The exception to this is for records with an authorized retention period of 100 years or more where agencies are required to follow the requirements of OAR 166-017-0045(3) prior to converting or destroying the paper records.

- **Model Policy Language**
  Oregon Board of Dentistry will maintain a filing system of the agency's paper records based on authorized retention schedules. The filing system will include the location of records, retention periods and procedures for retrieval to ensure accessibility of agency records.

ELECTRONIC RECORDS

At a minimum, agencies must establish a filing system and naming conventions for all agency records stored in an electronic format. The filing system and naming conventions must support the agency's inventory of electronic records and must include the location of the records in agency directories, retention periods, access controls and privacy conditions of the records.

Before deleting any large electronic record system, the agency must ensure that all retention periods have been met before the data is destroyed.

- **Model Policy Language**
  Oregon Board of Dentistry shall maintain a filing system and naming conventions for all agency records stored in electronic format based on the agency's authorized retention schedules. The filing system and naming conventions will include the location of records in agency directories, retention periods, access controls and privacy conditions to support management of the agency's inventory of electronic records.

  Oregon Board of Dentistry shall work with the State Archivist to ensure that retention periods for all records have been met before any data is destroyed and prior to deleting any large electronic record system.

VIII. PUBLIC RECORDS REQUESTS

Agencies will process and respond to all official requests for public records as timely as possible, consistent with the proper exercise of judgment relating to the agency's other duties. Agencies shall develop and adopt internal policies and procedures to appropriately manage, track and fulfill requests for public records.

Additional guidance and policies related to requests for public records will be the subject of separate statewide standard protocols, process and procedures (DAS Statewide Procedures ###-###-###, under development).

Instructions and supporting forms for submitting a public records request must be accessible, clear and user friendly.

- **Model Policy Language**
  Oregon Board of Dentistry shall respond to all official requests for public records as timely as possible, consistent with the proper exercise of judgment relating to the Oregon Board of Dentistry other duties.

  Additional policies and procedures related to requests for public records (intake, processing, and disclosure and/or determinations related to fees and charges) are the subject of separate agency policies and statewide protocols, processes and procedures.

IX. DISPOSITION AND DESTRUCTION OF PUBLIC RECORDS

Public Records retained beyond their authorized retention period, may be subject to public disclosure upon request, even if their retention was not required by law. Unless otherwise stated, a retention period shall be

calculated from the date the public record was created. Retention periods are both a minimum retention and maximum retention period.

Agencies shall dispose of and/or destroy public records in accordance with the requirements of OAR Chapter 166-300.

Pursuant to ORS 357.855, the State Archivist shall be consulted by state employees within the executive branch for advice and assistance with determining the disposition of certain record types, not accounted for in State Agency General or Special Retention Schedules and reconciliation of unforeseen issues regarding public records.

- **Model Policy Language**
  Oregon Board of Dentistry shall dispose of and/or destroy public records in accordance with the requirements of authorized records retention schedules and OAR chapter 166-300.

  Pursuant to ORS 357.855, the State Archivist shall be consulted by Oregon Board of Dentistry employees for advice and assistance with determining the disposition of certain record types, not accounted for in State Agency General or Special Retention Schedules and reconciliation of unforeseen issues regarding public records.

DAS DEPARTMENT OF ADMINISTRATIVE SERVICES	POLICY NUMBER 107-001-020
STATEWIDE POLICY	EFFECTIVE DATE July 1, 2016
EXHIBIT A – Model Public Records Management Policy	

POLICY

ORS 192.018 requires every state agency to have a "written policy that sets forth the agency's use, retention and ownership of public records" so that public records are being maintained and managed appropriately across state agencies, enterprise-wide, from the time of creation of a public record to the time of final disposition of the public record.

Agencies are required to seek review and approval from the State Archivist, in accordance with ORS 192.018, prior to adopting an internal public records management policy.

Agencies must review and, if necessary, update their public records management policy to reflect changes in applicable laws and policies and/or changing business needs and ensure ongoing accessibility at least once per biennium. Any updates or revisions must be submitted for review and approval by the State Archivist in accordance with ORS 192.018, prior to adoption.

SPECIAL SITUATIONS

- Retained records may be subject to public disclosure upon request, even if their retention was not required by law. The statutes requiring public disclosure of records apply more broadly than the statutes requiring records to be retained.
- Agencies are not required to create public records that would not otherwise exist.
- Only the official copy of a public record must be retained. Stock of publications are not public records and may be preserved for convenience or destroyed.

GENERAL INFORMATION

The goal of this Policy is to ensure public records are managed and maintained appropriately within Oregon Board of Dentistry and consistently across the enterprise of state government.

This Oregon Board of Dentistry Public Records Management Policy, adopted in accordance with the requirements of DAS Statewide Policy 107-011-020 and ORS 192.018, addresses the following components:

I. Public Records Maintenance
II. Roles and Responsibilities
III. Education and Training
IV. Access and Ownership
V. Integrity
VI. Retention Generally
VII. Storage and Retrieval
VIII. Public Records Requests
IX. Disposition and Destruction

COMPLIANCE

Oregon Board of Dentistry shall develop and implement internal processes and procedures that support compliance, deter abuse and detect violations of this Policy.

DEFINITIONS

"**Cloud-computing**" has the same meaning as defined in the National Institute of Standards and Technology (NIST) Special Publication 800-145.

"**Custodian**" refers to a public body mandated, directly or indirectly, to create, maintain, care for or control a public record. "Custodian" does not include a public body that has custody of a public record as an agent of another public body that is the custodian, unless the public record is not otherwise available.

"**Instant Messaging**" refers to real-time text communications between or among computers or mobile devices over the Internet or functionally similar communications network.

"**Metadata**" is data that provides information about other data. Metadata assists in resource discovery by allowing resources to be found by relevant criteria, identifying resources, bringing similar resources together, distinguishing dissimilar resources, and giving location information.

"**Public Record**" has the meaning established in ORS 192.005. In general it refers to information that is prepared, owned, used or retained by a state agency or political subdivision; relates to an activity, transaction or function of a state agency or political subdivision; and is necessary to satisfy the fiscal, legal, administrative or historical policies, requirements or needs of the state agency or political subdivision.

"**Social Media**" refers to web-based and mobile communication technologies that allow the creation and exchange of user-generated content such as comments or responsive postings. Examples of "social media" as of the time this Policy is adopted include but are not limited to Twitter, Flickr, blogging sites, Facebook, YouTube and Instagram.

"**Text Messaging**" refers to messages exchanged between fixed-line phones or mobile phones and fixed or portable devices over a network. Excluded from the definition of "text messages" are electronic mail ("e-mail") communications, whether such messages are exchanged among or between official State of Oregon e-mail accounts or e-mail accounts maintained by private entities.

"**Unified Communications**" refers to IBM Unified Communications and, more specifically, the packaged services or user-profiles available to agencies (e.g. instant messaging, video conferencing, telephony, call management and call control across multiple systems etc.).

POLICY GUIDELINES

II. PUBLIC RECORDS MAINTENANCE

Public records shall be maintained and managed in a manner that protects the integrity of the records within Oregon Board of Dentistry without regard to the technology or medium used to create or communicate the record, from the time of creation of a public record to the time of final disposition of the public record as determined by their authorized records retention schedule.

III. ROLES AND RESPONSIBILITIES

Oregon law requires agencies to designate an Agency Records Officer "to coordinate its agency's Records Management Program" (ORS 192.105 (2)(a)). Oregon Board of Dentistry records officer, will **s**erve as primary liaison with the State Archivist and receive training from the State Archivist in performing their duties.

Oregon Board of Dentistry will ensure agency public records are managed in accordance with their authorized

records retention schedules, from the time of creation to final disposition, by assigning designated staff/positions with the following responsibilities:
Executive Director has designated that only the Executive Assistant/Office Manager are responsible for fulfilling all public records requests for the Agency.

IV. EDUCATION AND TRAINING

Basic public records training will be completed as a component of Oregon Board of Dentistry new employee orientation training; and incorporated as part of regular employee training, completed once a biennium. Oregon Board of Dentistry will utilize the following training program to provide public records training:
Direct on the job training from the Executive Director and the Executive Assistant/Office Manager. Also, utilize DAS approved training, ilearn modules and/or the State Archivist.

V. ACCESS AND OWNERSHIP

Without regard to how public records are being stored, Oregon Board of Dentistry will have custody and control over public records. Through on-going review of technological advances, agencies shall ensure all public records are maintained and accessible for as long as required by applicable retention schedules or litigation holds.

Oregon Board of Dentistry disaster mitigation process are addressed in the Oregon Board of Dentistry disaster preparedness and recovery plan and incorporated by the Agency and on record at the Agency.

VI. INTEGRITY

Oregon Board of Dentistry will ensure appropriate access and version controls are applied to all electronically stored records from record creation to final disposition.

The authenticity of each record can be demonstrated either by certified copy of paper records or via accompanying metadata for all electronic records.

VII. RETENTION GENERALL

Oregon Board of Dentistry will preserve and classify public records in accordance with ORS chapter 192, OAR chapter 166-300 and DAS Statewide Policy 107-004-050 regarding Information Asset Classification.

Oregon Board of Dentistry will work with the Archives Division to establish retention practices to ensure compliance with ORS chapter 192 and OAR chapter 166-300.

a. CLOUD-COMPUTING

Oregon Board of Dentistry practices and procedures with respect to public records management in the Cloud will ensure compliance with DAS Statewide Cloud-Computing Policy (DAS Statewide Policy 107-004-150; 107-004-150; 107-004-150 PR) and OAR chapter 166.

b. EMAIL

Official Email Accounts

In most circumstances, emails sent to or from a State employee's official email account will meet the definition of a public record. It is therefore Oregon Board of Dentistry policy that virtually all email messages composed or sent using employees' official equipment and/or official email addresses be for primarily business purposes.

When the Oregon Board of Dentistry receives a public records request, all official email accounts and systems used for official State business are subject to search and production.

Personal Email Accounts

If private email accounts must be used to conduct State business, it is Oregon Board of Dentistry policy

that employees copy their official email accounts on all such outgoing communications, and forward any received messages on which their official email accounts are not copied immediately or as soon as practicably possible

c. **INSTANT MESSAGING**

Oregon Board of Dentistry policy regarding Instant Messages shall be the same as that recited below regarding **TEXT MESSAGING**.

d. **SOCIAL MEDIA**

Any content placed on any Social Media platform by Oregon Board of Dentistry shall be an accurate copy of an official record that is retained elsewhere by the Oregon Board of Dentistry per the authorized records retention schedules.

Oregon Board of Dentistry will develop practices and procedures to manage agency use of social media to ensure public records are accurately captured and retained per authorized records retention schedules. [

- Agency Use Policy
  - The Agency does not utilize social media [Facebook, Twitter, Snapchat, etc…]
- Records Management Protocols
  - Agency Generated
  - Use Generated
  - Stored/Archived
- Site Maintenance and Monitoring Practices

e. **TEXT MESSAGING**

Acceptable Use:

Oregon Board of Dentistry employees may use text messaging to communicate factual and logistical information that: is not part of or related to conducting official state business, unless that information has been documented elsewhere; or will be documented and retained as a separate public record according to the agency's authorized records retention schedule.

In the absence of separate documentation, Oregon Board of Dentistry employees are not to use text messages for official purposes other than for routine communications that do not meet the definition of a "public record."

Examples of Acceptable Uses

- Scheduling.
- Requesting a call or email on a matter, without substantive discussion.
- Requesting or offering logistical assistance ("Can you help me get these boxes to the courthouse?")
- Forwarding any person's contact information ("I'm at 503-378-6002.")
- Explaining your current whereabouts, or inquiring about someone else's ("We're at the meeting discussing this morning's announcement. Are you around?")
- Describing facts or events that do not relate to the substance of the Office's work ("Spilled coffee all over myself right before trial!"), or that have been or necessarily will be separately recorded ("Mr. Jones just testified to the committee that our bill would cost taxpayers $3 million.")
- Inquiring about events like those in the previous bullet ("Has Mr. Jones testified in committee yet?")

Unacceptable Use:

Oregon Board of Dentistry employees must avoid communicating official state business or engaging in discussions regarding the primary business of employee's work over text-message.

As noted above, relevant facts pertaining to official state business may be reported only if they are already

documented in separate public records or they necessarily will be documented in a separate public record. If, notwithstanding this Policy, text message is used to communicate information (not otherwise documented) relating to official state business or primary business of the employee's work, such discussion is to be immediately converted and saved in a separate public record format (e.g. by forwarding the relevant text messages to an employee's official e-mail).

Because Oregon Board of Dentistry requires that no text message-based public records be created –or if they are created, that be converted and saved in an alternate format, which would serve as the official copy of the record - Oregon Board of Dentistry will not retain text messages.

Oregon Board of Dentistry employees' personal electronic devices should not be used to transmit text messages related to state business. Personal devices are subject to search if used to transmit text messages regarding official state business and/or information related to employee's work that rises to the level of creating a public record.

f. **UNIFIED COMMUNICATIONS**

The State of Oregon has entered into a contract with IBM to offer Unified Communications solutions directly to agencies. Agencies must carefully select a user profile which includes specific packaged services and determine which services should be active for employee use based on the agency-specific business needs.

Certain features offered to agencies, if actively used by agency employees for official state business, will result in the creation of public records. Agencies must develop internal policies and practices to ensure created public records are retained if necessary and otherwise, appropriately managed in accordance with authorized records retention schedules as well as other State and Federal policies and laws.

- **Model Policy Language**

  Oregon Board of Dentistry shall identify public records created by actively using Unified Communications features and ensure those records are appropriately managed in accordance with authorized records retention schedules as well as other applicable State and Federal policies and laws.

  Oregon Board of Dentistry shall implement the following practices and procedures to accurately capture public records created by use of active Unified Communications features receive training from IBM, DAS and/or the State Archivist in performing these duties.

g. **VOICEMAIL**

Unless otherwise required, Oregon Board of Dentistry will not retain messages on voicemail.

Email transcriptions of voicemails that are determined to be public records will be retained in accordance with authorized records retention schedules and may be subject to public disclosure upon request.

VIII. STORAGE AND RETRIEVAL

Paper Records:

Oregon Board of Dentistry will maintain a filing system of the agency's paper records based on authorized retention schedules. The filing system will include the location of records, retention periods and procedures for retrieval to ensure accessibility of agency records.

Electronic Records:

Oregon Board of Dentistry will maintain a filing system and naming conventions for all agency records stored in electronic format based on the agency's authorized retention schedules. The filing system and naming conventions will include the location of records in agency directories, retention periods, access controls and privacy conditions to support management of the agency's inventory of electronic records.

Oregon Board of Dentistry will work with the State Archivist to ensure that retention periods for all records have been met before any data is destroyed and prior to deleting any large electronic record system.

IX. PUBLIC RECORDS REQUESTS

Oregon Board of Dentistry will respond to all official requests for public records as timely as possible, consistent with the proper exercise of judgment relating to the Oregon Board of Dentistry other duties.

Additional policies and procedures related to requests for public records (intake, processing, and disclosure and/or determinations related to fees and charges) are the subject of separate agency policies and statewide protocols, processes and procedures.

X. DISPOSITION AND DESTRUCTION OF PUBLIC RECORDS

Oregon Board of Dentistry will dispose of and/or destroy public records in accordance with the requirements of authorized records retention schedules and OAR chapter 166-300.

Pursuant to ORS 357.855, the State Archivist shall be consulted by Oregon Board of Dentistry employees for advice and assistance with determining the disposition of certain record types, not accounted for in State Agency General or Special Retention Schedules and reconciliation of unforeseen issues regarding public records.

Dear Colleagues,

In an effort to improve customer service to the public and institute consistent, effective practices among state agencies, as well as to ensure the security of state data systems, I issued an executive order today to unify cyber security efforts across Oregon state government. In an era when we rely on integrated information technology and online data systems, cyber security is imperative. However, our efforts are continually challenged by aging information technology infrastructure and antiquated legacy systems. Now more than ever, it is critical that we work continuously to ensure secure information systems and build infrastructure able to keep pace with a dynamic, 21st-century business environment.

The Office of the State Chief Information Officer (OSCIO), led by Alex Pettit, is spearheading this cyber security reboot. The OSCIO will initiate a statewide, agency-by-agency assessment to identify security needs and vulnerabilities and will work with each agency to enhance information management systems and protocols. Additionally, the OSCIO will work with designated agency representatives to develop and conduct security awareness trainings, and coordinate the implementation of effective practices to better address information security needs.

I appreciate your engagement with this important work, and I encourage your cooperation with the OSCIO as we embark on this effort to strengthen cyber security. Bolstering our information management systems and remaining vigilant against the unrelenting threat of cyber attacks is critical to ensuring Oregon state services are resilient and ready to meet the challenges and optimize the advantages of an innovative, digital world.

Thank you for all you do in service to the people of Oregon.

Sincerely,
Kate Brown,
Governor

EXECUTIVE ORDER NO. 16-13

UNIFYING CYBER SECURITY IN OREGON

WHEREAS, information systems, networks, and critical infrastructure around the world are threatened by increasing and evermore sophisticated cyber-attacks; and

WHEREAS, the people of and businesses operating within Oregon have entrusted state government with a large repository of information that they expect will be protected and secured; and

WHEREAS, information is a strategic asset of the state of Oregon that should be managed and secured as a valuable state resource; and

WHEREAS, the continuous and efficient operation of state government information systems is both vital and necessary to the mission of providing government services in Oregon; and

WHEREAS, vulnerabilities of the state's information systems underscore the need to enhance the security of Oregon information systems, networks, and critical infrastructure; and

WHEREAS, aging information technology infrastructure and antiquated legacy information systems in use by state agencies remain vulnerable to cyberattack, placing private information about state employees and their dependents, consumers of state services, taxpayers, and the residents and businesses of Oregon at risk; and

WHEREAS, responsibility and accountability for the security of state information systems is currently dispersed and decentralized with the exception of the enterprise information resources, technology, and telecommunications infrastructure managed and overseen by the State Chief Information Officer.

WHEREAS, ORS 182.122 imposes on state agencies the responsibility to secure their information systems or implement information security plans, policies, standards, and procedures established by the State Chief Information Officer; and

WHEREAS, unification of the state's cyber security functions under the leadership of the State Chief Information Officer is necessary to protect the availability, integrity, and confidentiality of state information systems and the information stored in state information systems pursuant to ORS 182.122;

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EXECUTIVE ORDER NO. 16-13
PAGE TWO

NOW, THEREFORE IT IS HEREBY DIRECTED AND ORDERED:

1. All state agencies within the Executive department as defined in ORS 174.112, except the Secretary of State, State Treasurer, Attorney General of Oregon, Oregon Bureau of Labor and Industries, State Lottery, and public universities listed in ORS 352.002, shall carry out the actions necessary to unify information technology (IT) security functions.

2. Beginning on the effective date of this Executive Order, the State Chief Information Officer (CIO), or designee of the State CIO, and state agencies specified in section 1 shall work cooperatively to prepare for and develop a plan to execute the transfer of agency IT security functions and employees to the Office of the State CIO (OSCIO) by November 1, 2016.

3. In accordance with the plan, the Director of each state agency specified in section 1 shall deliver to the State CIO, or designee of the State CIO, all records related to the performance of the agency IT security functions transferred to OSCIO.

4. The Director of each state agency specified in section 1 shall execute a "Job Rotation — External Agreement" to assign employees engaged primarily in the performance of agency IT security functions to OSCIO. The job rotation shall begin within one month of the effective date of this Executive Order and shall end on June 30, 2017, or at a time decided by the mutual agreement of the sending agency's Director and the CIO. The sending agency shall continue to be responsible for the employees' compensation for the duration of the job rotation assignment.

5. The State CIO shall take possession of the records, and take charge of the employees specified in section 4, subject to the terms of the "Job Rotation — External Agreement," the state's ordinary practices in performing such agreements, applicable collective bargaining agreements, and other applicable law. As necessary to accomplish the missions and goals of the state and state agencies, the State CIO, or the State CIO's designee, may immediately redeploy transferred employees back to their respective agency of origin under the continuing supervision of the State CIO, or the State CIO's designee.

6. State agencies shall assist OSCIO and provide access to personnel and other resources necessary to successfully execute the job rotation.

7. The DAS Director, or designee of the DAS Director, shall ensure compliance with all applicable policy provisions and collective bargaining agreements,

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EXECUTIVE ORDER 16-13
PAGE THREE

including providing any notices required thereunder within the applicable time periods.

8. All state agencies shall cooperate in the development of and follow the plans, rules, policies, and standards adopted by the State CIO. Further, all state agencies shall provide OSCIO with full cooperation in the implementation of a statewide agency-by-agency risk-based security assessment and remediation program. The State CIO shall determine and charge the costs incurred by the program for third-party security evaluations, vulnerability assessments, other related technical services, and remediation measures to the state agencies that the State CIO serves. The state agency shall pay the cost to the State CIO in the same manner that other claims are paid. Additionally, state agencies will conduct and document the completion of OSCIO approved information security awareness training for all agency employees on an annual basis; report security metrics using methodologies developed by the OSCIO; and participate in activities coordinated by the OSCIO in order to better understand and address security incidents and critical cyber security threats to the state.

9. This Executive Order shall remain in effect until it is otherwise modified, amended or terminated.

Done at Salem, Oregon, this 12th day of September, 2016.

Kate Brown
GOVERNOR

ATTEST:

Jeanne P. Atkins
SECRETARY OF STATE

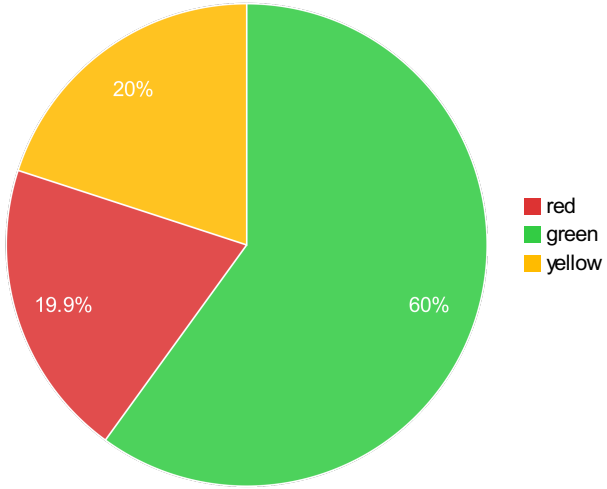
Dentistry, Board of

Annual Performance Progress Report

Reporting Year 2016

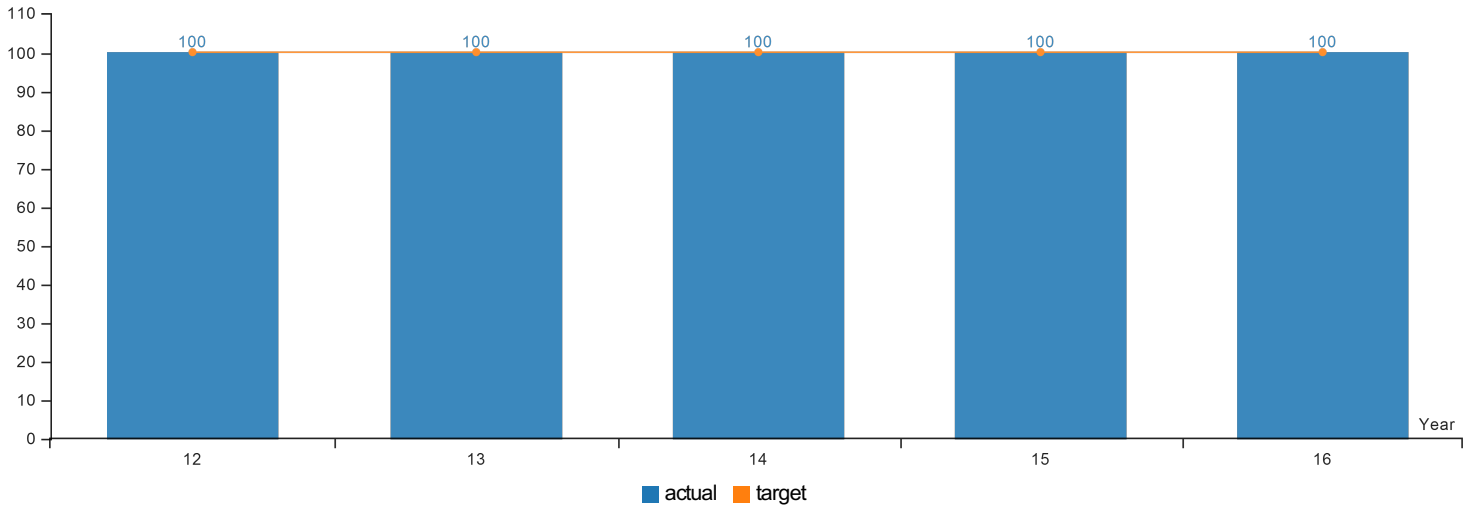
Published: 9/12/2016 1:16:14 PM

KPM #	Approved Key Performance Measures (KPMs)
1	Continuing Education Compliance - Percent of Licensees in compliance with continuing education requirements.
2	Time to Investigate Complaints - Average time from receipt of new complaints to completed investigation.
3	Days to Complete License Paperwork - Average number of working days from receipt of completed paperwork to issuance of license.
4	CUSTOMER SATISFACTION WITH AGENCY SERVICES - Percent of customers rating their satisfaction with the agency's customer service as "good" or "excellent": overall, timeliness, accuracy, helpfulness, expertise, availability of information.
5	Board Best Practices - Percent of total best practices met by the Board.



	Green	Yellow	Red
	= Target to -5%	= Target -6% to -15%	= Target > -15%
Summary Stats:	60%	20%	20%

KPM #1	Continuing Education Compliance - Percent of Licensees in compliance with continuing education requirements.
	Data Collection Period: Jul 01 - Jun 30



Report Year	2012	2013	2014	2015	2016
Percent of Licensees in Compliance with Continuing Education Requirements					
Actual	100%	100%	100%	100%	100%
Target	100%	100%	100%	100%	100%

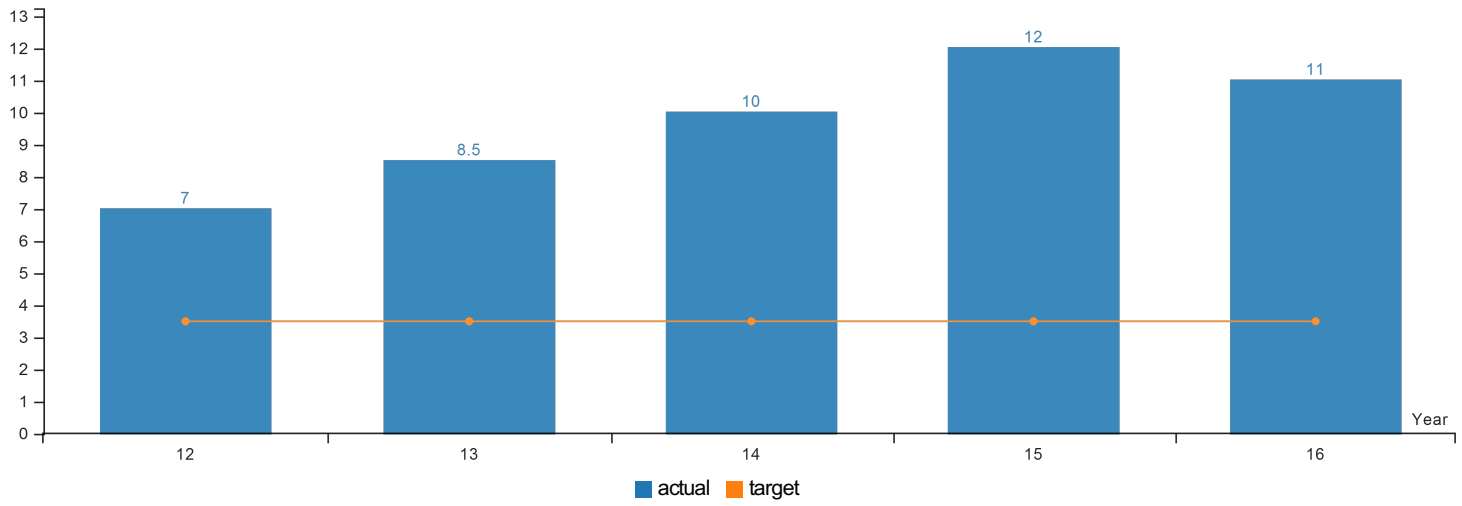
How Are We Doing

For FY 2016 we achieved this goal. The Board's strategy is that licensees should keep current on practice issues. One way to do this is to take continuing education courses on a biennial basis. To determine if the licensees are in compliance is to audit approximately 15% of all licensees to establish a baseline.

Factors Affecting Results

Experienced staff communicates with licensees regarding their continuing education requirements.

KPM #2	Time to Investigate Complaints - Average time from receipt of new complaints to completed investigation.
	Data Collection Period: Jul 01 - Jun 30



Report Year	2012	2013	2014	2015	2016
Average time to Investigate Complaints					
Actual	7	8.50	10	12	11
Target	3.50	3.50	3.50	3.50	3.50

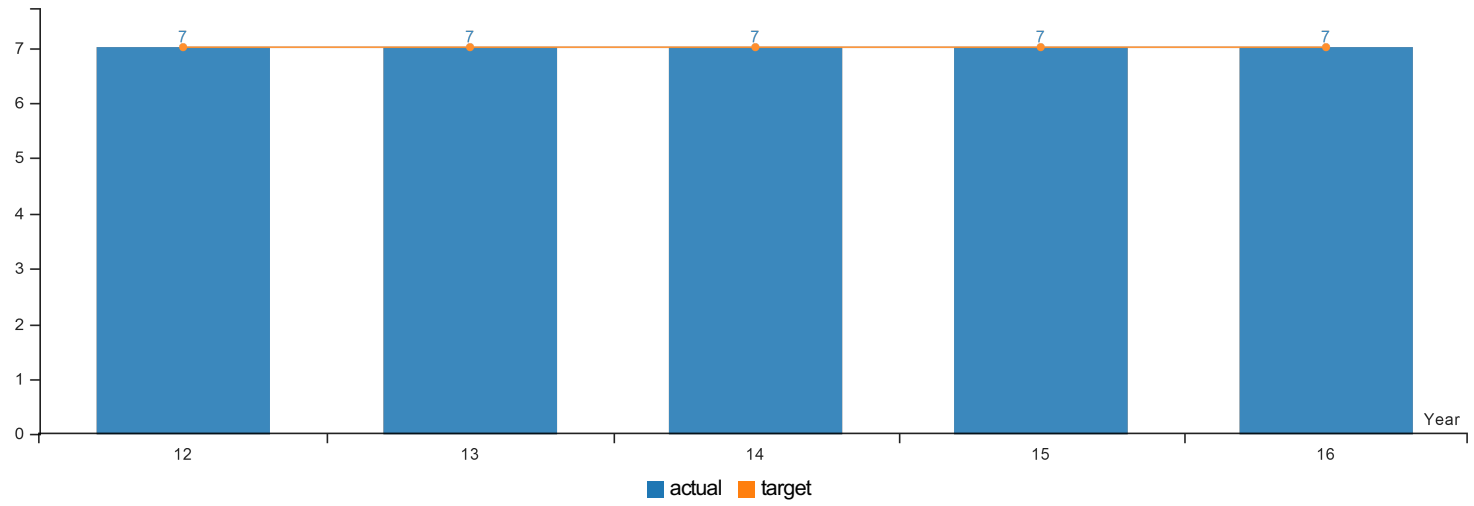
How Are We Doing

For FY 2016 we made progress on achieving our goal. The Board's strategy is that the investigation of complaints should take place in a timely fashion. By establishing the average time from the receipt of a new complaint until the investigation is completed is a way of measuring the timeliness of the Board's workload. The targets provide for a time frame to complete investigations based on the complexity of the issues and the staff available to conduct the investigation. The target of 3.5 months to complete an investigation is an excellent goal, but challenging now. Since 2010 the time to complete investigations has increased due to the volume and the complex nature of the cases, many involving multiple licensees. This Performance Measure was established in 2000.

Factors Affecting Results

The Board has seen an increase in the complexity of the complaints and these complaints are requiring a lot more time, as cases with multiple licensees involved do. When multiple licensees are involved it requires the investigators to review patient records from many different licensees. The investigations can drag on because of the delay in licensees providing records as well. We are also seeing a substantial number of cases involving payment and financial disputes, requiring an investigation and the end result is that they are monetary in nature and thus not truly within the jurisdiction of the Board. Certain cases that take an extraordinary long amount of time to investigate can skew the overall average time for all complaints closed.

KPM #3	Days to Complete License Paperwork - Average number of working days from receipt of completed paperwork to issuance of license.
	Data Collection Period: Jul 01 - Jun 30



Report Year	2012	2013	2014	2015	2016
Average Number of Working Days to Issue license after Paperwork is Completed.					
Actual	7	7	7	7	7
Target	7	7	7	7	7

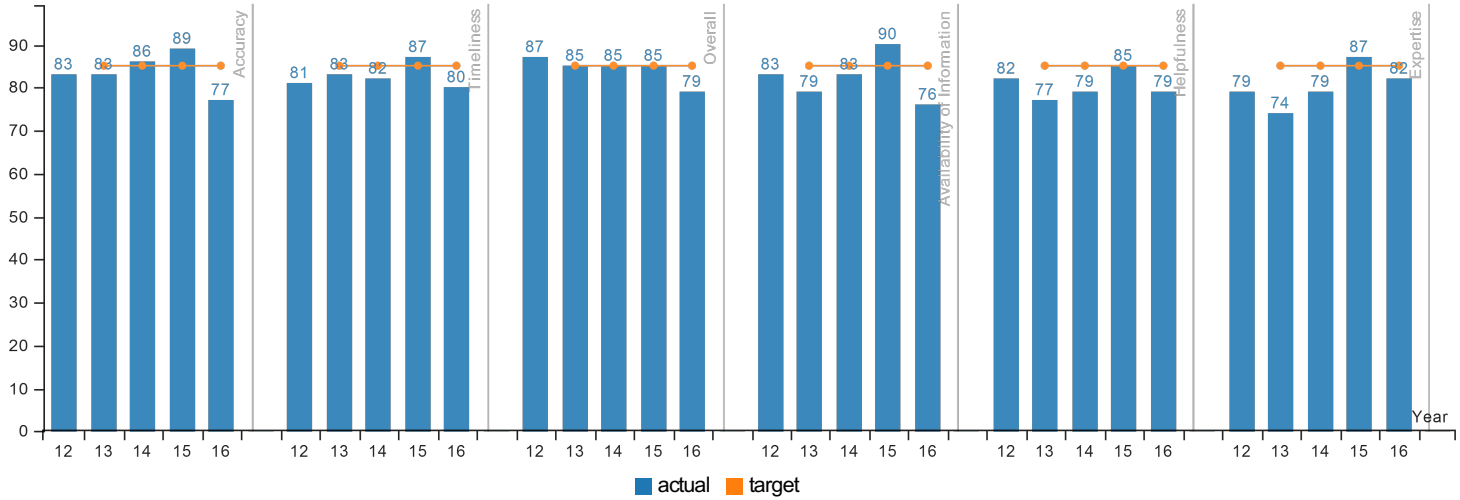
How Are We Doing

For FY 2016 we achieved our goal. The Board's strategy is that the processing of completed paperwork for the issuance of a license, either new or a renewal, should take place in a reasonable period of time to fulfill one of our statutory requirements and that those desiring to work in Oregon can do so in a timely fashion. Our staff works very efficiently on processing applications and working with applicants to get their paperwork in accurately and completely.

Factors Affecting Results

Our process for issuing licenses has been in place for many years and we continue achieving this goal year after year.

KPM #4	CUSTOMER SATISFACTION WITH AGENCY SERVICES - Percent of customers rating their satisfaction with the agency's customer service as "good" or "excellent": overall, timeliness, accuracy, helpfulness, expertise, availability of information.
	Data Collection Period: Jul 01 - Jun 30



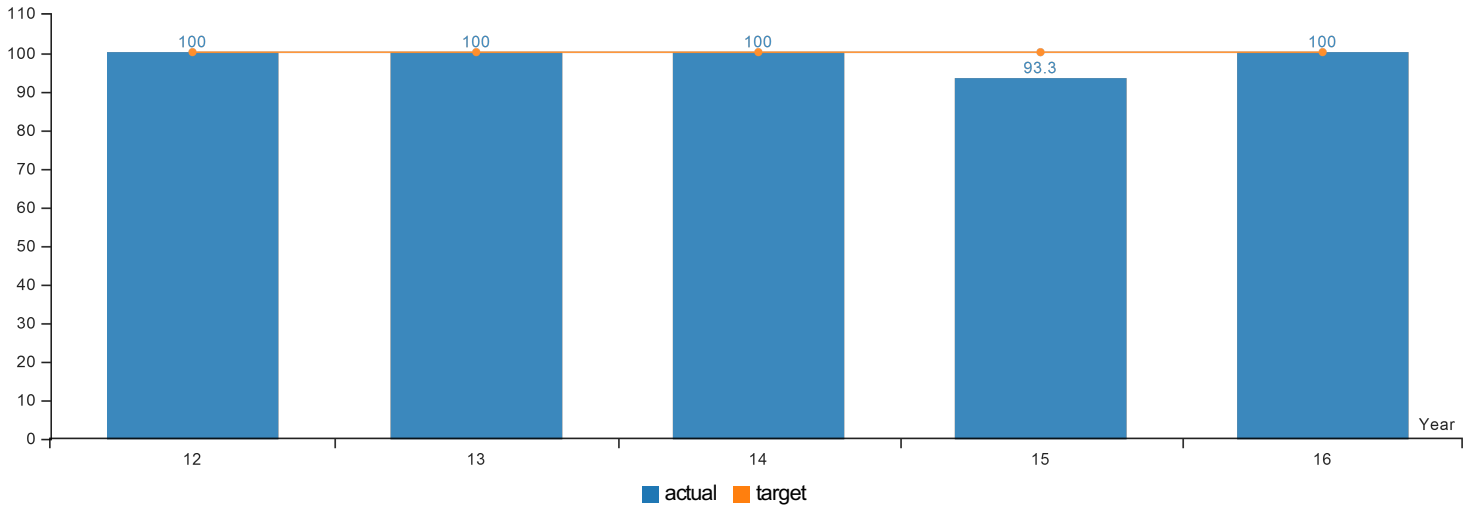
Report Year	2012	2013	2014	2015	2016
Accuracy					
Actual	83%	83%	86%	89%	77%
Target	TBD	85%	85%	85%	85%
Timeliness					
Actual	81%	83%	82%	87%	80%
Target	TBD	85%	85%	85%	85%
Overall					
Actual	87%	85%	85%	85%	79%
Target	TBD	85%	85%	85%	85%
Availability of Information					
Actual	83%	79%	83%	90%	76%
Target	TBD	85%	85%	85%	85%
Helpfulness					
Actual	82%	77%	79%	85%	79%
Target	TBD	85%	85%	85%	85%
Expertise					
Actual	79%	74%	79%	87%	82%
Target	TBD	85%	85%	85%	85%

For FY 2016 we were close to achieving our goal. In compliance with the Oregon Legislatures directive, the Board conducted a Customer Service Survey as one tool to determine the customer satisfaction with the accuracy of carrying out the statutory requirements and Mission of the Board. We receive overall strong positive feedback on the surveys that are completed and surveyed.

Factors Affecting Results

The positive results are not as strong as previous years. One reason for the lower results is that this is the first full fiscal year implementing a web based survey, phasing out the paper and postage surveys of previous years. This has shown a reduction in the number of surveys received. By comparison in FY 2015 we received 235 surveys. This FY(2016) we received 97 submissions. The administrative staff will review this matter closer, to attempt to get more surveys and feedback from our stakeholders. Nevertheless, we feel we are providing excellent assistance to those that contact us for information, help and guidance regarding the rules of dentistry and hygiene for the state of Oregon. This optimism is because our results in other areas of this report are similar or improved over last year. When people contact the office (during business hours), we have administrative staff answering their phone calls, not a voice mail system. We respond efficiently to email inquiries. We respond promptly to public records requests.

KPM #5	Board Best Practices - Percent of total best practices met by the Board.
	Data Collection Period: Jul 01 - Jun 30



Report Year	2012	2013	2014	2015	2016
Compliance with Best Practices Performance Measurement					
Actual	100%	100%	100%	93.30%	100%
Target	100%	100%	100%	100%	100%

How Are We Doing

For FY 2016 we achieved this goal. The Board's is in 100% compliance with Best Practices Performance Measurements for Governing Boards and Commissions.

Factors Affecting Results

The Board members are engaged and dedicated to their Board requirements and duties.

Best Practices Self-Assessment

Annually, Board members are to self-evaluate their adherence to a set of best practices and report the percent total best practices met by the Board (percent of yes responses in the table below) in the Annual Performance Progress Report as specified in the agency Budget instructions.

Best Practices Assessment Score Card

Best Practices Criteria	Yes	No
1. Executive Director's performance expectations are current.	✓	
2. Executive Director receives annual performance feedback.	✓	
3. The agency's mission and high-level goals are current and applicable.	✓	
4. The Board reviews the Annual Performance Progress Report.	✓	
5. The Board is appropriately involved in review of agency's key communications.	✓	
6. The Board is appropriately involved in policy-making activities.	✓	
7. The agency's policy option budget packages are aligned with their mission and goals.	✓	
8. The Board reviews all proposed budgets.	✓	
9. The Board periodically reviews key financial information and audit findings.	✓	
10. The Board is appropriately accounting for resources.	✓	
11. The agency adheres to accounting rules and other relevant financial controls.	✓	
12. Board members act in accordance with their roles as public representatives.	✓	
13. The Board coordinates with others where responsibilities and interest overlap.	✓	
14. The Board members identify and attend appropriate training sessions.	✓	
15. The Board reviews its management practices to ensure best practices are utilized.	✓	
Total Number	15	
Percentage of total:	100%	

The Board reviewed its Best Practices at the August 19, 2016 Board Meeting. The Board concluded that all best practices were achieved for fiscal year 2016.

Oregon
Kate Brown, Governor

Board of Dentistry
1500 SW 1st Ave. Ste 770
Portland, OR 97201-5837
(971) 673-3200
Fax: (971) 673-3202

To: OBD Board Members

From: Stephen Prisby, Executive Director

Date: August 30, 2016

Re: EPDH Reporting

I am attached the results for the last four years regarding reimbursement of services provided by expanded practice dental hygienists. This report was submitted to the Legislature on Sept. 2, 2016.

680.210 Compilation of data on expanded practice dental hygienists; reports by health insurers; report to legislature; rules.

(1) The Oregon Board of Dentistry shall compile data, including baseline data, in every odd-numbered year on the use of expanded practice dental hygienists, as defined in ORS 679.010, in this state.

(2)(a) The Department of Consumer and Business Services shall adopt rules requiring health insurers to report to the department on the reimbursement of services provided by expanded practice dental hygienists.

(b) The department shall provide the information collected under paragraph (a) of this subsection to the board.

(3) The board shall report to an interim legislative committee related to dental health on the reimbursement of services provided by expanded practice dental hygienists on or before October 1 of each even-numbered year. [2011 c.716 §12]

Oregon
Kate Brown, Governor

Department of Consumer and Business Services
Division of Financial Regulation
350 Winter St. NE, Room 410
P.O. Box 14480
Salem, OR 97309-0405

August 30, 2016

Stephen Prisby
Executive Director
Oregon Board of Dentistry
1500 SW 1st Ave., Ste. # 770
Portland OR 97201

Delivered by E-mail to: Stephen.Prisby@state.or.us

Dear Mr. Prisby:

I am writing in reference to the report to the Oregon Board of Dentistry on services provided by Expanded Practice Dental Hygienists between July 1st, 2014 and June 30th, 2016.

ORS 680.210 (2) requires that the Division of Financial Regulation (formerly known as the Oregon Insurance Division) provide information collected on the reimbursement of services provided by expanded practice dental hygienists to the Board of Dentistry. This information has been collected and aggregated and is being forwarded electronically with this letter.

All told, nine entities reported paying for services provided by expanded practice dental hygienists between July 1st, 2014 and June 30, 2016. The highest billed provider of these services was Advantage Dental Services, LLC, being billed in total $220,975, however they included a note with their report indicating *"None of these claims were for eligible members so the amount allowed would be $0 under the insurance plan and the amount of benefit paid by the insurer of the dental service would be $0. Basically these were all denied claims because the member was not eligible for any plan being administered by Advantage Dental Plan, Inc."* Oregon Dental Service was the largest provider of these services that made payment, with a total billed amount of 183,705 and total payments of $62,247 on claims for Oregon Health Plan members, and $19,671 on claims for members of commercial insurance plans. In total, $133,709 was paid on billing totaling just over $510,000.

The next reporting period for reimbursement of services provided by expanded practice dental hygienists will extend from July 1, 2016 through June 30, 2018. After receipt, data will again be forwarded to the Board of Dentistry at that time.

A spreadsheet aggregating submissions by the nine insurers reporting payment of these services for this reporting period has been forwarded electronically to you along with this letter. If you have any questions concerning this information, please feel free to contact me.

Sincerely,

Spencer Peacock
Market Analyst
(503) 947-7201
spencer.c.peacock@oregon.gov

Company	Amount billed by the EPDH to the insurer for the service provided.	Amount allowed for the service under the insurance plan.	Amount of benefit paid by the insurer for the dental service.	Amount owed by the insured for the service.	Amount of excluded charges owed by the insured.	Amount of excluded charges, if any, that the provider is not allowed to collect from the insured due to their provider agreement with the insurer.
Advantage Dental*	$220,975.06	-	-	$220,975.06	$220,975.06	-
Aetna Life	$6,217.40	$4,735.13	$3,936.98	$522.39	$522.39	$118.00
Cambia	$8,304.00	$7,147.08	$5,068.78	$2,746.26		
Cigna Life and Health	$60,643.00	$39,756.05	$27,530.38	$16,760.12	$4,849.50	$15,570.00
Dentegra	$12,891.00	$12,446.00	$7,311.00	$4,060.00	$5,135.00	$1,454.00
Lifemap	$835.00	$585.00	$354.50	$180.50	$250.00	-
Metlife	$480.00	$370.00	$320.00	$160.00	-	-
Oregon Dental Service	183,705.92	$81,918.76	$79,208.08	$2,710.68	$28,646.16	$73,233.09
PacificSource	$17,067.00	$11,184.72	$9,979.44	$852.49		$5,882.28
Total	**$511,118.38**	**$158,142.74**	**$133,709.16**	**$248,967.50**	**$260,378.11**	**$96,257.37**

Note

*Advantage Dental included a comment with their report "None of these claims were for eligible members so the amount allowed would be $0 under the insurance plan and the amount of benefit paid by the insurer of the dental service would be $0. Basically these were all denied claims because the member was not eligible for any plan being administered by Advantage Dental Plan, Inc."

Oregon
John A. Kitzhaber, MD, Governor

Department of Consumer and Business Services
Insurance Division
350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405
503-947-7980
Fax: 503-378-4351
www.insurance.oregon.gov

September 23, 2014

Patrick Braatz
Executive Director
Oregon Board of Dentistry
1600 SW 4th Ave.
Portland OR 97201

Delivered by E-mail to: Patrick.Braatz@state.or.us

Dear Mr. Braatz:

I am writing in reference to the report to the Oregon Board of Dentistry on services provided by Expanded Practice Dental Hygienists between July 1st, 2012 and June 30th, 2014.

ORS 680.210 (2) requires that the Insurance Division provide information collected on the reimbursement of services provided by expanded practice dental hygienists to the Board of Dentistry. This information has been collected and aggregated and is being forwarded electronically with this letter.

All told, only eight entities reported paying for services provided by expanded practice dental hygienists between July 1st, 2012 and June 30, 2014. The largest provider of these services was Advantage Dental Services, LLC, a vendor operating on behalf of the Oregon Health Plan. They report having been billed for 32,985 of these services with total payments of $103,596.74. Oregon Dental Service was also a large provider of these services, with total payments of $29,294.94 on claims for Oregon Health Plan members, and $10,716.33 on claims for members of commercial insurance plans. In total, $162,937.42 was paid on billing totaling over $900,000.

This reporting requirement is still not well known by the insurance industry, in spite of efforts by the Insurance Division to increase awareness through sending electronic notifications to industry and in some cases, direct contact with industry representatives. The next reporting period for reimbursement of services provided by expanded practice dental hygienists will extend from July 1, 2014 through June 30, 2016. After receipt, data will again be forwarded to the Board of Dentistry at that time.

A spreadsheet aggregating submissions by the eight insurers reporting payment of these services for this reporting period has been forwarded electronically to you along with this letter. If you have any questions concerning this information, please feel free to contact me.

Sincerely,

Cliff Nolen, AIE, AIRC
Chief Market Analyst
(503) 947-7221
cliff.nolen@state.or.us

Company Name	Mailing Address	Phone Number	Contact Name	Amount Billed for Services	Amount Allowed per plan	Benefit Paid by Insurer	Excluded Charges
Regence BlueCross Blue Shield of Oregon	P O Box 1271 Portland, OR 97207	503-525-6523	Daniel Striplin	$10,711.00	$6,014.00	$4,511.00	$0.00
Cigna Health	900 Cottage Grove Rd Bloomfield, CT 06002	770-261-3448	Jean Wirtz	$635.00	$80.00	$80.00	$555.00
Pacific Source	P O Box 7068 Springfield, OR 97475	541-684-5251	Gary Holliday	$12,980.95	$9,539.24	$8,592.59	$3,441.71
Dentegra Insurance Company	11155 International Dr Rancho Cordova, CA 95670	916-861-1562	Felicia Kemp	$9,217.00	$9,117.00	$5,225.00	$3,892.00
Madison National	P O Box 5008 Madison, WI 53705	602-861-6070	Shellie Howard	$118.00	$117.82	$92.82	$0.00
Life Map	P O Box 1271 Portland, OR 97207	503-220-6380	Laura Fruge	$1,775.00	$1,263.00	$828.00	$0.00
Advantage Dental/OHP	442 SW Umatilla Ave Suite 200 Redmond, OR 97756	541-504-3935	Jeanne Dysert	$776,404.63	$103,985.74	$103,596.74	$389.00
ODS	601 SW 2nd Ave Portland, OR 97204	503-948-5544	Bill Ten Pas	$108,902.14	$44,138.81	$42,044.09	$2,094.72
	Totals			$920,743.72	$174,255.61	$164,970.24	$10,372.43

Oregon
Kate Brown, Governor

Board of Dentistry
1500 SW 1st Ave. Ste 770
Portland, OR 97201-5837
(971) 673-3200
Fax: (971) 673-3202

September 14, 2016

Sent Via Email

Dear Honorable State Legislators:

The Oregon Board of Dentistry (OBD) has undergone significant changes over the past 16 months including the hiring of a new executive director, adding new board members, hiring new staff and undertaking strategic planning for the first time since 2007. The Board unanimously agreed in the strategic plan that stakeholder outreach was an important component of the plan in communicating the OBD's mission and priorities. This letter to you is part of the communications plan to share with you important news, to ensure open and positive communications and to be a resource when necessary, on any issue you or your constituents feel needs our attention.

With the upcoming legislative session the OBD is aware of a number of forthcoming ideas and legislative concepts that may impact the statutes and rules that govern dentistry and dental hygiene in our state. We strive to bring our expertise and experience to the table when necessary on any potential statute change that could impact the practice of dentistry or dental hygiene in the state. Please contact us should you need input on any legislative concepts or statute changes.

The executive director and his staff have been proactive in presenting Board updates to all Licensees on important matters involving upcoming rule changes, prescription opioid abuse prevention and overviews of Board operations and practices.

The OBD has established good working relationships with the three main professional associations within the state- the Oregon Dental Association, Oregon Dental Hygienists' Association and Oregon Dental Assistants Association, along with the smaller dental specialty groups and national groups which influence dentistry in the U.S. The OBD also works closely with the OHSU School of Dentistry and the colleges that offer dental hygiene programs in the state, on important topics such as licensure and updates on Board statutes and rules. The OBD of course stays connected and up to date with the Oregon Health Authority, the state's dental director and other state health regulatory boards on any matters relating to oral health care and the practice of safe dentistry in the state.

The 2017-2020 Strategic Plan is posted on our website at **http://www.oregon.gov/dentistry/docs/StrategicPlanning/OBD%20Strategic%20Plan%202017-2020%20FINAL.pdf.** The Board's new mission is "to promote high quality oral health care in the State of Oregon by equitably regulating dental professionals."

The Board, after considerable discussion and planning through the strategic planning process, has identified 5 priorities in the new strategic plan:

1.) Ensure Patient Safety
2.) Manage Change in the Practice of Dentistry
3.) Manage Investigations & Case Complexity
4.) Plan for OBD Staff Attrition
5.) Retain OBD Autonomy

These priorities are expounded upon in the strategic plan. The OBD is committed to meeting its statutory obligations and being a critical and integral part of the oral health and patient safety that all Oregonians deserve.

Sincerely,

Julie Ann Smith, D.D.S, M.D., M.C.R.
President

Stephen Prisby
Executive Director

Todd Beck, D.M.D. - Vice President
James Morris
Yadira Martinez, R.D.H.
Alton Harvey, Sr.
Brandon Schwindt, D.M.D.
Amy B. Fine, D.M.D.
Alicia Riedman, R.D.H.
Gary Underhill, D.M.D.
Jose Javier, D.D.S.

Oregon Board of Dentistry

2017 - 2020

Strategic Plan

Adopted August 19, 2016

Attachment #8

Oregon Board of Dentistry

2017 – 2020 Strategic Plan

Board members & staff of the Oregon Board of Dentistry who participated in the development of this strategic plan at the April 23, 2016 planning session:

Julie Smith, DDS, MD, MCR- President
Todd Beck, DMD – Vice President
James Morris
Yadira Martinez, RDH
Alicia Riedman, RDH
Alton Harvey, Sr.
Gary Underhill, DMD
Amy B. Fine, DMD
Brandon Schwindt, DMD
Jonna Hongo, DMD

Stephen Prisby - Executive Director
Paul Kleinstub, DDS, MS - Dental Director/Chief Investigator
Teresa Haynes – Exam & Licensing Manager
Harvey Wayson –Investigator
Daryll Ross - Investigator
Ingrid Nye – Office Specialist
Lori Lindley – Sr. Asst. Attorney General

Sue Diciple - Meeting Facilitator

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OVERVIEW

The authority and responsibilities of the Oregon Board of Dentistry (OBD) are contained in Oregon Revised Statutes Chapter 679 (Dentists), Chapter 680.010 to 680.205 (Dental Hygienists), and Oregon Administrative Rules, Chapter 818. These statutes charge the OBD with the responsibility to regulate the practice of dentistry and dental hygiene by enforcing the standards of practice established in statute and rule.

In late 2015 the board and staff of the OBD discussed and approved a strategic planning initiative. The launch was timely, as the last time the board conducted a strategic planning process and developed a plan was in 2007. All OBD board members joined the board after 2008 and a new executive director was hired in June 2015.

In order to deliver on its statutory obligations and its mission - *to promote high quality oral health care in the State of Oregon by equitably regulating dental professionals* - the OBD is challenged to address a rapid and accelerating rate of change. Significant shifts are occurring in dentistry practice, organizational structures, business models and markets. As a result the OBD is experiencing increase in the number of complaints submitted, the technical complexity of cases, and litigation in response to patient complaints and resulting investigations.

The OBD is also experiencing internal change. Its small staff of expert and experienced professional investigators and administrative staff will experience a high degree of attrition due to retirements within the upcoming four years.

The OBD sees its mission as elevating the standard of oral health care in Oregon, not solely though regulation but through information, outreach and education. Surveys conducted in 2014 and 2015 indicate an 85% approval rating for the OBD among those returning the surveys; however more remains to be done to ensure that oral healthcare practitioners in Oregon are informed and educated about the Dental Practice Act and the rules and statutes that regulate dentistry in Oregon.

The OBD mission exhorts the agency to ensure high standards and quality of oral health care. However economic forces in general and a widening income-to-cost-of-living gap in Oregon are forcing many to seek lowest-cost dentistry options. Defining *"high quality oral health care"* that is accessible at all income levels while providing clear guidelines for practitioners and for OBD's investigative staff is a mission-critical challenge. The board was unanimous in adding the word "equitably" to the mission statement, assuring and clarifying that both the public and licensees will be treated fairly in all matters before the board.

This strategic plan outlines the OBD's approach to exercising its statutory responsibilities while adapting to rapid change. The OBD approaches the challenges outlined in this plan with confidence and commitment to the profession it regulates and the welfare of those receiving dental care in Oregon.

THE OBD MISSION & SWOT ASSESSMENT

The Mission of the Oregon Board of Dentistry

To promote high quality oral health care in the State of Oregon by equitably regulating dental professionals.

Board of Dentistry Strengths, Weaknesses, Opportunities & Threats

Opportunities

- To continue to build trust with stakeholders through transparency, predictability, effective and updated means of communication, due process, and treating all with respect.
- To implement process improvement including conversion from paper to electronic media prior to the upcoming retirements of experienced staff members.
- To train new staff before attrition limits the opportunity for knowledge transfer.
- To advocate for and ultimately to retain the autonomy of OBD and other Oregon regulatory boards.
- To better involve other entities that have an impact on the practice of dentistry.
- To institute continuous learning for board members beginning with on-boarding and continuing throughout their OBD service.

Threats

- The paradigm shift toward corporate dentistry and managed care creates challenges for regulation of oral health care providers in Oregon.
- Negative perception of the OBD among a small but vocal number of licensees.
- Insufficient flexibility and access to facilitative technologies with the potential to streamline processes and procedures, saving time and cost and offering enhanced decision support.

Strengths

- A high level of support among licensees demonstrated by the results of 2014 & 2015 surveys that show OBD approval rating at 85%.
- A diverse, open, ethical, committed board whose members "*put the patient first.*"
- Staff expertise, work ethic and experience.
- A fair and thorough investigative process that results in well-vetted reports, recommendations and decisions.

Weaknesses

- Lack of control over funding.
- Timeliness limited by staffing level.
- Upcoming staff attrition is not yet addressed with a plan.
- Length of time required to bring new board and staff members up-to-speed.

STRATEGIC PRIORITY A

Ensure Patient Safety

The practice of dentistry is increasingly following trends in the market. In the rush to capture emerging demand some practitioners are offering services for which they do not have the requisite training and expertise.

The volume of complaints submitted to OBD is large (approximately 250/year) due to a variety of problems including a recent increase arising from surgical procedures such as dental implants. This trend can be anticipated to grow as the practice of dentistry becomes increasingly competitive and market-driven. This trend is accompanied by an increase in the number of complaints that are litigated, adding time and complexity to investigative and regulatory processes.

Goals

➡ Reduce patient risk due to implant complications and failure.

➡ Strengthen the approach to sedation safety.

Action Items

Implants

- Convene a stakeholder workgroup.
- Analyze and determine minimum training requirements.
- Adopt education requirements to be completed prior to placement of implants.
- Establish implant rules.

Sedation

- Review and refine OBD's rules for sedation.
- Audit sedation complaints.
- Establish protocols and an overall approach to ensure sedation safety.

STRATEGIC PRIORITY B

Manage Change in the Practice of Dentistry

The growth of national corporate entities providing dentistry services in Oregon has complicated the regulatory landscape and is emerging as a challenge to the standards of patient care upheld in Oregon. Linking complaints to a specific office location or practitioner within a large corporate dentistry provider can be difficult. Response to requests for documents and information from such entities is often slow and complicated, fostering delays in the investigative process.

Goals

➡ Enforce the state statute on dental practice ownership.

Action Items

- Explore and if determined feasible take action on facility permitting.
- Communicate the law requiring dental practice ownership to entities wishing to establish dental practices in Oregon.

STRATEGIC PRIORITY C

Manage Case Complexity

The number of complaints received by the OBD is growing at between 3% - 5% per year, collateral with an increase in case complexity due to shifts in the practice of and market for oral health care services. Key contributors to increases in complaints and complexity include the growing demand for surgical procedures such as implants, practitioners performing procedures outside of their skill set, and a trend toward case litigation. These trends are straining the OBD's capacity and impacting the time-to-resolution of investigations.

Goals

➡ Reduce time to complete investigations.

➡ Reduce backlog.

Action Items

- Establish a toolkit for process improvement and streamlining.
- Enforce the statute regarding timeframe for licensee response to OBD requests.
- Communicate with and educate licensees on OBD's investigative process.

STRATEGIC PRIORITY D

Plan for Attrition

A significant percentage of OBD staff is becoming eligible for retirement. This will result in an exodus of expertise and institutional knowledge. Impacts of unfilled positions or lengthy ramp-up time could include stress on remaining staff, added cost, and delay in processing complaints. OBD is endeavoring in this planning cycle to anticipate attrition in key positions and plan for timely and effective succession.

Goal

➡ Maintain capacity and competency at all levels in the agency.

Action Items

- Plan and implement cross-training.
- Document job duties and standard work practices.
- Establish a succession plan and contingencies.
- Establish training procedures for new board and new staff members.
- Evaluate and enhance board member on-boarding.

STRATEGIC PRIORITY E

Retain OBD Autonomy

A mission-critical concern for the OBD is the trend toward consolidation of Oregon regulatory entities into the auspices of large state bureaucracies. The OBD considers its autonomy to be a key factor in the high confidence placed in it by state policymakers and licensees, its capacity to act both nimbly and equitably, and its ability to attract practitioners with the requisite levels of experience and qualifications to serve as board members.

Goal

➡ Maintain OBD autonomy.

Action Items

- Establish and deploy a strategy for stakeholder outreach.
- Communicate the value of OBD and the principle of regulatory board autonomy.

Oregon Board of Dentistry
STRATEGIC PLAN
2017– 2020

OBD MISSION

The mission of the Oregon Board of Dentistry is to promote high quality oral health care in the State of Oregon by equitably regulating dental professionals.

FIVE MISSION-CRITICAL PRIORITIES

A. Ensure Patient Safety	B. Manage Change in Dentistry Practice	C. Manage Case Complexity	D. Plan for Attrition	E. Retain OBD Autonomy
GOALS				
• Reduce risks due to implant complications and failure. • Strengthen the approach to sedation safety.	• Enforce the state statute on dental practice ownership.	• Reduce investigative window. • Reduce investigative case backlog.	• Maintain capacity & competency at all levels in the agency.	• Retain OBD autonomy.

ACTION AGENDA

Anticipated Milestones for the 2017-2020 Planning Cycle

<u>Implants</u>

- ➡ Convene a stakeholder workgroup.
- ➡ Analyze and determine minimum training requirements.
- ➡ Adopt education requirements to be completed prior to placement of implants.
- ➡ Establish implant rules.

<u>Sedation</u>

- ➡ Review and refine the OBD's rules for sedation.
- ➡ Audit sedation complaints.
- ➡ Establish protocols and approach for sedation safety.

- ➡ Explore and if determined feasible take action on facility permitting.
- ➡ Communicate the law requiring dental practice ownership to entities wishing to establish dental practices in Oregon.

- ➡ Establish a toolkit for process improvement and streamlining.
- ➡ Enforce the statute regarding timeframe for licensee response to OBD requests.
- ➡ Communicate with and educate licensees on OBD's investigative process.

- ➡ Plan and implement cross-training.
- ➡ Document job duties and standard work practices.
- ➡ Establish a succession plan and contingencies.
- ➡ Establish training procedures for new board and staff members.
- ➡ Evaluate and enhance board member on-boarding.

- ➡ Establish and deploy a strategy for stakeholder outreach.
- ➡ Communicate the value of OBD and the principle of regulatory board autonomy.

Oregon Board of Dentistry 2017-2020 Strategic Plan
Timeline & Milestones

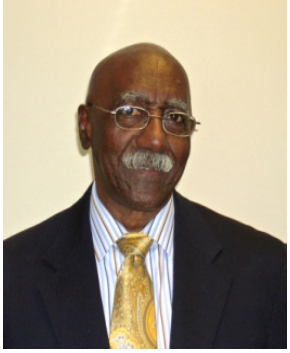
Strategic Priorities	2016-2017	2017-2018	2018-2019	2019-2020
Ensure Patient Safety				
Implants	• Stakeholder workgroup convened.	• Minimum training requirements analyzed and determined.	• Rules and education requirements in place.	GOAL: Reduced risk of implant complications/failure.
Sedation	• Rules for sedation reviewed and refined. • Sedation complaints audited. • Protocols and plan for safety & compliance established.	• Audit results reviewed. • Report drafted by staff re "State of Dental Sedation in OR".	• Sedation safety investigations conducted.	GOAL: Approach to sedation safety strengthened.
Manage Change in Dentistry Practice	• Concept of facility permitting investigated. • State law pertaining to local ownership of dental practices communicated to entities seeking to establish practices in Oregon.	• Facilities permitting, if feasible, planned and implemented. • *Ongoing communication about state law re practices in Oregon.*	• *Plan deployed.* • *Ongoing communication about state law re practices in Oregon.*	GOAL: State statute on dental practice ownership enforced.
Manage Case Complexity	• Toolkit for process improvement & streamlining established. • State statute requiring licensee response to request within specific timeframe enforced. • Communication and education for licensees on OBD's investigative process initiated.	• *Toolkit in use.* • *State statute enforced.* • *Communication and education on investigative process deployed.*	• *Toolkit in use.* • *State statute enforced.* • *Communication and education on investigative process deployed.*	GOAL: Reduce investigative window. GOAL: Investigative case backlog reduced.
Plan for Attrition	• Cross-training implemented. • Job duties and standard work practices documented. • Succession plan and contingencies established. • Training for staff and board, and board member on-boarding evaluated & enhanced.	• *Training and succession strategies deployed.*	• *Training and succession strategies deployed.*	GOAL: OBD capacity and competency maintained at all levels.

Attachment #8

Retain OBD Autonomy	• Strategic Outreach Plan established.	• *Outreach Plan deployed.*	• *Outreach Plan deployed.*	GOAL: OBD autonomy maintained.

Julie Ann Smith, D.D.S., M.D., M.C.R. - President

Todd Beck, D.M.D. - Vice President



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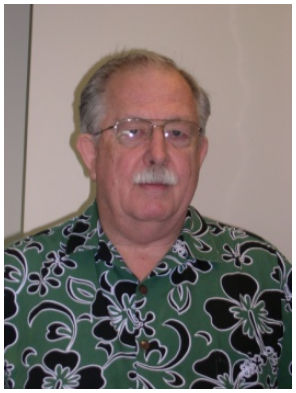


Daryll Ross - Investigator

Harvey Wayson – Investigator

Ingrid Nye – Office Specialist

Lori Lindley - Sr. Assistant Attorney General

413.590[1]

Pain management education required of certain licensed health care professionals

- • duties of Oregon Medical Board
- • rules

(1)A physician assistant licensed under ORS chapter 677, a nurse licensed under ORS chapter 678, a psychologist licensed under ORS **675.010 (Definitions for ORS 675.010 to 675.150)** to**675.150 (Enforcement procedures)**, a chiropractic physician licensed under ORS chapter 684, a naturopath licensed under ORS chapter 685, an acupuncturist licensed under ORS **677.759(License required)**, a pharmacist licensed under ORS chapter 689, a dentist licensed under ORS chapter 679, an occupational therapist licensed under ORS **675.210 (Definitions for ORS 675.210 to 675.340)** to **675.340 (Enforcement procedure)** and a physical therapist licensed under ORS **688.010 (Definitions for ORS 688.010 to 688.201)** to **688.201 (Disposition of receipts)** must complete one pain management education program described under ORS **413.572 (Additional duties of commission)**.

(2) The Oregon Medical Board, in consultation with the Pain Management Commission, shall identify by rule physicians licensed under ORS chapter 677 who, on an ongoing basis, treat patients in chronic or terminal pain and who must complete one pain management education program established under ORS**413.572 (Additional duties of commission)**. The board may identify by rule circumstances under which the requirement under this section may be waived. [Formerly **409.560**]

LC 531
2017 Regular Session
44300-016
8/16/16 (SCT/ps)

D R A F T

SUMMARY

Requires certain health care professionals and persons holding certificate of certified alcohol drug counselor to complete pain management education once every four years.

A BILL FOR AN ACT

Relating to pain management; amending ORS 413.590.

Be It Enacted by the People of the State of Oregon:

SECTION 1. ORS 413.590 is amended to read:

413.590. (1)**(a)** A [*physician assistant licensed under ORS chapter 677, a nurse licensed under ORS chapter 678, a psychologist licensed under ORS 675.010 to 675.150, a chiropractic physician licensed under ORS chapter 684, a naturopath licensed under ORS chapter 685, an acupuncturist licensed under ORS 677.759, a pharmacist licensed under ORS chapter 689, a dentist licensed under ORS chapter 679, an occupational therapist licensed under ORS 675.210 to 675.340 and a physical therapist licensed under ORS 688.010 to 688.201 must complete one pain management education program described under ORS 413.572.*] **person authorized to practice one of the following professions must complete the pain management education program described in ORS 413.572 once every four years:**

(A) A physician assistant licensed under ORS chapter 677;

(B) A nurse licensed under ORS chapter 678;

(C) A psychologist licensed under ORS 675.010 to 675.150;

(D) A chiropractic physician licensed under ORS chapter 684;

(E) A naturopathic physician licensed under ORS chapter 685;

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

(F) An acupuncturist licensed under ORS 677.759;

(G) A pharmacist licensed under ORS chapter 689;

(H) A pharmacy technician licensed under ORS chapter 689;

(I) A dentist licensed under ORS chapter 679;

(J) An occupational therapist licensed under ORS 675.210 to 675.340;

(K) A physical therapist licensed under ORS 688.010 to 688.201;

(L) An optometrist licensed under ORS chapter 683;

(M) A clinical social worker licensed under ORS 675.530;

(N) A professional counselor licensed under ORS 675.715;

(O) A marriage and family therapist licensed under ORS 675.715;

(P) A massage therapist licensed under ORS 687.011 to 687.250;

(Q) An expanded practice dental hygienist who holds a permit issued under ORS 680.200; and

(R) A speech-language pathologist licensed under ORS chapter 681.

(b) A person who holds a certificate of certified alcohol drug counselor from the Addiction Counselor Certification Board of Oregon or its successor organization must complete the pain management education program described in ORS 413.572 once every four years.

(2) The Oregon Medical Board, in consultation with the Pain Management Commission, shall identify by rule physicians licensed under ORS chapter 677 who, on an ongoing basis, treat patients in chronic or terminal pain and who must complete [*one*] **the** pain management education program established under ORS 413.572. The board may identify by rule circumstances under which the requirement under this section may be waived.

(3) Any state board that regulates a person authorized to practice one of the professions listed in subsection (1)(a) of this section may impose any form of discipline on a person under the laws of this state for violating this section.

Pain Management Commission

Oregon Pain Management Commission

- About Us
- Contact Us
- Members
- Meetings
- Meeting Archives

Pain Education Program

- Curriculum Reviews
- Required Module

Reports

Resources for Consumers

- Information and Support
- Classes, Workshops and Clinics
- Medication Safety

Resources for Health Professionals

- CEUs, Events, Conferences

- Health Evidence Review Commission
- Oregon Health Policy & Research
- Oregon Health Authority

Oregon Pain Management Commission

Subscribe to receive email notification of meetings and updates.

OPMC News

Next meeting

10/27/2016 1:00-4:00 pm

OHP/Prioritized List changes July 1, 2016: Expanded coverage for the assessment and conservative treatment of uncomplicated back pain and conditions

OPB Story: "Integrative Care for OHP Pain Sufferers: Less drugs, more options"

National Pain Strategy-A Comprehensive Population Health-Level Strategy for Pain

CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016

Pain Management Module – Required Continuing Education

The Oregon Pain Management Commission provides Oregon specific training required for certain licensed health care professionals as directed by ORS 413.590. Completion of the pain management module *Advancing Pain Management in Oregon* fulfills this requirement.

To complete the module:

- Please use MS Internet Explorer as your browser.
- The module is available in two formats to make it more accessible to users and persons with disabilities.
  - If you choose the PDF version, please download the latest version of Adobe Reader. Bookmarks have been added for ease in navigating.
  - The MS Word (.doc) version contains an index to aid in navigating the module.
- Complete the module.
- After you have read the module, you will be able to complete a survey and to print a certificate of completion. There is no test required for the module. Please save your printed certificate for your own records in case you are audited by your licensing board. And you're done! This completes your requirements with the OPMC.

Advancing Pain Management in Oregon

PDF version | MS Word version *Updated 7/29/16*

If you are unable to create/print the certificate, please email PMC.Info@state.or.us the following:

- Full name
- Professional designation (MD, RN, DMD, etc.)
- License number
- Module completion date
- Please allow 48-72 hours.

A Note about Continuing Education Hours

In addition to the Module, you are required to complete six (6) additional continuing education hours in pain or palliative care. Your licensing board, not the OMPC, has oversight of the proper required CEU accreditation. If you have questions regarding the additional 6 CEUs please contact your licensing board. For your convenience, we have compiled a list of Pain CEU Resources.

Attachment #9

Advancing Pain Management in Oregon

Oregon Health Authority

The Oregon Pain Management Commission (OPMC)

This online educational module qualifies as the required 1 (one) hour continuing education for pain management in Oregon. Additionally, all health care providers (with the exception of dentists) are required to select and complete an additional 6 (six) hours of continuing education related to pain and/or pain management in their area of interest.

Introduction:

The Oregon Pain Management Commission's goal is to offer education to improve understanding of pain and its treatment. Inadequate pain treatment, over-reliance on medications for pain management and lack of knowledge/support of biopsychosocial-informed pain self-management treatments are serious public health problems.

This module is intended to provide a foundation for advancing pain management in Oregon and to increase awareness regarding evidence-based treatments for the effective management of pain.

Pain treatment issues are complex and cannot be adequately addressed in this one-hour module. Information about additional expanded educational topics may be found on the Oregon Pain Management Commission's website. Providers may elect to address their specific interests/concerns related to the management of pain in the individually selected 6 (six) hour continuing education curriculum requirement which is beyond the OPMC's purview.

The Oregon Pain Management Commission (OPMC)

In 2001, the Oregon Legislature mandated the creation of a commission to focus on pain issues in Oregon. The OPMC is a 19 member advisory commission within the Oregon Health Authority. Its members are an interdisciplinary group of physicians (medical, naturopathic, osteopathic, chiropractic), physician assistants, nurse practitioners, dentists, pharmacists, nurses, psychologists, acupuncturists, physical therapists, occupational therapists, patient advocates, healthcare consumers and other interested individuals. In addition, two members from the Oregon Legislature—a member of the Senate and a member of the House of Representatives—serve as non-voting (ex officio) members.

Among the Commission's tasks is to develop requirements for pain management education for Oregon physicians and other healthcare licensees of the regulatory boards. Its mission is to improve pain management in the State of Oregon through education and development of pain management recommendations. The OPMC represents the concerns of patients in Oregon on issues of pain management to the Governor and the Legislative Assembly. This online pain management education module is updated biennially.

Although there are many challenges to achieving adequate pain management for all Oregonians, the OPMC has a vision for pain care in Oregon.

We believe that adequate pain management can be realized if there is effective collaboration and communication between regulatory agencies, healthcare providers, insurers and patients. Evidence-based pain management services should be as equally available as services for other common conditions or disease states of similar prevalence and health impact. The availability and quality of pain management resources should meet the needs of patients in our state.

A Call for Cultural Transformation:

The economic and social impacts of pain are thought to be greater than for any other single disease entity.

In the past pain was described on the basis of duration and evidence of healing. Definitions simply referred to pain as a physical symptom of illness or injury based on a stimulus response mechanism. Medical treatment focused on pharmacological management of physical symptoms and all pain was managed as acute. Persistent, untreatable pain was believed to be psychosomatic in a pejorative sense; patients were not believed or were thought to be malingering for some gain.

The economic impact of pain is significant. Pain is a leading reason patients seek medical care. A 2011 Institute of Medicine report[1] indicated chronic pain costs the nation up to $635 billion each year in medical treatment and lost productivity.

Chronic pain is a major public health problem because it affects millions of individuals, their families, and the healthcare system. It negatively affects lifestyle, function, self-efficacy, independence and psychosocial well-being. Chronic pain can cause loss of meaningful occupation, disruptions in family, work, and social relationships, and contributes to needless suffering and risks of suicide.

To prevent acute pain from transitioning to persistent (chronic) pain, appropriate and effective treatment of acute pain is vital. The treatment of acute pain must include biopsychosocial considerations. See Figure 1. Additionally, a new pathway to our approach in the management of pain must be considered. According to Jane C. Ballantyne, University of Washington, the "cultural transformation needed is demedicalization of the most common pain conditions". See Figure 2.

[1] Relieving Pain in America: A Blueprint for Transforming, Prevention, Care, Education, and Research, 2011: Institute of Medicine (IOM)

Figure 1: Biopsychosocial Model of Pain – Championed by Butler and Moseley and others, 2000.

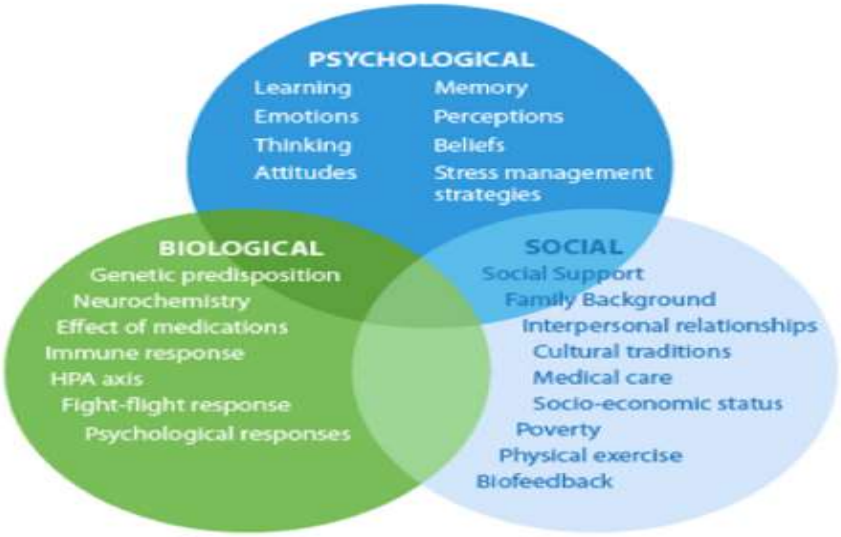
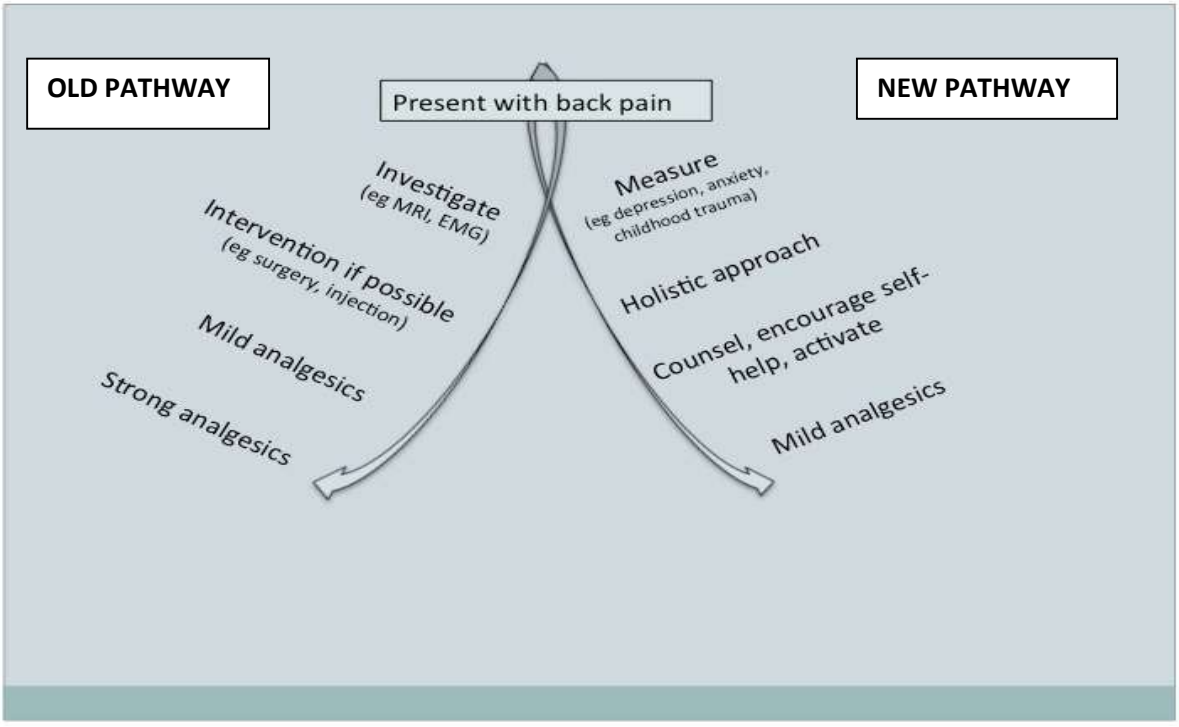


Figure 2: Courtesy of Jane C. Ballantyne, University of Washington, Seattle; Presentation: The evolution of the science of chronic pain: from the gate theory to central sensitization, May 20, 2016



How did we get here?

Neurobiology and underlying behavioral health issues associated with pain had limited understanding. Healthcare reimbursement systems discouraged interdisciplinary practices to treat chronic pain.

In 1980, a single paragraph written by J. Porter and H. Jick of Boston University Medical Center was published in the New England Journal of Medicine as a "Letter to the Editor" citing their review of patient files for the incidence of narcotic addiction in hospitalized patients. They concluded the development of addiction was rare in patients treated with narcotics[2].

In 1995, the president of the American Pain Society introduced a campaign entitled "Pain is the Fifth Vital Sign" at the society's annual meeting which encouraged health care professionals to more aggressively treat pain similar to heart rate and blood pressure. The pharmaceutical industry began promoting the use of opioid medications to treat chronic non-cancer pain as a means to address a newly defined pain crisis. By 2010, enough opioid pain relievers were sold to medicate every American adult with a typical dose of 5 mg of hydrocodone every 4 hours for 1 month[3].

When it comes to pain relief from opioids a significant gap exists between a patient's expectation and reality. In 2004 The American Journal of Emergency Medicine published a study[4] that assessed patient expectations for pain relief in the emergency room and found that patients often expect 75% of their pain to be relieved with opioids. A systematic review[5] of the efficacy and safety of opioids for the treatment of chronic non-cancer pain found that patients' actual pain relief was only 30%.

As pain was prioritized as a 5th vital sign, assessment of pain level became a central focus. Pain scales established a measurable goal and an expectation that the effectiveness of a treatment should be based solely on the reduction of the pain score. Prescribed medication became the default treatment in the absence of a better understanding of pain. Prevalence of pain and the increasing use of opioids have created a "silent epidemic" of distress, disability and danger to a large percentage of Americans. In 2010, the number of deaths due to unintentional drug overdoses exceeded the number of deaths due to motor vehicle traffic accidents. In September 2014 the National Institutes of Health reported[6] a dramatic increase in opioid prescriptions and use over the past 20 years. This increase in opiate prescriptions parallels a notable increase in opioid related overdoses and hospital admissions. The United States makes up 4.6% of the world's population and consumes over

[2] NEJM. 1980;302:123 published

[3] CDC. Vital Signs: Overdoses of Prescription Opioid Pain Relievers---United States, 1999-2008; November 4, 2011/60(43);1487-1492

[4] AM J Emerg Med. 2004 Jul;22(4):286-8

[5] Pain. 2004 Dec;112(3):372-80

[6] Pathways to Prevention Workshop: The Role of Opioids in the Treatment of Chronic Pain, 2014 National Instituted of Health (NIH)

80%[7] of the world supply of opioids. Oregon ranks 4th in the nation in inappropriate use of prescription pain killers for adults[8]. The Oregon Health Authority (OHA) Injury and Violence Prevention Fact Sheet reports that in 2013 there were over 3 million opioid prescriptions, accounting for over 54% of all prescriptions. In 2014, approximately 154 Oregonian deaths were related to opioid medications.

Pain prevention, assessment, and treatment are inadequate[9].

[7] International Narcotics Control Board Report 2008. United Nations Pubns., 2009, p.20

[8] Substance Abuse and Mental Health Services Administration. Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health, September 2015

[9] Relieving Pain in America: A Blueprint for Transforming, Prevention, Care, Education, and Research, 2011: Institute of Medicine (IOM)

What we know now:

> "Pain represents a national challenge. A cultural transformation is necessary to better prevent, assess, treat, and understand pain of all types. Government agencies, healthcare providers, healthcare professional associations, educators, and public and private funders of health care should take the lead in this transformation. Patient advocacy groups also should engage their diverse constituencies. To reach the vast multitude of people with various types of pain, the nation must adopt a population-level prevention and management strategy."
>
> —Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research, 2011: Institute of Medicine

A cultural shift occurred regarding pain. Risks were underestimated and beliefs evolved that patients should expect complete resolution of pain through medication. Pain scores and patient satisfaction surveys impacted treatment decisions. Patients developed tolerance to medications. Pain persisted and morphine equivalency doses increased. The end result is identified as the worst man-made epidemic in modern medical history.

Current research[10] identifies significant risks of associated harms and limited evidence of benefit in improving overall pain scores or functioning with long-term use of opioid medications. In light of what is being called an opioid epidemic, significant changes are being made to the way healthcare looks at the treatment of patients with pain.

National Pain Strategy calls for integrated pain care:

> "Healthcare providers, insurers, and the public need to understand that although pain is universal, it is experienced uniquely by each person, and care—which often requires a combination of therapies and coping techniques—must be tailored. Pain is more than a physical symptom and is not always resolved by curing the underlying condition. Persistent pain can cause changes in the nervous system and become a distinct chronic disease."
>
> —Relieving Pain in American: A Blueprint for Transforming, Prevention, Care, Education, and Research, 2011: Institute of Medicine (IOM)

[10] Ann Intern Med. 2015;162:276-286

Rethinking Pain: So how does pain work?

The International Association for the Study of Pain (IASP) defines pain as:

Nociception

"The neural process of encoding noxious stimuli." (IASP)
Nociception involves neural information about potentially harmful stimulus and can be thought of as a *danger message* to the brain.

Pain

"An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage." (IASP)

Central Sensitization

"Increased responsiveness of nociceptive neurons in the central nervous system to their normal or subthreshold afferent input." (IASP)

Peripheral sensitization

"Increased responsiveness and reduced threshold of nociceptive neurons in the periphery to the stimulation of their receptive fields." (IASP)

New understanding of pain allows us to develop and prioritize the best treatment plan with our patients. While there is great depth and complexity to the neuroscience of pain, which this module cannot address, some key things should be noted here.

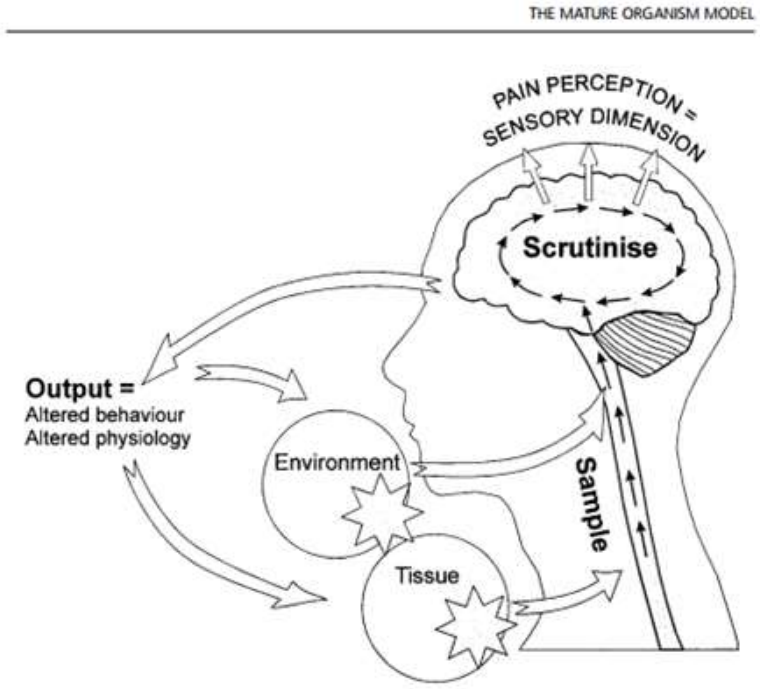
Pain and harm are not equivalent. The existence and severity of the pain experience is not directly correlated to tissue damage or injury. This is particularly relevant when working with complex persistent or chronic pain.

A pain experience is the result of an evaluation of threat to the individual and is based on assessment of input, including nociception. Nociception alone will not create a pain response. Rather it is necessary, when tissue is harmed, for the brain to attend to that stimulus and assign sufficient threat value to produce a response of pain.

With an acute injury, a healthy nervous system will accurately evaluate that threat has occurred and will produce a pain response. With persistent pain, there is less accuracy.

Below is a graphic illustration of this concept, from Louis Gifford, PT, showing the relationship between input, including nociceptive input, the central processing at the level of the brain, and the output response that includes the pain experience:

Figure 3: Mature Organism Model - Louis Gifford



Injury and the mature organism model: a possible initial stage. (From Gifford L S 1998 Pain the tissues and the nervous system: a conceptual model. Physiotherapy 84(1):27-36, with permission)

Example of a pain response essentially equivalent to the nociceptive input (acute injury):
You cut your hand and you experience immediate pain.

Example of nociceptive input without sufficient threat value to experience pain:
You cut your hand as you are running out of the house to get your child before they run into traffic. The threat of the traffic is greater than the threat of the hand injury and you don't feel pain until your child is safe. Or you injure your hand in a battlefield where the threat of the environment is so great that you don't feel the hand injury until you are in a safe environment.

Example of pain in complete absence of nociceptive input:

Phantom limb pain, where there is no longer any tissue at all, but the brain continues to process a representation of the hand in the brain (including the sensory cortex) and produces a pain response.

Pain is an experience that we naturally wish to avoid. Avoidant behavior is normal and healthy when it supports avoidance of stresses to healing tissues, helping us treat an injured part of the body more gingerly while we recover. Avoidant behavior becomes dysfunctional when the pain that is experienced is not related to tissue healing. This is known as fear avoidance and is a significant aspect of many people's persistent pain experience.

Fear-avoidance (Wall and Melzack)

> "Fear avoidance beliefs capture the dimension that pain is to be avoided rather than confronted. A rich literature demonstrates the disabling nature of these beliefs, largely in individuals with low back pain and the relationship with disability is typically greater than that with pain intensity."

Figure 4: Fear-avoidance Model – Vlaeyen, JW, Linton, SJ

The 'fear'-avoidance model. If pain, possibly caused by an injury, is interpreted as threatening (pain catastrophizing), pain-related fear evolves. This leads to avoidance behaviors, and hypervigilance to bodily sensations followed by disability, disuse and depression. The latter will maintain the pain experiences thereby fueling the vicious circle of increasing fear and avoidance. In non-catastrophizing patients, no pain-related fear and rapid confrontation with daily activities is likely to occur, leading to fast recovery. Pain catastrophizing is assumed to be also influenced by negative affectivity and threatening illness information.

Pain catastrophizing: (Quartana)

> "Pain catastrophizing is characterized by the tendency to magnify the threat value of a pain stimulus and to feel helpless in the presence of pain, as well as by a relative inability to prevent or inhibit pain-related thoughts in anticipation of, during, or following a painful event."

Pain catastrophizing affects how individuals experience pain. Sullivan et al developed the Pain Catastrophizing Scale and identified three key features of pain catastrophizing:

1. Rumination (e.g. "I can´t stop thinking about how much it hurts")
2. Magnification (e.g. "I´m afraid that something serious might happen")
3. Helplessness (e.g. "There is nothing I can do to reduce the intensity of my pain")

Neuroplasticity (Merriam Webster Medical Dictionary):

> "The capacity of the brain to develop and change throughout life, something Western science once thought impossible."

New understanding of the changeable nature of the nervous system, coupled with information from real-time research from functional magnetic resonance imaging (fMRI), makes clear the role of the brain and nervous system in changing the pain experience. The nervous system can adapt negatively to produce an ongoing persistent pain state, and can also change to significantly decrease a pain state.

This knowledge led to a change in terminology being adopted around the world. The term *chronic pain* (a condition that will remain static and with which a person must learn to cope), is now called *persistent pain*, which reflects the ongoing challenges of pain but acknowledges the nervous system is capable of change. Though we do not know how much a person's system will change with the right input, we know it can positively adapt to decrease their pain.

Pages 8-11, "Rethinking Pain: So How Does Pain Work?" Nora Stern, Providence Health & Services. *Copyright 2016. All Rights Reserved.*

Where do we go from here…?

Assessment:

Comprehensive assessment of a person with pain will allow the best selection of appropriate treatment. Treatment should focus on present and future level of function and self-efficacy. A good assessment should:

- "Recognize the difference between acute and chronic and the implications for the assessment and management of the patient." (from International Association for the Study of Pain (IASP) curriculum guidelines)
- Include appropriate assessment measures for the primary domains (sensory, affective, cognitive, physiological and behavioral) to account for the multi-dimensional nature of pain.
- Recognize both strengths and limitations of commonly used measures for diverse pain dimensions. For example, self-reporting, physical performance measures (such as Functional Capacity Evaluations), and physiological/autonomic response measures.
- Include pain modification assessment strategies to match inherent variable clinical presentations.
- Assess individual factors of pain: sociocultural characteristics, clinical characteristics, type and state, vulnerable populations.
- Refer to relevant health professionals appropriately and timely.
- Assess impact on daily life and quality of life.
- Utilize assessment strategies appropriate to communication problems related to age, language or physical or cognitive processing.
- Utilize behavioral and psychological measures of pain.
- Utilize standardized baseline and repeat measures of pain related to interference with function and quality of life.
- Include assessments which involve the limbic forebrain (emotions, mood, and cognitive aspects of pain).

Pain assessment should also include:

- A general history and physical exam evaluating general condition, musculoskeletal and neurologic systems, and the site of pain.
- Evaluation of self-reported pain and evaluation of behaviors or gestures suggestive of pain.
- Evaluation of subjective reported factors (location, onset/duration of pain, quality of pain with word descriptors, intensity of pain, variations/rhythms of pain, aggravating and alleviating factors of pain, associated symptoms, and potential pathology causation of pain).
- Evaluation of currently used therapeutic pain relief measures.

- A functional assessment evaluating prior level of function, pain-related changes or effect upon level of function, and impact on activities of daily living.
- A psychosocial assessment evaluating impact of pain on quality of life and meaning of pain in relation to an individual's age, roles, and skills, all within the context of culture and ethnicity. This evaluation should consider any history of depression, psychopathology, sexual, physical or emotional abuse, and chemical or alcohol dependency.

Treatment:

"Pain results from a combination of biological, psychological and social factors and often requires comprehensive approaches to prevention and management."

—Relieving Pain in American: A Blueprint for Transforming, Prevention, Care, Education, and Research, 2011: Institute of Medicine (IOM)

Just as the cause of an individual's pain may include many factors, the treatment of their pain may require a combination of physical, psychological and pharmacological treatment modalities to address the whole person.

Modifiable Life Factors that Impact Pain

Physical Factors
Posture
Function and Occupation
Neuroplasticity
Strength/Endurance/Pacing
Mobility/Movement
Sleep/Rest/Fatigue
Diet/-Nutrition

Psychological Factors
Mindfulness
Anxiety/Depression
Cognition/Attention
Happiness/Enjoyment
Self-Efficacy/Meaning/Purpose
Sense of Safety/Sense of Place
Self-Image/Shame

Social Factors
Caregiver Burden
Roles and Responsibilities
Social Support/Isolation
Transportation

Spiritual Factors
Suffering
Meaning of Pain
Faith/Religiosity
Hope/Despair

1. The Patient Must be Part of the Treatment Team

- The central member of a treatment team is the patient; the composition of the team should depend on the patient's need. The plan of care should be individualized and culturally appropriate.
- Pain management staff should educate the patient so they can participate as fully as possible in decision making and in self-management of pain.
- Family members may be part of the pain management team to assist with medication and other aspects of pain care. Strict adherence to HIPAA privacy policies and other ethical boundaries and risks, including the risks of medication diversion, should be kept in mind when involving family members.

2. Interprofessional/-Integrative Providers

- Each member of the pain treatment team needs to understand the anatomical and physiological basis of pain perception, the psychological factors that modify the pain experience, and the basic principles of pain management. Each team member should also understand modifiable lifestyle factors, self-management techniques and refer patients to appropriate disciplines.
- Clinical disciplines are equally important members of the pain care team.
- Effective management of severe and/or chronic pain usually involves more than one healthcare provider over the course of treatment, and clear communication between these providers is extremely important.
- All team members must be advised of any changes or developments by the involved specialists and other providers.
- Collaborative care models of chronic pain where the primary care clinician works collaboratively with behavioral specialists can result in improved outcomes for chronic pain management
- The Institute of Medicine, the World Health Organization and the International Association for the Study of Pain recommend all patients with chronic pain be referred to a lifestyle health educator.

Interprofessional Treatment Team

Medical Physician	Pharmacist	Exercise Physiologist
Naturopathic Physician	Nurse Practitioner	Massage Therapist
Chiropractic Physician	Nurse	Health Coach
Osteopathic Physician	Physician Assistant	Yoga Instructor
Dentist	Acupuncturist	
Psychiatrist	Physical Therapist	
Psychologist	Occupational Therapist	
Social Worker	Substance Use Counselor	

3. Never Medications Alone

If opioids are used, they should be combined with non-pharmacologic therapy and non-opioid pharmacologic therapy as appropriate[11].

"Reductions in prescribing should be evidenced based and clinically appropriate and not done out of fear."

—David Barbe, MD, MHA, stated at the 2016 Annual Meeting of the Oregon Medical Association Board of Trustees

All prescribers must:

- Recognize their responsibility for ensuring that prescription pain medications are available to the patients who need them.
- Take steps to prevent these medications from becoming a source of harm or abuse.
- Understand the special issues in pain management for patients who may already be opiate dependent.

47% of patients on opioid medication for 30 days in the first year of use will be on opioids 3 years later[12].

60% of patients on opioid medication for 3 months will still be on opioids 5 years later[13].

4. Pain Management Goals

Biopsychosocial and interdisciplinary treatment goals should:

- Measure treatment success by functional ability and self-efficacy not by absence of pain.
- Be Specific, Measurable, Achievable, Realistic and Time-based (SMART).

The cornerstones of good pain management practices include:

- Appropriate consultations, referrals, and diagnostic tests.
- Accurate record keeping and documentation.
- A treatment plan developed in collaboration with the patient with timely follow-up.

[11] CDC Guideline for Prescribing Opioids for Chronic Pain – United States 2016

[12] Express Scripts Report: December 2014; A Nation in Pain, Focusing on U.S. Opioid Trends for Treatment of Short-term and Longer-term Pain

[13] Martin BC et al. J Gen Intern Med 2011; 26: 1450-57;

Having the conversation about pain

Conversations should:

- Explain pain.
- Focus on function, quality of life and living a meaningful life while managing pain. Patients should be redirected away from focusing on the elimination of pain.
- Inform patients about treatment modalities and encourage activation/participation.
- Stress concern for the patient's safety and emphasize medical professionals are there to support them and help them safely and effectively manage pain.
- Include shared decision making: Make patients partners by involving them in decisions that affect their care. Set realistic short term goals.

Manage your reactions and emotions:

- These conversations can provoke anxiety and discomfort for the most confident and experienced providers.
- Breathe and remind yourself your role is to safely guide the patient's treatment.
- Be clear on the outcome you hope to reach *before* you enter the room.
- Practice what you might say.
- Actively listen to the patient's concerns, emotions and opinions.
- Stay in the medical expert role.
- Speak to what is behind a patient's comment, not to the comment itself.
- Speak to what you know to be true.
- Be prepared to "agree to disagree" with your patient.
- State how much you care about them and emphasize your confidence in their ability to make the proposed changes.

Changing behavior can be scary and create fear for the patient. Fear can *look* like resistance. The challenge is to get patients working with you. As Theodore Roosevelt said "people don't care how much you know, until they know how much you care."

- Be supportive and provide resources:
  - "I care about you and this in not safe; we need to make some changes."
  - "It is normal for you to feel anxious and skeptical about going to the pain program, but I am confident that you can do it."

The motivational interviewing technique is a collaborative person-centered process (using warmth, genuine empathy, and acceptance) to engage patients, elicit change talk and evoke motivation to make positive changes from the patient. Motivational interviewing[14] significantly increases adherence to chronic pain treatment in the short term.

[14] The Efficacy of Motivational Interviewing in Adults with Chronic Pain: A Meta-Analysis and Systematic Review, Dion Alperstein & Louise Sharpe, The Journal of Pain, Vol 17, No 4 (April), 2016: pp 393-403.

- Empower the patient by giving them options:
  - "Based on your risk factors, opioids are not a safe option. Would you be willing to discuss some non-opioid treatments?"
- Use reflection and validation:
  - "You seem ____ (upset, anxious, frightened) by what I have said."

Conclusion

Most Americans who live with chronic pain do not receive appropriate care[15]. Information is essential. There is much more to learn about chronic pain prevention and treatment; existing knowledge could be used more effectively to reduce substantially the numbers of people who suffer unnecessarily[16]. An interdisciplinary approach is required for optimal pain management. The National Pain Strategy states "access to safe and effective care for people suffering from pain remains a priority that needs to be balanced in parallel with efforts to curb inappropriate opioid prescribing and use practices." In Oregon, local and statewide efforts are being made to reduce the risks associated with the use of opioid medications that target abuse, addictions and unintentional overdose deaths. Coverage for non-pharmacologic treatments are being made through recent changes to the Oregon Health Plan's Prioritized List of Health Services. The revisions support funding for the assessment of pain, comprehensive and evidence-based inter-professional modes of treatment, and recommends early interventions to prevent chronicity. While continuing to champion education about inter-professional modes of effective treatment, the Oregon Pain Management Commission advocates for the following:

- Identify barriers to non-pharmacologic treatments for chronic pain that promote a biopsychosocial treatment approach to chronic pain with the goal of improved patient well-being and self-management of pain.
- Promote the use of and reimbursement for non-pharmacologic multi-modality interdisciplinary services for chronic pain.
- Promote collaborative models of pain management between primary care clinicians and sources of pain treatment expertise.
- Promote the use of the Chronic Care Model[17] that transforms care of chronic conditions from acute and reactive to proactive, planned, and population-based.
- Promote community programs that assist individuals with self-management of chronic pain.

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[15] (2011) Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research. Washington, DC, Institute of Medicine

[16] The National Pain Strategy: A Comprehensive Population Health-Level Strategy for Pain 2016

[17] Wagner EH, et al. Milbank Q 1996, Coleman et al. Health Affairs 2009, Stellefson et al. Prev Chronic Dis 2013, Miller et al. Med Care 2013

Additional Topics

Malignancy Pain

End of Life/ Palliative Care

Complex Regional Pain Syndrome

Diabetic Neuropathy

Herpetic Neuropathy

Fibromyalgia

Addictions/ Chemical Dependency/ Tolerance, Misuse, Abuse

Opioid Prescribing; Risk mitigation

Central Sensitization

Adverse Childhood Events

Post-Traumatic Stress Disorder

Cognitive Behavior Therapy

Medical Marijuana

Alexander Technique

Motivational Interviewing

Bibliography: Rethinking Pain

Gifford, L S. "Pain, the Tissues and the Nervous System: A conceptual model." *Physiotherapy* (1998): 84(1):27-36. with permission.

Gifford, Louis. "Topical issues in pain, Mature Organism Model." 1998.

Louw, Adrian, PT, PhD and Puentedura, Emilio PT, PhD, OPTP. *Therapeutic Neuroscience Edcuation*. International Spine and Pain Institute, 2013.

McMahon, Stephen, Koltzenburg, Martin, Tracey, Irene and Turk, Dennis. *Textbook of Pain*. Saunders, 2013.

Moseley, Lorimer and Butller, David. *Explain Pain*. Adelaide, Austrlia: Noigroup Publications, 2013.

—. *Sensitive Nervous System*. Adelaide, Australia: Noigroup Publications, 2006.

Quartana PJ, Campbell CM, Edwards RR. "Pain Catastrophizing: A Critical Review." *Expert Rev Neurother* (2009): 745-58.

Sullivan, Michael, PhD. *Pain Catastrophizing Scale Users Manual*. Copyright 1995, 2001, 2004, 2006, 2009. Departments of Psychology, Medicine, and Neurology School of Physical and Occupational Therapy, McGill University, n.d. <e-mail: michael.sullivan@mcgill.ca >.

Vlaeyen JW, Linton SJ. "Fear-avoidance and its consequences in chronic musculoskeletal pain: A state of the art." *Pain* (2000): 317-32. May 2 2016. <https://www.researchgate.net/publication/12534678_Vlaeyen_JW_Linton_SJ_Fear-avoidance_and_its_consequences_in_chronic_musculoskeletal_pain_A_state_of_the_art_Pain_85_317-32>.

Thank you!

Thank you for your time in learning more about pain management in Oregon, the complex nature of pain, evolving concepts about the treatment of pain and what is needed to ensure that all Oregonians have access to the best possible pain treatment available to them.

Continue to registration page

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Citizen Advocacy Center
2016 Annual Meeting

Program Announcement, Agenda, and Meeting Registration Form

Modernizing the Regulatory Framework for Telehealth

Presented in conjunction with CLEAR, the Oregon Health Licensing Office, the Oregon Board of Dentistry, the Oregon Medical Board, the Oregon Naturopathic Board, the Oregon Board of Nursing, the Oregon Board of Pharmacy, and the Oregon Physical Therapy Licensing Board

Saturday, September 17, 2016
and
Sunday, September 18, 2016

Portland Marriott Downtown Waterfront
1401 SW Naito Pkwy.
Portland, OR 97201
(503) 226-7600

On Saturday afternoon, September 17, 2016, and Sunday, September 18, 2016, immediately following the close of the CLEAR Annual Educational Conference at the Portland Marriott Downtown Waterfront, CLEAR and the Citizen Advocacy Center (CAC) will co-sponsor a national conference on Telehealth.

We are pleased that the Oregon Health Licensing Office, the Oregon Board of Dentistry, the Oregon Medical Board, the Oregon Naturopathic Board, the Oregon Board of Nursing, the Oregon Board of Pharmacy, and the Oregon Physical Therapy Licensing Board have agreed to act as co-sponsors of the meeting. We thank them!

This conference will be CAC's 2016 meeting, and will bring stakeholders together to identify and discuss ways in which the health professional regulatory system can facilitate the use of telehealth technologies and maximize the benefits to the public, consistent with safe, quality, affordable care. Many healthcare professionals and their respective boards are taking steps to enable the appropriate, safe use of telehealth technologies. The conference will address such topics as:

- How do patients feel about telehealth?
- What are the main regulatory hurdles that need to be overcome?
- How can telehealth outcomes be evaluated?

The Citizen Advocacy Center meeting registration form is on page 8 of this program.

We encourage you to also register for the CLEAR 2016 annual conference that is being held at the same hotel from Wednesday, September 14, 2016, through Saturday morning, September 17, 2016. CLEAR is offering Citizen Advocacy Center members the same discounted registration fee they offer their own members. CAC members should use the registration discount code, which is **clearcac**. For more information, visit the CLEAR website at http://clearhq.org/aec16/.

Since 1987, CAC has been serving the public interest by enhancing the effectiveness and accountability of health professional oversight bodies. We offer training, research and networking opportunities for public members and for the health care regulatory, credentialing, and governing boards on which they serve.

Created as a support program for the thousands of public members serving on health professional boards as representatives of the consumer interest, CAC soon became a resource for the health professional boards themselves.

FACULTY

WITH LINKS TO THEIR POWERPOINT PRESENTATIONS

(IN PDF FORMAT)

David Benton	Chief Executive Officer, National Council of State Boards of Nursing
Kristin Bork (Oregon Telehealth Pilot Projects)	Lead Policy Analyst at the Oregon Health Authority (OHA) in the Office of Health Information Technology (OHIT).
Cathy Britain (Telehealth Policy Trends and Considerations)	Executive Director, Telehealth Alliance of Oregon
Karen Goldman (Promoting Health Care Competition Through Advocacy - Telehealth	Staff, Federal Trade Commission
Mario Gutierrez (Consumer Engagement) Mario Gutierrez (Fixing Medicare and Medicaid)	Executive Director, Center for Connected Health Policy
Kathleen Haley (Telemedicine)	Executive Director, Oregon Medical Board
Susan Layton	Chief Operating Officer, Federation of State Boards of Physical Therapy (FSBPT)
Becky LeBuhn	Chair, Citizen Advocacy Center (CAC)
Linda Mann (The Virtual Dental Home - An innovative and effective system for providing dental care)	Director, Community Outreach, Capitol Dental Care, Oregon
Rick Orgain	Vice President, Association of Regulatory Boards of Optometry (ARBO)
Barbara Safriet	Professor of Health Law & Policy, Lewis & Clark Law School
Alex Siegel (Telepsychology and Ethical Practice)	Director of Examination Services, Association of State and Provincial Psychology Boards (ASPPB)
David Swankin	President and CEO, Citizen Advocacy Center (CAC)
Latoya Thomas (Modernizing the Regulatory Framework for Telehealth)	Director, State Policy Resource Center, American Telemedicine Association
Cody Wiberg	Executive Director, Minnesota Board of Pharmacy
Mark Yessian	Board Member, Citizen Advocacy Center (CAC)

Day One – Saturday, September 17, 2016

ALL SATURDAY SESSIONS ARE IN THE MOUNT HOOD ROOM

11:00 A.M. – REGISTRATION DESK OPENS – BOX LUNCH PROVIDED

12:00 P.M. – 12:30 P.M. – WELCOME AND INTRODUCTION REMARKS BY CAC AND CLEAR

12:30 P.M. – 1:30 P.M. – KEYNOTE ADDRESS: "TELEHEALTH POLICY TRENDS AND CONSIDERATIONS"

Cathy Britain, Executive Director of the Telehealth Alliance of Oregon (TAO), an advocate for the use of telehealth, will discuss developments in the realm of telehealth and consumer engagement. She will discuss how TAO pursues five important goals:

1) **Improve access** to high quality healthcare and healthcare workforce education through the use of broadband telecommunications;
2) **Promote collaborations** that advance the use of telehealth to deliver affordable high quality healthcare;
3) **Provide and promote education** about telehealth;
4) **Provide technical assistance** to existing telehealth programs or healthcare providers seeking to establish telehealth programs in Oregon; and
5) **Promote research** that supports appropriate decision-making for telehealth providers, insurers, and policy makers.

1:30 P.M. – 2:30 P.M. – CONSUMER PERSPECTIVES

At this session Mario Guiterrez, Executive Director of the Center for Connected Health Policy, will recount California consumer leaders' experiences with and attitudes toward telehealth. Kristin Bork from the Oregon Health Authority will provide an overview of the agency's five telehealth pilot projects that worked to address unique population and system challenges in areas such as behavior health, youth dental, dementia care, HIV services and connecting paramedics to clinics in rural areas. Linda Mann, Director of Community Outreach, Capitol Dental Oregon, will share successes and challenges of the dental pilot that provides telehealth-connected oral health teams for children who have not been receiving dental care in hard to reach areas.

2:30 P.M. – 3:00 P.M. – BREAK

3:00 P.M. – 4:00 P.M. – PROVIDER PERSPECTIVES

Latoya Thomas, Director, State Policy Resource Center, American Telemedicine Association, will share her views about how regulation and reimbursement policies can promote or inhibit the growth of safe and effective telehealth service delivery. She will also talk about the desirability of license mobility.

MEETING ADJOURNS FOR THE DAY, FOLLOWED BY EVENING COCKTAIL RECEPTION AND SHIMBERG EVENTS (SEE NEXT PAGE)

SHIMBERG EVENTS (TO BE HELD IN THE MOUNT HOOD ROOM)

5:00 P.M. – 6:00 P.M. COCKTAIL RECEPTION

6:00 P.M. – 6:45 P.M. SHIMBERG ADDRESS

6:45 p.m. Presentation of Ben Shimberg Memorial Public Service Award

Dr. Benjamin Shimberg, widely considered the "father" of accountability in professional and occupational licensing, was the first chair of CAC's board of directors until his death in September 2003. The board named Ben Chairman Emeritus of CAC and created an annual Ben Shimberg public service award. Each year, the board asks the award recipient to deliver a lecture.

This year's Shimberg Award winner is Kathleen Haley, Executive Director of the Oregon Medical Board.

Past recipients of the award were:

2015 Lisa McGiffert, Director, Consumers Union's Safe Patient Project
2014 ProPublica, accepted by Charles Ornstein and Tracy Weber
2013 Kathy Apple, former Executive Director, National Council of State Boards of Nursing (NCSBN)
2012 Paul Grace, President and Executive Director, National Board for Certification in Occupational Therapy
2011 Catherine Dower, former Associate Director for Research, Center for the Health Professions, UCSF
2010 Art Levin, Director, Center for Medical Consumers
2009 Sidney Wolfe, former Director, Public Citizen's Health Research Group
2008 Polly Johnson, former Executive Director of the North Carolina Board of Nursing
2007 Barbara Safriet, former Public Member on the Federation of State Boards of Physical Therapy
2006 John Rother, former Policy and Strategy Director for AARP
2005 Julie D'Angelo Fellmeth, Administrative Director, Center for Public Interest Law, University of San Diego School of Law, and former Enforcement Monitor for the Medical Board of California
2004 Mark Yessian, Former Regional Inspector General for Evaluation and Inspections, Boston Region, Office of the Inspector General, U.S. Department of Health and Human Services

Day Two – Sunday, September 18, 2016

ALL SUNDAY SESSIONS ARE IN SALON ONE

8:00 A.M. – REGISTRATION DESK OPENS – CONTINENTAL BREAKFAST WILL BE AVAILABLE

8:30 A.M. – 9:30 A.M. – WHAT'S THE FEDERAL TRADE COMMISSION UP TO?
A spokesperson for the FTC has been invited to talk about ways in which the agency's antitrust enforcement activities may relate to telehealth. She will comment on whether the FTC *Staff Guidance on Active Supervision of State Regulatory Boards Controlled by Market Participants* in the wake of the Supreme Court's *North Carolina Dental* decision has relevance to telehealth regulation. CAC board member Barbara Safriet who has monitored FCC programs and been a consultant to that agency will add her own comments and observations.

9:30 A.M. – 10:30 A.M. – VIEWS FROM STATE HEALTH PROFESSION REGULATORS – PART I (NURSING, PHYSICAL THERAPY AND PSYCHOLOGY)
Regulators representing these three professions will bring us up to date on the regulation of telehealth technologies in their fields. Just a few examples: nursing (represented by David Benton) pioneered the interstate compact concept that facilitates practice across jurisdictional lines. Physical therapy (represented by Susan Layton) is looking at how its regulators can avoid creating barriers to the safe and appropriate use of telehealth delivery methods. In psychology (represented by Alex Siegel), two mental healthcare reform bills introduced in the U.S. Congress in early 2016 have telehealth provisions.

10:30 A.M. – 11:00 A.M. – COFFEE BREAK

11:00 A.M. – 12:00 P.M. – VIEWS FROM STATE HEALTH PROFESSION REGULATORS – PART II (PHARMACY, OPTOMETRY AND MEDICINE)
Regulators representing these three professions will bring us up to date on the regulation of telehealth technologies in their fields. Just a few examples: In pharmacy (represented by Cody Wiberg) several states permit teleprescribing. Telehealth technology allows Iowa pharmacists in one location to manage pharmacies in other locations and consult with patients via teleconferencing. Teleophthalmology (represented by Rick Orgain) is gaining acceptance worldwide for both diagnosis and treatment. Among U.S. regulators, the Federation of State Medical Boards (medicine will be represented by Kathleen Haley) published advisory guidelines for its member boards.

12:00 P.M. – 12:45 P.M. – FIXING MEDICARE AND MEDICAID
Thus far, the conference has focused on licensing and regulation. Reimbursement policy can also help or hurt the expansion of telehealth delivery. At this session, Mario Gutierrez will discuss both Medicare and Medicaid policy vis a vis telehealth.

Medicare now largely limits telehealth payments through its traditional fee-for-service program to cases where people live some distance from providers, thus largely restricting this service to rural areas. Medicare Advantage programs and demonstration programs such as accountable care organizations also can provide medical consultations via computer or phone. Where telehealth is widely used, up to 70% of people's contact with their doctors is handled remotely. Medicaid programs (laws, regulations, and reimbursement policies) vary widely from state to state.

12:45 P.M. – MEETING ADJOURNS

HOTEL INFORMATION

The annual meeting is being held at the Portland Marriott, Downtown Waterfront, 1401 SW Naito Pkwy., Portland, OR 97201. You can make a reservation using the online booking tool at https://aws.passkey.com/e/14403676, or by calling (503) 226-7600 and identifying yourself as part of the CLEAR Annual Educational Conference Group block.

Because of an unexpectedly large number of room registrations, there are few, if any, rooms still available at the Portland Marriott. CLEAR, the cosponsor of our meeting, has arranged for 2 overflow hotels that are located within a mile of the Portland Marriot. **For information on how to reserve rooms at the overflow hotels, please contact Glenn Blind at** gblind@clearhq.org.

For Citizen Advocacy Center members who are interested in attending the CLEAR conference being held at the same hotel from Wednesday, September 14, 2016, through Saturday morning, September 17, 2016, register at http://clearhq.org/aec16/ using the code **clearcac** to receive the discounted registration rate.

MEETING REGISTRATION FORM

To register for our 2016 annual meeting, please complete this form and mail, email, or fax it to:

CAC

1400 16th Street NW ● Suite 101
Washington, D.C. 20036
Voice (202) 462-1174 ● FAX: (202) 354-5372
register@cacenter.org

Name:		
Title:		
Name of Organization or Board:		
Address:		
City:	State:	Zip:
Telephone:		
Email:		

PAYMENT OPTIONS:

6) Mail us a check payable to **CAC** for the appropriate amount,
7) Provide us with your email address so that we can send you an invoice, or
8) Provide the following information to pay by credit card:

Name on credit card:	
Credit card number:	
Expiration date and security code:	
Billing address:	

Signature Date

Registration fee: ☐ **$545.00**

Registration fee for individuals affiliated with CAC Member Organizations,
CLEAR Member Organizations, and Oregon Health Regulatory Boards: ☐ **$475.00**

CANCELLATION POLICY: NO REFUNDS ARE POSSIBLE, BUT YOUR FULL PAYMENT MAY BE APPLIED TOWARDS A FUTURE MEETING.

MEMBERSHIP INFORMATION

CAC offers memberships to state health professional licensing boards and other organizations and individuals interested in our work. We invite your agency to become a **CAC** member, and request that you put this invitation on your board agenda at the earliest possible date.

CAC is a not-for-profit, 501(c)(3) tax-exempt service organization dedicated to supporting public members serving on healthcare regulatory and oversight boards. Over the years, it has become apparent that our programs, publications, meetings, and services are of as much value to the boards themselves as they are to the public members. Therefore, the **CAC** board decided to offer memberships to health regulatory and oversight boards in order to allow the boards to take full advantage of our offerings.

We provide the following services to boards that become members:

1) **Free** copies of all **CAC** publications that are available to download from our website for **all** of your board members and **all** of your staff.
2) A **10% discount** for **CAC** meetings, including our fall annual meeting, for **all** of your board members and **all** of your staff;
3) A $20.00 discount for CAC webinars.
4) If requested, a **free** review of your board's website in terms of its consumer-friendliness, with suggestions for improvements;
5) **Discounted rates** for **CAC's on-site training** of your board on how to most effectively utilize your public members, and on how to connect with citizen and community groups to obtain their input into your board rule-making and other activities;
6) Assistance in **identifying qualified individuals** for service as public members.

The annual membership fees are as follows:

Individual Regulatory Boards	$275.00
"Umbrella" Governmental Agency plus regulatory boards	$275.00 for the umbrella agency, plus $225.00 for each participating board
Non-Governmental organizations	$375.00
Association of Regulatory Agencies or Organizations	$450.00
Consumer Advocates and other individuals NOT associated with a state licensing board, credentialing organization, government organization, or professional organization	$100.00

MEMBERSHIP ENROLLMENT FORM

To become a CAC Member Organization for the remainder of 2016 and all of 2017, please complete this form and mail or fax it to:

CAC

1400 16th Street NW ● Suite 101
Washington, D.C. 20036
Voice (202) 462-1174 ● FAX: (202) 354-5372

Name:		
Title:		
Name of Organization or Board:		
Address:		
City:	State:	Zip:
Telephone:		
Email:		

PAYMENT OPTIONS:

1) Mail us a check payable to **CAC** for the appropriate amount,
2) Provide us with your email address so that we can send you an invoice, or
3) Provide the following information to pay by credit card:

Name on credit card:	
Credit card number:	
Expiration date and security code:	
Billing Address:	

Signature Date

Our Federal Identification Number is 52-1856543.

Oregon Telehealth Pilot Projects

Supported by

Oregon Health Authority's State Innovation Model Grant

September 17, 2017

Kristin Bork, Lead Policy Analyst
Office of Health Information Technology

Attachment #10

Process

Oregon is one of six states to receive a State Innovation Model grant to advance health system transformation (2013). A portion of Oregon's SIM grant is dedicated to supporting and accelerating statewide health information technology initiatives.

2014
- OHA partners with ORH to administer
- RFP released (October)
- 67 Letters of Intent received (November)
- 13 invited to submit full proposals (November)
- 12 applications (December)

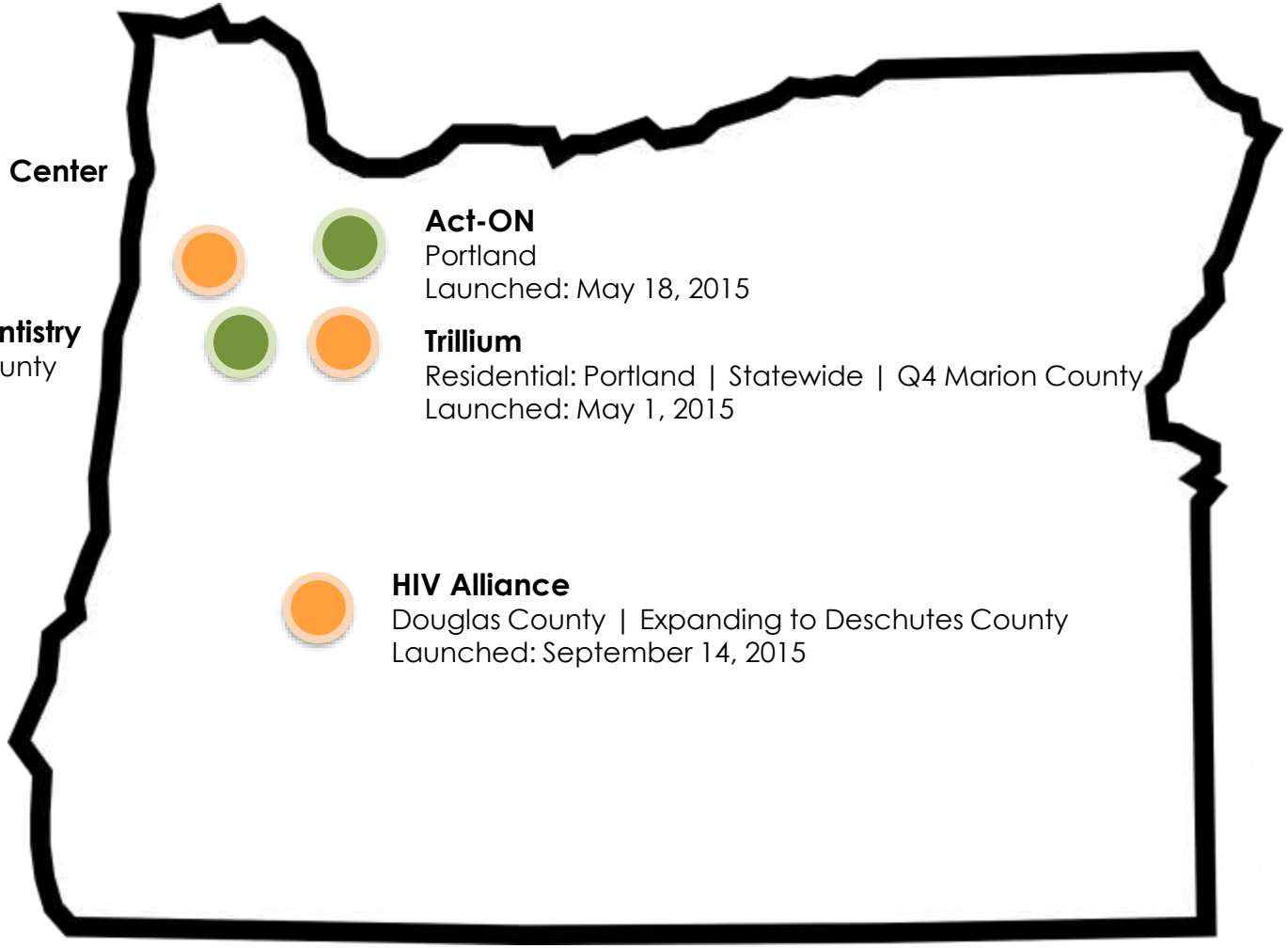
2015
- 5 projects awarded (January)
- Contracts signed (April)
- Projects begin (delayed: May to October)

2016
- Project implementation through August

Awardees

On target

Challenges meeting targets



Tillamook Regional Medical Center Community Paramedic
Tillamook County
Launched: October 1, 2015

Capitol Dental Care Tele-dentistry
Central School District, Polk County
Launched: September 8, 2015

Act-ON
Portland
Launched: May 18, 2015

Trillium
Residential: Portland | Statewide | Q4 Marion County
Launched: May 1, 2015

HIV Alliance
Douglas County | Expanding to Deschutes County
Launched: September 14, 2015

ACT-ON

Alzheimer's Care Via Telehealth Medicine for Oregon

About:

OHSU Layton Center created a Jabber video-conferencing telemedicine program to establish the:

- Reliability of standard measures of patient and caregiver well-being
- Feasibility of direct-to-home video dementia care

Successes:

Phase I (complete):

- Clinical assessments reliable except acute
- Oregon Alzheimer's Disease Center will fund a study

Phase II (in progress):

- Feasibility currently at 100%
- Physician and patient satisfaction high

Challenges:

- Equipment
- Connectivity
- Care-giver distress at questions

Capitol Dental Care

Tele-dentistry

About:

Collaboration between University of the Pacific, OHSU and Capitol Dental Care to:

Measure the efficacy and cost-effectiveness of the Expanded Practice Dentist Hygienist (EPDH) tele-dentistry model for K-2nd grade children in Polk County.

- Successes and challenges will be presented on in further detail by Capitol Dental.

Attachment #10

HIV-Alliance

Tele-pharmacist

About:

Video-conferencing with rural patients and collaborative practice agreements to enable Pharmacists to work with HIV specialists or primary care providers to coordinate care:

- Viewing and ordering labs
- Assessing and changing medication
- Education and follow-up monitoring with patients

Successes:

- Enrollment in Douglas County
- Documented challenges with licensing across state lines
- Documented success with complex patient care

Challenges:

- Physician buy-in
- Technology set-up for patients and connectivity (Zoom)
- Patient engagement
- Licensing across state lines
- Inter-agency collaboration

Tillamook Regional

Community Paramedic

About:

Hospital-based Community Paramedics (CP) visit patients identified as at-risk for hospital readmission. Using a Verizon hot-spot in the ambulance and a tablet, the CP can communicate directly with the clinic's Care Coordinator or the patient's provider.

Successes:

- 106 high-risk patients enrolled
- 88 home visits conducted
- 75 utilized telehealth consults

Challenges:

- Leadership buy-in including technology approval
- Provider buy-in and scheduling
- Hot spots not working in some rural areas
- Patient refusals

Trillium Family Services

Tele-pyschiatry

About:

Improve access to mental health services for vulnerable children in rural Oregon by providing psychiatric assessments, follow-up and medication management via videoconferencing for:

- SCIP and SAIP discharges
- Residential care
- Children in rural settings who cannot access outpatient psychiatry services.

Successes:

- 1 SCIP discharge
- 22 Residential
- 11 Outpatient

Challenges:

- Referrals
- Psychologist risk management tolerance
- Contracting with other agencies
- Modifying the Electronic Health Record

Questions?

Attachment #10

Telehealth Policy Trends and Considerations

Moving from the Present to the Future

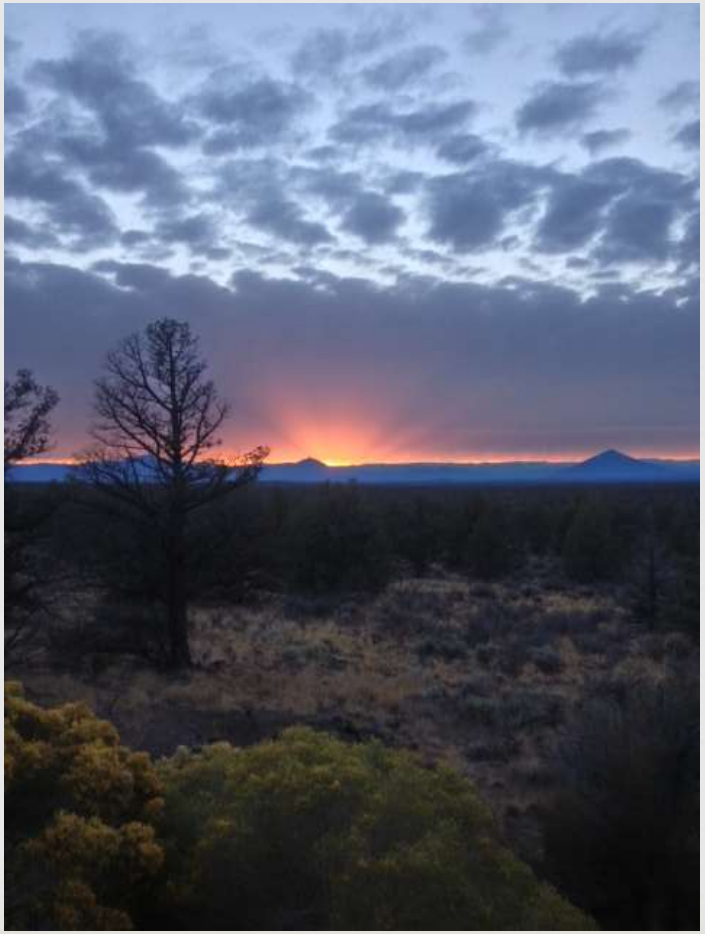
The Role of the Telehealth Alliance of Oregon

Cathy Britain, Executive Director

Attachment #10

From our large cities

To our vast deserts



Attachment #10

Oregon is a state of contrasts

- One place where we don't want large contrasts is in the health care for our citizens.

Attachment #10

"The care is the care no matter where."

- A stroke patient in the high desert of southeast Oregon should receive the same care as the stroke patient in Portland.
- An infant in need of resuscitation should benefit from the same skilled services as and infant in a childrens' hospital in Portland.
- A mom in a small town on the coast should be able to get care for her child with an earache at 11 pm without leaving her home in the same way as a mom living in the metro area.

Getting from philosophy to practice

- Telehealth is one of the tools that can help with this process.
  - Telehealth provides better/easier access to care
  - Telehealth is cost effective
  - Telehealth can improve the quality of care
  - Services delivered via telehealth consistently have a high degree of satisfaction among both patients and providers

Better/easier access to care

- Patients do not have to travel to receive care.
  - No need to leave homes, schools or workplaces
  - Do not have to travel long distances to receive specialty care (sometimes even primary care)
  - Medically fragile patients in skilled nursing facilities do not have to be transported to receive care
- Patients get to see specialists that they otherwise would be unable to see

Receiving stroke follow up care from home

Attachment #10

Telehealth is cost-effective

- Use of telehealth to provide non-urgent care can reduce expensive emergency room visits and visits to providers offices.
- Use of telehealth can reduce readmissions to hospitals for those with chronic conditions
- Use of telehealth can enable primary care providers to successfully maintain patients in their communities
- Use of telehealth saves patients time and money when they need non-urgent healthcare

Receiving care at work

Attachment #10

Telehealth can improve the quality of care

- Telehealth positively affects clinical outcomes of care in home-based programs
- Studies have shown that telehealth is effective in delivering pediatric acute care to children in school-based health settings.
- Telehealth that provides specialty care to a region results in significantly improved care for patients in that region
- It has not been shown that there is a significant difference in the ability of the provider to obtain clinical information, make an accurate diagnosis, and develop a treatment plan that produces the same desired clinical outcomes as compared to in-person care when used appropriately.

Project ECHO (UW)

Telehealth services have high satisfaction rates

- Telehealth provides the patient with the ability to see a specialist trained in the area that corresponds with the patient's condition.
- Telehealth provides a feeling of getting personalized care from a provider that has the patient's best interest in mind.
- Telehealth provides the patient with the ability to communicate with the provider in a very personal and intimate manner.

Mom watches over baby

Attachment #10

Telehealth Alliance of Oregon (TAO)

- Began as a committee of the Oregon Telecommunications Coordinating Council in 1999
- Incorporated as a 501 (c)(3) in 2005
- TAO is a resource center for anyone in Oregon interested in or currently providing telemedicine
- Our membership includes hospitals and health systems, clinics, provider associations, individuals and vendor/sponsors
- Our mission is to advance telemedicine knowledge, practice and policy in Oregon

How is TAO Funded?

- TAO is funded by memberships
- TAO is funded by vendor "champions"
- TAO's Summit is covered by registration fees, sponsors and exhibitors
- TAO has received small amounts of grant funding
- TAO does contract work for organizations and government agencies.

Knowledge Activities

- An Annual Meeting and Summit is held for members, vendors and others interested in telemedicine. The 2017 Summit is March 15-17 in Portland, Oregon
- TAO maintains a website at www.ortelehealth.org that includes information about telemedicine practice in Oregon and a Law and Policy review
- TAO members speak at meetings, conferences and at legislative events

Practice Activities

- TAO has an active sponsor/vendor group that helps provide new industry knowledge to members and support for TAO activities
- TAO maintains a resource service for anyone with questions regarding telemedicine practice
- TAO maintains a listerv using it to post information about webinars, conferences, new products and programs, etc. that might be useful to providers.

Policy Activities

- TAO is a "go-to" resource for telemedicine information for the State Legislature and the Oregon Health Authority.
- TAO is a convener of policy forums which can be used for discussion and clarification of new policies or to assist with the development of policies or legislation that will improve the practice of telemedicine.
- TAO has been instrumental in helping to write and pass SB 622 (1999), HJR 4 (2004), HJR 6 (2009), SB 24 (2009) and SB 144 (2015)

Moving telemedicine forward in Oregon

- Maintain a neutral discussion venue to deal with telemedicine issues
- Establish a better understanding among policy makers about telemedicine and it's importance in transforming care
- Help develop state regulations that keep pace with change and make sense for the system
- Create more participation by providers, provider associations, payers including CCOs
- Better manage information about telemedicine services in Oregon

TAO's Project with the Oregon Health Authority

- The project has three components:
  - The Law and Policy Review
    - http://www.ortelehealth.org/content/law-and-policy
  - The Oregon Telemedicine Services Portal
    - http://www.ortelehealth.org/portal
  - Gaps and Opportunities Inventory
    - http://www.ortelehealth.org/content/telehealth-oregon-gaps-and-opportunities-report

In closing…

- "What we must decide is how we are valuable rather than how valuable we are."

  - *Edgar Friedenberg*

To learn more about telemedicine in Oregon

- Go to the TAO website at www.ortelehealth.org
- Subscribe to the TAO listserv
- Become a member of TAO

Contact: Cathy Britain, Program Manager
541-910-7366, csbritain@gmail.org

The Federal Trade Commission: Promoting Health Care Competition Through Advocacy: Telehealth

Karen A. Goldman, Attorney Advisor
FTC Office of Policy Planning

Citizen Advocacy Center, Annual Meeting
Portland, OR
September 18, 2016

The views expressed herein are my own. They do not necessarily reflect the views of the Federal Trade Commission, any of its individual Commissioners, or the FTC's Office of Policy Planning.

About the FTC

- **Mission:** To prevent business practices that are anticompetitive, deceptive, or unfair to consumers, and to enhance informed consumer choice and public understanding of the competitive process
- **Consumer Protection:** The Federal Trade Commission Act provides that "unfair or deceptive acts or practices in or affecting commerce…are…declared unlawful." (15 U.S.C. § 45(a)(1))
- **Competition:** The FTC Act also prohibits "unfair methods of competition." (15 U.S.C. § 45(a))
  - Includes conduct that violates antitrust laws such as the Sherman Act
- **This presentation focuses on competition**

Competition Is Important!

- Competition benefits consumers, especially in industries undergoing rapid evolution and restructuring (like health care)
  - Promotes innovation
  - Expands supply
  - Improves quality and efficiency ("value")
  - May help to control costs
  - Prevents harmful accumulation or exercise of market power

Activities Regarding the Health Care Industry

- **FTC's range of tools**
  - **Law enforcement**, e.g., *N.C. State Board of Dental Examiners v. FTC*
  - **Research and scholarship** (15 U.S.C. § 46(b))
    - Reports, e.g., IMPROVING HEALTH CARE: A DOSE OF COMPETITION
    - Workshops, e.g., *Examining Health Care Competition*
  - **Advocacy comments** on laws & regulations
- Significant health care expertise, in both competition and consumer protection areas

What Is Competition Advocacy?

- Comments on state laws or regulations
  - Usually by request, or during an open comment period
- Provide a framework for thinking about public policy issues from a competition perspective
  - What is the likely competitive impact?
  - How will this affect consumers?
  - Any legitimate justifications to restrict competition?
  - Are there less restrictive alternatives?
- Protect consumers and fulfill other important public policy goals, BUT
  - Do not unnecessarily restrict legitimate business activities, especially those that may promote competition
  - Safety justifications may be pretextual

Health Care Advocacy: Scope of Practice and Supervision

- Principles
  - Allow health care professionals to practice to the top of their license
  - Unnecessary supervision requirements allow one group of professionals to restrict market access by competing professionals
  - Negative effects on access, cost, innovation
  - Examples:
    - Advanced Practice Registered Nurses and others
    - Other professions, e.g., dental hygienists
- Recent telehealth advocacy builds on this area

Roots of Telehealth Advocacy

- 2004 FTC & US Dep't of Justice report, **IMPROVING HEALTH CARE: A DOSE OF COMPETITION**
- Considered competitive effects of state restrictions on the interstate practice of telemedicine
  - "When used properly, telemedicine has considerable promise as a mechanism to broaden access, lower costs, and improve health care quality"
  - "[T]he practice of telemedicine has crystallized tensions between the states' role in ensuring patients have access to quality care and the anticompetitive effects of protecting in-state physicians from out-of-state competition"
- 2014 FTC workshop, ***Examining Health Care Competition***, considered telehealth

Regulatory Barriers to Telehealth

- Burdensome multi-state licensure requirements
- Unnecessary reimbursement restrictions
- Rigid in-person physical examination and related requirements
- Law/rules may benefit in-state practitioners

Alaska Telehealth Advocacy, March 25, 2016

- Comment on the telehealth provisions of SB 74
  - Response to open comment period of an Alaskan legislative committee
- Removed a barrier to the provision of telehealth services by out-of-state physicians
  - Eliminated an in-person physical examination requirement applicable only to out-of-state physicians
- Illustrates the potential for out-of-state providers to expand access to telehealth services

Restrictions on Telemedicine in Alaska Prior to Passage of SB 74

- A 2014 law allowed only Alaska-licensed physicians *located in* Alaska to prescribe drugs without a physical examination
- Created a barrier to telehealth services in a state that relies on telehealth to address provider shortages and provide care in remote regions
  - Alaska ranks 49th among the states and DC for meeting primary care needs and 48th for mental health
- Affected longstanding providers as well as new, virtual telehealth companies
  - E.g., state agency-provided behavioral health services, which do not ordinarily require a physical examination

Benefits of Eliminating the Restriction on Out-of-State Providers

- Could *double* the supply of physicians who could provide telehealth services
  - About 2000 Alaska-licensed physicians located out-of-state (≈ in-state)
- Potential to increase competition, enhance quality, and reduce costs
  - Reimbursement is much higher in Alaska than in other states, in part due to insufficient competition
- Potential for substantial savings on transportation costs paid by Alaska Medicaid
  - High transportation costs due to remoteness: $77 million, vs. $143 million for physician services

Lack of a Credible Justification for the Restriction

- Follow-up care and referrals from in-state physicians likely no better than from out-of-state physicians
  - Seattle physicians closer to Ketchikan than physicians in Anchorage
  - Out-of-state physicians may have previously worked in Alaska
- Out-of-state physicians held to state's licensure requirements and existing standard of care

Conclusion of Alaska Telehealth Advocacy

- The telehealth provisions of SB 74 appeared to be a procompetitive improvement in the law that would benefit Alaska health care consumers
- The bill passed

Advocacy on Delaware's Proposed Telehealth Regulations

- Regulations in response to definitions of telehealth and telemedicine that the Delaware legislature added to the practice act of each health care occupation in 2015
- Comments on telehealth regulations for occupational therapy (Aug. 3, 2016) and dietetics/nutrition (Aug. 16, 2016)
  - Responses to open comment periods
- These boards differed in regard to permitting the use of telehealth for an initial evaluation, or requiring an in-person initial visit

Board of Occupational Therapy Practice

- Avoided rigid in-person visit requirements for evaluation of a patient
  - Licensee would be responsible for determining whether telehealth is appropriate
  - Regulation would hold licensees to existing in-person standards of care
- Flexibility could enhance competition, access, and consumer choice
- Could help those with limited mobility obtain rehabilitation services

Board of Dietetics/Nutrition

- Would allow licensees to determine whether to use telehealth treatment
- Would hold licensees to existing in-person standards of care
- However, would require that *all* initial evaluations be carried out in-person

FTC Staff Analysis of Proposed Dietetics/Nutrition Regulation

- An in-person evaluation might not be necessary
  - Diagnosis and lab data from physician referral
  - Health professionals assisting patients at nursing facilities
  - Self-reported data might be sufficient
- Could discourage the use of telehealth and restrict consumer choice
- Do legitimate health and safety justifications support the restriction?
- Would allowing licensees to decide better promote competition and access to safe and affordable care?

Future Directions for Telehealth Advocacy?

- Developments in licensure
  - Licensure compacts for physicians, nurses, physical therapists, psychologists
  - Other approaches?
- Reimbursement restrictions
  - Geographic (rural)
  - Originating site: patient must be at a medical facility

Enforcement: Brief of the U.S. and the FTC as Amici Curiae Supporting Teladoc Court of Appeals for the 5th Cir., Sept. 9, 2016

- Argues that the Court of Appeals lacks jurisdiction because the district court order denying TMB's motion to dismiss on the basis of the state action doctrine is not immediately appealable
- If the Court finds jurisdiction, urges it to reject application of the state action doctrine because the "active supervision" requirement is not satisfied
- Takes no position on the merits of Teladoc's claims, but acknowledges that FTC staff is investigating the underlying actions that are the subject of the appeal

FEDERAL TRADE COMMISSION

FOR • THE • CONSUMER

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opp@ftc.gov

EXPANDING ACCESS TO QUALITY HEALTH CARE FOR THE UNDERSERVED THROUGH TELEHEALTH: THE CONSUMER PERSPECTIVE

Modernizing the Regulatory Framework for Telehealth Conference

September 17, 2016

877-707-7172
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CENTER FOR CONNECTED HEALTH POLICY

Mario Gutierrez
Executive Director

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Center for Connected Health Policy

The National Telehealth Policy Resource Center

We are part of the Public Health Institute, an independent, ***public interest*** organization dedicated to promoting better systems of care improved health outcomes & provide greater ***equity of health access to quality, affordable care and services for all***

HRSA/OAT GRANT 2012-2016

POLICY MAP >> REIMBURSEMENT >>

NATIONAL Telehealth Policy RESOURCE CENTER

About the Program | What is Telehealth | Telehealth Policy | Legal Issues | Health Information Technology

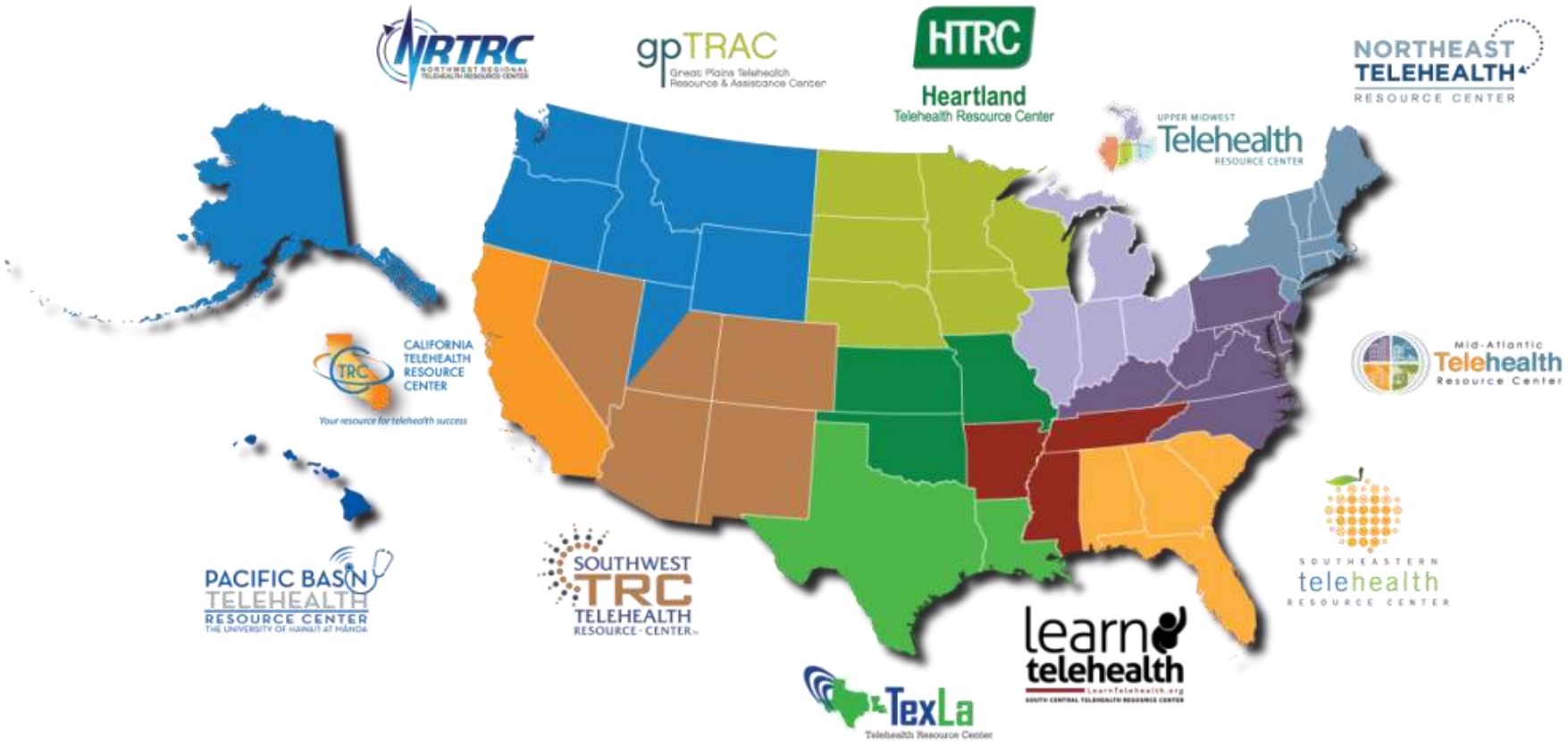
1 2 3 4 5

Telehealth technologies are valuable assets to help achieve the "Triple Aim" of improved quality of care, better health outcomes, and lowered costs.

Learn More >>

WWW.CCHPCA.ORG

TelehealthResourceCenters.org



TTAC
TelehealthTechnology.org

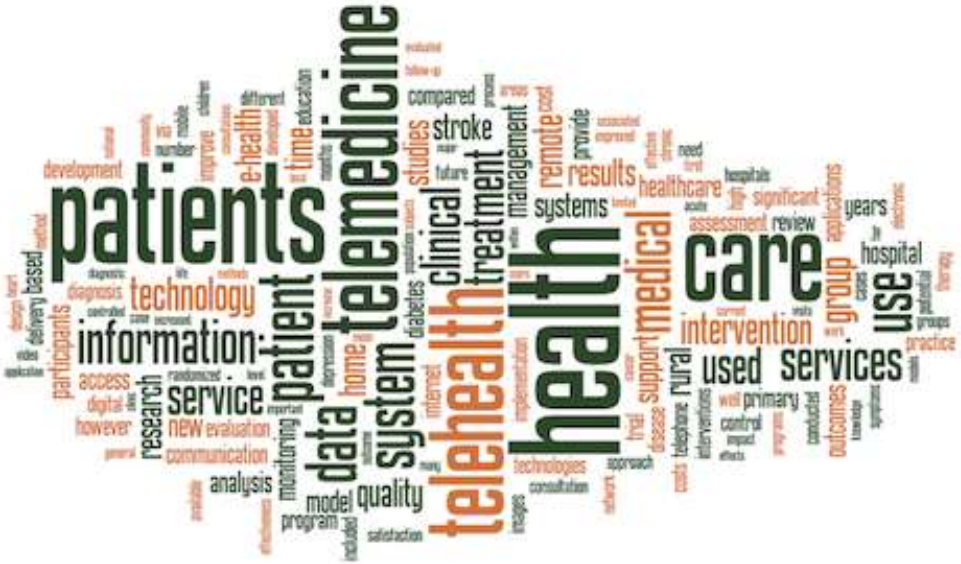
Center for Connected Health Policy

2 National Resource Centers

NRTRC	gpTRAC	NETRC
CTRC	HTRC	UMTRC
SWTRC	SCTRC	MATRC
PBTRC	TexLa	SETRC

12 Regional Resource Centers

THE VALUE PROPOSITION FOR TELEHEALTH



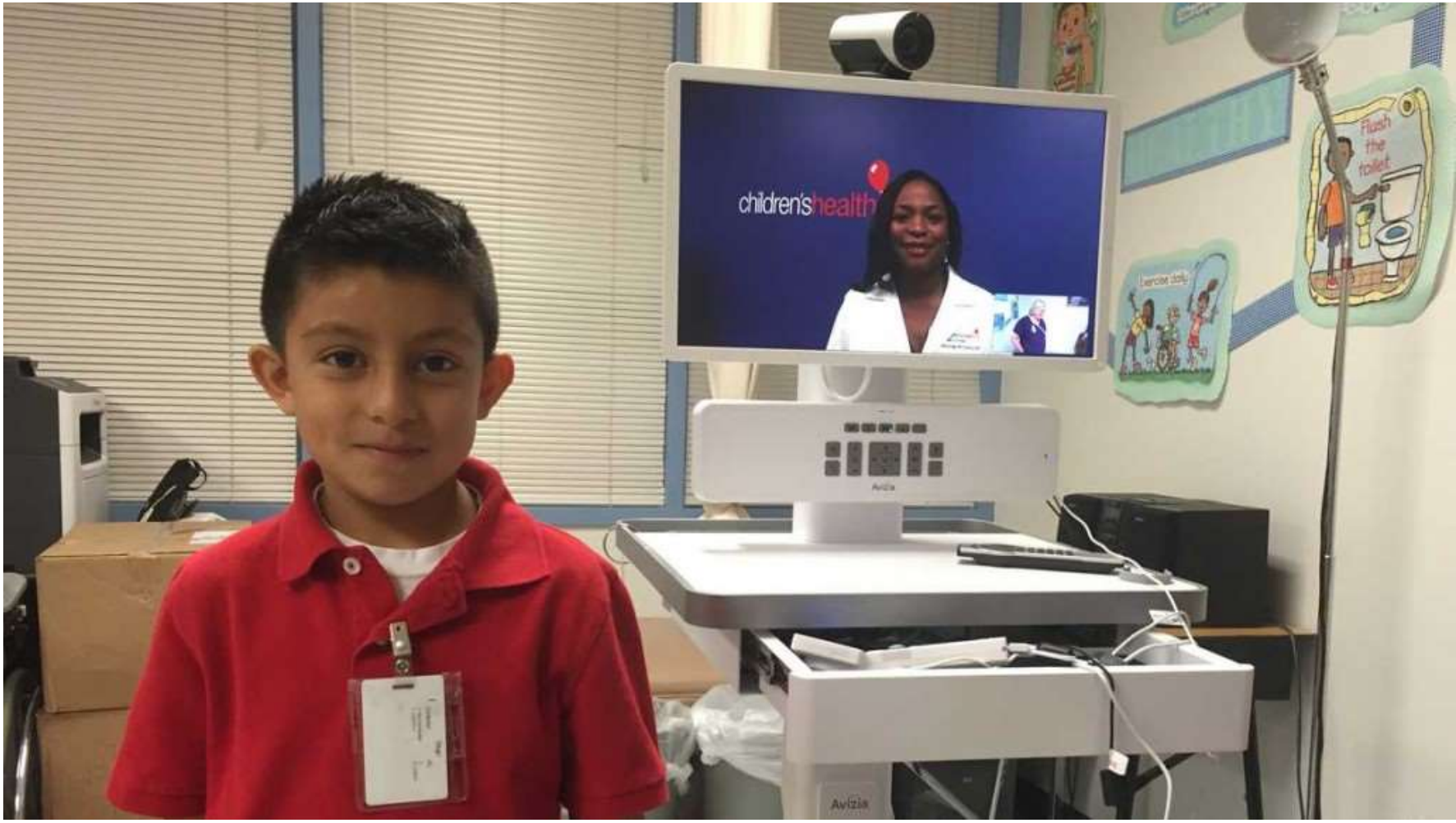
Advances in telecommunication technologies can help ***redistribute*** *health care* ***expertise and resources*** *to where and when it is needed, and create greater* ***value*** *among consumers, public & private payers, and health systems*

VALUE OF TELEHEALTH

1. Timely Access to Diagnosis & Treatment

- Primary and Specialty Care Services (Live or Asynchronous Store & Forward)
- Direct to Consumer
- Acute, Chronic, & Emergency Care

…WHERE THE CONSUMER IS LOCATED



Cost to the Consumer

Patients spend an average of nearly **two hours** for each out-patient visit, including travel, waiting, filling out forms and finally seeing a doctor. That equates to $43 in lost time for each visit.

JAMA Internal Medicine

VALUE OF TELEHEALTH

2. Enhanced Consultation/Communication

- Patient/Consumer ⟺ Health Care Team
  - Uses secure portal for email communication or live video using smart phone, tablet or computer.
  - Directly Connects Consumers to Care Team

PRIMARY TO SPECIALIST CONSULTATION

- **eConsult:** a web-based system that allows PCPs and specialists to securely share health information and discuss patient care
- Improves timely access to specialist while enhancing the PCP knowledge and services
- Web-based, asynchronous

VALUE OF TELEHEALTH

3. Remote Monitoring

- Management of Chronic Conditions
- In Home-Aging in Place
- Acute Intensive Care (Tele-ICU)
- Bluetooth or broadband connected

AGING IN PLACE WITH VIRTUAL CONNECTIVITY

- Allows Aging to Stay Home and in Community
- Enhances the Care Giver Support
- Prevents Expensive Institutionalization
- Reduces Sense of Isolation

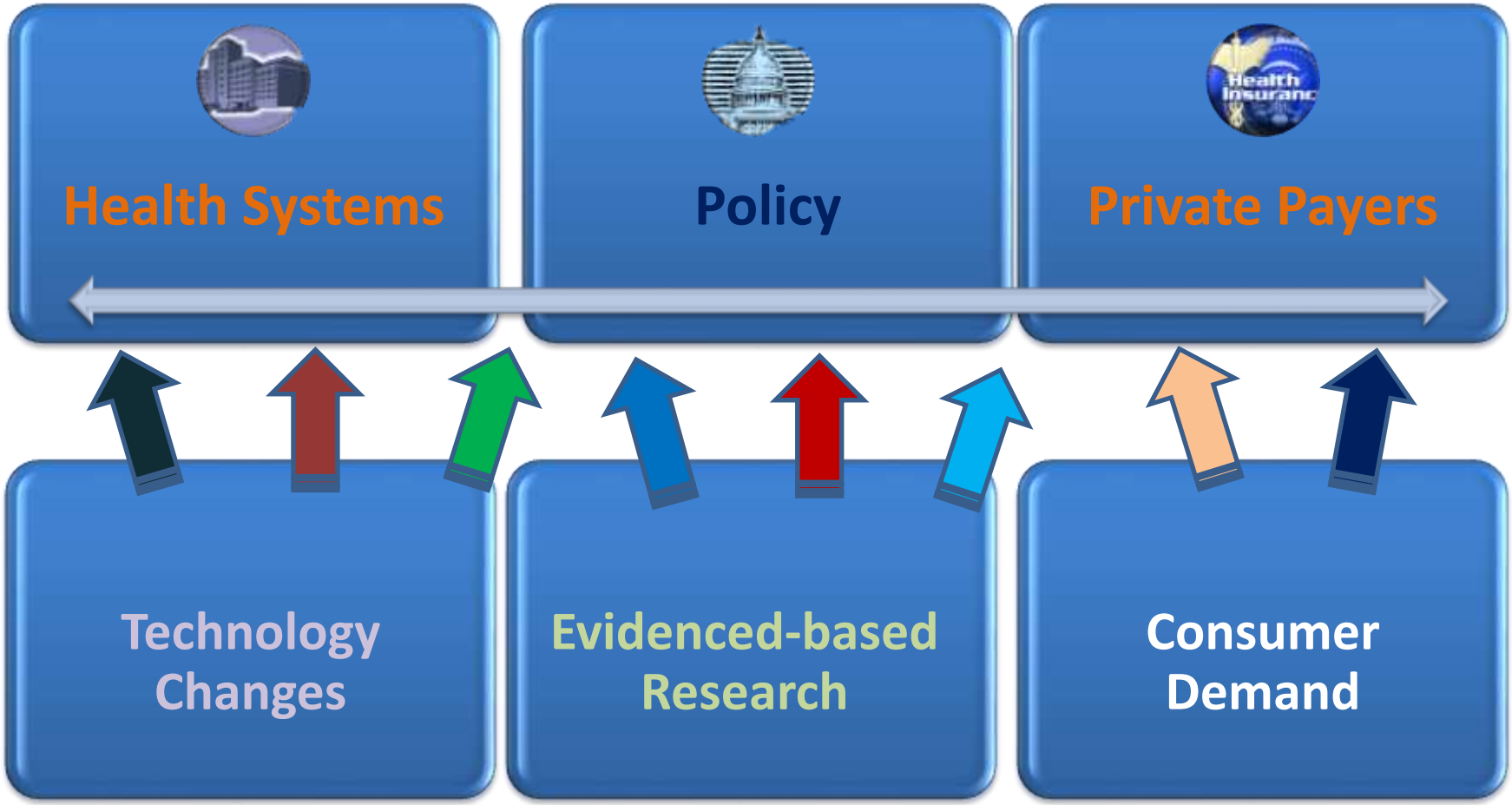
4. VALUE OF TELEHEALTH

MOBILE HEALTH

- Health care, public health, and health, education & personal health monitoring
- Supported by mobile phones, tablet computers, and other mobile communication devices
- Can be targeted (promoting healthy behavior and disease management) to wide-scale (disease outbreak alerts)

Attachment #10

Making Change Happen



Consumer Advocacy Convening- Lifting the Voice of the Users of Care

1. To provide information/educate consumer groups regarding telehealth and telehealth policy in California and nationally.
2. To align telehealth policy issues with the broader health care equity advocacy agendas
3. To formulate an action plan for advancing the consumer perspective in telehealth policy

HIGHLIGHTS OF CONSUMER CONVENING RESPONSES

How can telehealth help advance individual organization's policy agendas?

- Increase access for non-English speakers
- Expand the capacity of providers to see more patients
- Provide more culturally competent care
- Allows for aging in place in some instances and results in greater independence for older adults
- Help serve the undocumented

HIGHLIGHTS OF CONSUMER CONVENING RESPONSES

What can be done to increase the consumer's awareness of the value of telehealth?

- Need to educate patients and caregivers by:
  - Use of social media
  - Continually discuss telehealth option and make availability known
  - Providers telling patients about telehealth activities during appointments
  - Webinars/Town Hall meetings
  - Outreach targeting non-English speakers

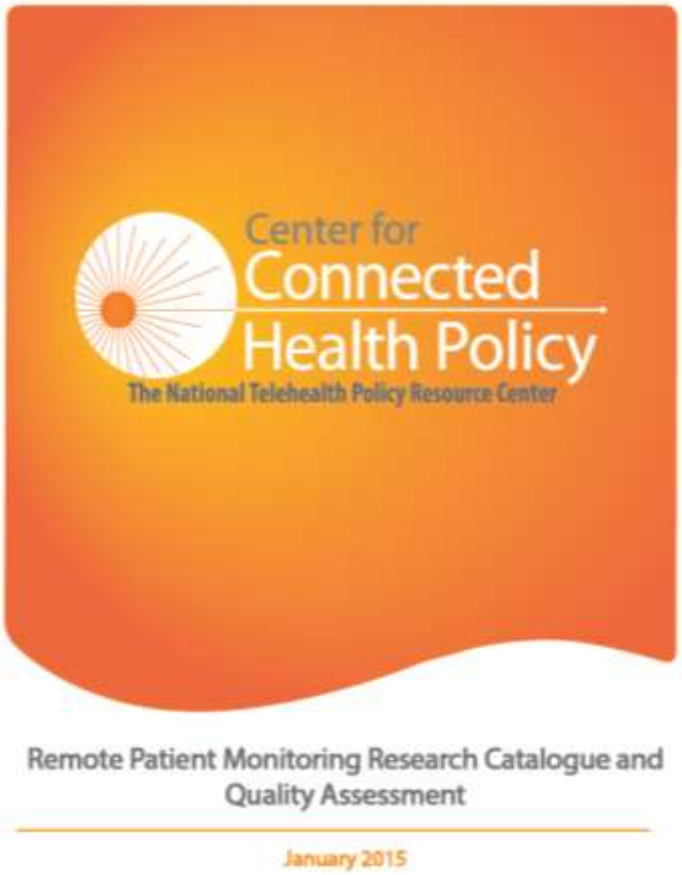
HIGHLIGHTS OF CONSUMER CONVENING RESPONSES

What concerns do you have regarding telehealth that we should be aware of?

- Security and privacy/HIPAA issues (especially for kids)
- Startup costs
- Ensuring the rights of consumer are protected
- Readiness of communities
- Over regulation
- Telehealth may not appropriate for all situations
- Policies should be community based and incorporated coordinated care

SHOW ME THE EVIDENCE!
Research Catalogues

- Peer-Reviewed Publication
- Post 2007
- Focused on Triple Aim
- Six to date:
  - Cost-Effectiveness
  - Remote Patient Monitoring
  - Tele-Dermatology
  - Tele-stroke
  - Tele-Mental Health
  - **Consumer Satisfaction**



PURPOSE

- To increase and organize evidence for patient satisfaction in telehealth
- Consumer perspective is critical to telehealth's success

SEARCH PARAMETERS

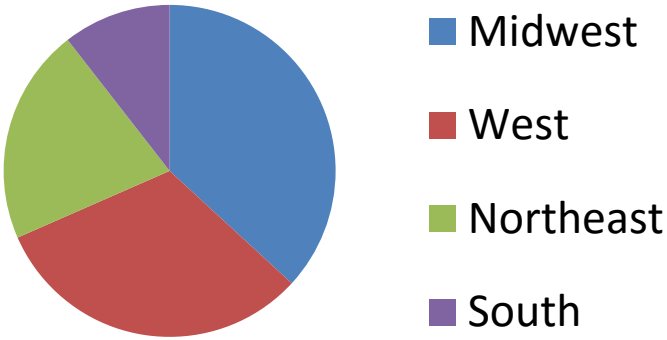
- Took place in United States
- Published post 2007
- Sample size no less than 50 (30 per group if there was a control)
- Primary focus on quality (satisfaction) of telehealth modality

ARTICLE SEARCH

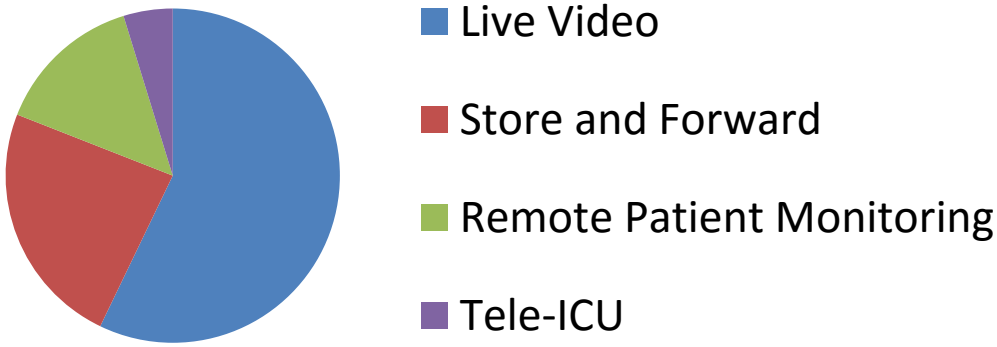
- Used DiscoverLibrary, Pub Med, Google Scholar, Science Direct, SAGE, and EBSCO
- Articles were examined independently by three reviewers who then met to discuss inclusion in the catalogue
- 19 Studies were selected

STUDY CHARACTERISTICS

Study by Region



Telehealth Modality



Clinical Domains

- Mental Health
- Chronic Conditions
- Sleep Medicine
- Dermatology
- Critical Care
- Neurology
- Pulmonary, Endocrine, and Rheumatology

Settings

- VA Clinics and Medical Centers
- Academic Medical Centers
- Hospitals
- CVS MinuteClinic
- Correctional Facility
- Not-for-Profit Organizations

STUDY RESULTS

- Patients were satisfied or highly satisfied with their care
- Most controlled trials found insignificant differences between telehealth satisfaction and traditional care
- 1 controlled study found significant differences in satisfaction in favor of telehealth at follow up
- Patients like convenience and time-savings of telehealth
- 1 study reported technical difficulties and concerns about the reliability of the diagnosis

GAPS IN THE RESEARCH

- Most studies did not have comparison groups
- Studies lack ethnic diversity
- More studies needed in South and Northeast
- Many studies focused on older patients;
- more studies needed on younger patients and caregivers
- Not a priority of researchers!

STATE POLICY BEYOND LEGISLATION:

- **Regulatory** and administrative actions still needed to fully implement legislation
- **Courts** also play a role in interpretation of legislative policy
- Professional **licensing** boards can limit the benefits of legislation

TECHNOLOGY-ENABLED HEALTH CARE TRENDS IN THE 21ST CENTURY

Attachment #10

Physician-centric → Consumer-centric

VIRTUAL CARE ANYWHERE

- A new report from information and analytics firm IHS says video consultations in US will jump to **75 million** virtual visits by 2020
- a recent report of Deloitte, the number of e-Visits will reach around **100 million** globally at the end of this year

TECHNOLOGY IS GROWING AND PART OF EVERYDAY LIFE

VIRTUAL PRIMARY & CHRONIC CARE

- *Kaiser Permanente*
  - *10.5 million virtual by email, scheduled phone call, or video in 2013 in Kaiser Permanente Northern California & over half nationally by 2017*
  - *By he end of the year this number will exceed the number of in-person visits.*

COMMERCIALIZATION OF HEALTH CARE: A FACT OF LIFE

take care clinic℠ at select Walgreens

American Well®

CVS CAREMARK

minute clinic®

Teladoc®

Dr DOCTOR on DEMAND

Talk to a board-certified physician from the comfort of home immediately!

A review, plus a $200 Target Gift Card Giveaway!

www.vivaveltora.com

Benefits vs Risks

- Convenience or-
  Misdiagnosis?
- Care and Rx Now
  But—no continuity
  or access to EMR?
- Over Prescribing?

Mercy Virtual

A hospital without beds

3 million virtual visits in the next 5 years

http://mercytelehealth.com

THANK YOU-FOR MORE INFORMATION PLEASE VISIT OUR WEBSITE: WWW.CCHPCA.ORG

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MARIOG@CCHPCA.ORG

TRANSFORMING HEALTH CARE WITH CONNECTED HEALTH TECHNOLOGY

STATE AND FEDERAL TELEHEALTH POLICY TRENDS AND ISSUES

Modernizing the Regulatory Framework for Telehealth Conference
September 17, 2016

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CENTER FOR CONNECTED HEALTH POLICY

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OFFICE of ADVANCEMENT OF TELEHEALTH
NTRC-Policy

POLICY MAP >> REIMBURSEMENT >>

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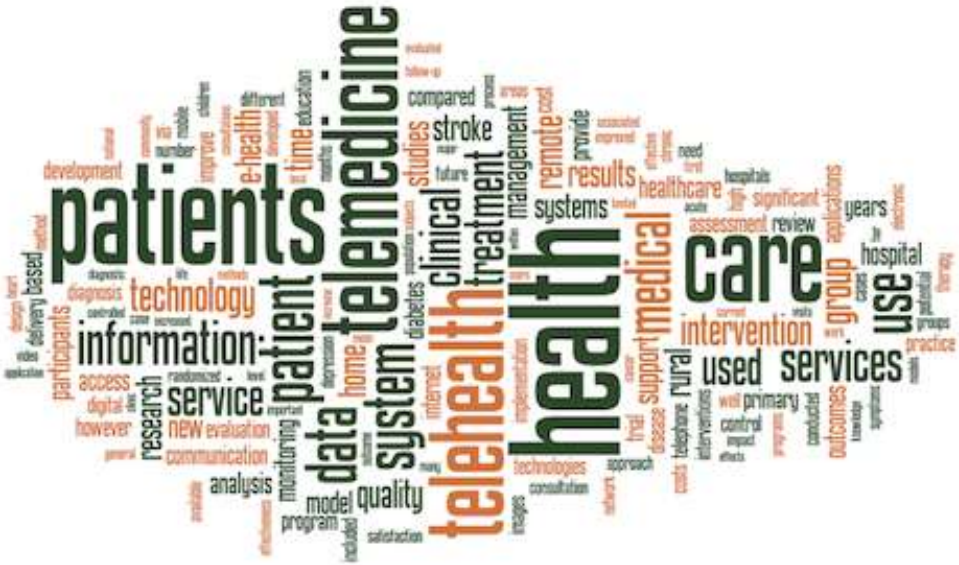
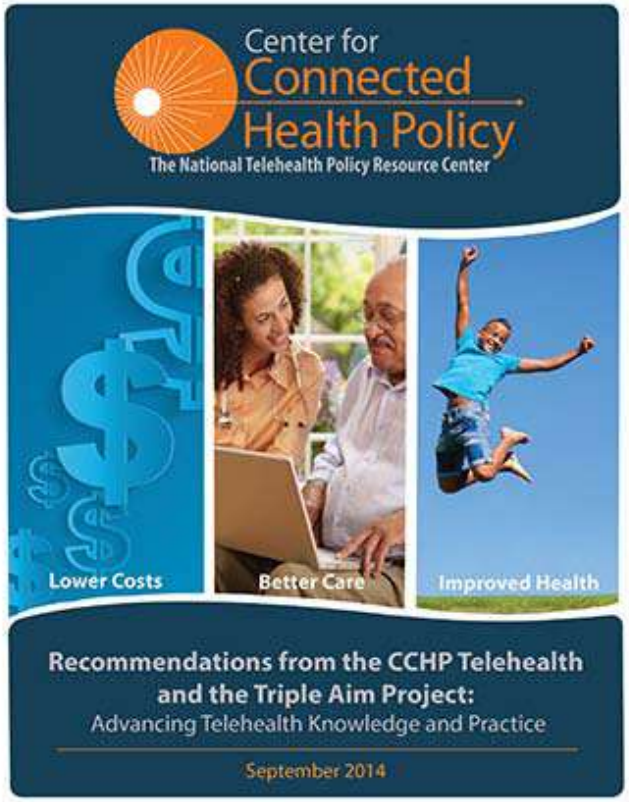
THE *VALUE* PROPOSITION FOR TELEHEALTH



Advances in telecommunication technologies can help ***redistribute*** *health care* ***expertise and resources*** *to where and when it is needed, and create greater* ***value*** *among consumers, public & private payers, and health systems*

Improve Health
Lower Costs
TRIPLE AIM
Better Care


Center for Connected Health Policy
The National Telehealth Policy Resource Center
Lower Costs
Better Care
Improved Health
Recommendations from the CCHP Telehealth and the Triple Aim Project:
Advancing Telehealth Knowledge and Practice
September 2014

TELEHEALTH STATE-BY-STATE POLICIES, LAWS & REGULATIONS

Telehealth Policy

National Policy

- State Laws and Reimbursement Policies
- Medicare
- Medicaid

Home » Telehealth Policy » National Policy » State Laws and Reimbursement Policies

State Laws and Reimbursement Policies

The Center for Connected Health Policy helps you stay informed about telehealth-related laws, regulations, and Medicaid programs. We cover current and pending rules and regulations for the U.S. and all fifty states.

Laws, Regulations, Pending Bills State & Federal

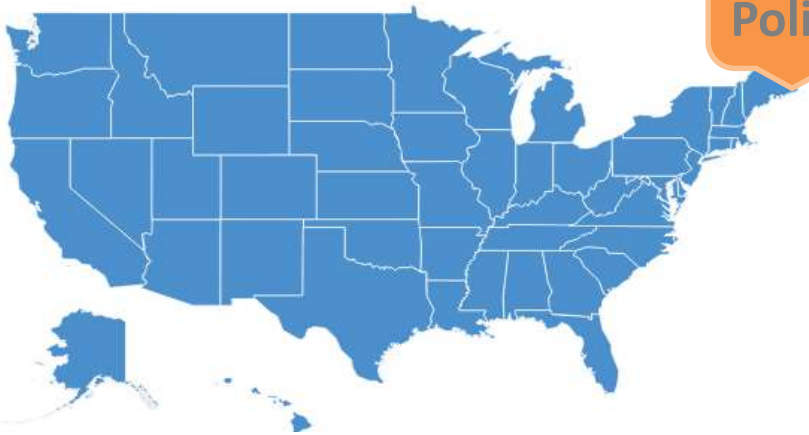
All Current Laws and Policies

All Pending Legislation and Regulations

Full Report "State Telehealth Laws and Reimbursement Policies"

Law and Policies by State:

Interactive Policy Map



Calendar

Government Health Care Congress 2015 ; Medicaid Summit »

JULY 14-16, 2015

Arlington, Virginia

Don't miss the opportunity to hear CCHP's executive director, Mario Gutierrez, speak at the 2015 Government Health Care Congress; Medicaid Summit! Health insurance executives, state and federal officials will gather across three summits to discuss the future of Medicaid expansion, Medicare regulations, access to care, cost savings and Dual Eligible demonstrations. For more information or to register for this

KEY POLICY AREAS OF ANALYSIS & REFORM

- **Definition:** Telemedicine or telehealth?
- **Reimbursement:** by modality (live video, Store and forward, remote patient monitoring)
- **On-line Prescribing:** In-person exam required?, who is eligible, and what type of drugs)
- **Consent:** (written, verbal, none?)
- **Cross-state licensing:** conditional practice, FSMB compact
- **Private Payer Parity:** (parity of service, payment, conditioned to terms of policies?)
- **Location of Service:** originating site requirements
- **Site Transmission Fee:** yes, no?

NO TWO STATES ARE ALIKE!

43 states
Have a definition
for TELEMEDICINE

32 states & DC
definition for ***TELEHEALTH***

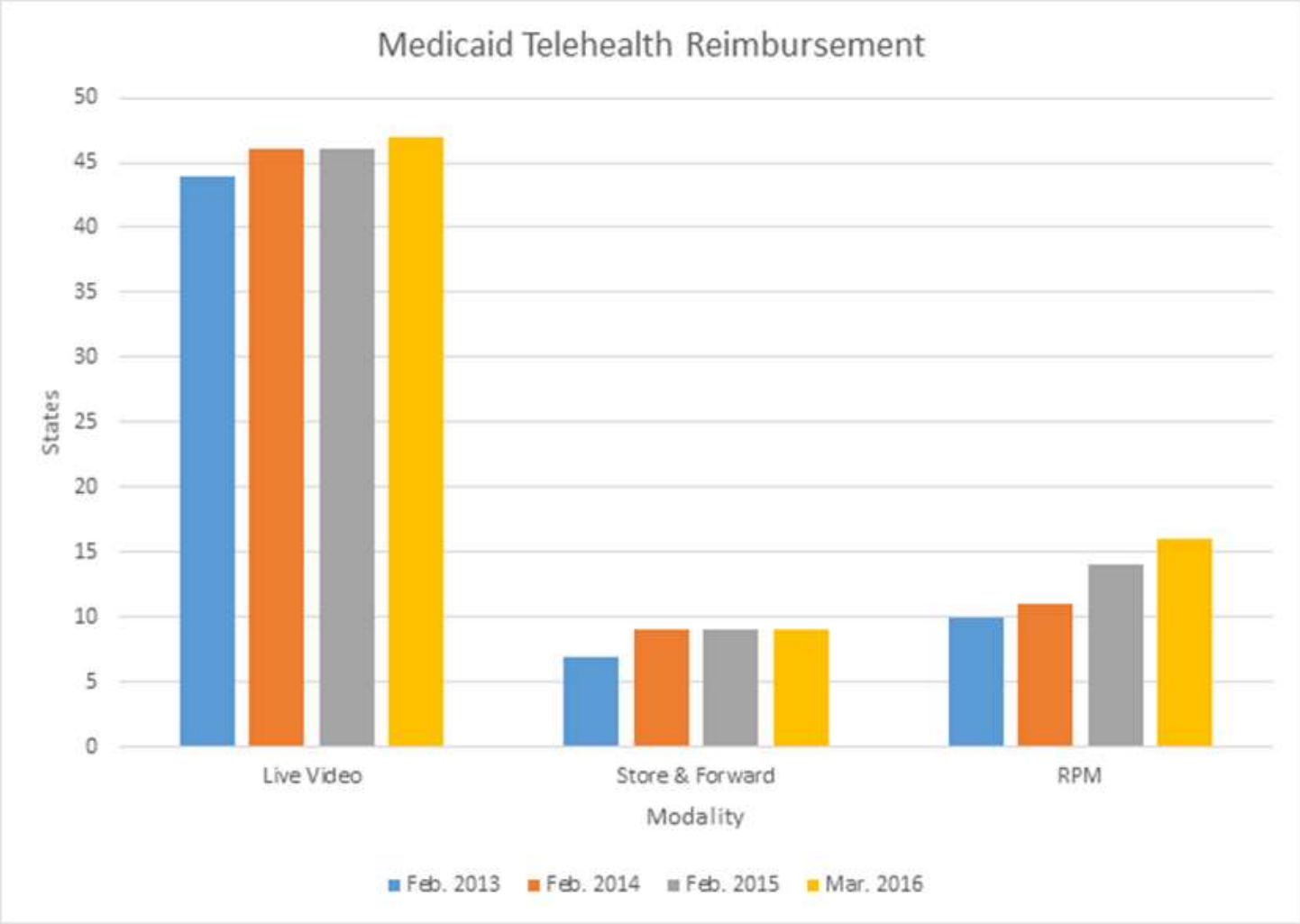
Reimbursement:
Live Video: 47 states

Store and Forward
Only in 9 states

Remote Patient Monitoring
16 states

Reimburse for all three: Only **5** states

MEDICAID REIMBURSEMENT TRENDS

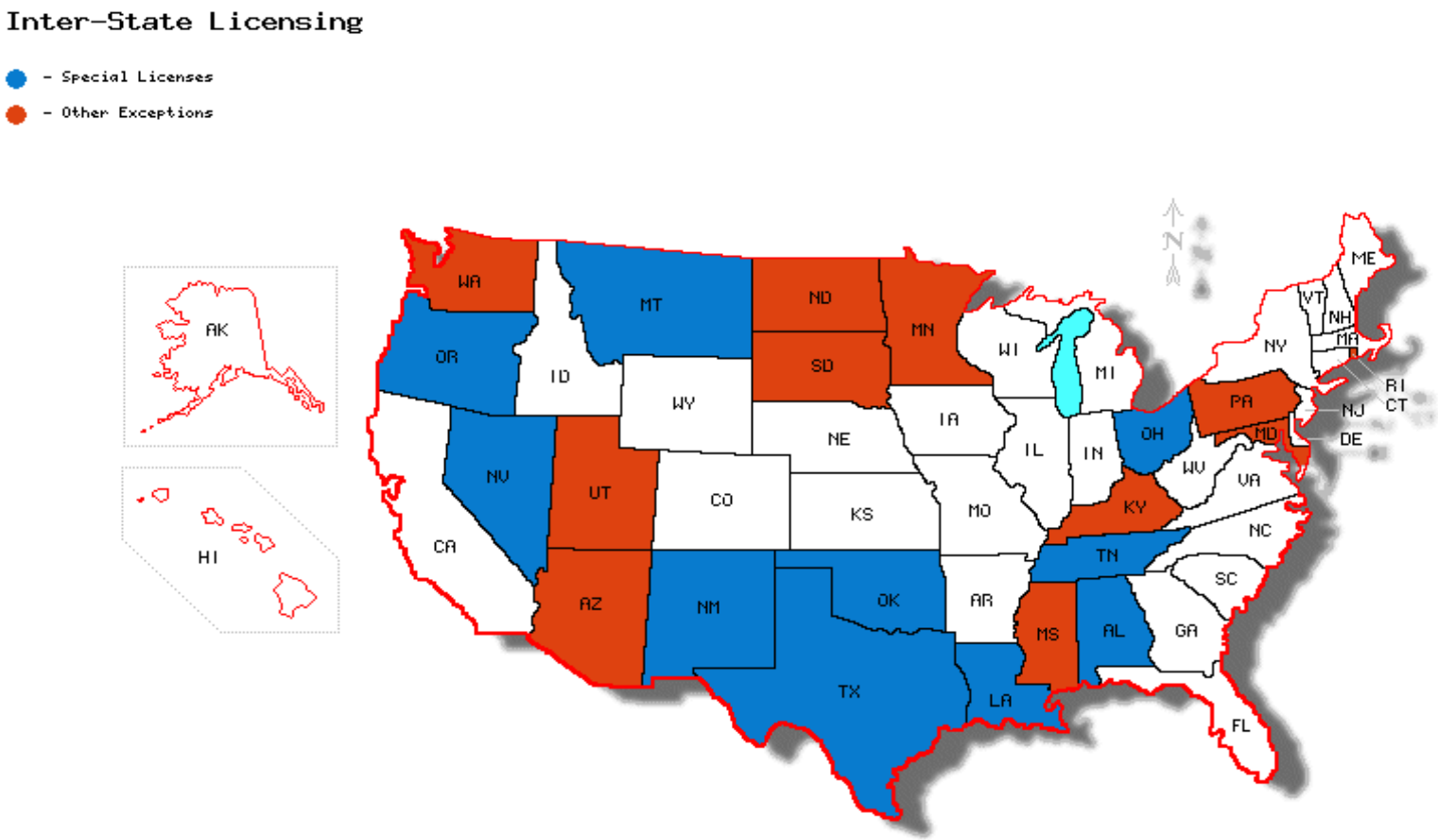


CROSS-STATE LICENSING
FSMB INTERSTATE LICENSURE COMPACT

- Created an **Interstate Commission** to implement an expedited medical licensure process
- Current status (7 state minimum) **17** states have now passed the language
& 8 states have pending legislation

- Does **not** allow license portability

CROSS STATE LICENSING LAWS/REGS



Source: diymaps.net (c)

Attachment #10

PARITY IN PAYMENT WITH IN-PERSON

27 states and DC

have active telehealth private payer laws

This is the most common policy change at the state level!

Parity is difficult to determine:

-Parity in services covered vs. parity in payment

-many states make their telehealth private payer laws

"subject to the terms and conditions of the contract"

LEGISLATION IN 2016

158 telehealth related bills

introduced in 30 states

Most common legislation addresses:

- **Reimbursement**
- **Telehealth professional standards (need for in-person exam, prescribing, etc.)**
- **Cross-State Licensing**

All Incremental Approaches to Needed Change

STATE POLICY BEYOND LEGISLATION:

- **Regulatory** and administrative actions still needed to fully implement legislation
- **Courts** also play a role in interpretation of legislative policy
- Professional **licensing** boards can limit the benefits of legislation

Non-Medical Licensing Board Actions

- Texas Occupational Therapy Board: Last year passed a regulation allowing telehealth to be used to **supervise** non-licensed staff.
- Colorado Medical Services Board: Allows **supervision** of RNs at a Local Public Health Agency to give vaccinations by a supervising provider to occur via telemedicine.
- Colorado Dental Board (proposed): Requires a dentist who **supervises** a dental hygienist that provides interim therapeutic restoration under telehealth supervision to have a physical practice location in Colorado for purposes of patient referral for follow up care.

Typical Language in Standards

- Must conform to scope & standards of practice
- Must comply with other laws/regs
- Must properly identify patient
- Must obtain some type of informed consent
- Must have a system in place to address medical or clinical emergencies
- Must meet technology standards/HIPAA

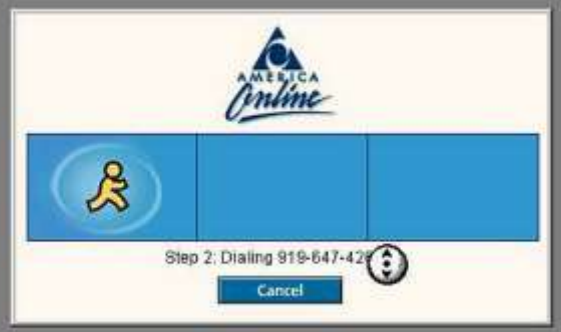
FEDERAL TELEHEALTH POLICIES

Attachment #10

POLICY DEVELOPS MORE SLOWLY THAN TECHNOLOGY

FEDERAL MEDICARE TELEHEALTH POLICY:

- Title XXIII of the Social Security Act established **Medicare** in July, **1965**
- **42 USC 1395m** of the Social Security Act added in **2000** provides the basic telehealth coverage for fee-for-service Medicare beneficiaries—few amendment since.



Attachment #10

FEDERAL MEDICARE TELEHEALTH POLICY: OUTDATED &DISCRIMINATORY

- Reimbursement is available for only a limited number of Medicare Part B services
- Reimbursement limited to ***live video only as medical visit***
- This **originating site** must be a medical facility and **not** the patient'shome.
- Can ***only*** occur when the originating site is in a defined **rural area**:
  - a Health Professional Shortage Area (HPSA), a county outside of any Metropolitan Statistical Area (MSA), or an AK/HI demonstration project

MEDICARE & ADVANTAGE PLANS

- Nearly 20 years after such videoconferencing technology has been available for health services, fewer than **one percent** of Medicare beneficiaries use it- less than 1% of Medicare Expenditures.
- Anthem and a University of Pittsburgh Medical Center Health Plan in western Pennsylvania are the **only two** Medicare Advantage insurers offering the virtual visits 6/15

Next Generation ACO-
Breakthrough for Telehealth

- Greater access to home visits, telehealth services, and skilled nursing facilities;
- "benefit enhancements" allow circumvention of Medicare rules that go beyond benefits of Medicare Advantage -Alternative Payment Model
- Would allow ACOs to utilize the technology *regardless of a patient's geographic location*.
- Only 20 Pilots in first two years

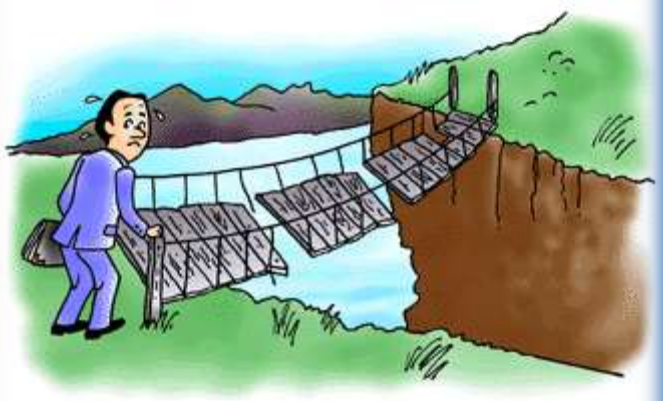
MedPAC: POTENTIAL POLICY PRINCIPLES IF TELEHEALTH COVERAGE IS EXPANDED

- **FFS-**Cover services with low potential for unnecessary use (e.g., tele-stroke)?
- Allow **primary care** providers to offer more telehealth under **PMPM** payment?
- **Bundled payment/ACOs**: Expand coverage if providers at risk for total spending for episode or population?
- **MA**: Allow plans to include supplemental telehealth services in bids?

AFFORDABLE CARE ACT: MOVING FROM VOLUME TO VALUE

Volume-based

- Pay for service (volume)
- Cost-based reimbursement
- Hospital/physician independence
- Inpatient focus
- Stand-alone care systems
- Illness care



Value-based

- Pay for results (quality/efficiency)
- Shared risk
- Partnerships and collaborations
- Continuum of care
- Community health improvement (HIT)
- Wellness care

Physician-centric → Consumer-centric

Federal Legislative Landscape 2016

- **HR 2066 (Rep Harper) Telehealth Enhancement Act of 2015:**
  - Authorizes an Accountable Care Organization to include coverage of telehealth and remote patient monitoring as supplemental health care benefits to the same extent as in a Medicare Advantage plan
  - Recognizes telehealth services and remote patient monitoring in the national pilot program on payment bundling
  - Includes additional originating sites for telehealth care (but without receiving payment of a facility fee): any critical access hospitals, sole community hospitals, home telehealth sites, as well as others
- **HR 3081 & S 1778 (Rep Nunes) TELEmedicine for MEDicare Act of 2015:**

  Allows a Medicare participating physician to provide services across state lines via telehealth to a Medicare beneficiary ***without being licensed in the beneficiary state***, as long as the provider holds a valid license in their own state.
- **S 2484 (Senator Schatz) The CONNECT for Health Act:**
  - Would require telemedicine or RPM bridge demonstration waivers
  - Would eliminate some of the current Medicare restrictions for bridge demonstrations
- **HR 2948 (Rep Thompson) Medicare Telehealth Parity Act of 2015:**
  - Phased-in approach to expand eligible facilities and eliminate geographic restrictions
  - Expand eligible providers and services

Congressional Budget Office

- Estimated cost savings of telehealth expansion in Medicare Advantage Plans over a decade: **$0 vs** White House estimate of **$160 million**
- Leaders of the Finance Committee's chronic care work are looking for good research on cost to impact CBO "score" this fall.

Federal Health IT Strategic Plan Recently Added TH Strategies

- Increase the use of telehealth, virtual medicine, and innovative technologies (e.g., sensors, mobile technology, medical devices, assistive technologies, eVisits) in Federal care delivery systems and programs
- Incorporate telehealth and mobile health technologies and services within Federal programs providing or paying for health care
- Increase access to broadband connectivity for health IT applications, such as high-resolution imaging, telehealth, and mobile health

MACRA and TELEHEALTH

Directed Medicare to develop programs that would reimburse providers through either:

- Alternate Payment Methods(APMs) with bundled payments for a specific episode of care, shared savings with or without shared financial risk, global payments, or

- More global payment contracts that focus on demonstrating high-quality performance and patient satisfaction

- A Merit-Based Incentive Payment System (MIPS) that would adjust a provider's payment based on high-quality performance, resource use, use of an ONC-certified EHR system, and demonstration of clinical practice improvement (CPI) activities that could include use of *telehealth*

THANK YOU-FOR MORE INFORMATION PLEASE VISIT OUR WEBSITE:

WWW.CCHPCA.ORG

MARIOG@CCHPCA.ORG

Telemedicine

Oregon Medical Board

Kathleen Haley, JD
Executive Director

Attachment #10

What is Telemedicine?

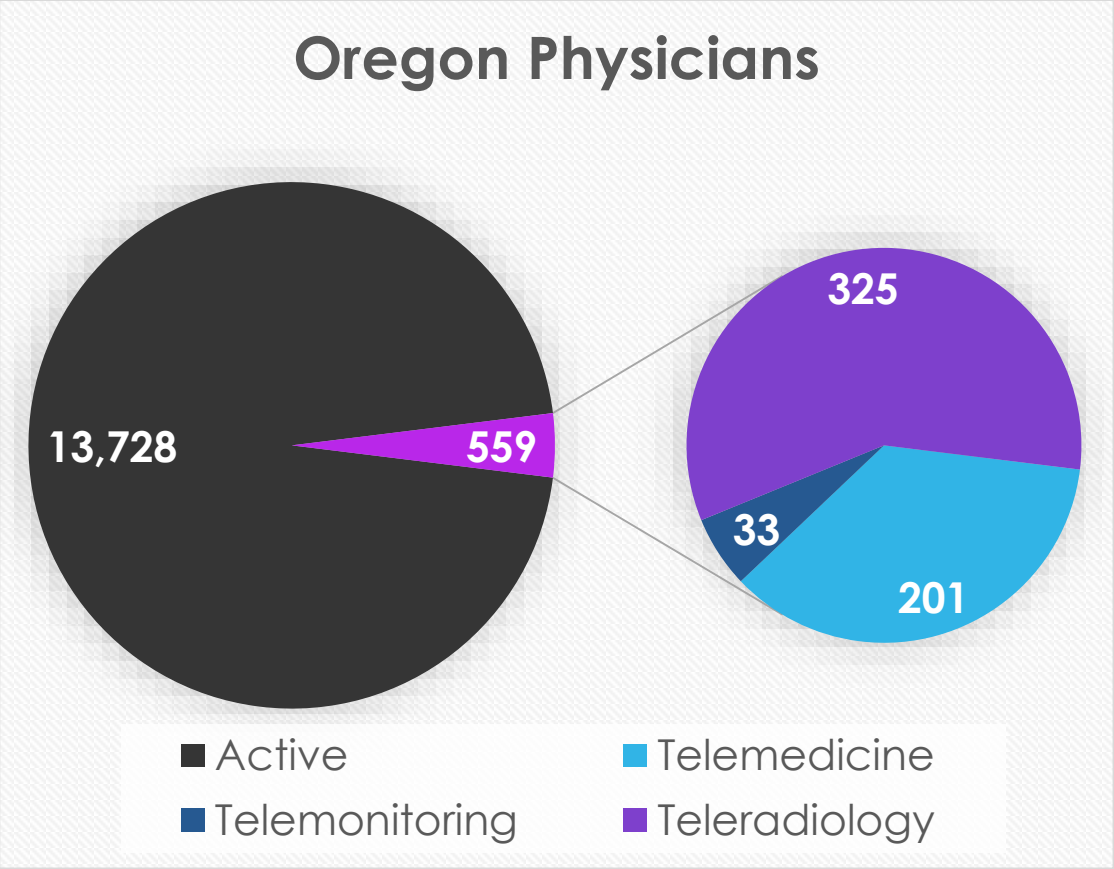
- Direct rendering of a diagnosis or treatment to a patient by electronic means
- Telemedicine occurs *intra*-state and *inter*-state

Tenets of Telemedicine

- Practice of medicine occurs where the patient is located
- Health care professional (physician) must be licensed in the state
- Care is held to the same standard as in-person care

Oregon Licensure

- Full active license allows physician to practice telemedicine intrastate
- For health care professionals outside of Oregon:
  - Telemedicine license
  - Teleradiology license
  - Telemonitoring license



Attachment #10

Statement of Philosophy: Telemedicine

The Oregon Medical Board considers the full use of the patient history, physical examination, and additional laboratory or other technological data all important components of the physician's evaluation to arrive at a diagnosis and to develop therapeutic plans. In those circumstances when one or more of those methods are not used in the patient's evaluation, the physician is held to the same standard of care for the patient's outcome.

Adopted January 2012

www.oregon.gov/omb/board/philosophy/Pages/Telemedicine.aspx

Oregon Reimbursement

Senate Bill 144 (2015)

- Health plans must cover telehealth services if:
  - Synchronous, two-way interactive video conferencing is used,
  - Service is covered when provided in person,
  - Service is provided safely and according to standard of care, and
  - Privacy and security laws are maintained.
- The patient does not need to be at a health care facility.

The mission of the Oregon Medical Board is to ensure the health, safety, and wellbeing of Oregon citizens by regulating the practice of medicine in a manner that promotes access to quality care.

Kathleen Haley, Executive Director
Kathleen.Haley@state.or.us

The Virtual Dental Home: An innovative and effective system for providing dental care

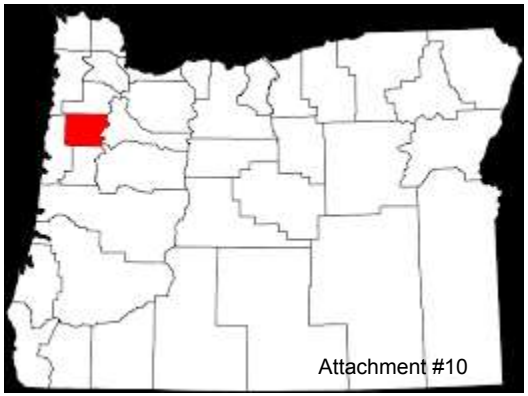
Linda Mann, EPDH
Director, Community Outreach, Capitol Dental Care

Attachment #10

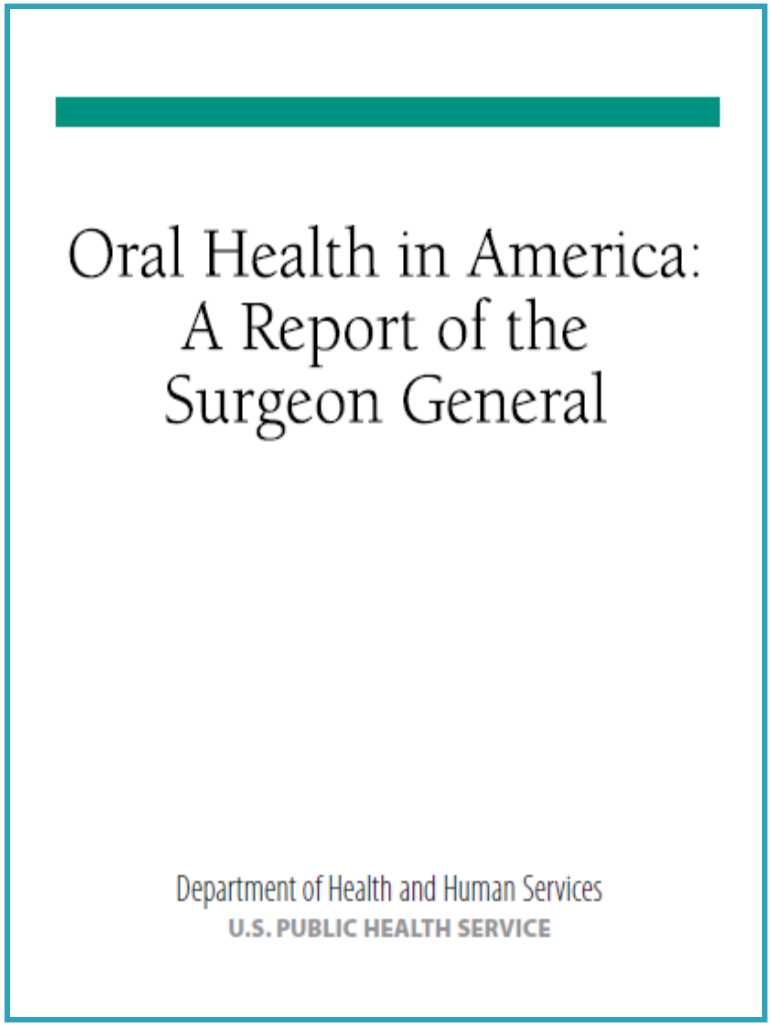
The Virtual Dental Home

Attachment #10

Collaboration between Capitol Dental Care, OHSU, and the University of the Pacific to provide access to dental care for children in the Central School District in Polk County, Oregon.



Underserved Populations


Oral Health in America:
A Report of the
Surgeon General

Department of Health and Human Services
U.S. PUBLIC HEALTH SERVICE

Attachment #10

CDA JOURNAL, VOL 40, NO

The Virtual Dental Home: Bringing Oral Health to Vulnerable and Underserved Populations

PAUL GLASSMAN, DDS, MA, MBA; MAUREEN HARRINGTON, MPH; MAYSA NAMAKIAN, MPH; AND PAUL SUBAR, DDS, EDD

ABSTRACT Large and increasing oral health disparities in the U.S. population led the Institute of Medicine to call for expanded research and demonstration of delivery systems that test new methods and technologies. These new methods include delivering oral health services in nontraditional settings, using nondental professionals, expanded roles for existing dental professionals and new types of dental professionals, and incorporating telehealth technologies. The virtual dental home is a system that demonstrates the characteristics called for by the IOM.

Project Aims:

1. Demonstrate the ability to create and deploy telehealth-connected oral health teams capable of reaching children who have not been receiving dental care on a regular basis and providing community-based dental diagnostic, prevention and early intervention services;

2. Undertake on-site data collection for diagnostic records and preform preventive procedures designed to keep children from developing advanced dental disease;

Project Aims continued:

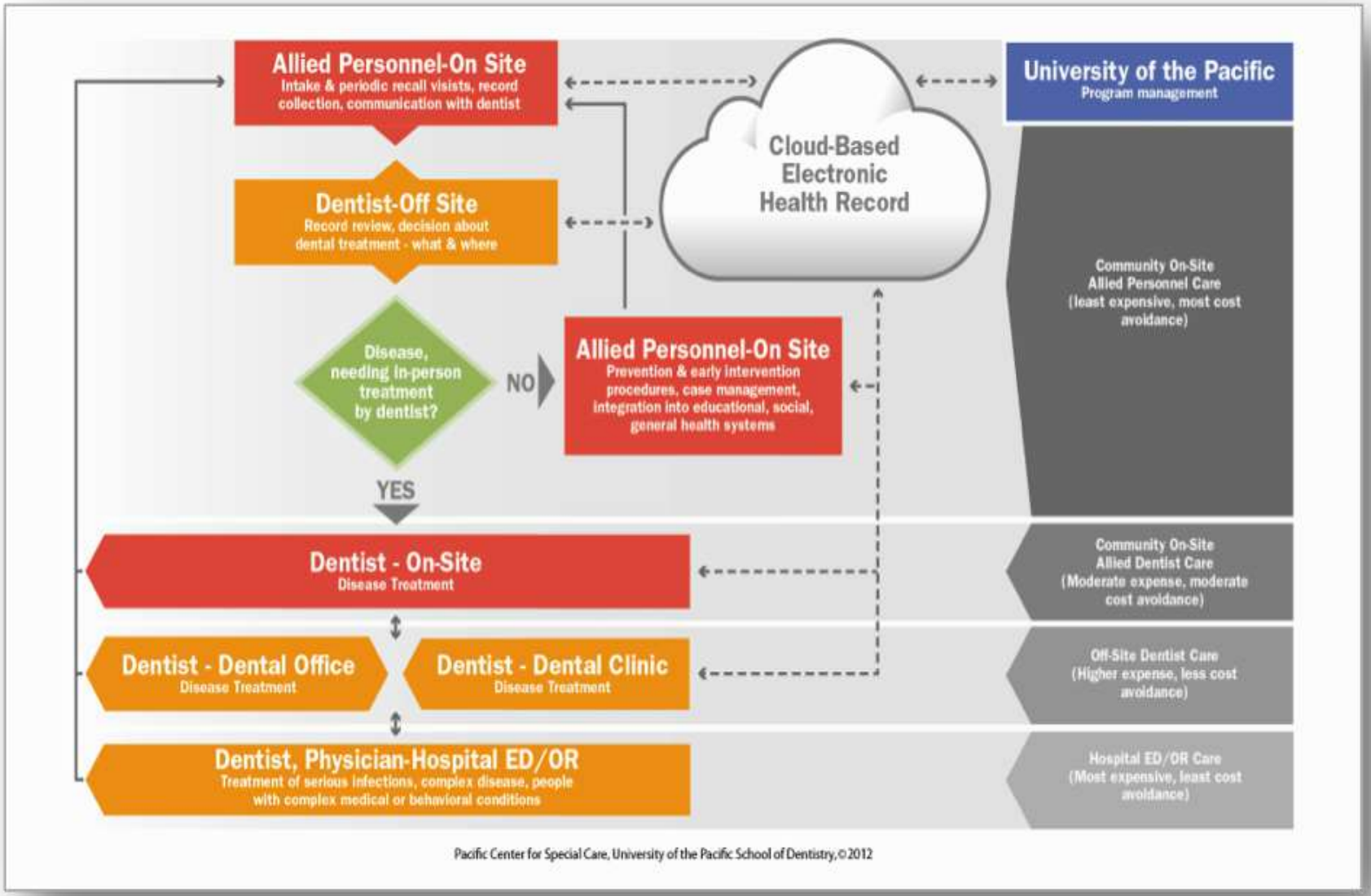
3. Demonstrate a reduced need for most children to be seen by dentists in stationary dental practices or clinics (the Virtual Dental Home);

4. Achieve the Triple Aim in oral health care in Oregon with people having better experiences of care, better oral health and doing so at a lower the cost per-capita; and

5. Develop lessons that can be used to disseminate the Virtual Dental Home concept throughout Oregon.

Measures and Targets

Measures	Target	Actual
Distribution and collection of consent forms.	70% consent forms are returned	83%
Percent of children who receive prevention services in the school setting.	75% of children with "yes" consent form receive prevention services.	90%
By June 2016, 60%(---) of children receiving tele-dentistry services maintain oral health in their school setting.	60% of children seen maintain health in school setting.	47%
Demonstrate the viability of this method or providing care.	Target date 7/2016	Goal achieved



Attachment #10

EHR: Radiographs

Denticon!3.5 :: - Patient Window -:: Welcome, PGLASSMAN :: - Windows Internet Explorer

https://www.denticon.com/Imaging/ASPX/xray.aspx

Scheduler | Patient | Transactions | Charting | Reports | Utilities | Setup | Office [redacted] | Help | Logout

Patient

DentiRay

Patie[redacted]
(H) : BD :
(C) :
(W) :

Type

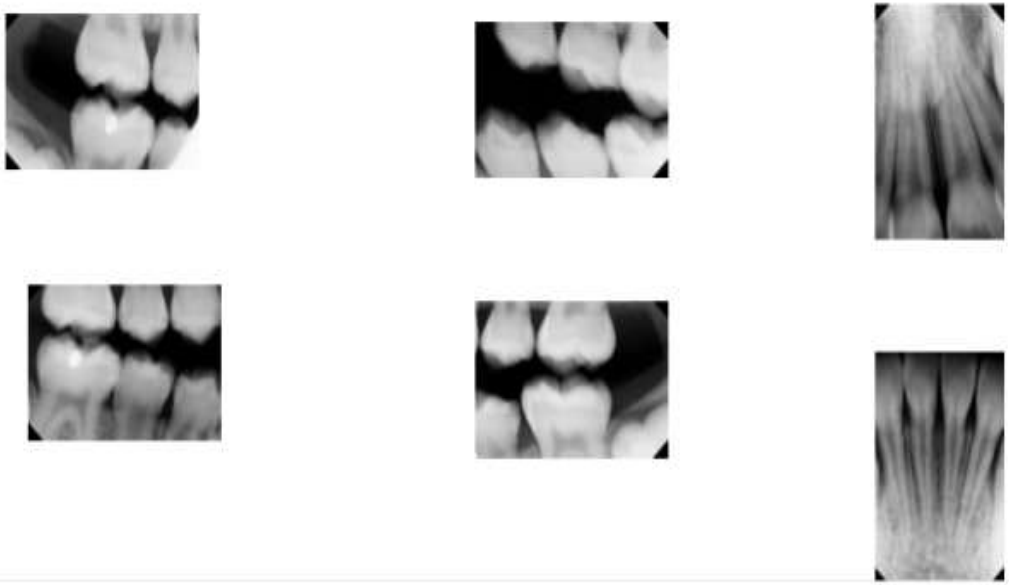
Patient ID: 477
Age/Sex: / F
First Visit: 11/29/2010
Last Visit: 03/28/2011

Responsible: [redacted]
Balance: 35.00 BD :
Est Ins: 0.00
Est Pat: 35.00

Prim. Ins:

Ben Rem: 0.00
Ded Rem: 0.00

X-Ray | Capture | Presentation



Select Series: Study 03232011 | Print Series | Delete Series | Move Series

Attachment #10

Denticon!! :- Patient Window -:: Welcome, CHAEKIM@MSN.COM :: - Internet Explorer provided by Dell

https://www.denticon.com/ASPX/Charting/PatChartNew.aspx

Scheduler Patient Transactions Charting Reports Utilities Setup Office Los Angeles Help Logout

Members Print Patient

Patient Chart

Patient:Mouse, Mickey M
(H) : 714-555-1212
(C) : 714-555-1213
(W) : 800-555-1212

Type Patient ID 100
CA Age/Sex: 55 / M
MD First Visit: 11/29/2004
RT Last Visit: 01/12/2009

Responsible:Mouse, Mickey M
Balance: 5835.40
Est Ins: 2838.10
Est Pat: 3001.30

Prim. Ins:Delta Dental of Cali
949-555-1212
Ben Rem: 0.00
Ded Rem: 0.00

Change Dentition View Chart as on 1/12/2009 Clear Selection Add Note Progress Notes Perio

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

Pre-existing Compl. Proc. Treat. Plans

Decay Restorative Crown Bridge Implant Denture Missing Impacted Erupted Watch

Pre-existing Conditions

Delete...

Type	Date	St	Code	Description	Th	Surf	Est. Ins.	Fee	Office
LEDGER	10/27/2008		D2140	Amalgam One Surface Perm/Prim	3	M	$0.00	$84.00	LA
LEDGER	10/27/2008		D2140	Amalgam One Surface Perm/Prim	4	M	$0.00	$84.00	LA
LEDGER	10/27/2008		D2140	Amalgam One Surface Perm/Prim	5	M	$0.00	$84.00	LA
LEDGER	10/27/2008		D2140	Amalgam One Surface Perm/Prim	6	M	$0.00	$84.00	LA
LEDGER	10/27/2008		D2140	Amalgam One Surface Perm/Prim	7	M	$0.00	$84.00	LA
LEDGER	10/27/2008		D2140	Amalgam One Surface Perm/Prim	8	M	$0.00	$84.00	LA
LEDGER	10/27/2008		D2140	Amalgam One Surface Perm/Prim	9	M	$0.00	$84.00	LA
LEDGER	10/27/2008		D2140	Amalgam One Surface Perm/Prim	10	M	$0.00	$84.00	LA
LEDGER	10/27/2008		D2140	Amalgam One Surface Perm/Prim	11	M	$0.00	$84.00	LA
LEDGER	10/27/2008		D2140	Amalgam One Surface Perm/Prim	12	M	$0.00	$84.00	LA
LEDGER	10/27/2008		D2140	Amalgam One Surface Perm/Prim	13	M	$0.00	$84.00	LA
LEDGER	1/12/2009		D2140	Amalgam One Surface Perm/Prim	2	M	$0.00	$84.00	LA

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Done Internet | Protected Mode: On 100%

Attachment #10

EHR: Photographs

Attachment #10

EHR: Photographs

Denticon!3.5 :- Patient Window -:: Welcome, PGLASSMAN :: - Windows Internet Explorer

https://www.denticon.com/imaging/aspx/xray.aspx

Scheduler Patient Transactions Charting Reports Utilities Setup Office [redacted] Help Logout

Patient

DentiRay

Patient [redacted] Type Patient ID 477 Responsible [redacted] Prim. Ins:
(H) : BD : Age/Sex: / F Balance: 35.00 BD :
(C) : First Visit: 11/29/2010 Est Ins: 0.00 Ben Rem: 0.00
(W) : Last Visit: 03/28/2011 Est Pat: 35.00 Ded Rem: 0.00

X-Ray Capture Presentation

Select Series: Study 02092011 Print Series Delete Series Move Series

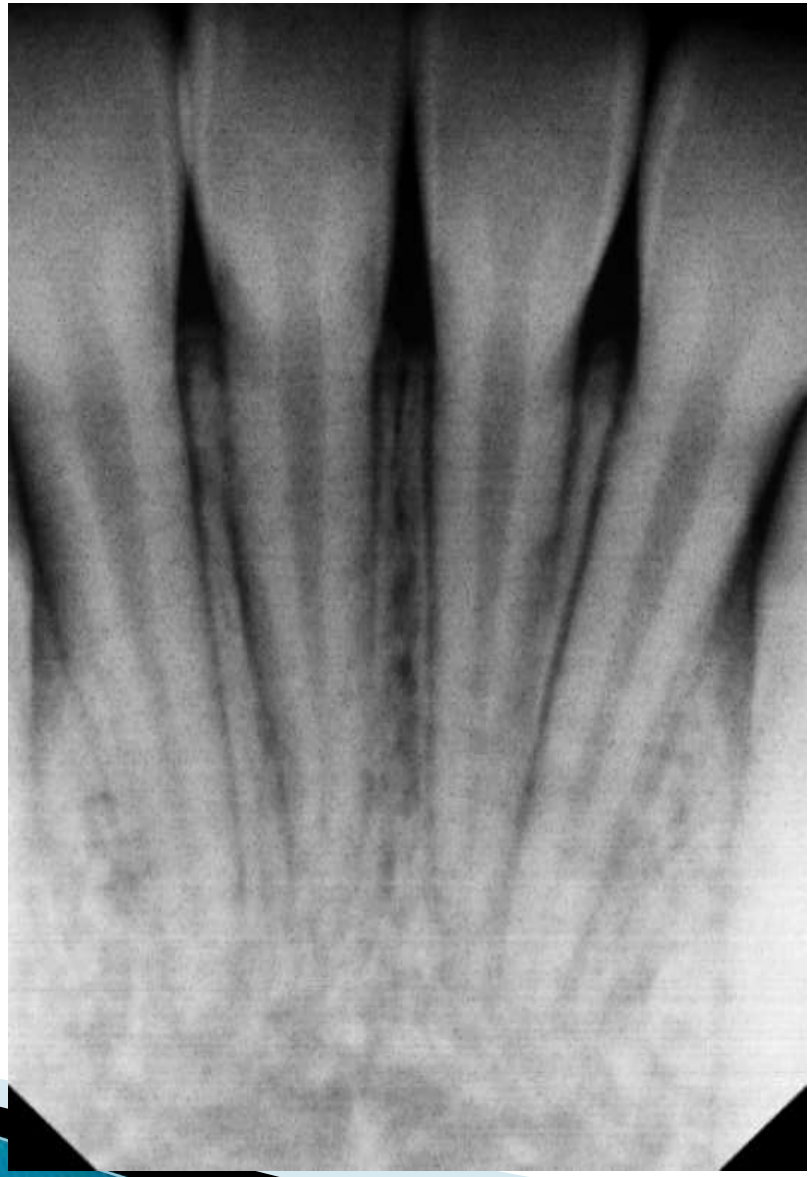
Attachment #10

EHR: Photographs

Attachment #10

EHR: Radiographs

EHR: Radiographs



Attachment #10

EHR: Risk Assessment

Denticon!3.5 ::- Patient Window -:: Welcome, PGLASSMAN :: - Windows Internet Explorer

https://www.denticon.com/ASPX/Patients/PatCarriesRisk.aspx

Scheduler | Patient | Transactions | Charting | Reports | Utilities | Setup | Office: Pacific Center For Special Care | Help | Logout

Members | Print | Patient

Add New Patient Caries Risk Assessment

Patient: Kin[redacted]	Type	Patient ID	109	Responsible: [redacted]	Prim. Ins:
(H): BD: [redacted]	TP	Age/Sex:	44 / M	Balance: 0.00 BD [redacted]	
(C):		First Visit:	07/30/2009	Est Ins: 0.00	Ben Rem: 0.00
(W):		Last Visit:	09/09/2010	Est Pat: 0.00	Ded Rem: 0.00

Date: 4/10/2011

Diagnosed Risk Level: Medium Risk Level (Score: 4)

Disease Indicators	Risk Factors	Protective Factors
☑ Visible cavities	☑ Visible heavy plaque	☑ Fluoride toothpaste daily
☐ Proximal lesions not in dentin	☑ Frequent snacking	☐ Fluoride rinse daily
☑ Smooth surface white spots	☑ Deep pits and fissures	☐ Hx of Peridex use
☐ Restorations in last 3 years	☐ Acidic pH	☐ Office fluoride in the last 6 months
	☐ ATP (>1,499)	
	☐ Xerostomia	

Save... | Cancel

Attachment #10

Future plans

- Continuation of program in Polk County.
- Extend this model of care into other communities.
- Perform financial outcomes assessment
- Consider changes to payment structure

Successes

- Preventive care provided to 415 students
- Above average (83%) consent form return rate
- Able to keep 47% of the students healthy in the school setting (no need to refer to bricks and mortar office)
- Story of Jose
- Reduced fear of dental appointments

Attachment #10

Challenges

- Technology glitches
- Expectations related to time
- Space limitations
- Follow up care

Lessons learned

- Relationship building and communication are key
- Importance of school involvement
- Differences between Head Start and Elementary school

Telepsychology and Ethical Practice

Alex M. Siegel, J.D., Ph.D.
Association of State and Provincial Psychology Boards (ASPPB)

Attachment #10

Telepsychology

- What is it?
- Is it a new concept or just another mechanism to provide psychological services?
- Do you need specialized training to provide electronic services?
- Do you need to develop a separate ethics code for the telepsychology practice?
- Do you need to develop special competencies?
- How do you deal with different laws in different jurisdictions?

Telepsychology

- Telepsychology is defined … as the provision of psychological services using telecommunication technologies. Include but not limited to:
  - Telephones, mobile devices, interactive videoconferencing, email, chat, texting, and Internet(e.g. self-help, websites, blogs and social media)
- In writing or images, sounds or other data
- Synchronous with multiple parties in real times (videoconferencing, telephone) or
- Asynchronous (email, online bulletin boards, storing or forwarding information) (APA Guidelines)

Federal Telehealth/ Telepsych Policies

- Only Medicare beneficiaries in HPSAs (health professional shortage areas) or Non-MSAs
- Only interactive-video conferencing
- Only approved originating site- not patient's home or non health care setting
- Only approved providers- psychologists
- Only approved CPT codes psychotherapy included
- No separate CPT codes need GT modifier
- Approximately 27 bills introduced in Congress from 2012 to 2015
- Deborah Baker at APA Legal

Practice Considerations: Privacy/Security & Billing

HIPAA compliant technologies (not Skype)

- Encrypted
- Secure (e.g. access controls)
- Transmission quality
- Provide audit trail, breach notification, etc.

Reimbursement policies may vary by payer

- Medicare – Federal rate comparable to in-person, specific requirements for covered telehealth services to be reimbursed
- Medicaid – Varies by state
- Private Payers – Vary by payer, rates vary by payer and state

Federal Telehealth Policies

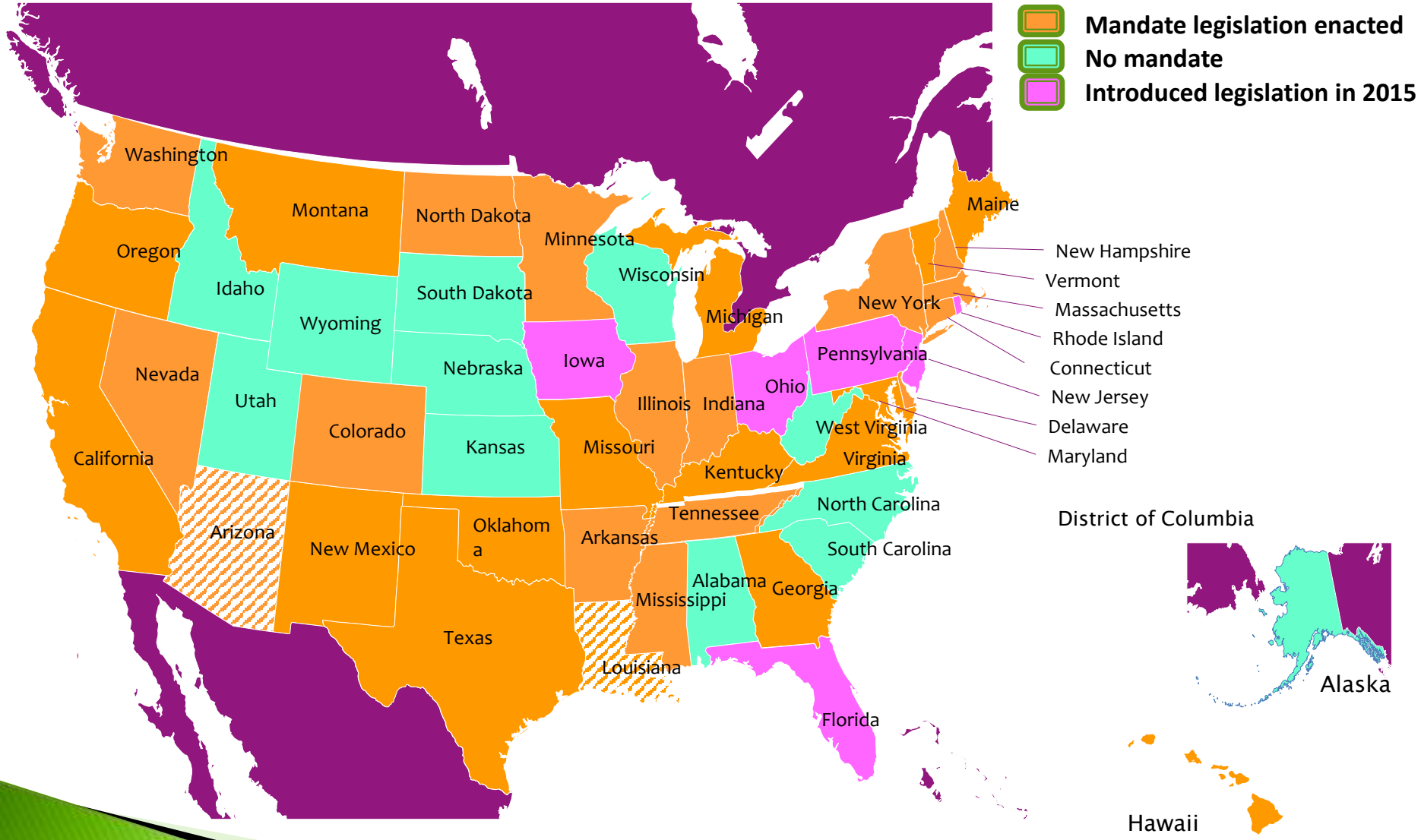
Medicare reimbursement for telehealth services

- Only Medicare beneficiaries in HSPAs or non-MSAs
- Only interactive audio-video conferencing
- Only approved originating sites → not a patient's home or non-health care setting
- Only approved providers → psychologists included
- Only approved CPT codes → psychotherapy services included
- No separate CPT codes → "GT" modifier

Other federal policies

- HR 1832 -- the Service Members Telemedicine & E-Health Portability (STEP) Act enacted in 2011
- Approximately 27 telehealth-related bills introduced, to date, in Congress for 2015-16

State Telehealth Coverage Mandates



American Psychological Association Practice Organization

Attachment #10

State Telehealth Mandates

- To date, 29 states + DC have enacted legislation prohibiting insurance companies from refusing to cover services delivered through telepractice if those same services would be covered if delivered in-person
- But not all require that reimbursement for telepractice be equivalent to services delivered in-person
- Several states allow insurers to limit coverage to providers who are part of an insurer's plan network
- Arizona limits coverage to rural areas whereas Louisiana appears to limit coverage to physician services only
- Telehealth or telemedicine generally defined as live audio-video conferencing (and sometimes, store & forward) -- usually not phone, email or fax
- This state mandate does not apply to any requirements for federal programs such as Medicare.

State Telehealth Practice Policies

Telepractice statutes or regulations

Licensing board advisory opinions

No statutes, regulations or policies

American Psychological Association Practice Organization

Attachment #10

Why Telepsychology?

- Licensing boards want licensees to be licensed in their state, where the patient and psychologist are located to protect the public.
- Psychologists want to be able to practice in cyber space without being licensed.
- Psychologists want to be able to provide better access to care to clients/ patients through the use of telecommunications technologies.
- It is untenable to require psychologists to be licensed in each state due to cost, etc.
- It is equally unrealistic for regulatory bodies to allow psychologists to practice in their state without some type of oversight.

TP Applications

- Assessment/Diagnosis
- Treatment
- Client Education
- Clinical Supervision
- Consultation
- Public education

Advantages of Telepsychology

- Access to specific professionals with special expertise who may be geographically remote;
- Possibility of combining face-to-face and remote care;
- Possibility of more frequent therapeutic contacts to assess treatment compliance, progress, etc.

Advantages of Telepsychology

- Access to clients in rural and otherwise less accessible locations;
- Extended hours of service, with possibility for consistent and continuous care;
- Client may feel less inhibited and more willing to disclose information

Disadvantages to Clients…

- Some presenting problems may be less appropriate for telepsychology;
- Some clients may be less appropriate for telepsychology;
- Capacity for crisis intervention may be diminished; and
- Misunderstandings may arise due to lack of non-verbal cues.

1.Competence of the Psychologist

- Psychologists who provide telepsychological services strive to take reasonable steps to ensure their competence with both the technologies used and the potential impact of the technologies on clients/patients, supervisees or other professionals.
  - Which technology works for each patient
  - Handling emergency situations/resources available in the distant community
  - Using telepsychology for supervision encouraged to consult with others who knowledgeable about the unique issues with telepsychology and local regulations

2. Standard of Care in the Delivery of Telepsychology Services

- Psychologists make every effort to ensure that ethical and professional standards of care and practice are met at the outset and through the duration of the telepsychology services they provide.
  - Apply same ethical standards that are required when providing in-person services
  - Field rapidly evolving, psychologists assess appropriateness of using telepsych during initial assessment (risk/benefits) and medium
    - Geography, cultural, patient competence, mental status
  - Monitor progress to determine if still appropriate

3. Informed Consent

- Psychologists strive to obtain and document informed consent that specifically address the unique concerns related to the telepsychology services they provide.
- When doing so, psychologists are cognizant of the applicable laws and regulations, as well as organizational requirements that govern informed consent in this area.
  - How will patients react
  - Confidentiality, information security and storage
  - Which laws govern

4. Confidentiality of Data and Information

- Psychologists who provide telepsychology services make reasonable effort to protect and maintain the confidentiality of the data and information relating to their clients/patients and inform them of the potentially increased risks to loss of confidentiality inherent in the use of the telecommunication technologies, if any.
  - Don't need to be IT expert but should consult
  - Social media
  - HIPAA Compliant
  - Protecting from Breaches

5. Security and Transmission of Data and Information

- Psychologists who provide telepsychology services take reasonable steps to ensure that security measures are in place to protect data and information related to their clients/patients from unintended access or disclosure.
  - Security of patient records
    - Viruses, flawed software, hackers (informed consent), hard drives problems
    - Develop policies and procedures unique to telepsych for the impact of intended and unintended consequences

6. Disposal of Data and and Technologies

- Psychologists who provide telepsychology services make reasonable efforts to dispose of data and information and the technologies used in a manner that facilitates protection from unauthorized access and accounts for safe and appropriate disposal.
  - Develop P&P to maximally preserve patient confidentiality and privacy
    - Securely dispose of software and hardware

7. Testing and Assessment

- Psychologists are encouraged to consider the unique issues that may arise with test instruments and assessment approaches designed for in-person implementation when providing telepsychology services.
  - Integrity of assessment validity and reliability
  - Adhere to *The Standards for Educational and Psychological Testing* (APA/National Council on Measurement in Education/American Educational Research Association)

8. Interjurisdictional Practice

- Psychologists are encouraged to be familiar with and comply with all relevant laws and regulations when providing telepsychology services to clients/patients across jurisdictional and international borders.

Interjurisdictional Telepsychological Practice

- Which laws to apply?
  - Where psychologist is located?
  - Where patient is located?
  - Which state has jurisdiction?
  - What to do with conflicting laws
    - Duty to Warn
    - Duty to Report
    - Record Keeping

What is a Compact?

- Contract between states
- Effective means of addressing common problems
- Creates economies of scale
- Responds to national priorities
- Retains collective state sovereignty over issues belonging to the states

Why Compacts?

- Legislators understand compacts
- Flexible, enforceable means of cooperation
- States given up rights to act unilaterally but retain shared control
- Not creating a “legal fiction” but creates a law which is binding on the states and participating psychologists

About PSYPACT

- Cooperative agreement enacted into law by participating states
- Interstate compact designed to:
  - Facilitate the practice of psychology using telecommunication technologies (telepsychology) across participating state lines through Authorization to Practice Interjurisdictional Telepsychology(unlimited)

    AND
  - Allow for temporary in-person, face-to-face psychological practice for up to 30 work days per year in each PSYPACT state through Temporary Authorization to Practice

How PSYPACT Works?

- PSYPACT becomes operational when seven states enact PSYPACT into law.
- Psychologists who wish to practice under PSYPACT obtain:
  - E.Passport (certificate for telepsychology)
  - Interjurisdictional Practice Certificate (IPC) for temporary in-person, face-to-face practice
- PSYPACT states communicate and exchange information including verification of licensure and disciplinary sanctions.
- The Commission is the governing body of PSYPACT and is responsible for its oversight and the creation of its Rules and Bylaws.

Benefits of PSYPACT

- Increases client/patient access to care
- Facilitates continuity of care when client/patient relocates, travels, etc.
- Certifies that psychologists meet acceptable standards of practice
- Promotes cooperation between PSYPACT states in the areas of licensure and regulation
- Compact states authority to hold licensees accountable
- Offers a higher degree of consumer protection across state lines
- Promotes ethical and legal interjurisdictional practice

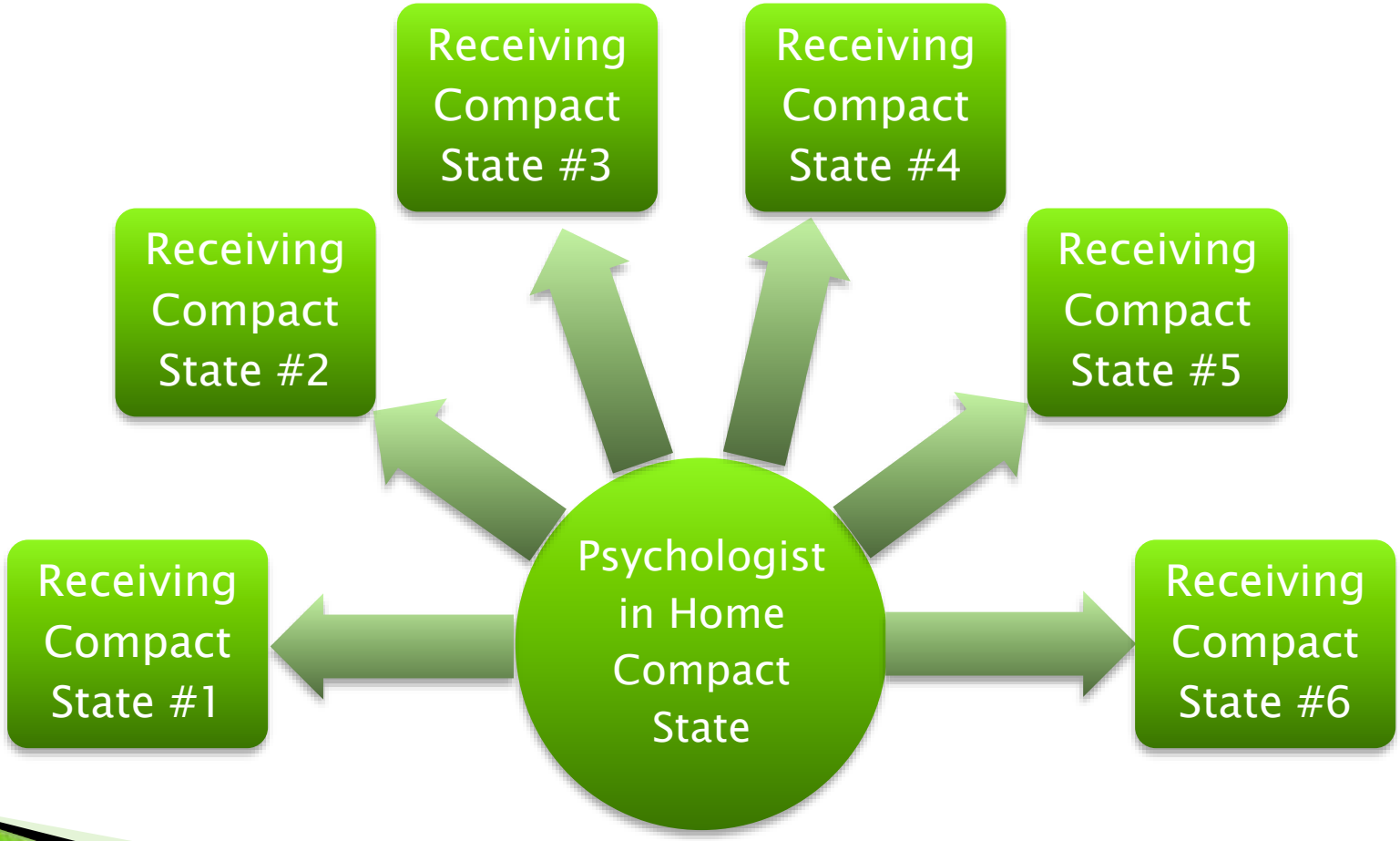
Challenges of PSYPACT

- Needs to be general enough but specific enough since can't change it once adopted
- Not too high of a bar to exclude everyone or too low of a bar of allow everyone
- Degree requirements Masters v. Doctorate
- Does not apply when psychologists are licensed in both Home and Receiving/Distant States
- Does not apply to permanent face to face practice

Authorization to Practice Interjurisdictional Telepsychology

A licensed psychologist's authority to practice telepsychology, within the limits authorized under this Compact, <u>into</u> another Compact State.

How Telepyschological Practice Works under PSYPACT



Attachment #10

Thank you!

Questions? Comments?

Send to
Alex Siegel at
asiegel@asppb.org
or
Janet Orwig at
jorwig@asppb.org

AMERICAN TELEMEDICINE ASSOCIATION

Citizen Advocacy Center 2016 Annual Meeting:

Modernizing the Regulatory Framework for Telehealth

Latoya S. Thomas

September 17, 2016

Attachment #10

About ATA

The American Telemedicine Association (ATA) is the leading international resource and advocate promoting the use of advanced remote medical technologies.

ATA and our members work to fully integrate telemedicine into transformed healthcare systems to improve quality, equity and affordability of healthcare throughout the world.

- Established in 1993
- Over 8,000 members world-wide

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About ATA

Convener

- **13** Special Interest Groups (SIGs)
- **3** Regional Chapters
- **4** Corporate Councils
- **51** State Forums
- Telehealth Conferences
  - **Fall Forum: New Orleans – September 28-30 2016**
  - **Annual Meeting: Orlando – April 2017**
  - **Telehealth Capitol Connection (TCC) Congressional Briefing Series**

Accreditation Program

Practice Guidelines

- **14** e.g. urgent care, mental, rehabilitation, diabetic retinopathy

Public Policy

- Multi-state
- Federal
- International

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21st Century Landscape

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Telehealth in the Home

- **36** state Medicaid plans cover telehealth in the home
- **17** state Medicaid plans cover remote patient monitoring
- **Better health** outcomes and cost savings

- Clinical applications: Primary and urgent care, Skilled nursing, mental and behavioral health, telerehabilitation, obstetrical care and monitoring, long term and post-acute care, chronic disease management

Telehealth in Healthcare Facilities

- Access to specialty care
  - Triage
  - Stroke
  - Dermatology
  - ICU
  - Psychiatry
  - Obstetrics
  - Alcohol and substance abuse counseling
- Hospitals, community health centers, rural health clinics, skilled nursing facilities, provider's office
- Statewide and regional networks of care
- Linguistic and cultural competency
- Care coordination
- Remote image interpretation
- Integrated care

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School-based Telehealth

- **2000** school-based health centers nationally
- **25** million children currently eligible for Medicaid
- **18** state and community-based programs using school-based telehealth
- **18** state Medicaid plans cover telehealth in schools
- Clinical applications: Primary care, mental and behavioral health, dentistry, speech-language therapy

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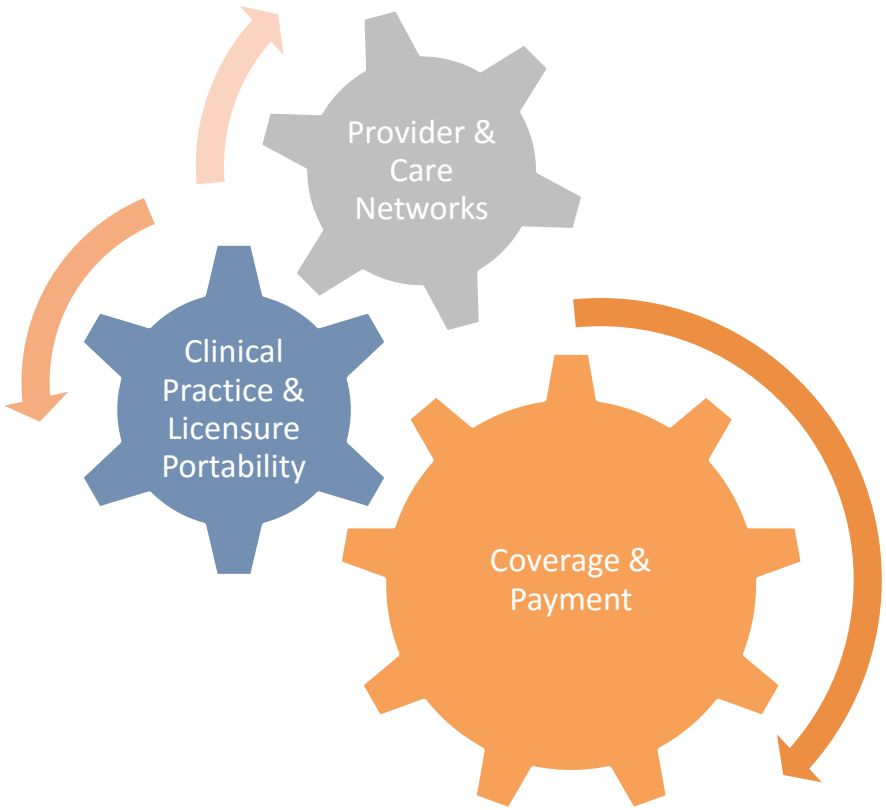
Opportunities & Goals



- **Knock down government barriers**
- **Promote "value" innovative payment and service models**
- **Address care delivery problems: Cost, access, outcomes, productivity**

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Policy Reforms

- Service coverage and reimbursement
  - State regulated plans
  - Federal programs
- Comparable clinical practice standards
- Licensure portability
- State taskforces and workgroups

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Telemedicine in Medicaid

- **Medicaid**
  - **No federal statute or regulation on telemedicine coverage in Medicaid**
  - **States have a lot of flexibility and may offer comparable coverage and reimbursement of telemedicine-provided services to that of in-person – LEVERAGE, LEVERAGE, LEVERAGE**
  - **Telemedicine is not a new service. It is a way of delivering already covered services**
  - **State FOCUS: Reduction in costs and improvements in quality**

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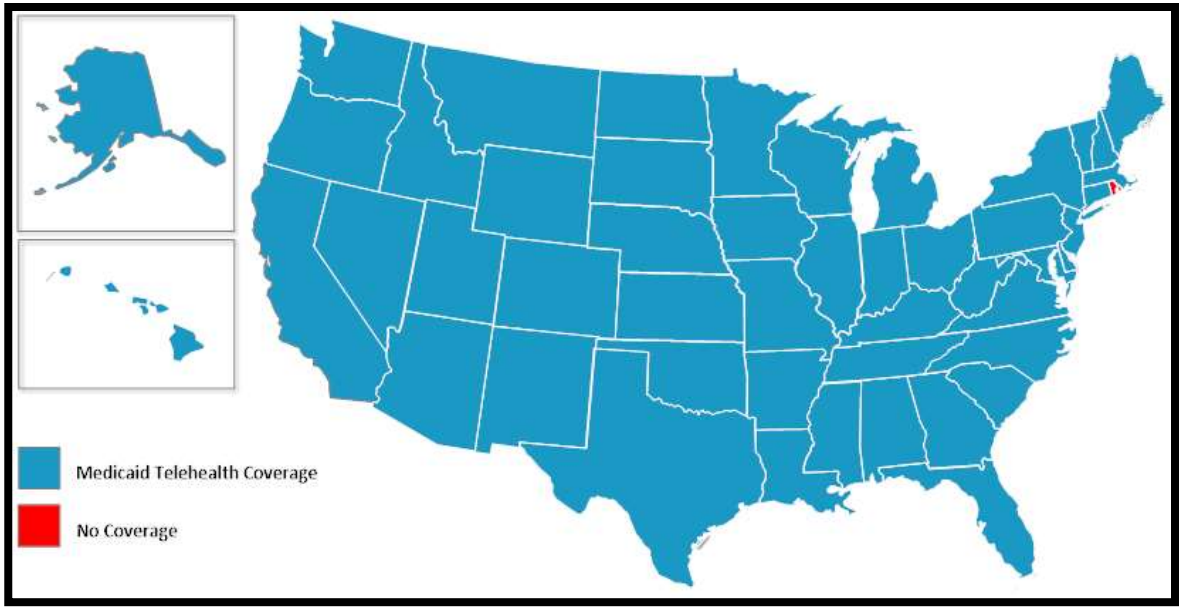
50 State Medicaid Models Today

- **All cover imaging**
- **49 states cover something**
  - **49** telemental health
  - **36** home telehealth
  - **17** remote patient monitoring
  - **12** store-and-forward



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Attachment #10

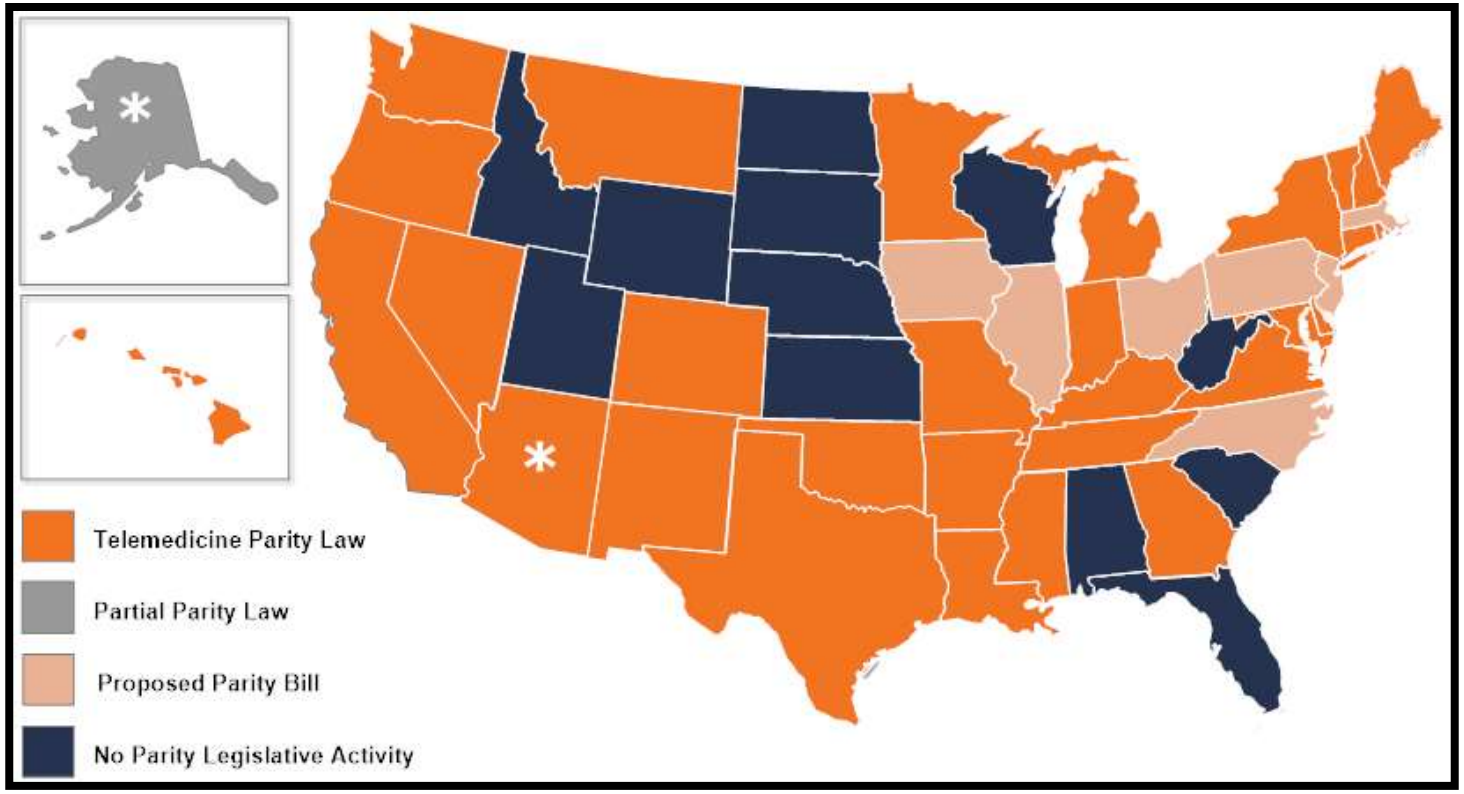
Telemedicine Service Coverage Gaps: Medicaid vs. Medicare

	DE	MS	NV	NM	MEDICARE
Parity	A	A	A	A	**F**
Patient Setting	A	A	A	A	**C**
Eligible Technologies	F	B	F	C	**C**
Distance or Geography Restrictions	A	A	A	A	**C**
Eligible Providers	A	A	A	A	**C**
Physician-provided Services	A	A	B	A	**B**
Mental/behavioral Health Services	A	A	A	A	**B**
Rehabilitation	A	N/A	A	A	**F**
Home Health	B	A	B	B	**F**
Informed Consent	B	B	A	A	**A**
Telepresenter	A	A	A	A	**A**

Source: Thomas, L. & Capistrant, G. American Telemedicine Association. "State Telemedicine Gaps Analysis" January 2016.

Attachment #10

States with Parity Laws for Private Insurance Coverage of Telemedicine (2016)



States with the year of enactment: Alaska (2016)*, Arizona (2013)*, Arkansas (2015), California (1996), Colorado (2001), Connecticut (2015), Delaware (2015), Georgia (2006), Hawaii (1999), Indiana (2015), Kentucky (2000), Louisiana (1995), Maine (2009), Maryland (2012), Michigan (2012), Minnesota (2015), Mississippi (2013), Missouri (2013), Montana (2013), Nevada (2015), New Hampshire (2009), New Mexico (2013), New York (2014), Oklahoma (1997), Oregon (2009), **Rhode Island (2016)**, Tennessee (2014), Texas (1997), Vermont (2012), Virginia (2010), Washington (2015) and the District of Columbia (2013)

States with proposed/pending legislation: In 2016, Illinois, Iowa, Massachusetts, New Jersey, North Carolina, Ohio, and Pennsylvania

**Coverage applies to certain health services.*

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The State of Telemedicine in Your Professional Board

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The State of Telemedicine in Your Professional Board

- **Hold telemedicine to the same standard as in-person care**
  - Remote supervision of other health professionals
  - Establishing a provider-patient relationship
  - Initial and follow-up visits
  - Telepresenter/facilitator
  - Patient informed consent
  - Provider and patient location
  - Technology allowed
  - Prescribing and Dispensing

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Interstate Licensure Models

National Reciprocity
Department of defense
Department of veterans affairs (S 2170 and HR 2516)
Medicare (S 1778 and HR 3081)
Expedited
Federation of State Medical Boards (*FSMB*) – 17 states joined
Alabama, Arizona, Colorado, Idaho, Illinois, Iowa, Kansas, Minnesota, Mississippi, Montana, Nevada, New Hampshire, South Dakota, Utah, West Virginia, Wisconsin and Wyoming.
Mutual Recognition
National Council for State Boards of Nursing (*Enhanced NLC*)
Arizona, Florida, Idaho, Missouri, New Hampshire, Oklahoma, South Dakota, Tennessee, Virginia, and Wyoming
Idaho and Wyoming joined the *APRN Compact*
Association for State and Provincial Psychology Boards (*PSYPACT*) – Needs 7 states
Arizona
Federation of State Boards of Physical Therapy – Needs 10 state
Oregon and Tennessee

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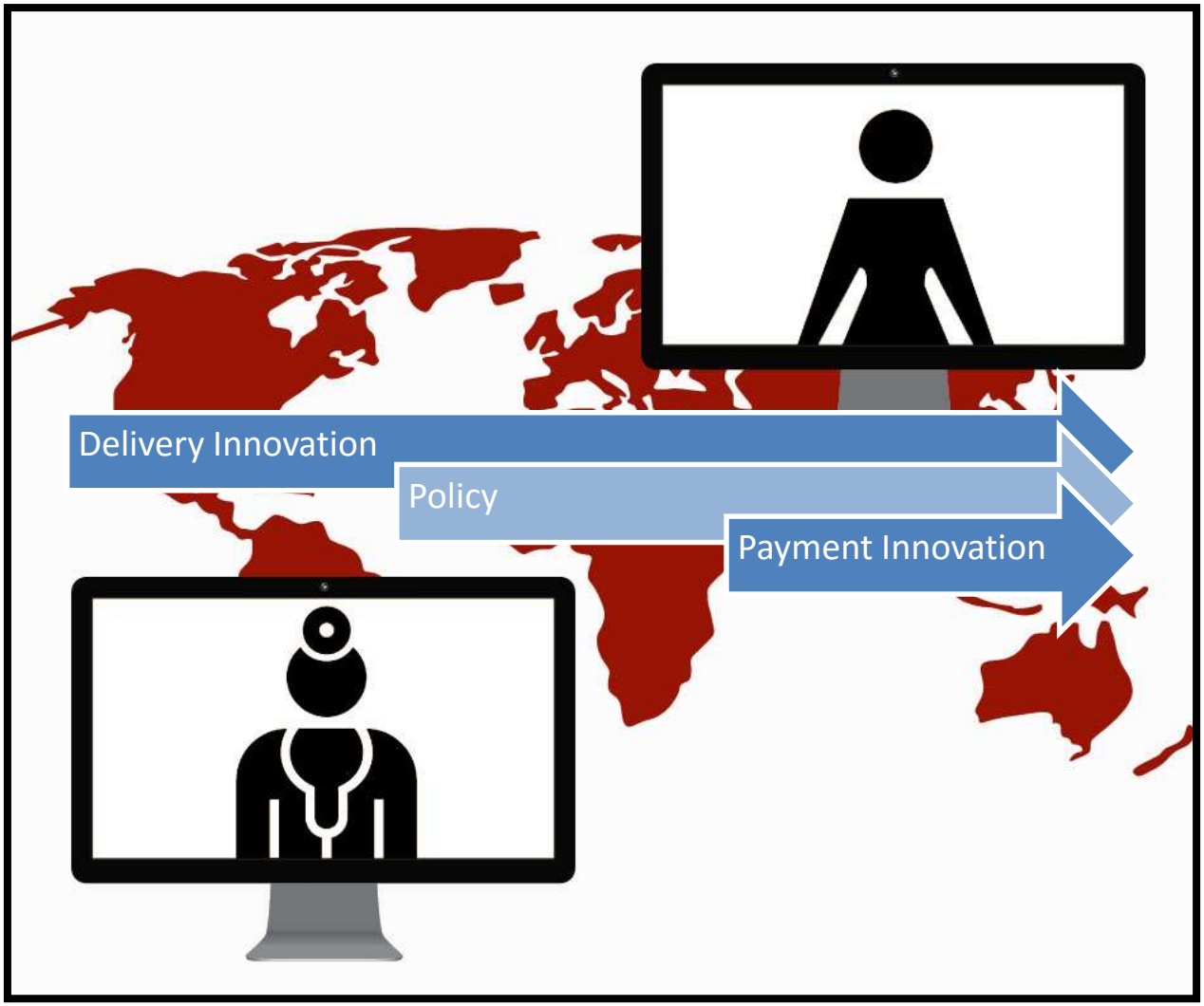
Moving Forward



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ATA State Policy Resources

www.americantelemed.org/policy/state-policy-resource-center

- **2016 ATA Policy Priorities**
- **State Policy Toolkits**
- **State Gaps Analyses**
- **State Legislative Matrix**
- **(Members Only)**
  - State Legislative and Regulatory Trackers
  - Monthly State Webinar
- **State Policy Checklist**
- **ATA Wiki**
- **Telemedicine Practice Guidelines**
- **State Medicaid Best Practices**
  - Telemental and Behavioral
  - Remote Patient Monitoring and Home Video Visits
  - Store-and-forward
  - School-based
  - Managed Care
  - Telestroke
  - High-risk Pregnancies
  - Telerehabilitation

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Save the Date

- **Southeastern State Town Hall**
- **Licensure portability for psychologists, PTs, and nurses**
- **Medicare payment reform**

Attachment #10

OREGON SIM TELEHEALTH PILOT PROJECT GRANTS

Attachment #10

PROCESS

In April 2013, the Center for Medicare & Medicaid Innovation awarded a State Innovation Model grant to Oregon. A portion of Oregon's SIM grant is dedicated to supporting and accelerating state-wide Health Information Technology initiatives.

2014

- OHA partners with ORH to administer
- RFP released (October)
- 67 Letters of Intent received (November)
- 13 invited to submit full proposals (November)
- 12 applications (December)

2015

- 5 projects awarded (January)
- Contracts signed (April)
- Projects begin (delayed: May to October)

2016

- Project implementation through August

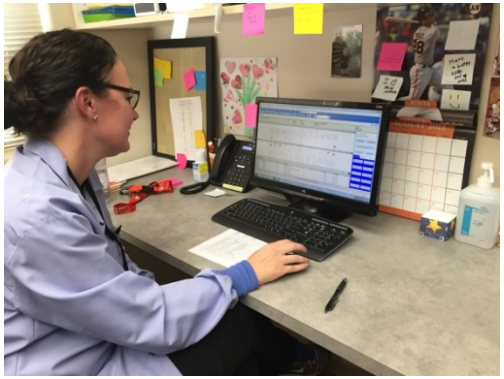
The Virtual Dental Home: An innovative and effective system for providing dental care

Linda Mann, EPDH

Director, Community Outreach, Capitol Dental Care

Attachment #10

The Virtual Dental Home



OREGON HEALTH & SCIENCE UNIVERSITY OHSU

capitol dental SM

UNIVERSITY OF THE PACIFIC
Arthur A. Dugoni School of Dentistry

Underserved Populations

Oral Health in America: A Report of the Surgeon General

Department of Health and Human Services
U.S. PUBLIC HEALTH SERVICE

VIRTUAL DENTAL HOME

CDA JOURNAL, VOL 40, Nº7

The Virtual Dental Home: Bringing Oral Health to Vulnerable and Underserved Populations

PAUL GLASSMAN, DDS, MA, MBA; MAUREEN HARRINGTON, MPH; MAYSA NAMAKIAN, MPH; AND PAUL SUBAR, DDS, EDD

ABSTRACT Large and increasing oral health disparities in the U.S. population led the Institute of Medicine to call for expanded research and demonstration of delivery systems that test new methods and technologies. These new methods include delivering oral health services in nontraditional settings, using nondental professionals, expanded roles for existing dental professionals and new types of dental professionals, and incorporating telehealth technologies. The virtual dental home is a system that demonstrates the characteristics called for by the IOM.

Attachment #10

Project Aims

1. Demonstrate the ability to create and deploy telehealth-connected oral health teams.

2. Undertake on-site data collection

3. Demonstrate a reduced need for most children to be seen by dentists in stationary dental practices or clinics (the Virtual Dental Home);

4. Achieve the Triple Aim in oral health care in Oregon with people having better experiences of care, better oral health and doing so at a lower the cost per-capita; and

5. Develop lessons that can be used to disseminate the Virtual Dental Home concept throughout Oregon.

Challenges

- Expectations related to time
- Space limitations in schools
- Follow up care
- Continued funding for evaluation

Successes

- Preventive care provided to 415 students
- Above average (83%) consent form return rate
- Able to keep 47% of the students healthy in the school setting (no need to refer to bricks and mortar office)
- Reduced fear of dental appointments

Attachment #10

Telemental Health Pilot Project

Trillium Family Services

Grant #148315

Project Period 5/2/2015 – 9/30/2016

Attachment #10

The Perceived Problem

- All of Oregon, except for Clackamas County, Washington County, and parts of Lane County, are designated as Health Professional Shortage Areas for mental health according to the Health Resources and Services Administration.
- Trillium's goal is to discharge clients from their residential programs as soon as clinically appropriate.
  - However, many of their clients are put on waitlists – sometimes for six months – to see a psychiatrist in their community, which is a requirement for their discharge.
- Trillium sought to bridge the gap between their services and clients' physicians in their home communities.
- Additionally, the majority of the children served in Trillium's school-based programs have limited access to mental health services, especially child psychiatry.

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The Plan

- Trillium proposed to identify PRTS, SAIP and SCIP clients from rural areas and partner with the family and treatment team to set-up tele-psychiatry services with a Trillium provider following discharge.

- Trillium planned to support clients in their school-based Outpatient programs to access tele-psychiatry services from their school.

- The client and their Trillium school-based therapist would connect with one of Trillium's child psychiatrist or psychiatric mental health nurse practitioner.

Trillium
FAMILY SERVICES℠

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Implementation

- Some goals of the grant were met, although Trillium did not achieve their original targets on any of the activities.

Grant Activity	Target	Actual	Eligible Referrals
Follow-Up Psychiatry after Discharge from PRTS, SAIP and SCIP	80 clients per year	1 client served	14 clients
OP Psychiatry Services	Up to 300 clients	11 clients served	21 clients
Family Therapy & Visits for Residential Clients	Up to 200 clients	22 clients served	42 clients
Contracting with CCOs & Counties	Up to 19 CCOs & Counties	6 CCOs with agreements, 1 contract in review	n/a

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Challenges

- "You need this"
  (Unshared Perception)

- "But this is what we usually do"
  (Internal Marketing Challenges)

- "We prefer face to face"
  (External Marketing Challenges)

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FAMILY SERVICES℠

Successes

- Youth from secure inpatient program whose community could provide a psychiatrist for three months.
- Several youth received school-based services.
- Inpatient families used equipment for family sessions and visits.
- Telehealth equipment used for legal hearings.

Trillium FAMILY SERVICES℠

Questions? Trillium Contacts

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  - Senior Business Analyst
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- **Melody Kayser, BA**
  - Pilot Project Administrator
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  - (503) 813-7719
- **Lana Shotwell, LPC**
  - VP of Community-Based Programs
  - lshotwell@trilliumfamily.org

Trillium FAMILY SERVICES℠

Telehealth
Pilot Project

Eric Swanson, MBA, NRP
Executive Director
Strategy & Business Development

Adventist Health

Attachment #10

Project Overview

The Telehealth Pilot Project at Tillamook Regional Medical Center pilots the use of telehealth services in providing community-based paramedicine services to individuals in their home setting.

Attachment #10

Project Goal

The project's primary target population is individuals at risk for readmission to the hospital. Our target number visits by August 1, 2016 is 100.

Attachment #10

Why This Project?

Challenges

Lessons Learned

HIV Alliance Telehealth and Collaborative Practice Pilot Project

- **Combines an HIV specialist pharmacist/physician collaborative practice with telehealth consultation for people living with HIV in rural Oregon**
  - Patients meet with HIV specialist pharmacist via HIPAA compliant videoconferencing software
    - Consultations range from 15-60 min
    - Focus on medication adherence to achieve health goals
  - HIV specialist pharmacist uses remote EMR access to communicate with providers, write prescription and labs orders
  - HIV specialist pharmacist coordinates with patient and all of their providers to optimize HIV antiretroviral therapy as well as medications for comorbid conditions

Attachment #10

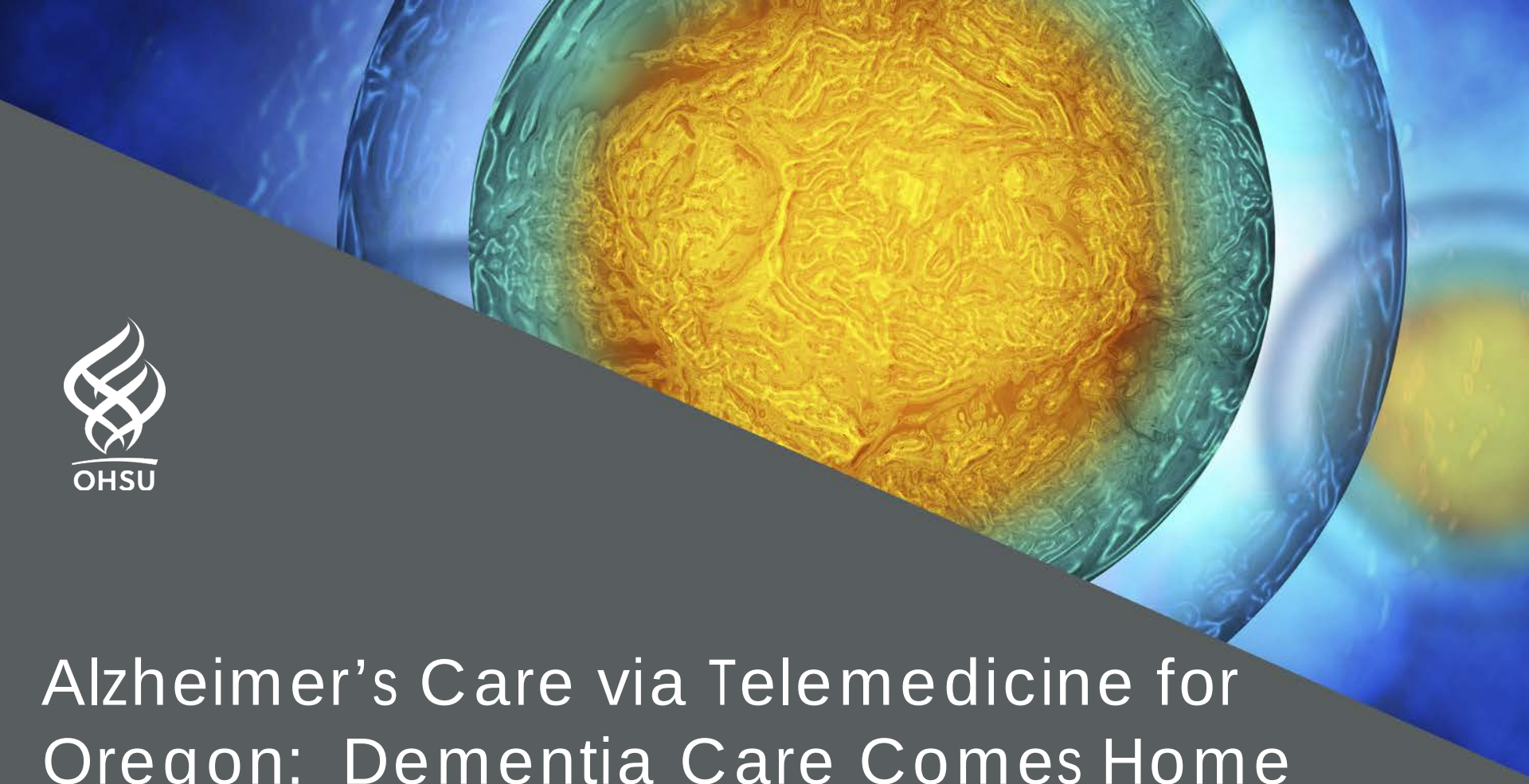
- **Patients living with HIV in rural Oregon face many barriers in their care**
  - Geography-long distances to specialist providers
  - Expertise-rural primary care providers may not be comfortable treating HIV
  - Income-patients can not afford to miss work or travel long distances
  - Multiple comorbid health conditions that increase potential for drug interactions
  - HIV associated stigma in their local community
- **Telehealth and HIV specialist pharmacist services can help mitigate these barriers in a cost effective way**
  - Patients may meet with specialist pharmacist without leaving their home
  - HIV specialist pharmacists are experts in HIV and culturally competent
  - Recognition of unique drug and disease state interactions inherent to HIV
  - Prompt recognition of the need for escalated health care
  - Specialist pharmacists cost less than specialist physicians

- **Primary goal of this project:** improve access to HIV care for people living with HIV in rural areas

- **Goals of this project include:**
  - Improvements in HIV viral load and CD4 count
  - Improvements in HIV and comorbid medication adherence
  - Improved comorbid disease state markers
  - Patient and provider satisfaction
  - Improved patient engagement in healthcare
  - Building a sustainable model of specialist pharmacist services

- **Challenges in implementing this project:**
  - Timeline challenges in recruiting providers
  - Challenges in cross-state medical licensing
  - Physician buy-in to telehealth and collaborative practice
  - Patient recruitment was short of goals

- **Greatest successes of this project:**
  - Demonstrated improvements in viral load and CD4
  - Demonstrated improvements in medication adherence
  - Improvements in lab markers for comorbid disease states
  - Patients were very satisfied with the program
    - 92% of patients felt the pharmacist explained topics so the patient could understand
    - 90% of patients would like to see further clinical pharmacist telehealth services
  - Improved communication with partner providers
  - Negotiated contracts with Coordinated Care Organizations to continue HIV clinical pharmacist services



Alzheimer's Care via Telemedicine for Oregon: Dementia Care Comes Home

Layton Center for Aging and Alzheimer's Disease
Lindauer, A., NP, PhD; Seelye, A., PhD; Lyons, B., PhD; Dodge, H., PhD; Mattek, N., MPH; Mincks, K., BA; Silbert, L., Klein, E., Kaye, J., MD; Erten-Lyons, D., MD

Attachment #10

Background

Attachment #10

ACT-ON

- Two Phases:
  - Phase I: Establishes the reliability of scales used to assess dementia progression and caregiver health
  - Phase II: Establish the feasibility of providing comprehensive dementia care directly to the home

Results

- 37 dyads completed visits conducted by 4 separate providers.
- Test calls took on average 64.1 minutes (range 36-120).
- Feasibility was 98.2%.
- 43% of calls had some degree of technical difficulty.
- 100% of dyads felt they received good care, had good communication and were satisfied with the visit.
- 100% of providers felt that the visit provided high quality care.
- Independent rater review of selected videos, suggest that telemedicine visits can meet AAN quality guidelines for dementia care.

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Lessons Learned & Recommendations

1. It is possible to assess and care for persons with dementia and their caregivers using telemedicine technology

2. Patient perceptions and supervision needs should be considered during caregiver interviews.

3. Sophisticated telemedicine equipment, reliable internet connections, and late-model home computers are needed for successful visits.

4. Health care providers, caregivers and patients need reliable, experienced technical consultants to minimize frustration for all involved.

AmericanTelemed.org
ATAwiki.org

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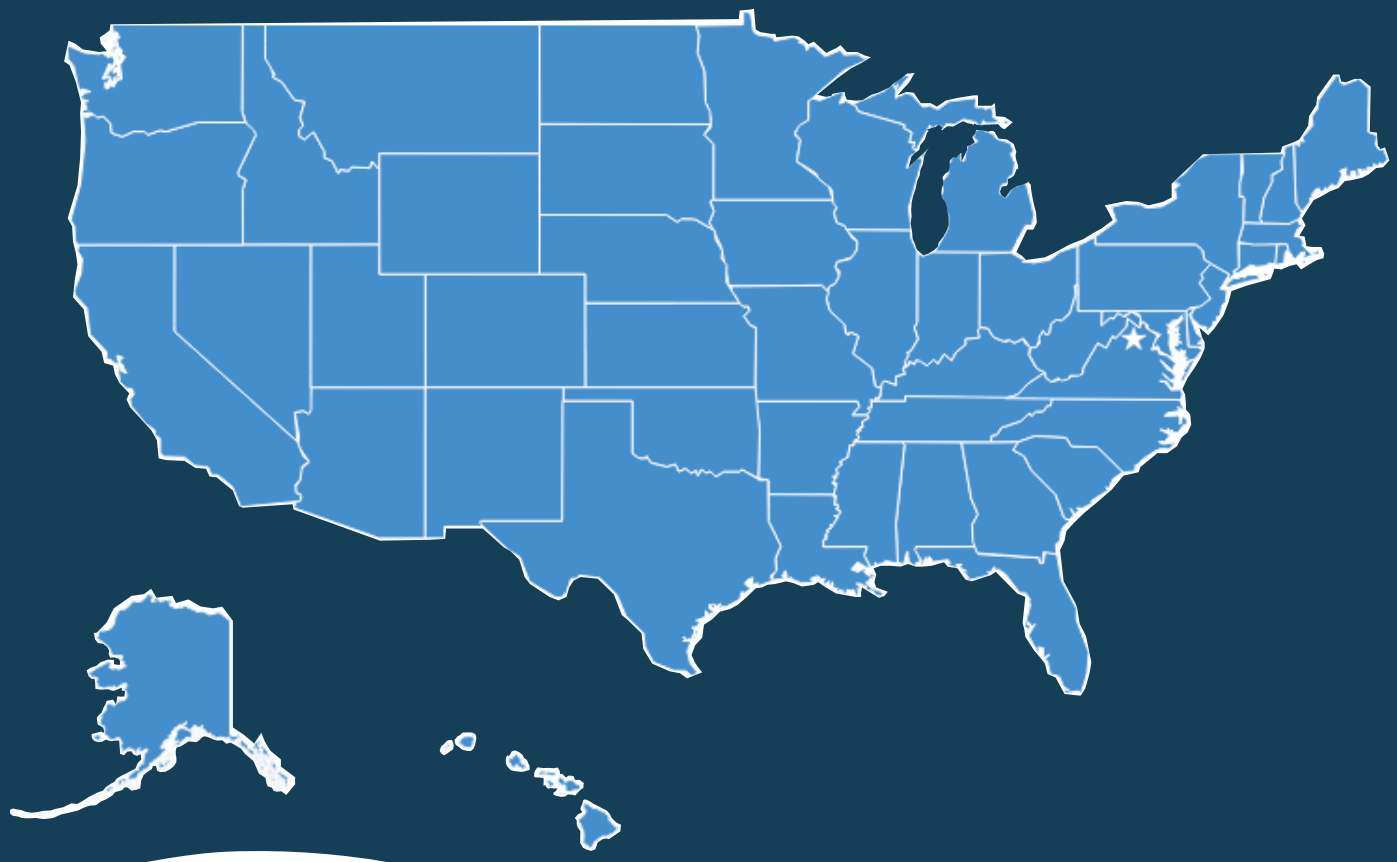
Center for Connected Health Policy

The National Telehealth Policy Resource Center



State Telehealth Laws and Medicaid Program Policies

A Comprehensive Scan of the 50 States and District of Columbia

August 2016

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Attachment #10

State Telehealth Laws and Medicaid Program Policies

Introduction

The Center for Connected Health Policy's (CCHP) updated fourth annual edition of "State Telehealth Laws and Reimbursement Policies" offers policymakers, health advocates, and other interested health care professionals the most current summary guide of telehealth-related policies, laws, and regulations for all 50 states and the District of Columbia. States continue to pursue their own unique set of telehealth policies as more and more legislation is introduced each year. Some states have incorporated policies into law, while others have addressed issues such as definition, reimbursement policies, licensure requirements, and other important issues in their Medicaid Program Guidelines.

While this guide focuses primarily on Medicaid fee-for-service policies, information on managed care is noted in the report if it was available. The report also indicates any particular areas where we were unable to find information. Every effort was made to capture the most recent policy language in each state as of August 2016. Recently passed legislation and regulation have also been included in this version of the document with their effective date noted in the report. This information also is available electronically in the form of an interactive map and search tool accessible on our website cchpca.org. Consistent with previous editions, the information will be continually updated, as laws, regulations and administrative policies are constantly changing.

Telehealth Policy Trends

While many states are beginning to expand telehealth reimbursement, others continue to restrict and place limitations on telehealth delivered services. Although each state's laws, regulations, and Medicaid program policies differ significantly, certain trends are evident when examining the various policies. Live video Medicaid reimbursement, for example, continues to far exceed reimbursement for store-and-forward and remote patient monitoring. However, over the past six months there has been a slight uptake in Medicaid policy allowing for store-and-forward as well as remote patient monitoring reimbursement, although generally on a limited basis. For example, Connecticut is allowing for store-and-forward reimbursement for physician-to-physician email consults (known as eConsult) exclusively, while Missouri has added store and forward and remote patient monitoring reimbursement, but limited it to specific specialties. Hawaii also made significant changes in July, passing one of the most comprehensive and progressive telehealth laws in the country. A unique element of their law is that as of Jan. 1, 2017, liability insurers in Hawaii will be required to provide malpractice coverage for providers delivering services via telehealth, equivalent to the rate they would charge for providers doing the same services in-person.

A few additional significant findings include:

- Forty-eight states and Washington DC provide reimbursement for some form of live video in Medicaid fee-for-service. This is up one state from CCHP's March 2016 edition of this report, due to Utah Medicaid restoring the telemedicine section in their provider manual, which was unintentionally left out of a prior version.

- Twelve state Medicaid programs reimburse for store and forward, up three states from March 2016.
- Nineteen state Medicaid programs provide reimbursement for remote patient monitoring, up three states from March 2016.
- Seven state Medicaid programs (Alaska, Hawaii, Illinois, Minnesota, Mississippi, Missouri and Washington) reimburse for all three, although certain limitations apply. Also note that laws addressing Medicaid reimbursement in Hawaii and Missouri go into effect at a later date.

How to Use this Report

Telehealth policies are organized into eleven categories that address the distinct issues of definition, Medicaid reimbursement by type of service, licensing, and other related requirements. The first column indicates whether policy has been codified into law and/or in state regulation. The second column indicates whether the policy is defined administratively in the Medicaid program, unless otherwise noted. In many instances the specific policy is found in law and/or regulations and administrative policy, but that is not always the case. This report primarily addresses the individual state's policies that govern telehealth use when seeking Medicaid coverage for service. However, we have also included a specific category that describes whether a state has established any specific policies that require private insurers to pay for telehealth services. A glossary is also available at the end of the report.

We hope you find the report useful, and welcome your feedback and questions. You can direct your inquiries to Mei Kwong, Project Director of the CCHP National Telehealth Resource Center for Policy at meik@cchpca.org, or Christine Calouro, Project Coordinator, at christinec@cchpca.org. We would also like to thank our colleagues at each of the twelve HRSA-funded Regional Telehealth Resource Centers who contributed to ensuring the accuracy of the information in this document. For further information, visit cchpca.org.

This report is for informational purposes only, and is not intended as a comprehensive statement of the law on this topic, nor to be relied upon as authoritative. Always consult with counsel or appropriate program administrators.

Mario Gutierrez
Executive Director
September 2016

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A Comprehensive Scan of the 50 States and the District of Columbia: Findings and Highlights

The Center for Connected Health Policy's (CCHP) annual updated report of state telehealth laws and Medicaid reimbursement policies is the fourth edition of this report. An interactive map version of the report is available on CCHP's website, cchpca.org. Due to constant changes in laws, regulations, and policies, CCHP will continue to update the information in both PDF and map formats throughout the year to keep it as accurate and timely as possible.

It should be noted that even if a state has enacted telehealth policies in statute and/or regulation, these policies may not have been incorporated into its Medicaid program. Throughout the report, CCHP has notated changes in law that have not yet been incorporated into the Medicaid program, as well as laws and regulations that have been approved, but not yet taken effect.

Methodology

CCHP examined state law, state administrative codes, and Medicaid provider manuals as the report's primary resources. Additionally, other potential sources such as releases from a state's executive office, Medicaid notices, transmittals or newsletters were also examined for relevant information. In a few cases, CCHP directly contacted state Medicaid personnel in order to clarify specific policy issues. Most of the information contained in this report specifically focuses on fee-for-service; however, information on managed care plans has also been included if available from the utilized sources. Newly approved regulations related to specific telehealth standards for various professions were noted in the "Comment" section of the state's page if found.

The survey focused on eleven specific telehealth-related policy areas. These areas were chosen based upon the frequency they have appeared in discussions and questions around telehealth reimbursement and laws. These areas are:

- Definition of the term telemedicine/telehealth
- Reimbursement for live video
- Reimbursement for store-and-forward
- Reimbursement for remote patient monitoring (RPM)
- Reimbursement for email/phone/fax
- Consent issues
- Location of service provided
- Reimbursement for transmission and/or facility fees

- Online prescribing
- Private payer laws
- Cross-state licensure

Key Findings

No two states are alike in how telehealth is defined and regulated. While there are some similarities in language, perhaps indicating states may have utilized existing verbiage from other states, noticeable differences exist. These differences are to be expected, given that each state defines its Medicaid policy parameters, but it also creates a confusing environment for telehealth participants to navigate, particularly when a health system provides health care services in multiple states. In some cases, states have duplicated aspects of Medicare's policy on telehealth, while others have developed their own policies for their Medicaid program.

Below are summarized key findings in each category area contained in the report.

Definitions

States alternate between using the term "telemedicine" or "telehealth". In some states both terms are explicitly defined in law and/or policy and regulations. In some cases, "telehealth" is used to reflect a broader definition, while "telemedicine" is used mainly to define the delivery of clinical services. Additional variations of the term, primarily utilizing the "tele" prefix are also becoming more prevalent. Specifically, the term "telepractice" is being used frequently as it relates to telehealth used specifically in physical and occupational therapy, behavioral therapy, and speech language pathology. "Telesychiatry" is also a term commonly used as an alternative when referring specifically to psychiatry services.

Some states put specific restrictions within the definitions, which often limits the term to "live" or "interactive", excluding store and forward and RPM from the definition and subsequently from reimbursement. The most common restriction states place on the term telemedicine/telehealth is the exclusion of email, phone, and/or fax from the definition. Forty-eight states and the District of Columbia have a definition in law, regulation, or their Medicaid program for telehealth, telemedicine, or both. Two states, Alabama and New Jersey, still lack a legal definition for both terms.

Medicaid Reimbursement

Forty-eight states and the District of Columbia have some form of reimbursement for telehealth in their public program. The two states that we determined did not have any written definitive reimbursement policies are:

- Massachusetts
- Rhode Island

Earlier this year, Iowa's Medicaid program confirmed that they do provide reimbursement for telehealth. This policy change came as a result of IA Senate Bill 505 which required the Department of Human Services to adopt formal rules regarding their longstanding (although unwritten) policy to provide reimbursement for telehealth. However, the rule that was adopted simply states that "in person contact between a provider and patient is not required for payment for services otherwise covered and appropriately provided through telehealth as long as it meets the generally accepted health care practices and standards prevailing in the applicable professional community." Neither the legislation nor the rule provides a definition of telehealth, which leaves the policy vague and up for interpretation. Therefore, it is unclear whether store and forward or RPM services would fall under the umbrella of this telehealth policy.

In our previous edition, CCHP noted the absence of Utah's telemedicine policy, which had been inexplicably deleted from their provider manual. However, that section has now been restored and therefore Utah has been removed from CCHP's list of states lacking live video telemedicine reimbursement.

The researchers found that Florida's 2014 version of their Practitioner Provider Manual, which was previously available through FL's Medicaid website, is no longer accessible. Instead, a 2012 Practitioner Provider Manual is available that does not address FL Medicaid's telemedicine policy, as the 2014 manual does. However, CCHP continues to count Florida as a state that provides live video telehealth reimbursement, due to administrative code indicating FL Medicaid reimburses for real time interactive telemedicine.

It should be noted that Massachusetts employs managed care plans in its Medicaid program. We did not examine whether the participating managed care plans provided any form of telehealth reimbursement.

Live Video

The most predominantly reimbursed form of telehealth modality is live video, with every state offering some type of live video reimbursement in their Medicaid program (except for the two states listed above). However, what and how it is reimbursed varies widely. The spectrum ranges from a Medicaid program in a state like New Jersey, which will only reimburse for telepsychiatry services, to states like California, which reimburses for live video across a wide variety of medical specialties. In addition to restrictions on specialty type, many states have restrictions on:

- The type of services that can be reimbursed, e. g. office visit, inpatient consultation, etc.;
- The type of provider that can be reimbursed, e. g. physician, nurse, physician assistant, etc.; and
- The location of the patient, referred to as the originating site.

These restrictions have been noted within the report to the extent possible.

Store-and-Forward

Store-and-forward services are only defined and reimbursed by a handful of state Medicaid Programs. In many states, the definition of telemedicine and/or telehealth stipulates that the delivery of services must occur in "real time," automatically excluding store-and-forward as a part of telemedicine and/or telehealth altogether in those states. Of those states that do reimburse for store-and-forward services, some have limitations on what will be reimbursed. For example, California only reimburses for teledermatology, teleophthalmology and teledentistry. Currently, twelve states reimburse for store-and-forward. This number does not include states that only reimburse for teleradiology (which is commonly reimbursed, and not always considered 'telehealth'). Hawaii and Missouri both passed legislation in the 2016 legislative session to provide reimbursement for store and forward in their Medicaid programs, however both go into effect at a later date. States that do reimburse for store-and-forward include:

- Alaska
- Arizona
- Connecticut
- California
- Hawaii (Eff. Jan. 1, 2017)
- Illinois
- Minnesota
- Mississippi
- Missouri (eff. Nov. 26, 2016)
- New Mexico
- Virginia
- Washington

It should also be noted that Connecticut has limited reimbursement to a very specific type of store-and-forward, they term “eConsult”, which is a certain secure email system that allows healthcare providers to engage in email consultations with each other regarding a particular patient.

Remote Patient Monitoring (RPM)

Nineteen states have some form of reimbursement for RPM in their Medicaid programs, which is an increase of three states since CCHP’s March 2016 edition. The policies in each of the three states added in this edition, (Hawaii, Kentucky and Missouri) go into effect at a later date. As with live video and store-and-forward reimbursement, many of the states that offer RPM reimbursement have a multitude of restrictions associated with its use. The most common of these restrictions include only offering reimbursement to home health agencies, restricting the clinical condition for which symptoms can be monitored, and limiting the type of monitoring device and information that can be collected.

For example, Colorado requires the patient to be receiving services for at least one of the following: congestive heart failure, chronic obstructive pulmonary disease, asthma, or diabetes. Further, the patient must still meet other conditions. In Minnesota, RPM reimbursement is only available for skilled nursing visits and in the Elderly Waiver and Alternative Care programs. Utah reimburses RPM through a Medicaid skilled nursing facility pilot program for diabetes patients living in rural areas only, and other conditions still apply. Utah also allows for outpatient long-term cardiac monitoring when there is prior authorization and additional criteria are met. Alaska’s Medicaid program has the least restrictive RPM reimbursement policy, requiring only that services be provided by a telemedicine application based in the recipient’s home with the provider only indirectly involved in service provision.

The states that currently offer some type of RPM reimbursement in their Medicaid program are:

- Alabama
- Alaska
- Colorado
- Hawaii (Eff. Jan. 1, 2017)
- Illinois
- Indiana
- Kansas
- Kentucky (Eff. July 1, 2017)
- Louisiana
- Maine
- Minnesota
- Mississippi
- Missouri (Eff. Nov. 26, 2016)
- New York
- South Carolina
- Texas
- Utah
- Vermont
- Washington

In addition to state Medicaid programs, Pennsylvania and South Dakota offer RPM reimbursement through their Department of Aging Services.

Note that the states listed are only for RPM in the home where some specific information related to technology or telecommunication could be found. Some states reimburse for home health services, but no further details of what modality was reimbursed could be located. Additionally, some states may already be reimbursing for tele-ICU (a form of RPM); however, these were not included.

Email/Phone/Fax

Email, telephone, and fax are rarely acceptable forms of delivery unless they are in conjunction with some other type of system. States either are silent or explicitly exclude these forms, sometimes even within the definition of telehealth and/or telemedicine.

Transmission/Facility Fee

Thirty states will reimburse either a transmission, facility fee, or both. Medicare also reimburses for a facility fee for the originating site provider.

Location of Service

Although the practice of restricting reimbursable telehealth services to rural or underserved areas, as is done in the Medicare program, is decreasing, some states continue to maintain this policy. Colorado's Medicaid program added language to their telemedicine webpage indicating that "clients can receive services through the use of telemedicine, whether they live in rural or urban areas". Yet their telemedicine manual states that Medicaid managed care organizations are prohibited from requiring a face to face visit in instances where the member resides in a county with 150,000 or fewer residents and the county has the technology necessary to provide telemedicine services. Other states are even more ambiguous in their geographical restrictions on telehealth. In South Dakota's Medicaid program, they simply state that an originating and distant site cannot be located in the same community. However, only nine states currently have these types of restrictions, and the overall trend is to eliminate such limitations. Three states that have removed such a policy in recent years are Idaho, Nevada and Missouri. Although Hawaii currently has a geographic restriction in their Medicaid program, this should be eliminated when recently passed legislation takes effect Jan. 1, 2017.

A more common practice is for state Medicaid programs to limit the type of facility that may be an originating site, often excluding the home as a reimbursable site, impacting RPM as a result. Currently twenty-five states have a specific list of sites that can serve as an originating site for a telehealth encounter, with ten states adding eligible originating site lists to their policy since July 2015. Some state Medicaid programs also require a licensed in-state provider to be physically located within the state in order to enroll as a Medicaid provider (for example California), while others have clarified that this is in fact not necessary (for example, Virginia).

Consent

Twenty-nine states include some sort of informed consent requirement in their statutes, administrative code, and/or Medicaid policies. This requirement can sometimes apply to the Medicaid program, a specific specialty or all telehealth encounters that occur in the state, depending on how and where the policy is written. States with informed consent policies include:

- Alabama
- Arizona
- California
- Colorado
- Connecticut
- Delaware
- Florida
- Georgia
- Idaho
- Indiana
- Kansas
- Kentucky
- Louisiana
- Maine
- Maryland
- Mississippi
- Missouri
- Nebraska
- Nevada
- New Jersey
- Ohio
- Oklahoma
- Pennsylvania
- Tennessee
- Texas
- Vermont
- Virginia
- West Virginia
- Wyoming

Licensure

Nine state medical (or osteopathic) boards issue special licenses or certificates related to telehealth. The licenses could allow an out-of-state provider to render services via telemedicine in a state where they are

not located, or allow a clinician to provide services via telehealth in a state if certain conditions are met (such as agreeing that they will not open an office in that state). States with such licenses are:

- Alabama
- Louisiana
- Maine
- New Mexico
- Ohio
- Oklahoma
- Oregon
- Tennessee (Osteopathic Board only)
- Texas

Since March 2016, The Tennessee Medical Board eliminated their telemedicine license (effective Oct. 31, 2016). Individuals granted a telemedicine license under the former version of the rule may apply to have the license converted to a full license. Under certain circumstances individuals who do not convert to a full license can retain their telemedicine license.

Montana and Nevada have also both dropped their telemedicine special license in the past year, however unlike Tennessee, they adopted the Federation of State Medical Boards (FSMB)'s Interstate Medical Licensure Compact, along with fifteen other states. The compact allows for an Interstate Commission to form an expedited licensure process for licensed physicians to apply for licenses in other states. The specific details about how the compact will function are not yet available. States that have adopted the FSMB's Compact language include:

- Alabama
- Arizona
- Colorado
- Idaho
- Illinois
- Iowa
- Kansas
- Minnesota
- Montana
- Nevada
- New Hampshire
- South Dakota
- Utah
- West Virginia
- Wisconsin
- Wyoming

Still other states have laws that don't specifically address telehealth and/or telemedicine licensing, but make allowances for practicing in contiguous states, or in certain situations where a temporary license might be issued provided the specific state's licensing conditions are met.

Online Prescribing

There are a number of nuances and differences across the states. However, most states consider using only an internet/online questionnaire to establish a patient-provider relationship (needed to write a prescription in most states) as inadequate. States may also require that a physical exam be administered prior to a prescription being written, but not all states require an in-person examination, and some specifically allow the use of telehealth to conduct the exam.

Private Payers

Currently, thirty-five jurisdictions have laws that govern private payer telehealth reimbursement policies. However, Washington's private payer law does not go into effect until Jan. 1, 2017, and Rhode Island's law doesn't go into effect until Jan. 1, 2018. Not all of these laws mandate reimbursement. Additionally, some private payer laws require that the reimbursement amount for a telehealth-delivered service be equal to the amount that would have been reimbursed, had the same service been delivered in-person; however, this is not always the case.

Additional Findings

Although liability insurance is not a category tracked in this report, Hawaii's revised telehealth law (effective Jan. 1, 2017) addressing the subject warrants mentioning. The new law requires that liability insurers provide malpractice coverage for providers delivering services via telehealth, equivalent to the rate they would charge for providers doing the same services in-person. This may inspire other states to introduce similar legislation in the future.

Current Legislation

In the 2016 legislative session, forty-four states have introduced over 150 telehealth-related pieces of legislation. Many bills address different aspects of reimbursement in regards to both private payers and Medicaid, with some bills making changes to existing reimbursement laws. Many states have also proposed legislation that would adopt the Federation of State Medical Board's model language for an Interstate Medical Licensure Compact. **Where appropriate, newly passed and/or approved legislation and regulations are noted for each state. However, many of these changes may not currently be in effect.**

To learn more about state telehealth related legislation, visit CCHP's interactive map at cchpca.org.

This report is for informational purposes only, and is not intended as a comprehensive statement of the law on this topic, nor to be relied upon as authoritative. Always consult with counsel or appropriate program administrators.

Alabama

Medicaid Program: Alabama Medicaid

Program Administrator: Alabama Medicaid Agency

Regional Telehealth Resource Center:
Southeast Telehealth Resource Center
PO Box 1408
Waycross, GA 31501
(888) 138-7210
www.setrc.us

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
No reference found.	There is no explicit definition of "telemedicine" given in state Medicaid policy. However, the provider manual states, "Services must be administered via an interactive audio and video telecommunications system which permits two-way communication between the distant site physician and the origination site where the recipient is located (this does not include a telephone conversation, electronic mail message, or facsimile transmission between the physician, recipient, or a consultation between two physicians)." ***Source: AL Medicaid Management Information System Provider Manual, p. 572 (28-17), (Jul. 2016).***
Live Video Reimbursement	
No reference found.	Alabama Medicaid reimburses for live video for the following services: • Consults; • Office or other outpatient visits; • Individual psychotherapy; • Psychiatric diagnostic services; • Neurobehavioral status exams. However, for some specialties, special conditions or circumstances must be present for reimbursement to occur. For all telemedicine services, an appropriately trained staff member or employee familiar with the patient or the treatment plan must be immediately available in person to the patient. ***Source: AL Medicaid Management Information System Provider Manual, p. 572 (28-17), (Jul. 2016) & AL Admin. Code r. 560-X-6-.14 (2011).***
Store and Forward Reimbursement	
No reference found.	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Remote Patient Monitoring Reimbursement	
No reference found.	In Home Monitoring Program Alabama Medicaid will reimburse remote patient monitoring through the In Home Monitoring Program. Patients with the following medical conditions may register for the program: • Diabetes • Congestive Heart Failure The Alabama Department of Public Health (ADPH) Nurse Care Manager evaluates the patient, provides any needed equipment such as a scale, glucometer, blood pressure cuff and phone with a speaker. Data transmission occurs through a secure telephone call. ***AL Medicaid Management Information System Provider Manual, p. 755 (39-32), (Jul. 2016).***
Email/Phone/FAX	
No reimbursement for telephone. No reference found for email or FAX. ***Source: AL Admin Code r. 560-X-6-.14 (2011).***	No reimbursement for email. No reimbursement for telephone. No reimbursement for FAX. ***AL Medicaid Management Information System Provider Manual, p. 572 (28-17), (Jul. 2016).***
Online Prescribing	
No reference found.	No reference found.
Consent	
No reference found.	A written informed consent is required prior to an initial telemedicine service. ***AL Medicaid Management Information System Provider Manual, p. 572 (28-17), (Jul. 2016).***
Location	
No reference found.	Originating site must be located in Alabama. The distant site may be located outside of Alabama as long as the physician has an Alabama license and is enrolled as an Alabama Medicaid provider. For rehabilitative services, the originating site must be: • Physician's office; • Hospital; • Critical Access Hospital; • Rural Health Clinic; • Federally Qualified Health Center;

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	• Community mental health center (to include co-located sites with partnering agencies; • Public health department. *AL Medicaid Management Information System Provider Manual, p. 833 (105-12), (Jul. 2016).*
Cross-State Licensing	
"A special purpose license allowing practitioners licensed in other states to practice across state lines may be issued." *Source: Code of AL Sec. 34-24-502 - 507 (2012).* AL passed legislation to be a part of the interstate licensing compact *Source: AL Act 2015-197 (2015).*	Providers must have an Alabama license. *AL Medicaid Management Information System Provider Manual, p. 572 (28-17), (Jul. 2016).*
Private Payers	
No reference found.	No reference found.
Site/Transmission Fee	
No reference found.	No reimbursement for originating site or transmission fees. *AL Medicaid Management Information System Provider Manual, p. 572 (28-17), (Jul. 2016).*
Miscellaneous	
The Alabama Board of Medical Examiners adopted new rules to establish standards for telehealth medical services. See "comments" section for additional details not included in the categories above.	Effective for dates of service 1/16/2012 and thereafter, all physicians with an Alabama license, enrolled as a provider with the Alabama Medicaid Agency, regardless of location, are eligible to participate in the Telemedicine Program to provide medically necessary telemedicine services to Alabama Medicaid eligible recipients. In order to participate in the telemedicine program: • Physicians must be enrolled with Alabama Medicaid with a specialty type of 931 (Telemedicine Service) • Physician must submit the telemedicine Service Agreement/Certification form • Physician must obtain prior consent from the recipient before services are rendered. This will count as part of each recipient's benefit limit of 14 annual physician office visits currently allowed. *Source: AL Medicaid Management Information System Provider Manual, p. 572 (28-17), (Jul. 2016).*

Comment:

Professional Board Telehealth-Specific Regulations

- AL Board of Optometrists *(Source: AL Admin Code 630-X-13-.02)*
- AL Board of Nursing *(Source: AL Admin Code 610-X-6-.16).*

Alaska

Medicaid Program: Alaska Medicaid

Program Administrator: Alaska Dept. of Health and Social Services, Division of Public Assistance

Regional Telehealth Resource Center:
Northwest Regional Telehealth Resource Center
2900 12th Ave. N., Ste. 30W
Billings, MT 59101
(888) 662-5601
www.nrtrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Telemedicine means the practice of health care delivery, evaluation, diagnosis, consultation, or treatment, using the transfer of medical data through audio, video, or data communications that are engaged in over two or more locations between providers who are physically separated from the patient or from each other." ***Source: AK Admin. Code, Title 7, 12.449 (2012).***	"Alaska Medicaid will pay for telemedicine services delivered in the following manner: • Interactive method: Provider and patient interact in 'real time' using video/camera and/or dedicated audio conference equipment. • Store-and-forward method: The provider sends digital images, sounds, or previously recorded video to a consulting provider at a different location. The consulting provider reviews the information and reports back his or her analysis. • Self-monitoring method: The patient is monitored in his or her home via a telemedicine application, with the provider indirectly involved from another location." ***Source: State of AK Dept. of Health and Social Svcs., Alaska Medical Assistance Provider Billing Manuals for Community Behavioral Health Services, Early and Periodic Screening, Diagnosis, and Treatment, Hospice Care, Inpatient Psychiatric Services, Independent Laboratory Services, Appendices. (Accessed Aug. 2016).*** Telemedicine is identical to a "traditional" health-care visit except it uses a different "mode of delivery;" with telemedicine, the healthcare provider and the patient are not in the same physical location. Instead, providers use telemedicine applications, such as video, audio, and/or digitized image transmissions, to link the patient and the provider. There are two primary telemedicine methods, or applications: Interactive and store-and-forward. With the interactive method, video/camera equipment and/or audio equipment is used to hold a "real-time" (live) consultation between a patient and a healthcare provider at a different location. The store-and-forward method, however, requires healthcare providers to send digital images, sounds, or previously recorded video to another provider at a different location. This "consulting" provider then reviews the information and reports his or

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	her findings to the provider who sent the information. ***Source: State of AK Dept. of Health and Social Svcs., Alaska Medical Assistance Provider Billing Manuals for Tribal Facility Services. Updated 6/4/13. (Accessed Aug. 2016).***
Live Video Reimbursement	
(See Medicaid column)	Alaska's Medicaid program will reimburse for services "provided through the use of camera, video, or dedicated audio conference equipment on a real-time basis" ***Source: AK Admin. Code, Title 7, 110.625(a) (2012).*** Alaska Medicaid will pay for a covered medical service furnished through telemedicine application if the service is: • Covered under traditional, non-telemedicine methods; • Provided by a treating, consulting, presenting or referring provider; • Appropriate for provision via telemedicine Eligible services: • Initial or one follow-up office visit; • Consultation made to confirm diagnosis • A diagnostic, therapeutic or interpretive service • Psychiatric or substance abuse assessments; • Individual psychotherapy or pharmacological management services. ***Source: AK Dept of Health and Social Svcs., AK Alaska Medical Assistance Provider Billing Manuals, Section1: Physician, Advance Nurse Practitioner, MHPC, Therapies, Audiology, School Based Services, Physician Assistant, RBRS, SBS, Tribal, Vision: Services, Policies and Procedures, (Accessed Aug. 2016) & AK Admin. Code, Title 7, 110.630.*** No reimbursement for: • Home and community-based waiver services; • Pharmacy; • Durable medical equipment; • Transportation; • Accommodation services; • End-stage renal disease; • Direct-entry midwife; • Private duty nursing; • Personal care assistants; • Visual care, dispensing or optician services; • Technological equipment and systems associated with telemedicine application. ***Source: AK Admin. Code, Title 7, 110.635 (2012) & AK Dept of Health and Social Svcs., AK Alaska Medical Assistance Provider Billing Manual, Section1: Physician, Advance Nurse Practitioner,***

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	Physician Assistant: Services, Policies and Procedures, (Accessed Aug. 2016)
Store and Forward Reimbursement	
(See Medicaid column)	Alaska Medicaid will reimburse for services delivered through store-and-forward. ***Source: AK Dept. of Health and Social Svcs., Alaska Medical Assistance Provider Billing Manual, Section1: Physician, Advance Nurse Practitioner, Physician Assistant: Services, Policies and Procedures, (Accessed Aug. 2016)*** To be eligible for payment under store-and-forward the service must be "provided through the transference of digital images, sounds, or previously recorded video from one location to another to allow a consulting provider to obtain information, analyze it, and report back to the referring provider." ***Source: AK Admin. Code, Title 7, 110.625(a) (2012).***
Remote Patient Monitoring Reimbursement	
(See Medicaid column)	Alaska Medicaid will reimburse for services delivered through self-monitoring. ***Source: AK Dept of Health and Social Svcs., Alaska Medical Assistance Provider Billing Manual, Section1: Physician, Advance Nurse Practitioner, Physician Assistant: Services, Policies and Procedures, (Accessed Aug. 2016)*** To be eligible for payment under self-monitoring or testing, "the services must be provided by a telemedicine application based in the recipient's home, with the provider only indirectly involved in the provision of the service." ***Source: AK Admin. Code, Title 7, 110.625(a) (2012).***
Email/Phone/FAX	
(see Medicaid column)	No reimbursement for telephone. No reimbursement for FAX. ***Source: AK Dept. of Health and Social Svcs., Alaska Medical Assistance Provider Billing Manual, Section1: Physician, Advance Nurse Practitioner, Physician Assistant: Services, Policies and Procedures, (accessed Aug. 2016)*** Reimbursement for phone, only if part of a dedicated audio conference system. No reimbursement for FAX. ***Source: AK Admin Code, Title 7, 110.625 (2012).***
Online Prescribing	
<u>Newly Passed Legislation</u> A physician is not subject to disciplinary sanctions for rendering a diagnosis, treatment or prescribing a prescription drug (except a controlled substance) without	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
a physical examination if the physician or another health care provider is available for follow up care and the physician requests that the person consent to sending a copy of all records of the encounter to the person's primary care provider. The AK Medical Board is required to adopt regulations that establish guidelines for a physician who is rendering a diagnosis, treatment or prescribing without conducting a physical exam. *Source: AK Statute, Sec. 08.64.364 (SB 74 – 2016).* Physicians are prohibited from prescribing medications based solely on a patient-supplied history received by telephone, FAX, or electronic format. *Source: AK Admin. Code, Title 12, Sec. 40.967.*	
Consent	
No reference found.	No reference found.
Location	
No reference found.	No reference found.
Cross-State Licensing	
No reference found.	No reference found.
Private Payers	
Newly Passed Legislation (Now Effective) Private payers required to provide coverage for mental health benefits provided through telemedicine. *Source: AK Statute, Sec. 08.64.364 (HB 234 – 2016).*	No reference found.
Site/Transmission Fee	
No reference found.	The department will pay only for professional services for a telemedicine application of service. The department will not pay for the use of technological equipment and systems associated with a telemedicine application to render the service. *Source: AK Admin. Code, Title 7, 110.635(b) (2012).* **Community Behavioral Health Services** The department will pay a community behavioral health services provider for facilitation of a telemedicine session if: • The Telemedicine communication equipment is supplied by the provider; • The electronic connection used by the treating provider and the recipient are established and maintained by the provider; • The provider remains available during the telemedicine session to reestablish failed

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	connection before the intended end of the telemedicine session; and • The provider documents in the recipient's clinical record a note summarizing the facilitation of each telemedicine session (although the facilitating provider is not required to document a clinical problem or treatment goal as these are to be documented by the treating provider). This service may be rendered to the following eligible recipients: • Child or adult experiencing a substance use disorder or emotional disturbance • Adult experiencing a serious mental illness ***Source: AK Admin. Code, Title 7, 135.290.***
Miscellaneous	
The Department of Commerce, Community and Economic Development is required to adopt regulations for establishing and maintaining a registry of businesses performing telemedicine in the state. ***Source: AK Statute, Sec. 44.33.381. (SB 74 – 2016).***	

Comments: Alaska and Hawaii are the only two states with Medicare coverage of store and forward services.

Arizona

Medicaid Program: Arizona Health Care Cost Containment System (AHCCCS)

Program Administrator: Arizona Health Care Cost Containment System Administration

Regional Telehealth Resource Center
Southwest Telehealth Resource Center
PO Box 245105
Tucson, AZ 85724
(520) 626-4498
www.southwesttrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
Under Arizona Statute, Public Health & Safety, "telemedicine means the practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data through interactive audio, video or data communications that occur in the physical presence of the patient, including audio or video communications sent to a health care provider for diagnostic or treatment consultation." ***Source: AZ Revised Statute Sec. 36-3601 (2012).*** Under State Administrative Code, Department of Insurance, Health Care Services Organizations Oversight, "telemedicine means diagnostic, consultation, and treatment services that occur in the physical presence of an enrollee on a real-time basis through interactive audio, video, or data communication." ***Source: AZ Admin. Code Sec. R20-6-1902 (2012).*** "Telemedicine means the interactive use of audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. Does not include the sole use of an audio-only telephone, a video-only system, a facsimile machine, instant messages or electronic mail." ***Source: AZ SB 1353 (2013).*** Under the Board of Behavioral health, "telepractice" means providing behavioral health services through interactive audio, video or electronic communication that occurs between the behavioral health professional and the client, including any electronic communication for evaluation, diagnosis and treatment, including distance counseling, in a secure platform, and that meets the requirements of telemedicine pursuant to section 36-3602.	Service delivery via telemedicine can be in one of two models: *Real time* means the interactive, two-way transfer of information and medical data, which occurs at two sites simultaneously: the hub site and spoke site … Diagnostic, consultation and treatment services are delivered through interactive, audio, video and/or communication. *Store-and-forward* means transferring medical data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation. ***Source: AZ Health Care Cost Containment System, AHCCCS Fee-For-Service Provider Manual, Ch. 10: Professional and Technical Services, p. 38 (10-38), (3/30/2016) & HIS/Tribal Provider Billing Manual, p. 42 (8/42), (7/26/2016). (Accessed Aug. 2016).*** Telemedicine is "the practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data between the originating and distant sites through real time interactive audio, video or data communications that occur in the physical presence of the member." Telehealth is "the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance." ***Source: AZ Health Care Cost Containment System, AHCCCS Medical Policy for AHCCCS Covered Services, Ch. 300, p. 177 (320-21). Jul. 2016. (Accessed Aug. 2016).*** Telemedicine means the practice of health care delivery, diagnosis, consultation, and treatment and the transfer of medical data through interactive audio, video, and data communications that occur in the physical presence of the patient. ***Source: AZ Health Care Cost Containment System Telehealth Policy. Mar. 2015. (Accessed Aug. 2016).***

STATE LAW/REGULATIONS	MEDICAID PROGRAM
NOTE: Rules regarding the use of telepractice will be adopted beginning Nov. 1, 2015. *Source: AZ Revised Statute Sec. 32-3251(15) (2015).*	
Live Video Reimbursement	
Health Care Service Organizations (HCSO) are allowed, but not mandated, to provide access to covered services through telemedicine, telephone, and email. *Source: AZ Admin. Code Sec. R20-6-1915 (2012)* Private payers are required to provide coverage for live video consultations when treating specific conditions and the originating site is located in a rural region. Allowed Conditions • Trauma • Burn • Cardiology • Infectious diseases • Mental health disorders • Neurologic diseases including strokes • Dermatology A rural region is defined as: • An area that is located in a county with a population of less than nine hundred thousand persons; or • A city or town that is located in a county with a population of nine hundred thousand persons or more and whose nearest boundary is more than thirty miles from the boundary of a city that has a population of five hundred thousand persons or more. *Source: AZ Statutes 20-841.09.*	<u>Fee for Service Provider Manual</u> AHCCCS will reimburse for medically necessary services provided via live video in their fee for service program. Eligible services: • Cardiology; • Dermatology; • Endocrinology; • Hematology/oncology; • Home Health • Infectious diseases; • Neurology; • Obstetrics/gynecology; • Oncology/radiation; • Ophthalmology; • Orthopedics; • Pain clinic; • Pathology; • Pediatrics and pediatric sub-specialties; • Radiology; • Rheumatology; • Surgery follow-up and consults; *Source: AZ Health Care Cost Containment System, AHCCCS Fee-For-Service Provider Manual, Ch. 10: Professional and Technical Services, p. 38 (3/30/2016) & HIS/Tribal Provider Billing Manual, p. 42 (8/42), (7/26/2016). (Accessed Jul. 2015).* <u>Additional Covered Services (Located in AHCCCS Policy Manual)</u> • Behavioral Health • Diagnostic consultation and Evaluation 1. Psychotropic medication adjustment and monitoring 2. Individual and family counseling 3. Case management *(Home health not listed as a covered service in this manual)* *Source: AZ Health Care Cost Containment System, AHCCCS Medical Policy for AHCCCS Covered Services, Ch. 300, p. 177 (320-21). Jul. 2016. (Accessed Aug. 2016).* Additional Covered Services (listed in Telehealth Policy) • Behavioral Health • Inpatient consultation • Medical Nutrition Therapy (MTN) • Office, outpatient, and surgery follow-up-

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	consultations • Pain management • Pharmacy management Telehealth policy lists covered codes. ***Source: AZ Health Care Cost Containment System Telehealth Policy. Mar. 2015. (Accessed Aug. 2016).*** **<u>Eligible Providers</u>** • Physician • Registered nurse practitioner • Physician assistant • Certified nurse midwife • Clinical psychologist • Licensed clinical social worker • Licensed marriage and family therapist • Licensed professional counselor Out-of-state providers may provide and bill for spoke and/or hub telehealth services. ***Source: AZ Health Care Cost Containment System Telehealth Policy. Mar. 2015. (Accessed Aug. 2016).*** Behavioral health services are covered for AHCCS and KidsCare patients. Covered behavioral health services: • Diagnostic consultation and evaluation; • Psychotropic medication adjustment and monitoring; • Individual and family counseling; • Case management. The patient's primary care provider (PCP), attending physician, other medical professional employed by the PCP, or an attending physician who is familiar with the patient's condition, must be present. Other medical professionals: • Registered nurses; • Licensed practical nurses; • Clinical nurse specialists; • Registered nurse midwives; • Registered nurse practitioners; • Physician assistants; • Physical, occupational, speech, and respiratory therapists; • Trained telepresenter familiar with the recipient's medical condition. For behavioral health services, the patient's physician, case manager, behavioral health professional, or tele-

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	presenter must be present. ***Source: AZ Health Care Cost Containment System, AHCCCS Fee-For- Service Provider Manual, Ch. 10: Professional and Technical Services, p. 39 (10-39), (3/30/2016) & HIS/Tribal Provider Billing Manual, p. 42 (8/42), (7/26/2016). (Accessed Aug. 2016).*** <u>AHCCCS Policy Manual</u> AHCCCS covers real-time teledentistry for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) aged members when provided by a registered dental providers. ***Source: AZ Health Care Cost Containment System, AHCCCS Medical Policy for AHCCCS Covered Services, Ch. 300, p. 177 (320-21). Jul. 2016. (Accessed Aug. 2016).*** Teledentistry services will be reimbursed for enrollees under the age of 21. ***Source: AZ Bill SB 1282 (2015).***
Store and Forward Reimbursement	
The definition of "telemedicine", which describes telemedicine as occurring in the "physical presence" of the patient, would exclude store and forward. ***Source: AZ Admin. Code Sec. R20-6-1902 (2012).***	<u>Fee for Service Provider Manual</u> AHCCCS will reimburse for store-and-forward in their fee-for-service program. The same services are covered for store and forward, as for real time. Real time telemedicine is the only type of reimbursement available in the field of Behavioral Health Services. ***Source: AZ Health Care Cost Containment System, AHCCCS Fee-For- Service Provider Manual, Ch. 10: Professional and Technical Services, p. 38 (10-38), (3/30/2016) & HIS/Tribal Provider Billing Manual, p. 42 (8/42), (7/26/2016). (Accessed Aug. 2016).*** <u>AHCCCS Policy Manual</u> AHCCCS only covers for store and forward (and is subject for review) the following: • Dermatology • Radiology • Ophthalmology • Pathology AHCCCS does not consider asynchronous or "store and forward" applications to be telemedicine, but it may be utilized to deliver services. ***Source: Arizona Health Care Cost Containment System. AHCCCS Medical Policy Manual for AHCCCS Covered Services, Ch. 300, Policy 320 Services With Special Circumstances, p. 177 (320-21). Jul. 2016. (Accessed Aug. 2016).*** The following exceptions may be eligible for reimbursement, but are not considered a "telemedicine service":

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	• A provider in the role of tele-presenter may be providing a separately billable service, such as an electrocardiogram or an X-ray. The service is covered, but not the tele-presenting. • A consulting distant-site provider may offer a service that does not require real-time patient interaction. Reimbursement only for dermatology, radiology, ophthalmology, and pathology. It is subject to review by AHCCCS Medical Management. • When a patient in a rural area presents within three hours of onset of stroke symptoms, AHCCCS will reimburse the consulting neurologist if the consult is placed for assistance in determining appropriateness of thrombolytic therapy even when the patients' condition is such that real-time video interaction cannot be achieved. ***Source: AZ Health Care Cost Containment System, AHCCS Medical Policy Manual, Medical Policy for AHCCCS Covered Services, Ch. 300, Policy 320: Services With Special Circumstances, p. 180 (320-23). Jul. 2016. (Accessed Aug. 2016).***
Remote Patient Monitoring Reimbursement	
No reference found.	Home health is listed as a reimbursable service in fee for service, but no other reference was found or explanation of what is considered a "home health" service. ***Source: AZ Health Care Cost Containment System, AHCCCS Fee-For- Service Provider Manual, Ch. 10: Professional and Technical Services, p. 38 (10-38), (3/30/2016) & HIS/Tribal Provider Billing Manual, p. 42 (8/42), (7/26/2016). (Accessed Aug. 2016).*** <u>AHCCCS Policy Manual</u> AHCCCS program only reimburses for telemedicine delivered via real time, Home Health is not a covered service under this program. ***Source: AZ Health Care Cost Containment System .AHCCCS Medical Policy Manual for AHCCCS Covered Services, Ch. 300, Policy 320 Services With Special Circumstances, p. 180 (320-23). Jul. 2016. (Accessed Aug. 2016).***
Email/Phone/FAX	
Health Care Service Organizations are allowed, but not mandated, to provide covered services through telemedicine, telephone, and email. ***Source: AZ Admin. Code Sec. R20-6-1915 (2012).*** No Phone No Email No Fax	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Source: AZ Statutes 20-841.09.	
Online Prescribing	
Physicians are prohibited from issuing a prescription to patients without having a physical or mental health status examination to establish a provider-patient relationship. The physical or mental health status examination can be conducting during a real-time telemedicine encounter. *Source: Arizona Revised Statute Sec. 32-1401 (SB 1339).*	No reference found.
Consent	
Providers must obtain and document oral or written consent before delivery of services. Oral consent should be documented on the patient's medical record. *Source: AZ Revised Statute Sec. 36-3602 (2012).*	No reference found.
Location	
Private payers are required to provide coverage when the originating site is located in a rural region, which is defined as: • An area that is located in a county with a population of less than nine hundred thousand persons; or • A city or town that is located in a county with a population of nine hundred thousand persons or more and whose nearest boundary is more than thirty miles from the boundary of a city that has a population of five hundred thousand persons or more. *Source: AZ Statutes 20-841.09.*	Eligible hub or spoke sites for Indian Health Services or tribal providers: • Indian Health Service clinic; • Tribally-governed facility; • Urban clinic for American Indians; • Physician or other provider office; • Hospital; • Federally Qualified Health Center (FQHC). *Source: AZ Health Care Cost Containment System Telehealth Policy. Mar. 2015. (Accessed Aug. 2016).* Fee for service manual definitions: Hub site – "the location of the telemedicine consulting provider, which is considered the place of service." Spoke site – "the location where the recipient is receiving the telemedicine service." *Source: AZ Health Care Cost Containment System, AHCCCS Fee-For- Service Provider Manual, Ch. 10: Professional and Technical Services, p. 38 (10-38), (3/30/2016) & HIS/Tribal Provider Billing Manual, p. 42 (8/42), (7/26/2016). (Accessed Aug. 2016).*
Cross-State Licensing	
An out-of-state doctor may engage in a single or infrequent consultation with an Arizona physician. *Source: AZ Revised Statute Sec. 32-1421 (2012).*	<u>AHCCCS Policy Manual</u> A consultation by a non-Arizona licensed provider may occur if: • It is to a specific patient in the AHCCCS program; • The provider is registered with AHCCCS;

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	• The provider is licensed in the state the consultation is being provided from, or the provider is employed by an Indian Health Services, Tribal or Urban Indian Health program and appropriately licensed based on IHS and Tribal facility requirements. *Source: AZ Health Care Cost Containment System, AHCCS Medical Policy Manual, Medical Policy for AHCCCS Covered Services, Ch. 300, Policy 320: Services With Special Circumstances, p. 180 (320-23). Jul. 2016. (Accessed Aug. 2016).*
Private Payers	
Private payers are required to provide coverage for live video consultations when treating specific conditions and the originating site is located in a rural region. Allowed Conditions • Trauma • Burn • Cardiology • Infectious diseases • Mental health disorders • Neurologic diseases including strokes • Dermatology A rural region is defined as: • An area that is located in a county with a population of less than nine hundred thousand persons; or • A city or town that is located in a county with a population of nine hundred thousand persons or more and whose nearest boundary is more than thirty miles from the boundary of a city that has a population of five hundred thousand persons or more. *Source: AZ Statutes 20-841.09.*	No reference found.
Site/Transmission Fee	
No reference found.	A facility fee is not an AHCCCS covered service. *Source: AZ Health Care Cost Containment System Telehealth Policy. Mar. 2015. (Accessed Aug. 2016).*
Miscellaneous	
Arizona explicitly prohibits the use of telemedicine to provide an abortion. *Source: AZ Revised Statute Sec. 36-3604 (2012).*	AHCCCS Policy Manual There is reimbursement for non-emergency transportation to and from the telemedicine originating site. *Source: AZ Health Care Cost Containment System, AHCCS Medical Policy Manual, Medical Policy for AHCCCS Covered Services, Ch. 300, Policy 320: Services With Special*

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	Circumstances, p. 181 (320-24). Jul. 2016. (Accessed Aug. 2016).

Arkansas

Medicaid Program: Arkansas Medicaid

Program Administrator: Arkansas Department of Human Services

Regional Telehealth Resource Center
South Central Telehealth Resource Center
4301 W. Markham St. #519
Little Rock, AR 72205
(855) 664-3450
learntelehealth.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Telemedicine" means the medium of delivering clinical healthcare services by means of real-time two-way electronic audio-visual communications, including without limitation the application of secure video conferencing, to provide or support healthcare delivery that facilitates the assessment, diagnosis, consultation, or treatment of a patient's health care while the patient is at an originating site and the healthcare professional is at a distant site." ***Source: AR Code 23-79-1601(5).***	Arkansas Medicaid defines telemedicine services as "medical services performed as electronic transactions in real time. In order for a telemedicine encounter to be covered by Medicaid, the practitioner and the patient must be able to see and hear each other in real time." ***Source: 016 06 06 Code of AR Rules and Regs. (CARR) 024 (2012).*** The Medicaid manual describes telemedicine as, "Interactive electronic consultations are physician consultations, 'face-to-face' in real time, via two-way electronic data exchange." ***Source: AR Provider Manual, Section II: Physician/Independent Labe/CRNA/Radiation Therapy Center, p. 32. (Accessed Aug. 2016)*** Arkansas Medicaid defines telemedicine services as medical services performed as electronic transactions in real time. In order for a telemedicine encounter to be covered by Medicaid, the practitioner and the patient must be able to see and hear each other in real time. Physician interpretation of fetal ultrasound is covered as a telemedicine service if the physician views the echography or echocardiography output in real time while the patient is undergoing the procedure. ***Source: AR Provider Manual, Section II: Rural Health Clinic, p. 6 & Federally Qualified Health Centers, p. 10 (Accessed Aug. 2016).*** "Telemedicine" means the medium of delivering clinical healthcare services by means of real-time two-way electronic audio-visual communications, including without limitation the application of secure video conferencing, to provide or support healthcare delivery that facilitates the assessment, diagnosis, consultation, or treatment of a patient's health care while the patient is at an originating site and the healthcare professional is at a distant site.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	Source: AR Code 23-79-1601(5).
Live Video Reimbursement	
A health plan shall cover the telehealth-delivered services of an Arkansas-licensed physician on the same basis it would if the services were delivered in-person. *Source: AR Code 23-79-1602(c) (1).* A distant site provider will not utilize telemedicine to treat a patient located in Arkansas unless a professional relationship exists between the healthcare provider and the patient or as otherwise meets the definition of a professional relationship as defined in Section 17-80-117(a)(4). (See Comments section below). Existence of a professional relationship is not required in the following circumstances: • Emergency situations where life or health of the patient is in danger or imminent danger or • Simply providing information in a generic nature not meant to be specific to an individual patient. *Source: AR Code 17-80-117(e) (1).*	Arkansas Medicaid will reimburse for up to two visits per patient, per year. A benefit extension request may be approved if it is medically necessary. Covered visits: • Consults; • Fetal echography and echocardiography (must be transmitted in real time); • Non-emergency visits in a physician's office, a clinic or a hospital outpatient department; • Inpatient hospital visits; • Federally Qualified Health Centers (FQHC) encounters. Specific CPT codes apply. See manual for special billing instructions. AR Medicaid covers telemedicine evaluation and management services of an attending physician at the local site only when the physician is physically attending the patient and is presenting the case to a consulting physician at the remote site by means of telemedicine media. *Source: AR Provider Manual, Section II: Physician/Independent Lab/CRNA/Radiation Therapy Center, p. 68 & 129. (Accessed Aug. 2016)* *Source: (fetal echography and echocardiography): AR Provider Manual, Section II: Hospital/CAH/End Stage Renal Disease, p. 32. and Section II: Rural Health Clinics, p. 6. (Accessed Aug. 2016)* *Source (FQHC only): AR Provider Manual, Section II: Federally Qualified Health Center, p. 11. (Accessed Aug. 2016)* There is reimbursement for live video for "Telepsych" services under the Rehabilitative Services for Persons with Mental Illness (RSPMI) program. See Medicaid manual for list of rehabilitative services that can be provided through telemedicine to beneficiaries under age 21 and above age 21. **Note**: These services are only available when, at a minimum, the Arkansas Telehealth Network (ATN) recommended audio video standards for real-time, two-way interactive audiovisual transmissions are met. Providers also must be able to link or connect to ATN, to ensure HIPAA compliance. Providers must receive prior authorization. An employee of the clinic must also be in the same room as the beneficiary. *Source: AR Provider Manual, Section II: Rehabilitative Services for Persons with Mental Illnesses, p. 15. (Accessed Aug. 2016)*

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	Live video services will be reimbursed the same as if the services were provided in-person if conditions in AR Code 17-80-117 such as provision of services provided by an Arkansas licensed or certified healthcare provider, professional relationship (see Comments section) and eligible originating site. *Source: AR Code 23-79-1602.*
Store and Forward Reimbursement	
Store and forward shall not be considered telemedicine, but the use of it is not prohibited. *Source: AR Code 17-80-117(b) (4) (A).*	No reimbursement. Arkansas Medicaid requires telemedicine to occur in real-time. *Source: AR Provider Manual, Section II: Physician/Independent Labe/CRNA/Radiation Therapy Center, p. 68. (Accessed Aug. 2016)* Store and forward shall not be considered telemedicine, but the use of it is not prohibited. *Source: AR Code 17-80-117(b) (4) (A).* Radiology procedures are reimbursed as telemedicine when billed properly. *Source: AR Provider Manual, Section II: Physician/Independent Labe/CRNA/Radiation Therapy Center, p. 132. (Accessed Aug. 2016)*
Remote Patient Monitoring Reimbursement	
No reference found.	No reference found.
Email/Phone/FAX	
No reference found.	No reference found.
Online Prescribing	
A proper physician/patient relationship can be established via real time audio and video telemedicine. *Source: AR Rules and Regulation. Sec. 060.00.16.* When abortion inducing drugs are used, the initial administration must occur in the same room and in the physical presence of the prescribing physician. *Source: AR Rules and Regulation. Sec. 060.00.16.* Without a prior and proper patient-provider relationship, providers are prohibited from issuing prescriptions solely in response to an Internet questionnaire, an Internet consult, or a telephone consult. *Source: AR Code Annotated Sec. 17-92-1003 (2012).* The standards of appropriate practice in traditional health care professional-patient settings shall govern the	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
licensed healthcare professional's treatment recommendations made via electronic means, including issuing a prescription via telemedicine. *Source: AR Code 17-80-117(b).*	
Consent	
The healthcare professional shall follow applicable state and federal laws, rules and regulations for informed consent. *Source: AR Code 17-80-117(c) (1).*	The healthcare professional shall follow applicable state and federal laws, rules and regulations for informed consent. *Source: AR Code 17-80-117(c) (1).*
Location	
Patients must be in a physician's office or a hospital. *Source: 016 06 Code of AR Rules and Regs. (CARR) 036 (2012).*	Eligible Originating Site • In-patient or non-emergency hospital • Physician office or clinic • Ambulatory surgical center • FQHC; or • Emergency department. *Source: AR Provider Manual, Section II: Physician/Independent Lab/CRNA/Radiation Therapy Center, p. 128. (Accessed Aug. 2016)* **Not to go into effect until July 1, 2016:** Eligible Originating site is the offices of a healthcare professional or a licensed health care entity where the patient is located at the time services are provided via telemedicine. The home of a patient in connection with treatment for end-stage renal disease is also an eligible originating site. *Source: AR Code 17-80-117(a) (4).*
Cross-State Licensing	
An out of state physician utilizing an electronic medium who performs an act that is part of a patient care service that was initiated in Arkansas, including interpretation of an X-ray, that would affect the diagnosis or treatment, is engaged in the practice of medicine and subject to regulation by the Arkansas State Medical Board. *Source: AR Code Revised 17-95-206 (2012)* Healthcare providers must be fully licensed or certified in Arkansas to provide services in the state unless the out-of-state provider is only providing episodic consultation services. *Source: AR Code 17-80-117(d) (1-2).*	Healthcare providers must be fully licensed or certified in Arkansas to provide services in the state unless the out-of-state provider is only providing episodic consultation services. *Source: 17-80-117(d) (1-2).*
Private Payers	
A health plan shall cover the telehealth-delivered services of an Arkansas-licensed physician on the same	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
basis it would if the services were delivered in-person. *Source: AR Code 23-79-1602(c) (1).*	
Site/Transmission Fee	
A facility fee is not prohibited, but it is not mandated. *Source: AR Code 23-79-1602(d) (3).*	A facility fee is not prohibited, but it is not mandated. *Source: AR Code 23-79-1602(d) (3).*
Miscellaneous	
The Board of Examiners in Speech-Language Pathology and Audiology defines "telepractice" as telespeech, teleaudiology, teleSLP, telehealth or telerehabilitation when used separately or together. It defines "telepractice service" as the application of telecommunication technology equivalent in quality to services delivered face-to-face to deliver speech-language pathology or audiology services, or both, at a distance for assessment, intervention or consultation, or both. *Source: AR Code Sec. 17-100-103.*	

COMMENTS:

New Regulations Passed

- AR Board of Examiners in Speech-Language Pathology and Audiology ***(Source: Title 17-100-202, Sec. 12) http://www.abespa.com/pdf/rules_regs092615.pdf***

Recently Passed Legislation

Arkansas prohibits the use of telemedicine to administer drugs that provide medical abortions.

Source: AR Bill SB 53 (2015).

A "professional relationship" between healthcare provider and patient means at a minimum:

- The healthcare professional has previously conducted an in-person examination and is available to provide appropriate follow-up care, when necessary, at medically necessary intervals;
- The healthcare professional personally knows the patient and the patient's relevant health status through an ongoing personal or professional relationship, and is available to provide appropriate follow-up care, when necessary, at medically necessary intervals;
- The treatment is provided by a healthcare professional in consultation with, or upon referral by, another healthcare professional who has an ongoing relationship with the patient and who has agreed to supervise the patient's treatment, including follow-up care;
- An on-call or cross-coverage arrangement exists with the patient's regular treating healthcare professional;

- A relationship exists in other circumstances as defined by rule of the Arkansas State Medical Board for healthcare professionals under its jurisdiction and their patients; or
- A relationship exists in other circumstances as defined by rule of a licensing or certification board for other healthcare professionals under the jurisdiction of the appropriate board and their patients if the rules are no less restrictive than the rules of the Arkansas State Medical Board.

Source: 17-80-117(a) (4).

California

Medicaid Program: Medi-Cal

Program Administrator: California Dept. of Health Care Services (DHCS)

Regional Telehealth Resource Center:
California Telehealth Resource Center (CTRC)
2001 P Street, Suite 100
Sacramento, CA 95811
(916) 341-3378 / (877) 590-8144
www.caltrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Telehealth means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers." ***Source: CA Business & Professions Code Sec. 2290.5 (2012).*** Telemedicine is "the ability of physicians and patients to connect via technology other than through virtual interactive physician/patient capabilities, especially enabling rural and out-of-area patients to be seen by specialists remotely." ***Source: CA Code of Reg. Title 10 Sec. 6410.***	Telehealth [according to the Telehealth Advancement Act of 2011] "is the mode of delivering health care services and public health utilizing information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a patient's health care while the patient is at the originating site and the health care provider is at the distant site." "Telemedicine [according to CMS] is the use of medical information exchanged from one site to another using interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time, interactive communication between the patient and physician or practitioner at the distant site to improve a patient's health. Medi-Cal uses the term telemedicine when it makes a distinction from telehealth." ***Source: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth. Pg. 1. (Dec. 2013) (Accessed Aug. 2016).***
Live Video Reimbursement	
Private payers may reimburse for live video. *(See "Private Payers" section).* ***Source: CA Health & Safety Code Sec. 1374.13 (2012).*** *(also see Medicaid column)*	Medi-Cal will reimbursement for services provided via live video. ***Source: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth. Pg. 1. (Dec. 2013), (Accessed Aug. 2016).***
Store and Forward Reimbursement	
Private payers may reimburse for store and forward. ***Source: CA Business & Professions Code Sec. 2290.5 (2012).*** *(also see Medicaid column)*	Medi-Cal will reimburse for store and forward services for tele-dermatology, tele-ophthalmology and teledentistry. ***Source: Sec. 14132.725 of the Welfare and Institutions Code.*** ***Source (tele-dermatology & tele-ophthalmology): CA Department of Health Care Services. Medi-Cal Part 2 General Medicine***

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	Manual. Telehealth. Pg. 5. (Dec. 2013), (Accessed Aug. 2016). Allied dental professionals are not permitted to bill for teledentistry. Live transmissions are only billable if the beneficiary requests it. Specific list of acceptable CPT codes included in Denti-Cal Handbook. *Source: Denti-Cal Provider Handbook. (4-11 to 4-12) Pg. 123-124. (Aug. 2016).*
Remote Patient Monitoring Reimbursement	
No reference found.	No reference found.
Email/Phone/FAX	
No reference found.	Medi-Cal does not reimburse for telephone calls, electronic mail messages or facsimile transmissions. *Source: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth. Pg. 5. (Dec. 2013), (Accessed Aug. 2016).*
Online Prescribing	
Providers are prohibited from prescribing or dispensing dangerous drugs or dangerous devices on the Internet without an appropriate prior examination and medical indication. *Source: CA Business & Professions Code Sec. 2242.1(a).*	No reference found.
Consent	
The originating site provider must obtain and document verbal or written patient consent prior to service delivery. *CA Health & Safety Code Sec. 1374.13.* **Occupational Therapy** Oral informed consent must be obtained by the originating site prior to the use of telehealth to deliver health services. *Source: CA Code of Regulations, Title 16, Div. 39, Art. 8, Sec. 4172.* **Behavioral Sciences** A licensee must obtain informed consent from a client. *Source: CA Code of Regulations, Title 16, Div. 18, Art. 1, Sec. 1815.5.*	Provider must obtain oral consent from the patient and document it in the patient record. *Source: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth. Pg. 2. (Dec. 2013), (Accessed Aug. 2016).*
Location	
Health plans cannot limit the settings where services are provided. Settings are still subject to contract terms and conditions.	The type of setting where services are provided is not limited.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Source: CA Health & Safety Code Sec. 1374.13 (2012).	*Source: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth. Pg. 1. (Dec. 2013), (Accessed Aug. 2016).*
Cross-State Licensing	
No reference found.	No reference found.
Private Payers	
Private payers cannot require that in-person contact occur before payment is made for covered telehealth services, subject to contract terms and conditions. *Source: CA Health & Safety Code Sec. 1374.13 (2012).*	No reference found.
Site/Transmission Fee	
No reference found.	Medi-Cal will reimburse the originating site a facility fees, and originating and distant site for live video transmission costs. *Source: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth. Pg. 2. (Dec. 2013), (Accessed Aug. 2016).*
Miscellaneous	
The CA Board of Occupational Therapy adopted a new rule titled, "Standards of Practice for Telehealth," to establish standards and expectations associated with the delivery of occupational therapy services via information and communication technology. Any licensed health care provider or marriage and family therapist, intern or trainee is an authorized telehealth provider. *Source: Assembly Bill 250 (2015), CA Business and Professions Code Sec. 2290.5.*	Medi-Cal covers telehealth to the extent services are allowable and reimbursed according to the department's telehealth manual in the California Children's Services Program (CCS), Genetically Handicapped Person's Program (GHPP) and Child Health and Disability Prevention Program (CHDP). *Source: CA Department of Health Care Services. Medi-Cal Special Programs FAQs. (Accessed Aug. 2016).* Telehealth services and supports are among the services and supports authorized to be included by individual program plans developed for disabled individuals by regional centers that contract with the State Department of Developmental Disabilities. *Source: Welfare and Institutions Code Sec. 4512.*

Comments:

New Regulations Passed

- CA Board of Occupational Therapy *(Source: Title 16, Div. 39, Sec. 4172)*
- CA Board of Behavioral Sciences (*Source: CA Code of Regulations, Title 16, Div. 18, Art. 1, Sec. 1815.5)*

Colorado

Medicaid Program: Colorado Medicaid

Program Administrator: Colorado Dept. of Health Care Policy and Financing

Regional Telehealth Resource Center:
Southwest Telehealth Resource Center
PO Box 245105
Tucson, AZ 85724
(520) 626-4498
www.southwesttrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Telemedicine means the delivery of medical services and any diagnosis, consultation, or treatment using interactive audio, interactive video, or interactive data communication." *Source: CO Revised Statutes 12-36-102.5 (2012).* **Effective on or after Jan. 1, 2017:** Telehealth means a mode of delivery of healthcare services through telecommunications systems, including information, electronic, and communication technologies, to facilitate the assessment, diagnosis, consultation, treatment, education, care management, or self-management of a covered person's health care while the covered person is located at an originating site and the provider is located at a distant site. The term includes synchronous interactions and store-and-forward transfers. Telehealth does not include the delivery of health care services via telephone, facsimile machine or electronic mail. *Source: CO Revised Statutes 10-16-123(2) (h) (4) (e) (I & II) (2015).* **Workers' Compensation** Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve, maintain or assist patients' health status. Closely associated with telemedicine is the term "telehealth", which is often used to encompass a broader definition of remote health care that does not always involve clinical services. Videoconferencing, transmission of still images, e-health including patient portals, remote monitoring of vital signs and continuing medical education are all considered part of telemedicine and telehealth. *Source: 7 CO Regs. Rule 18.*	Telehealth services include the installation and on-going remote monitoring of clinical data through technologic equipment in order to detect minute changes in the client's clinical status that will allow Home Health agencies to intercede before a chronic illness exacerbates requiring emergency intervention or inpatient hospitalization. *Source: CO Medical Assistance Program, Home Health Billing Manual, p. 11 (Apr. 2016), (Accessed Aug. 2016).* Telemedicine is a way of giving services to Health First Colorado (Colorado's Medicaid Program) clients who live a significant distance away from the providers they need to see. Telemedicine involves two providers: an "originating provider" and a "distant provider." The provider where the client is located is the originating provider and the provider in another location is the distant provider. Providers must have special equipment to provide telemedicine services. Telemedicine does not mean visits by telephone or fax. … Telemedicine services are provided "live" by audio-video communications between two providers. The distant provider is a consultant to the originating provider. Sometimes the distant provider may be the only provider involved in the visit, such as with mental health sessions. Providers such as doctors, nurse practitioners and mental health providers can provide services if they have the special equipment. *Source: CO Department of Health Care Policy and Financing. "Telemedicine". (Accessed Aug. 2016).* Telehealth allows for the monitoring of a member's health status remotely via equipment, which transmits data from the member's home to the member's home health agency. The purpose of providing telehealth

STATE LAW/REGULATIONS	MEDICAID PROGRAM
"Telehealth" means a mode of delivery of health care services through telecommunication systems, including information, electronic, and communication technologies, to facilitate the assessment, diagnosis, consultation, treatment, education and care management of a resident's health care when the resident and practitioner are located at different sites. Telehealth includes 'telemedicine' as defined in Section 12-36-102.5(8), C.R.S." *Source: 6 CO Regs. Rule 1011-1. Ch. 5.*	services is to assist in the effective management and monitoring of members whose medical needs can be appropriately and cost-effectively met at home through the frequent monitoring of data and early intervention. *Source: CO Department of Health Care Policy and Financing. "Home Health Telehealth". (Accessed Aug. 2016). <https://www.colorado.gov/pacific/hcpf/home-health-telehealth>*
Live Video Reimbursement	
Health plans for patients in counties with 150,000 or fewer residents cannot require face-to-face contact between a provider and a patient for services that could be appropriately provided through telemedicine, subject to the terms and conditions of the health benefit plan. *Source: CO Revised Statutes 10-16-123 (2012).* *(also see Medicaid column & "Private Payers" section)* **<u>Effective Jan. 1, 2017:</u>** A health benefit plan that is issued, amended or renewed shall not require in-person contact between a provider and a covered person for services appropriately provided through telehealth, subject to the terms and conditions of the plan. *Source: CO Revised Statutes 10-16-123(2) (a) (2015).*	Colorado Medicaid will reimburse for medical and mental health services. Services shall be subject to reimbursement policies developed by the medical assistance program. Reimbursement must be the same as in-person services. *Source: CO Revised Statutes 25.5-5-320 (2012).Dec.* Telemedicine services must be provided "live". The patient and the distant provider interact with one another in real time through an audio-video communications circuit. Peripherals may be included, such as transmission of a live ultrasound exam. *Source: CO Medical Assistance Program, Telemedicine Manual, p. 2 (Dec. 2015), (Accessed Mar. 2016).* Only the Health First CO providers that have special telemedicine equipment can serve clients through telemedicine. A list of approved services is available to providers, which include preventive and routine medical care, psychotherapy and obstetrical ultrasounds. *Source: CO Department of Health Care Policy and Financing. "Telemedicine". (accessed Aug. 2016) <https://www.colorado.gov/pacific/hcpf/telemedicine>* Colorado Medicaid does not pay for provider or patient education when education is the only service provided via telemedicine. No enrolled managed care organization may require face-to-face contact between a provider and a client for services appropriately provided through telemedicine if: • The client resides in a county with a population of 150,000 or fewer residents and • The county has the technology necessary to provide telemedicine services. The use of telemedicine is not required when in-person care by a participating provider is available to an

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	enrolled client within a reasonable distance. The originating site can bill for assisting the distant site provider with an exam. See telemedicine manual for specific billing instructions. ***Source: CO Medical Assistance Program, Telemedicine Manual, p. 2-6 (Dec. 2015), (Accessed Aug. 2016).***
Store and Forward Reimbursement	
No reimbursement based upon definition of "telemedicine" which describes telemedicine as "interactive" implying that it happens in real time. ***Source: CO Revised Statutes 12-36-102.5 (2012).*** **<u>Effective Jan. 1, 2017:</u>** A health benefit plan that is issued, amended or renewed shall not require in-person contact between a provider and a covered person for services appropriately provided through telehealth, subject to the terms and conditions of the plan. Reimbursement based upon the definition of "telehealth". ***Source: CO Revised Statutes 10-16-123(2) (a) (2015).***	The CO Medical Assistance Program will only reimburse for "live" telemedicine, excluding store and forward. Peripherals, such as transmission of a live ultrasound exam, may be reimbursed. ***Source: CO Medical Assistance Program, Telemedicine Manual, p. 2 (Dec. 2015), (Accessed Aug. 2016).***
Remote Patient Monitoring Reimbursement	
(see Medicaid column)	The CO Medical Assistance Program will reimburse for Remote Patient Monitoring at a flat fee set by the state board when all these requirements are met: • The patient is receiving services from a home health provider for at least one of the following: congestive heart failure, chronic obstructive pulmonary disease, asthma, or diabetes; • The patient requires monitoring at least five times weekly to manage the disease, as ordered by a physician or podiatrist; • The patient has been hospitalized two or more times in the last 12 months for conditions related to the disease; • The patient or caregiver misses no more than five monitoring events in a 30-day period; • The patient's home has space for all program equipment and full transmission capability. ***Source: (Reimbursement): CO Revised Statutes 25.5-5-321.*** ***Source: (Requirements): 10 CO Code of Regulation 2505-10.*** Eligible member must meet the following criteria: • Must receive home health services from provider who has opted to provide telehealth services • Member must require frequent and on-going monitoring/management of their disease or

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	condition • Member's home or caregiver must be willing and able to comply with vital sign self-monitoring • Member must have an eligible condition *Source; CO Department of Health Care Policy and Financing. "Home Health Telehealth". (Accessed Aug. 2016). <https://www.colorado.gov/pacific/hcpf/home-health-telehealth>* Additional restrictions apply. See Colorado Code of Regulations for more information. Medicaid Home Health will reimburse for services only if the patient has no other insurance. *Source: 10 CO Code of Regulation 2505-10.* CO Medicaid reimburses telehealth monitoring for qualified clients (see above requirements). Acute home health agencies and long-term home health agencies are reimbursed for the initial installation and education of telehealth monitoring equipment and can be billed once per client per agency. The agency can also bill for every day they receive and review the client's clinical information. No prior authorization needed, but agencies should notify the Department or its designee when a client is enrolled in the service. *Source: CO Medical Assistance Program, Home Health Billing Manual, p. 7 & 11-12 (Sept. 2015), (Accessed Aug. 2016).*
Email/Phone/FAX	
Private payers and the managed care system are not required to cover telephone or FAX services. *Source: CO Revised Statutes 10-16-123 and Colorado Revised Statutes 25.5-5-414 (2012).* **<u>Effective on or after Jan. 1, 2017</u>** Telehealth does not include the delivery of health care services via telephone, facsimile machine or electronic mail. *Source: CO Revised Statutes 10-16-123(2) (h) (4) (e) (II) (2015).*	No reimbursement for telephone. No reimbursement for FAX. *Source: CO Medical Assistance Program, Telemedicine Manual, p. 2 (Dec. 2015), (Accessed Aug. 2016).*
Online Prescribing	
Pharmacists are prohibited from dispensing prescription drugs if they know, or should have known, that it was on the basis of an internet-based questionnaire, an Internet-based consult, or a telephone consultation, all without a valid pre-existing patient-practitioner relationship.	No reference found.

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Source: 3 CO Code of Regulation 719-1 (2012). **Workers' Compensation** The physician-patient relationship/psychologist-patient relationship can be established through live audio/video services. *Source: 7 CO Regs. Rule 18.*	
Consent	
Providers shall give all first-time patients a written statement that includes the following: • The patient may refuse telemedicine services at any time, without loss or withdrawal of treatment; • All applicable confidentiality protections shall apply to the services; • The patient shall have access to all medical information from the services, under state law. *Source: CO Revised Statutes 25.5-5-320 (2012).* **Workers' Compensation** The patient needs to give consent. *Source: 7 CO Regs. Rule 18.*	The Medicaid requirement for face-to-face contact between provider and client may be waived prior to treating the client through telemedicine for the first time. The rendering provider must furnish each client with all of the following written statements which must be signed by the client or the client's legal representative: • The client retains the option to refuse the delivery of health care services via telemedicine at any time without affecting the client's right to future care or treatment and without risking the loss or withdrawal of any program benefits to which the client would otherwise be entitled. • All applicable confidentiality protections shall apply to the services. • The client shall have access to all medical information resulting from the telemedicine services as provided by applicable law for client access to his or her medical records. These requirements do not apply in an emergency. *Source: CO Medical Assistance Program, Telemedicine Manual, p. 3 (Dec. 2015), (Accessed Aug. 2016).*
Location	
Workers' Compensation Services provided via telecommunications technologies are not covered if the client has access to comparable service within 30 miles of his/her place of residence. Telehealth facilities can bill for the originating site fee if the site is in a: • County outside of a Metropolitan Statistical Area (MSA), or • A Health Professional Shortage Area, either located outside of an MSA or in a rural census tract, as determined by the office of Rural Health Policy within the Health Resources and Services Administration (HRSA) Authorized originating sites include: • The office of a physician or practitioner • A hospital • A critical access hospital (CAH) • A rural health clinic (RHC)	No enrolled managed care organization may require face-to-face contact between a provider and patient for services provided through telemedicine if: • The member resides in a county with a population of 150,000 or fewer residents; and • The county has the technology necessary to provide telemedicine services *Source: CO Medical Assistance Program, Telemedicine Manual, p. 3 (Dec. 2015), (Accessed Aug. 2016).* All Health First Colorado (Colorado's Medicaid Program) clients can receive services through the use of telemedicine, whether they live in rural or urban areas. *Source: CO Department of Health Care Policy and Financing. "Telemedicine". (accessed Aug. 2016) <https://www.colorado.gov/pacific/hcpf/telemedicine>*

STATE LAW/REGULATIONS	MEDICAID PROGRAM
• A federally qualified health center (FQHC) • A hospital based or critical access hospital based renal dialysis center (including satellite) • A skilled nursing facility (SNF) • Community Mental Health Center *Source: 7 CO Regs. Rule 18.*	
Cross-State Licensure	
No reference found.	No reference found.
Private Payers	
Health plans for patients in counties with 150,000 or fewer residents cannot require face-to-face contact between a provider and a patient for services that could be appropriately provided through telemedicine. These services are subject to all terms and conditions of the health plans. *Source: CO Revised Statutes 10-16-123 (2012).* **Effective Jan. 1, 2017:** A health benefit plan that is issued, amended or renewed shall not require in-person contact between a provider and a covered person for services appropriately provided through telehealth, subject to the terms and conditions of the plan. *Source: CO Revised Statutes 10-16-123(2) (a) (2015).*	No reference found.
Site/Transmission Fee	
Effective Jan. 1, 2017: A carrier shall include in the payment for telehealth interactions reasonable compensation to the originating site for the transmission cost incurred during the delivery of health care services through telehealth except for when the originating site is a private residence. *Source: CO Revised Statutes 10-16-123(2) (c) (2015).*	The CO Medical Assistance Program will reimburse for transmission costs, at a rate set by their state department. *Source: CO Revised Statutes 25.5-5-320 (2012).* The originating site may bill for a facility fee. Eligible providers for a facility fee includes: • Physician • Clinic • Osteopath • FQHC • Psychologist • MA Psychologist • Physician Assistant • Nurse Practitioner • Rural Health Clinic CO Medicaid pays a transmission fee when certain CPT codes are billed. See Telemedicine Manual for specific code list.

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	Source: CO Medical Assistance Program, Telemedicine Manual, p. 4-6 (Dec. 2015), (Accessed Aug. 2016).
Miscellaneous	
Effective Jan. 1, 2017: A provider is not required to document or demonstrate that a barrier to in-person care exists to trigger coverage under a health benefit plan for services provided through telehealth. *Source: CO Revised Statutes 10-16-123(2) (c) (2015).*	No reference found.

Comments: Colorado law includes in its definition of "health care services" the rendering of services via telemedicine.

CO Revised Statutes 10-16-102 (2012).

Connecticut

Medicaid Program: Medical Assistance Program

Program Administrator: Connecticut Dept. of Social Services

Regional Telehealth Resource Center:
Northeast Telehealth Resource Center
11 Parkwood Drive
Augusta, ME 04330
(207) 622-7566 / (800) 379-2021
www.netrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Telemedicine means the use of interactive audio, interactive video or interactive data communication in the delivery of medical advice, diagnosis, care or treatment…Telemedicine does not include the use of facsimile or audio-only telephone." *Source: CT General Statute 17b-245c.* "Telehealth" means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and mental health, and includes (A) interaction between the patient at the originating site and the telehealth provider at a distant site, and (B) synchronous interactions, asynchronous store and forward transfers or remote patient monitoring. Telehealth does not include the use of facsimile, audio-only telephone, texting or electronic mail." See private payers section. *Source: CT Public Act No. 15-88 (2015); SB 467.*	No reference found.
Live Video Reimbursement	
Newly Passed Legislation (Now Effective) CT Medicaid is required (within available state and federal resources) provide coverage for telehealth services for categories of health care services that the commissioner determines are clinically appropriate to be provided through telehealth, cost effective for the state and likely to expand access to services for whom accessing healthcare poses an undue hardship. *Source: CT Public Act No. 16-198 (SB 298 – 2016).* Reimbursement for services provided via live video. *Source: CT Public Act No. 15-88 (2015); SB 467.*	Connecticut's Medical Assistance Program will not pay for information or services provided to a client by a provider electronically or over the telephone. *Source: CT Provider Manual. Physicians and Psychiatrists. Sec. 17b-262-342. Pg. 9, Aug, 2013 and CT Provider Manual. Psychologists. Sec. 17b-262-472. Pg. 7. (Accessed Mar. 2016).* Exception: • Case management behavioral health services for clients age eighteen and under. *Source: CT Provider Manual. Behavioral Health. Sec. 17b-262-918. Feb. 1, 2013. Pg. 6. (Accessed Mar. 2016).*

Store and Forward Reimbursement	
Reimbursement for services provided via store-and-forward. See private payers section. *Source: CT Public Act No. 15-88 (2015); SB 467.*	**Change to State Plan Amendment (Now Effective)** Federally Qualified Health Centers can be reimbursed for electronic consults (e-consults) for specialty care (provider to provider communication). *Source: Notice of Proposed Medicaid State Plan Amendment. CT Department of Social Services. SPA 16-0021. (Accessed Aug. 2016).*
Remote Patient Monitoring Reimbursement	
No reference found.	No reference found.
Email/Phone/FAX	
There is no reimbursement for telephone or FAX. *Source: CT General Statutes17b-245c & CT Public Act No. 15-88 (2015); SB 467.*	The department shall not pay for information or services provided to a client over the telephone. *Source: CT Provider Manual. Clinic. Sec. 17b-262-823. Ch. 8, pg. 20, July 17, 2014. (Accessed Mar. 2016).*
Online Prescribing	
No telehealth provider shall prescribe schedule I, II or III controlled substances through the use of telehealth. *Source: CT Public Act No. 15-88 (2015); SB 467.*	No reference found.
Consent	
At the time of the telehealth interaction, the provider shall provide information to the patient treatment information, limitations of the telehealth platform, and obtain consent from the patient to provide telehealth services and disclose to the patient's primary care provider records of the telehealth interaction. *Source: CT Public Act No. 15-88 (2015); SB 467.*	No reference found.
Location	
No reference found.	No reference found.
Cross-State Licensing	
Department of Public Health may establish a process of accepting an applicant's license from another state and may issue that applicant a license to practice medicine in the state without examination, if certain conditions are met. *Source: CT General Statutes Sec. 20-12 (2012).*	No reference found.
Private Payers	
Each individual health insurance policy and group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 shall provide coverage for treatment provided via telehealth if that it was covered if provided in-person and shall be subject to the same terms and conditions of the	No reference found.

policy. *Source: CT Public Act No. 15-88 (2015); SB 467.*	
Site/Transmission Fee	
No telehealth provider can charge a facility fee. *Source: CT Public Act No. 15-88 (2015); SB 467.*	No reference found.
Miscellaneous	

Comments: In 2012, a new law allowed the Commissioner of Social Services to establish a demonstration project to offer telemedicine as a Medicaid-covered service at Federally Qualified Health Centers. The Commission is considering design options for a pilot.

Source: CT General Statutes17b-245c.

District of Columbia

Medicaid Program: District of Columbia Medicaid

Program Administrator: District of Columbia Dept. of Health Care Finance

Regional Telehealth Resource Center:
Mid-Atlantic Telehealth Resource Center
PO Box 800711
Charlottesville, VA 22908-0711
(434) 906-4960 / (855) MATRC4U
www.matrc.org

STATE LAW	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Telehealth" means the delivery of healthcare services through the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment; provided, that services delivered through audio-only telephones, electronic mail messages, or facsimile transmissions are not included. ***Source: DC Code Sec. 31-3861.***	Telehealth is defined as the delivery of healthcare services through the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment, provided, that services delivered through audio-only telephones, electronic mail messages, or facsimile transmissions are not included. For the purposes of coverage by the Department of Health Care Finance (DHCF), telehealth and telemedicine shall be deemed synonymous. … Telemedicine is a service delivery model that delivers healthcare services through a two-way, real time interactive video-audio communication for the purpose of evaluation, diagnosis, consultation, or treatment. ***Source: DC Municipal Regulation. Title 29, Ch. 9, Sec. 910, .99 & Physicians Billing Manual. DC Medicaid. 7/12/2016. Sec. 12-7. Pgs. 47-49.***
Live Video Reimbursement	
Medicaid is required to pay for telehealth services if the same service would be covered when delivered in person. ***Source: DC Code 31-3863.***	Effective June 23, 2016 DC Medical Assistance Program will reimburse eligible providers for eligible healthcare services rendered via telemedicine in DC. Patient must be with a provider at the originating site. Must be an approved telemedicine provider. The following providers are considered an eligible originating site, as well as eligible distant site provider: • Hospital • Nursing facility • Federally Qualified Health Center • Clinic • Physician Group/Office • Nurse Practitioner Group/Office • DCPS • DCPCS

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	• Core Service Agency Distant site providers may only bill for the appropriate codes outlined (see manual). Special reimbursement parameters for FQHCs: • When FQHC is originating site: An FQHC provider must deliver an FQHC-eligible service in order to be reimbursed the appropriate PPS or fee for service (FFS) rate at the originating site; • When FQHC is distant site: An FQHC provider must deliver an FQHC-eligible service in order to be reimbursed the appropriate PPS or FFS rate; and • When FQHC is Originating and Distant Site: In instances where the originating site is an FQHC, the distant site is an FQHC, and both sites deliver a service eligible for the same clinic visit/encounter all-inclusive PPS code, only the distant site will be eligible to be reimbursed for the appropriate PPS rate for an FQHC-eligible service. Covered Services: • Evaluation and management • Consultation • Behavioral healthcare services • Rehabilitation services including speech therapy ***Source: DC Municipal Regulation. Title 29, Ch. 9, Sec. 910, .99 & Physicians Billing Manual. DC Medicaid. 7/12/2016. Sec. 12-7. Pgs. 47-49.***
Store and Forward Reimbursement	
No reference found.	No reimbursement for store and forward. ***Source: DC Municipal Regulation. Title 29, Ch. 9, Sec. 910, .99 & Physicians Billing Manual. DC Medicaid. 7/12/2016. Sec. 12-7. Pgs. 47-49.***
Remote Patient Monitoring Reimbursement	
No reference found.	No reimbursement for remote patient monitoring. ***Source: DC Municipal Regulation. Title 29, Ch. 9, Sec. 910, .99 & Physicians Billing Manual. DC Medicaid. 7/12/2016. Sec. 12-7. Pgs. 47-49.***
Email/Phone/FAX	
No reimbursement requirement for audio-only telephones, electronic mail messages or facsimile transmissions. ***Source: Code Sec. 31-3861.***	DC Medicaid does not reimburse for service delivery using audio-only telephones, e-mail messages or facsimile transmissions. ***Source: DC Municipal Regulation. Title 29, Ch. 9, Sec. 910, .99 & Physicians Billing Manual. DC Medicaid. 7/12/2016. Sec. 12-7. Pgs. 47-49.***

STATE LAW	MEDICAID PROGRAM
Online Prescribing	
No reference found.	No reference found.
Consent	
No reference found.	Written consent required. *Source: DC Municipal Regulation. Title 29, Ch. 9, Sec. 910, .99 & Physicians Billing Manual. DC Medicaid. 7/12/2016. Sec. 12-7. Pgs. 47-49.*
Location	
No reference found.	Eligible originating sites: • Hospital • Nursing facility • Federally Qualified Health Center • Clinic • Physician Group/Office • Nurse Practitioner Group/Office • DCPS • DCPCS • Core Service Agency *Source: DC Municipal Regulation. Title 29, Ch. 9, Sec. 910, .99 & Physicians Billing Manual. DC Medicaid. 7/12/2016. Sec. 12-7. Pgs. 47-49.*
Cross-State Licensing	
No reference found.	No reference found.
Private Payers	
Private payers are required to pay for telehealth services if the same service would be covered when delivered in person. A health insurer may not impose any annual or lifetime dollar maximum on coverage for telehealth services. *Source: DC Code Sec. 31-3862.*	No reference found.
Site/Transmission Fee	
No reference found.	No transaction or facility fee. *Source: DC Municipal Regulation. Title 29, Ch. 9, Sec. 910, .99 & Physicians Billing Manual. DC Medicaid. 7/12/2016. Sec. 12-7. Pgs. 47-49.*
Miscellaneous	
DHCF required to send a Telemedicine Program Evaluation survey to providers, effective Jan. 1, 2017. *Source: DC Municipal Regulation. Title 29, Ch. 9, Sec. 910, .99.*	

Delaware

Medicaid Program: Delaware Medical Assistance Program

Program Administrator: Delaware Health and Social Services Dept., Division of Social Services

Regional Telehealth Resource Center:
Mid-Atlantic Telehealth Resource Center
PO Box 800711
Charlottesville, VA 22908-0711
(434) 906-4960 / (855) MATRC4U
www.matrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Telehealth, as set forth in the Board's rules and regulations, means the use of electronic communications to provide and deliver a host of health-related information and healthcare services, including physical therapy and athletic training related information and services, over large and small distances. Telehealth encompasses a variety of healthcare and health promotion activities, including education, advice, reminders, interventions, and monitoring of intervention." *Source: DE Code. Title 24, Sec. 2602.* ***Group and Blanket Insurance, & Health Insurance Contracts*** ***Also applies to: Physicians, Podiatry, Optometry, Chiropractic, Dentistry, Nursing, Occupational Therapy, Physical Therapy, Mental Health, Psychology, Dietetic and Nutrition Therapy, and Clinical Social Work*** Telehealth means the use of information and communications technologies consisting of telephone, remote patient monitoring devices or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services as described in regulation. *Source: DE House Bill 69 (2015); Title 18, Sec. 3370; & Title 18, Sec. 3571R; DE Code Title 24, Sec. 1702, Sec. 502, Sec. 701, Sec. 1101, Sec. 1902, Sec. 2002, Sec. 2101, Sec. 2502, Sec. 3002, Sec. 3502, Sec. 3802, & Sec. 3902.* ***Group and Blanket Insurance, & Health Insurance Contracts*** Telemedicine means a form of telehealth which is the delivery of clinical health care services by means of real time two-way audio, visual or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support healthcare	"Telemedicine is the use of telecommunication and information technologies to provide clinical health care at a distance". *Source: DE Dept. of Health and Social Svcs., Press Release DHSS-59-2012, (Jun. 27, 2012). (Accessed Aug. 2016).*

STATE LAW/REGULATIONS	MEDICAID PROGRAM
delivery which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient's health care by a health care provider practicing within his or her scope of practice as would be practiced in-person with a patient, and legally allowed to practice in the state, while such patient is at an originating site and the health care provider is at a distant site. *Source: DE House Bill 69 (2015); Title 18, Sec. 3370; & Title 18, Sec. 3571R.* ***Applies to: Physicians, Podiatry, Optometry, Chiropractic, Dentistry, Nursing, Occupational Therapy, Physical Therapy, Mental Health, Psychology, Dietetic and Nutrition Therapy, Clinical Social Work*** Telemedicine means a form of telehealth which is the delivery of clinical health care services by means of real time two-way audio, visual or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support healthcare delivery which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient's health care by a licensee practicing within his or her scope of practice as would be practiced in-person with a patient and with other restrictions as defined in regulation. *Source: DE House Bill 69 (2015) & DE Code Title 24, Sec. 1702, Sec. 502, Sec. 701, Sec. 1101, Sec. 1902, Sec. 2002, Sec. 2101, Sec. 2502, Sec. 3002, Sec. 3502, Sec. 3802, & Sec. 3902.* ***Applies to: Mental Health Counseling, Chemical Dependency Counseling, or Marriage and Family Therapy*** "Telehealth Services" means the practice of Mental Health Counseling, Chemical Dependency Counseling, or Marriage and Family Therapy (hereinafter referred to as Behavioral Health Practice) by distance communication technology such as but not necessarily limited to telephone, email, Internet-based communications, and videoconferencing. *Source: DE Admin. Code Title 24, Sec. 3000. http://regulations.delaware.gov/AdminCode/title24/3000.shtml*	
Live Video Reimbursement	
No reference found.	The Delaware Medical Assistance Program will reimburse for "telemedicine-delivered services." *Source: DE Dept. of Health and Social Svcs., Press Release DHSS-59-2012, (Jun. 27, 2012). (Accessed Aug. 2016).* The GT modifier (which indicates the service occurred via interactive audio and video telecommunication system) can be used for Early and Periodic Screening,

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	Diagnostic and Treatment Services through the School Based Health Services program. ***Source: DE School Based Health Services Specific Policy Manual, pg. 62 (Apr. 1, 2016). (Accessed Aug. 2016).***
Store and Forward Reimbursement	
No reference found.	No reference found.
Remote Patient Monitoring Reimbursement	
No reference found.	No reference found.
Email/Phone/FAX	
No reference found.	Federally Qualified Health Centers Telephone consultations are covered services that are included in the payment made to the FQHC and should not be billed as an encounter. ***Source: Delaware FQHC Provider Specific Policy Manual, pg. 5. (Accessed Aug. 2016).***
Online Prescribing	
Pharmacists are prohibited from dispensing prescription drug orders through an Internet pharmacy if the pharmacist knows that the prescription order was issued solely on the basis of an Internet consultation or questionnaire, or medical history form submitted to an Internet pharmacy through an Internet site. ***Source: DE Code, Title 16 Sec. 4744 (2012).*** ***APRNs and Physicians*** Establishing a proper provider-patient relationship includes: • Verifying the location of requesting patient; • Disclosing the provider's identity and credentials; • Obtaining consent; • Establishing a diagnosis through acceptable medical practices, including a physical exam; • Discuss with patient the diagnosis; • Ensure availability of distant site provider or coverage of patient for follow up care; and • Provide written visit summary to patient ***Physician & APRNs*** Without a prior patient-provider relationship providers are prohibited from issuing prescriptions based on internet questionnaire, internet consult or a telephone consult. Prescriptions through telemedicine and under a physician-patient relationship may include controlled substances, subject to limitations set by the Board.	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Source: DE House Bill 69 (2015); Title 24, Sec. 1769D & DE Code Title 24, Sec. 1932. ***Physicians*** Prior to a diagnosis and treatment a physician using telemedicine must either provide: • An appropriate in-person exam; • Have another DE licensed practitioner at the originating site with the patient at the time of diagnosis; • Diagnosis must be based using both audio and visual communication; or • The service meets standards of establishing a patient-physician relationship included as part of evidenced-based clinical practice guidelines in telemedicine developed by major medical specialty societies. *Source: DE House Bill 69 (2015); Title 24, Sec. 1769D.*	
Consent	
Informed consent must be obtained to establish a physician-patient relationship over telehealth. *Source: DE House Bill 69 (2015); Title 24, Sec. 1769D & DE Code Title 24, Sec. 1932.* ***Applies to: Mental Health Counseling, Chemical Dependency Counseling, or Marriage and Family Therapy*** Must obtain consent. *Source: DE Admin. Code Title 24, Sec. 3000. http://regulations.delaware.gov/AdminCode/title24/3000.shtml*	No reference found.
Location	
An approved originating site may include the DMAP member's place of residence. *Source: 19 DE Reg. 191.*	Eligible originating sites: • Hospitals; • Federally qualified health centers (FQHC); • Public health clinics; • Program for All-Inclusive Care for the Elderly (PACE) centers. *Source: DE Dept. of Health and Social Svcs., Press Release DHSS-59-2012, (Jun. 27, 2012). (Accessed Aug. 2016).*
Cross-State Licensing	
No reference found.	No reference found.
Private Payers	
Private payers must provide coverage for the cost of health care services provided through telemedicine, and telehealth as directed through regulations by the Department.	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Insurers must pay for telemedicine services at the same rate as in-person. ***Source: Title 18, Sec. 3370; & Title 18, Sec. 3571R.***	
Site/Transmission Fee	
Private payers: Payment for telemedicine must include reasonable compensation to the originating or distant site for the transmission cost. ***Source: Title 18, Sec. 3370; & Title 18, Sec. 3571R.***	The originating site will be reimbursed a facility fee for the telemedicine space and equipment. ***Source: DE Dept. of Health and Social Svcs., Press Release DHSS-59-2012, (Jun. 27, 2012). (Accessed Aug. 2016).***
Miscellaneous	

Comments:

Professional regulation with telehealth specific standards

- Physical Therapists and Athletic Trainers ***(Source: DE Statute Title 24, Sec. 2602)***
- Board of Mental Health and Chemical Dependency Professionals ***(Source: DE Admin. Code Title 24, Sec. 3000)***

Florida

Medicaid Program: Florida Medicaid

Program Administrator: Florida Dept. of Children and Families

Regional Telehealth Resource Center:
Southeast Telehealth Resource Center
PO Box 1408
Waycross, GA 31501
(888) 138-7210
www.setrc.us

STATE LAW	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Telemedicine means the practice of medicine by a licensed Florida physician or physician assistant where patient care, treatment, or services are provided through the use of medical information exchanged from one site to another via electronic communications. Telemedicine shall not include the provision of health care services only through an audio only telephone, email messages, text messages, facsimile transmission, *Source: FL Admin Code 64B8-9.0141 & 64B15-14.0081.* Telemedicine: The practice of health care delivery by a practitioner who is located at a site other than the site where a recipient is located for the purposes of evaluation, diagnosis, or treatment. *Source: FL Admin Code 59G-1.057.*	Telemedicine is "the use of telecommunication and information technology to provide clinical care to individuals at a distance, and to transmit the information needed to provide that care." *Source: FL Dept. of Health, Child Protection Team Program, Policy and Procedure Handbook, p.79 (Jun. 2015). (Accessed Aug. 2016).* "Telemedicine is the practice of health care using telecommunication equipment by the treating provider (at the spoke site) for the provision of approved covered services by the consulting provider (at the hub site) for the purpose of evaluation, diagnosis or treatment." *Source: FL Dept. of Health, Specialized Therapeutic Services Coverage and Limitations Handbook, p.12 (Mar. 2014) & FL Community Behavioral Health Services Coverage and Limitations Handbook, p. 10 (Mar. 2014). (Accessed Aug. 2016).*
Live Video Reimbursement	
FL Medicaid reimburses for real time interactive telemedicine. *Source: FL Admin Code 59G-1.057.*	For Community Behavioral Health Services Coverage providers must implement technical written policies and procedures for telemedicine systems that comply with HIPAA, as well as state and federal laws related to patient privacy. *Source: FL Community Behavioral Health Services Coverage and Limitations Handbook, p. 10 (Mar. 2014). (Accessed Aug. 2016).*
Store and Forward Reimbursement	
No reference found.	No reference found.
Remote Patient Monitoring Reimbursement	
No reference found.	No reference found.
Email/Phone/FAX Restrictions	
No reimbursement for telephone, chart review, electronic mail messages or facsimile transmissions.	No reference found.

STATE LAW	MEDICAID PROGRAM
Source: FL Admin Code 59G-1.057. "Telemedicine shall not include the provision of health care services only through an audio only telephone, email messages, text messages, facsimile transmission, U.S. Mail or other parcel service, or any combination thereof." *Source: FL Admin Code 64B8-9.0141 & 64B15-14.0081.*	
Online Prescribing	
Controlled substances shall not be prescribed through the use of telemedicine, except for the treatment of psychiatric disorders. Exception: physicians can order controlled substances through the use of telemedicine for patients hospitalized in a facility licensed pursuant to Ch. 395, F.S. Prescribing medication solely on the basis of an electronic medical questionnaire is not allowed. A physician-patient relationship may be established through telemedicine. *Source: FL Admin Code 64B8-9.0141 & 64B15-14.0081.* Prior to e-prescribing, physicians and physician assistants must document a patient evaluation, including history and physical examination, to establish the diagnosis for which any drug is prescribed, and discuss treatment options with the patient. These rules don't apply in emergency situations. *Source: FL Admin. Code 64B8-9.014.*	No reference found.
Consent	
No reference found.	No reference found.
Location	
No reference found.	For Specialized Therapeutic Services & Community Behavioral Health Services, the service must be delivered from a facility that is enrolled in Medicaid as a community behavioral health services provider. *Source: FL Dept. of Health, Specialized Therapeutic Services Coverage and Limitations Handbook, p.46 (Mar. 2014) & FL Community Behavioral Health Services Coverage and Limitations Handbook, p. 24 (Mar. 2014). (Accessed Aug. 2016).* Both the hub and spoke sites must be located in Florida. *Source: FL Dept. of Health, Specialized Therapeutic Services Coverage and Limitations Handbook, p.9-12 (Mar. 2014) FL Community Behavioral Health Services Coverage and Limitations Handbook, p. 9-10 (Mar. 2014). (Accessed Aug. 2016).*

STATE LAW	MEDICAID PROGRAM
Cross State Licensing	
No reference found.	No reference found.
Private Payers	
No reference found.	No reference found.
Site/Transmission Fee	
No reference found.	No reference found.
Miscellaneous	
Florida's Board of Medicine and Osteopathic Medicine adopted "Standards for Telemedicine Practice". See "Comments" for details not included in the categories above. ***Source: FL Admin Code 64B8-9.0141.***	

Comments: In 1998, the Child Protection Team (CPT) Program implemented a telemedicine network that links CPT teams with remote or satellite CPT offices, or local facilities, such as hospital emergency rooms, county health departments, or child advocacy centers, to facilitate telemedicine assessments for abuse, abandonment, and neglect of children in remote or rural areas.

Only specially trained CPT physicians, advanced registered nurse practitioners or physician assistants can perform these exams. And only specifically trained registered nurses at presenting sites may participate in the exam.

Source: Florida Department of Health, Child Protection Team Program, Policy and Procedure Handbook, p. 30 (Jun. 2015). (Accessed Aug. 2016).

Florida Children's Medical Services (CMS) is a collection of programs for special needs children. CMS' Telemedicine Program services are provided by approved CMS Network providers to Medicaid children enrolled in CMS. Eligible sites are limited.

Source: Florida Children's Medical Services, Families, Health Services (Accessed Aug. 2016).

Professional Board Telehealth-Specific Regulations

- FL Board of Medicine ***(Source: FL Admin Code 64B8-9.0141)***
- FL Board of Osteopathic Medicine ***(Source: Florida Admin Code 64B15-14.0081)***

Georgia

Medicaid Program: Georgia Medicaid

Program Administrator: Georgia Dept. of Community Health

Regional Telehealth Resource Center:
Southeast Telehealth Resource Center
PO Box 1408
Waycross, GA 31501
(888) 138-7210
www.setrc.us

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Telemedicine means the practice, by a duly licensed physician or other health care provider acting within the scope of such provider's practice, of health care delivery, diagnosis, consultation, treatment, or transfer of medical data by means of audio, video, or data communications which are used during a medical visit with a patient or which are used to transfer medical data obtained during a medical visit with a patient. Standard telephone, facsimile transmissions, unsecured e-mail, or a combination thereof do not constitute telemedicine services." ***Source: Official Code of GA Annotated Sec. 33-24-56.4 (2012).***	"Telemedicine is the use of medical information exchange from one site to another via electronic communications to improve patients' health status. It is the use of two-way, real time interactive communication equipment to exchange the patient information from one site to another via an electronic communication system. This includes audio and video telecommunication equipment." "Closely associated with telemedicine is the term 'telehealth,' which is often used to encompass a broader definition of remote healthcare that does not always involve clinical services. Telehealth is the use of telecommunication technologies for clinical care (telemedicine), patient teachings and home health, health professional education (distance learning), administrative and program planning, and other diverse aspects of a health care delivery system." ***Source: GA Dept. of Community Health, GA Medicaid Telemedicine Handbook, p. 2, (Jan. 2016). (Accessed Aug. 2016).***
Live Video Reimbursement	
Georgia requires coverage of telemedicine services (which includes live video), subject to contract terms and conditions. *(See "Private Payers" section).* ***Source: GA Rules & Regulations. Sec. 33-24-56.4 (2012).***	Georgia Medicaid will reimburse for live video when the service is "medically necessary, the procedure is individualized, specific, and consistent with symptoms or confirmed diagnosis of an illness or injury under treatment, and not in excess of the member's needs." Eligible services: • Office visits; • Pharmacologic management; • Limited office psychiatric services; • Limited radiological services; • A limited number of other physician fee schedule services.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	Eligible providers who may bill for telemedicine services: • Physician • Physician Assistant • Clinical Psychologist • Nurse Practitioner • Clinical Nurse Specialist ***Source: GA Dept. of Community Health, GA Medicaid Telemedicine Handbook, p. 3-4, (Jan. 2016). (Accessed Aug. 2016).*** Local Education Agencies are allowed to enroll in the Health Check Program to serve as telemedicine originating sites only. ***Source: GA Dept. of Community Health, Children's Intervention School Services (CISS). July 1, 2016. VI-4 (p. 9). (Accessed Aug. 2016).*** ***GA Dept. of Community Health, Health Check EPSDT. July 1, 2016. X-5. p. 59. (Accessed Aug. 2016).*** Georgia Medicaid will reimburse for mental health services for residents in nursing homes via telemedicine (although not available in all areas of the state) for "dual eligibles" (Medicaid and Medicare). Nursing facilities and community behavioral health rehabilitation (CBHRS) service providers can arrange for the provision of specialized services to residents either in nursing facilities, via telemedicine or at the CBHRS location for residents in the Preadmission Screening and Resident Review Serious Mental Illness and dually diagnosed populations. ***Source: GA Dept. of Community Health, Division of Medical Assistance, Part II Policies and Procedures for Community Behavioral Health Rehabilitation Services, p. 30 & 36 (Jul. 2016). (Accessed Aug. 2016) & GA Dept. of Community Health, Division of Medical Assistance, Part II Policies and Procedures for Nursing Facilities, p. H-1 (p. 153). Jul. 1, 2016. (Accessed Aug. 2016).***
Store and Forward Reimbursement	
No reference found.	Georgia Medicaid will not reimburse for store and forward because these services do not include direct, in-person patient contact. However, telemedicine handbook indicates that cardiography, echocardiography, ultrasounds and x-rays are services that can be performed via telemedicine (which is defined as occurring via an interactive telecommunications system). ***Source: GA Dept. of Community Health, GA Medicaid Telemedicine Handbook, p. 4 & p. 8, (Jan. 2016). (Accessed Aug. 2016).***
Remote Patient Monitoring Reimbursement	
No reference found.	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Email/Phone/FAX	
No reimbursement for FAX. No reimbursement for telephone. No reimbursement for email. *Source: Official Code of GA Annotated Sec. 33-24-56.4 (2012).*	No reimbursement for FAX. No reimbursement for telephone. No reimbursement for email. *Source: GA Dept. of Community Health, GA Medicaid Telemedicine Handbook, p. 8, (Jan. 2016). (Accessed Aug. 2016).*
Online Prescribing	
Physicians are prohibited from prescribing controlled substances or dangerous drugs based solely on an electronic consult. *Source: GA Rules & Regulations revised 360-3-.02 (2012).*	No reference found.
Consent	
No reference found in statute.	The referring provider must obtain prior written consent. *Source: GA Dept. of Community Health, GA Medicaid Telemedicine Handbook, p. 5, (Jan. 2016). (Accessed Aug. 2016).*
Location	
No reference found.	Eligible originating sites: • Provider offices; • Hospitals; • Critical Access Hospitals (CAH); • Rural Health Clinics (RHC); • Federally Qualified Health Centers (FQHC); • Skilled nursing facilities; • Community mental health centers; • GA public health clinics; • School-based clinics. Eligible distant sites: • Provider offices; • Hospitals; • Critical Access Hospitals (CAH); • Rural Health Clinics (RHC); • Federally Qualified Health Centers (FQHC); • Skilled nursing facilities; • Community mental health centers; • GA public health clinics. Providers located within 50 miles of the GA border who routinely treat GA Medicaid/Peachcare for Kids members may enroll with in-state status. Providers who meet the Medicaid credentialing requirements and are currently enrolled in GA Medicaid are eligible to bill and be reimbursed. *Source: GA Dept. of Community Health, GA Medicaid*

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	Telemedicine Handbook, p. 3-4, (Jan. 2016). (Accessed Aug. 2016). FQHCs and RHCs cannot bill an originating site fee and distant site fee for telehealth services on the same encounter. *Source: GA Dept. of Community Health, Policies and Procedures for Federally Qualified Health Services and Rural Health Clinic Services, p. 22, (Jul. 2016), (accessed Aug. 2016).* Local Education Agencies are allowed to enroll in the Health Check Program to serve as telemedicine originating sites only. *Source: GA Dept. of Community Health, Children's Intervention School Services (CISS). July 1, 2016. VI-4 (p. 9) & GA Dept. of Community Health, Health Check EPSDT. July 1, 2016. X-5. p. 59. (Accessed Aug. 2016).*
Cross-State Licensure	
Must be a Georgia licensed practitioner. *Source: GA Admin. Code Sec. 360-3-.07*	Providers must have a Georgia license. *Source: GA Dept. of Community Health, GA Medicaid Telemedicine Handbook, p. 3, (Jan. 2016). (Accessed Aug. 2016).*
Private Payers	
Requires coverage of telemedicine services, subject to contract terms and conditions. *Source: GA Rules & Regulations. Sec. 33-24-56.4 (2012).*	No reference found.
Site/Transmission Fee	
No reference found.	Rural Health Clinics and FQHCs can collect a telehealth origination site facility fee. *Source: GA Dept. of Community Health, Policies and Procedures for Federally Qualified Health Services and Rural Health Clinic Services, p. 22, (Jul. 2016), (accessed Aug. 2016).* Originating sites can bill for a facility fee. The cost of telemedicine equipment and transmission is not a covered service (unless a technical component of an x-ray, ultrasound or electrocardiogram is performed). *Source: GA Dept. of Community Health, GA Medicaid Telemedicine Handbook, p. 3 & 8, (Jan. 2016). (Accessed Aug. 2016).*
Miscellaneous	
	Other Non-Covered Services: • Services rendered via web cam or internet based technologies that are not part of a secured network and do not meet HIPAA encryption compliance • Video cell phone interaction

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	Source: GA Dept. of Community Health, GA Medicaid Telemedicine Handbook, p. 8, (Jan. 2016). (Accessed Aug. 2016).

Comments:

Professional Board Telehealth-Specific Regulations

- GA Composite Medical Board ***(Source: GA Admin. Code Sec. 360-3-.07)***

Hawaii

Medicaid Program: Hawaii Quest

Program Administrator: Hawaii Dept. of Human Services

Regional Telehealth Resource Center:
Pacific Basin Telehealth Resource Center
Telehealth Research Institute, John A. Burns School of Medicine
651 Ilalo Street
Honolulu, HI 96813
(808) 692-1090
www.pbtrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
Newly Passed Legislation (Effective Jan. 1, 2017) "Telehealth" means the use of telecommunications services, as defined in section 269-1, to encompass four modalities: store and forward technologies, remote monitoring, live consultation, and mobile health; and which shall include but not be limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced health care services and information while a patient is at an originating site and the health care provider is at a distant site. Standard telephone contacts, facsimile transmissions, or e-mail text, in combination or by itself, does not constitute a telehealth service for the purposes of this section." ***Source: HI Revised Statutes Ch. 346, § 671, 457-2, 453-1.3, § 431:10A-116.3, 466J-6 & 453-2 (SB 2395).***	No reference found.
Live Video Reimbursement	
Newly Passed Legislation (Effective Jan. 1, 2017) Hawaii Medicaid and private payers are required to cover telehealth services (which includes live video) equivalent to reimbursement for the same services provided in-person. ***Source: HI Revised Statutes § 346 & 431:10A-116.3 (SB 2395 - 2016).*** *(See Medicaid column & "Private Payers" Section)*	Hawaii Quest will reimburse for live video, as long as it "includes audio and video equipment, permitting real-time consultation among the patient, consulting practitioner and referring practitioner." ***Source: Code of HI Rules 17-1737 (2012).***
Store and Forward Reimbursement	
Newly Passed Legislation (Effective Jan. 1, 2017) Hawaii Medicaid and private payers are required to cover appropriate telehealth services (which includes	Hawaii Quest requires the patient to be "present and participating in the telehealth visit" therefore excluding store and forward from reimbursement.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
store and forward) equivalent to reimbursement for the same services provided in-person. *Source: HI Revised Statutes § 346 & 431:10A-116.3 (SB 2395 - 2016).* *(also see Medicaid column)*	*Source: Code of HI Rules 17-1737.* Telemedicine-based retinal imaging and interpretation is not a covered service for PPS reimbursement. *Source: Med-QUEST Provider Manual. Ch. 21: Federally Qualified Health Centers. Mar. 2016. (Accessed Aug. 2016).*
Remote Patient Monitoring Reimbursement	
Newly Passed Legislation (Effective Jan. 1, 2017) Hawaii Medicaid and private payers are required to cover appropriate telehealth services (which includes remote patient monitoring) equivalent to reimbursement for the same services provided in-person. *Source: HI Revised Statutes § 346 & 431:10A-116.3 (SB 2395 - 2016).*	No reference found.
Email/Phone/FAX	
No reimbursement for email. No reimbursement for telephone. No reimbursement for FAX. *Source: HI Revised Statutes § 431:10A-116.3.* *(also see Medicaid column)*	No reimbursement for email. No reimbursement for telephone. No reimbursement for FAX. *Source: Code of HI Rules 17-1737 (2012).* **Behavioral Health Services** Telephone services may not be billed to Medicaid as an office visit. *Source: Medicaid Provider Manual. Ch. 15 Behavioral Health Services. Oct. 18, 2002. (Accessed Mar. 2016).*
Online Prescribing	
Prescribing providers must have a provider-patient relationship prior to e-prescribing. This includes: • A face-to-face history and physical exam; • A diagnosis and therapeutic plan; • Discussion of diagnosis or treatment with the patient; • Availability of appropriate follow-up care. *Source: HI Revised Statutes § 329-1 (2012).* Treatment recommendations made via telemedicine are appropriate for traditional physician-patient settings that do not include a face-to-face visit, but in which prescribing is appropriate, including on-call telephone encounters and encounters for which a follow-up visit is arranged. Issuing a prescription based solely on an online questionnaire is prohibited. **Newly Passed Legislation (Effective Jan. 1, 2017)** A physician-patient relationship may be established via	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
telehealth if the patient is referred to the telehealth provider by another health care provider who has conducted an in-person consultation and has provided all pertinent patient information to the telehealth provider. ***Source: HI Revised Statutes § 453-1.3.***	
Consent	
No reference found.	No reference found.
Location	
(see Medicaid column)	Eligible originating sites: • Hospitals; • Critical Access Hospitals; • Rural Health Clinics; • Federally Qualified Health Centers; • Federal telehealth demonstration project sites. In addition, originating sites must be located in one of the following: • A federally designated Rural Health Professional Shortage Area; • A county outside of a Metropolitan Statistical Area; • An entity that participates in a federal telemedicine demonstration project. ***Source: Code of HI Rules 17-1737 (2012).***
Cross-State Licensing	
Out-of-state radiologists may provide services in Hawaii. ***Source: HI Revised Statutes § 453-2(b) (6).*** Commissioned medical officers or psychologists employed by the US Department of Defense and credentialed by Tripler Army Medical Center are exempt from licensing requirements when providing services to neighbor island beneficiaries within a Hawaii national guard armory. ***Source: HI Revised Statutes Sec. 453-2(3).***	No reference found.
Private Payers	
Hawaii requires coverage of telehealth services equivalent to reimbursement for the same services provided via-face-to-face contact. ***Source: HI Revised Statutes § 431:10A-116.3.***	No reference found.
Site/Transmission Fee	
No reference found.	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Miscellaneous	
Newly Passed Legislation (Effective Jan. 1, 2017) Professional liability insurance for health care providers must provide malpractice coverage for telehealth equivalent to coverage for the same services provided via face-to-face contact. *Source: HI Revised Statutes §671 (SB 2395 - 2016).*	

Comments: In July 2011, Hawaii began implementing a mobile medical van telehealth pilot project, staffed by primary care providers, for consults with other health care providers.

HI Revised Statutes, Div. 1, Title 20, Ch. 346 Note (2012).

Hawaii and Alaska are the only two states with Medicare coverage of store and forward services.

Idaho

Medicaid Program: Idaho Medicaid

Program Administrator: Idaho Dept. of Health and Welfare

Regional Telehealth Resource Center:
The Northwestern Regional Telehealth Resource Center
2900 12th Ave. N., Ste. 30W, Billings, MT 59101
(888) 662-5601
www.nrtrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Telehealth is an electronic real-time synchronized audio-visual contact between a consultant and participant related to the treatment of the participant. The consultant and participant interact as if they were having a face-to-face service." *Source: ID Administrative Code 16.03.10.681 (2012).* Psychiatric Telehealth is an electronic real time synchronous audio-visual contact between a physician and participant related to the treatment of the participant. The participant is in one (1) location, called the hub site, with specialized equipment including a video camera and monitor, and with the hosting provider. The physician is at another location, called the spoke site, with specialized equipment. The physician and participant interact as if they were having a face-to-face service. *Source: ID Administrative Code 16.03.09 Sec. 502* Telehealth services means health care services provided by a provider to a person through the use of electronic communications, information technology, asynchronous store and forward transfer or synchronous interaction between a provider at a distant site and a patient at an originating site. Such services include, but are not limited to, clinical care, health education, home health and facilitation of self-managed care and caregiver support. *Source: ID House Bill 189 (2015) & ID Code Sec. 54-5603.* Telehealth is synchronous interaction telehealth encounters, delivered as defined in Title 54, Chapter 57, Idaho Code. *Source: ID Administrative Code 16.03.09 Sec. 502.*	Telehealth is health care services provided by a provider to a participant through the use of electronic communications, information technology, synchronous interaction between a provider at a distant site and a patient at an originating site. *Source: Medicaid Telehealth Policy. Rev. 7/1/2016. (Accessed Aug. 2016).*
Live Video Reimbursement	
Telehealth services that are properly identified in accordance with billing requirements are covered under	Idaho Medicaid reimburses for specific services via telehealth.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Medicaid for physicians, within limitations defined by the Department in the Idaho Medicaid Provider Handbook. Subject to primary care provider communication requirements. Telehealth services are covered for advanced practice registered nurses enrolled as Healthy Connections providers, within the limitations defined in the Idaho Medicaid Provider Handbook. ***Source: ID Administrative Code 16.03.09 Sec. 210, 502 & 565.***	If the department elects to reimburse for other services, Medicare coverage and reimbursement standards will be used as a general guideline. To the extent possible, participants must be given the opportunity to select their provider. Providers must develop and document evaluation processes and participant outcomes. The following services are allowed through telehealth when provided by a physician or midlevel practitioner: • Primary care services • Specialty services • Psychotherapy with evaluation and management • Psychotherapy diagnostic interview • Pharmacological management • Therapeutic consultation and crisis intervention Reimbursement limited to specific CPT codes. Must be referred by a primary care provider. ***Source: Medicaid Telehealth Policy. Rev. 7/1/2016 & Idaho MMIS Provider Handbook: allopathic and Osteopathic Physicians. Jun. 2016, p. 29. (Accessed Aug. 2016).*** Telehealth services can be provided as an encounter by an Indian Health Service facility, federally qualified health clinic and rural health clinic, ***Source: Idaho MMIS Provider Handbook: Ambulatory Health Care Facility. Aug. 2016, p. 9, 12 & 19 (Accessed Aug. 2016).*** Occupational therapists, physical therapists and speech language pathologists may provide services through telehealth. Covered telehealth services include speech therapy provided by licensed speech language pathologists as well as therapeutic procedures and activities provided by licensed occupational therapists and licensed physical therapists. Evaluations must be performed with an in-person visit to the participant and is not covered through telehealth. The physician order must specifically allow the services to be provided via telehealth. ***Source: Medicaid Telehealth Policy. Rev. 7/1/2016 & ID MMIS Provider Handbook. Speech, Language and Hearing Service Providers. July 1, 2016 & ID MMIS Provider Handbook. Respiratory, Developmental, Rehab and Restorative Services. Jul. 2016. Pg. 7-8 & 14-15, (Accessed Aug. 2016).*** Psychiatric telehealth services not provided through Idaho Behavioral Health Plan is limited to psychiatric services for:

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	• Diagnostic assessment • Pharmacological management • Psychotherapy with evaluation and management services Services are not reimbursed when provided through a videophone or webcam. *Source: ID Administrative Code 16.03.09 Sec. 502* Through the Children's Waiver Services, Idaho Medicaid will reimburse for crisis intervention consults, or individual consults by a therapeutic consultant via live video. *Source (service type): ID Administrative Code 16.03.10.683 (2012).* Community Based Rehabilitation Services (CBRS) supervision is included in the CBRS reimbursement rate. It is not separately reimbursable. *Medicaid Telehealth Policy. Rev. 7/1/2016. (Accessed Aug. 2016).*
Store and Forward Reimbursement	
No reference found.	Idaho Medicaid will only reimburse for "two-way live video services". *Source: Medicaid Telehealth Policy. Rev. 7/1/2016. (Accessed Aug. 2016).*
Remote Patient Monitoring Reimbursement	
No reference found.	No reference found.
Email/Phone/FAX	
Recently Passed Legislation (Now Effective) Reimbursement not available in fee-for-service for telephone, email or fax between a physician and participant. *Source: ID Administrative Code 16.03.09 Sec. 502.*	No reimbursement for telephone, email or fax. *Source: Medicaid Telehealth Policy. Rev. 7/1/2016. (Accessed Aug. 2016).*
Online Prescribing	
Prescribing physicians must have prescriber-patient relationship, which includes a documented patient evaluation adequate to establish diagnoses and identify underlying conditions and/or contraindications to the treatment. Prescriptions based solely on online questionnaires or consults outside of an ongoing clinical relationship are prohibited. *Source: ID Code § 54-1733 (2012).* **Recently Passed Legislation**	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Prescriptions can be issued as long as there is an established provider-patient relationship, provided that the prescription is not for a controlled substance unless prescribed in compliance with 21 USC section 802(54)(A). No drug can be prescribed for the purpose of abortion. If a provider-patient relationship is not yet established, the provider must take appropriate steps to establish the relationship by use of two-way audio and visual interaction, provided that the applicable Idaho community standard of care has been satisfied. ***Source: ID House Bill 189 (2015) & ID Code Sec. 54-5603 through 5607.***	
Consent	
A patient's consent must be obtained. ***Source: ID Code Sec. 54-5608 & IDAPA 22.01.15).***	Participant informed consent is required. ***Source: Medicaid Telehealth Policy. Rev. 7/1/2016. (Accessed Aug. 2016).***
Location	
No reference found.	No reference found.
Cross-State Licensing	
Idaho adopted the Federation of State Medical Board (FSMB)'s model language for an interstate medical licensure compact. ***Source: ID House Bill 150. ID Code Title 54, Ch. 18.***	Providers of telehealth services must be licensed by the Idaho Board of Medicine. ***Source: Medicaid Telehealth Policy. Rev. 7/1/2016. (Accessed Aug. 2016).***
Private Payers	
No reference found.	No reference found.
Site/Transmission Fee	
No reference found.	No originating site fee. ***Source: Medicaid Telehealth Policy. Rev. 7/1/2016. (Accessed Aug. 2016).***
Miscellaneous	

Comments:

Idaho has a "Telehealth Council" that meets regularly to coordinate and develop a comprehensive set of standards, policies, rules and procedures for the use of telehealth and telemedicine in Idaho.

Source: State of Idaho. Telehealth Council. (Accessed Aug. 2016)

Professional Board Telehealth-Specific Regulations

- ID Board of Medicine ***(Source: IDAPA 22.01.15) https://adminrules.idaho.gov/rules/current/22/0115.pdf***

Illinois

Medicaid Program: Illinois Medicaid

Program Administrator: Illinois Dept. of Healthcare and Family Services

Regional Telehealth Resource Center:
Upper Midwest Telehealth Resource Center
2901 Ohio Boulevard, Ste. 110
Terre Haute, IN 47803
(855) 283-3734 ext. 232
www.umtrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
The Medical Practice Act of 1987 defines 'telemedicine' as "the performance of diagnosing patients, prescribing drugs, maintaining a medical office, etc., including but not limited to rendering written or oral opinions concerning diagnosis or treatment of a patient in Illinois by a person located outside the State of Illinois as a result of transmission of individual patient data by telephonic, electronic, or other means of communication from within this State." ***Source: IL Compiled Statutes, Chapter 225, 60/49.5 (2012).*** The Administrative Code for the Department of Healthcare and Family Services defines 'telemedicine' as "the use of a telecommunication system to provide medical services for the purpose of evaluation and treatment when the patient is at one medical provider location and the rendering provider is at another location." ***Source: IL Admin. Code, Title 89,140.403 (2012).*** Under the Department of Public Health, telemedicine means the provision of clinical services to patients by physicians and practitioners from a distance via electronic communications. ***Source: IL Admin. Code, Title 77, Sec. 250.310*** *(also see Medicaid column)*	"Telemedicine" is the use of a telecommunication system to provide medical services for the purpose of evaluation and treatment when the patient is at one medical provider location and the rendering provider is at another location. ***Source: IL Admin. Code, Title 89,140.403 (2012).*** "Telehealth is defined as the use of a telecommunication system to provide medical services between places of lesser and greater medical capability and/or expertise, for the purpose of evaluation and treatment. Medical data exchanged can take the form of multiple formats: text, graphics, still images, audio and video. The information or data exchanged can occur in real time (synchronous) through interactive video or multimedia collaborative environments or in near real time (asynchronous) through "store and forward" applications." ***Source: IL Dept. of Healthcare and Family Svcs., Expansion of Telehealth Services, Informational Notice, Jan. 1, 2010. (Accessed Aug. 2016).*** ***Source: IL Dept. of Healthcare and Family Svcs., Handbook for Practitioners. Ch. A-200 Policy and Procedures, p. 37 & Handbook for Encounter Clinic Services, pg. 17-18 (Aug. 2016). (Accessed Aug. 2016).***
Live Video Reimbursement	
Occupational therapy may be provided by telehealth as long as the standard of care is the same as in person care. ***Source: IL Statute, 225 ILCS 75/2. (Sunsets on Jan. 1, 2024).*** *(see Medicaid column)*	Illinois Medicaid will reimburse for live video under the following conditions: • A physician or other licensed health care professional must be present with the patient at all times with the patient at the originating site; • The distant site provider must be a physician, physician assistant, podiatrist or advanced practice

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	nurse who is licensed by Illinois or the state where the patient is located; • The originating and distant site provider must not be terminated, suspended or barred from the Department's medical programs; • Medical data may be exchanged through a telecommunication system; • The interactive telecommunication system must, at a minimum, have the capability of allowing the consulting distant site provider to examine the patient sufficiently to allow proper diagnosis of the involved body system. The system must also be capable of transmitting clearly audible heart tones and lung sounds, as well as clear video images of the patient and any diagnostic tools, such as radiographs. An encounter clinic serving as the distant site shall be reimbursed as follows: 1. If the originating site is another encounter clinic, the distant site encounter clinic shall receive no reimbursement from the Department. The originating site encounter clinic is responsible for reimbursement to the distant site encounter clinic; and 2. If the originating site is not an encounter clinic, the distant site encounter clinic shall be reimbursed for its medical encounter. The originating site provider will receive a facility fee. ***Source: IL Admin. Code Title 89, 140.403.*** Eligible originating site providers include: • Physicians; • Podiatrists; • Local health departments; • Community mental health centers; • Outpatient hospitals; • Encounter Rate Clinics • Federally Qualified Health Centers (FQHC); • Rural Health Clinics (RHC) Eligible distant site providers include: • Physicians; • Podiatrists; • Advanced practice nurses; • Encounter Rate Clinics • Federally Qualified Health Centers (FQHC); • Rural Health Clinics; ***Source: IL Dept. of Healthcare and Family Svcs., Expansion of Telehealth Services, Informational Notice, Jan. 1, 2010. (Accessed Aug. 2016).*** ***Source: IL Dept. of Healthcare and Family Svcs., Handbook for Practitioners. Ch. A-200 Policy and Procedures, p. 38. (Accessed Aug. 2016).***

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	Distant Site providers may not seek reimbursement for their services when the Originating Site is an encounter clinic. The Originating Site encounter clinic is responsible for reimbursement to the Distant Site provider. Non-enrolled providers rendering services as a Distant Site provider shall not be eligible for reimbursement from the department, but may be reimbursed by the Originating Site provider. Under the department's telehealth policy, providers will be paid as either an Originating Site or Distant Site. ***Source: IL Dept. of Healthcare and Family Svcs., Expansion of Telehealth Services, Informational Notice, Jan. 1, 2010. (Accessed Aug. 2016).*** ***Source: IL Dept. of Healthcare and Family Svcs. Handbook for Practitioners. Ch. A-200 Policy and Procedures, p. 38 & Handbook for Encounter Clinic Services, pg. 17-18 (Aug. 2016). (Accessed Aug. 2016).*** **Psychiatric Services** With the exception of group psychotherapy, tele-psychiatry is covered, if all of the conditions stated above are met. Tele-psychiatry eligible originating site providers: • Physician; • Other licensed healthcare professional or other licensed clinician; • Mental health professional; • Qualified mental health professional ***Source: IL Dept. of Healthcare and Family Svcs., Expansion of Telehealth Services, Informational Notice, Jan. 1, 2010. (Accessed Aug. 2016).*** ***Source: IL Dept. of Healthcare and Family Svcs., Handbook for Practitioners. Ch. A-200 Policy and Procedures, p. 38 & Handbook for Encounter Clinic Services pg. 17-18 (Aug. 2016). (Accessed Aug. 2016).***
Store and Forward Reimbursement	
(see Medicaid column)	Illinois Medicaid will reimburse a provider at a distant site when they "review the medical case without the patient being present." ***Source: IL Administrative Code, Title 89 ,140.403 (2012).*** The Illinois Medicaid definition encompasses store and forward. "The information or data exchanged can occur in real time (synchronous) through interactive video or multimedia collaborative environments or in near real time (asynchronous) through "store and forward" applications." ***Source: IL Dept. of Healthcare and Family Svcs., Expansion of Telehealth Services, Informational Notice, Jan. 1, 2010.***

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	(Accessed Aug. 2016). *Source: IL Dept. of Healthcare and Family Svcs., Handbook for Practitioners. Ch. A-200 Policy and Procedures, p. 38, & Handbook for Encounter Clinic Services pg. 17-18 (Aug. 2016) (Accessed Aug. 2016).*
Remote Patient Monitoring Reimbursement	
No reference found.	IL Medicaid will cover home uterine monitoring with prior approval and when patient meets specific criteria. *Source: IL Dept. of Healthcare and Family Services, Handbook for Durable Medical Equipment, Chapter M-200, Policy and Procedures for Medical Equipment and Supplies, p. 56 (Sept. 2015). (Accessed Aug. 2016).*
Email/Phone/FAX	
(see Medicaid column)	No reimbursement for email. No reimbursement for telephone. No reimbursement for FAX. *Source: IL Dept. of Healthcare and Family Services, Handbook for Practitioners Rendering Medical Services, Chapter A-200, Policy and Procedures for Medical Services, p. 38 (August 2010) & Source: IL Administrative Code, Title 89 ,140.403 (2012). (Accessed Aug. 2016).*
Online Prescribing	
No reference found.	No reference found.
Consent	
No reference found.	No reference found.
Location	
(see Medicaid column)	Eligible originating site: • Physician office; • Podiatrist office; • Local health departments; • Community mental health centers; • Outpatient hospitals; • Rural health clinics; • Encounter Rate Clinics • Federally Qualified Health Centers; *Source: IL Dept. of Healthcare and Family Svcs., Expansion of Telehealth Services, Informational Notice, Jan. 1, 2010. (Accessed Aug. 2016).*
Cross-State Licensing	
Illinois adopted legislation to join the Interstate Medical Licensure Compact. *Source: IL Public Act 099-0076 (2015).*	For medical services, the provider rendering the service at the distant site can be a physician, physician assistant, podiatrist or advanced practice nurse, who is licensed by the State of Illinois or by the state where the patient is located.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	For psychiatric services, the provider rendering the service at the distant site must be a physician licensed by the State of Illinois, or by the state where the patient is located, who has completed an approved general psychiatry residency program or a child and adolescent psychiatry residency program. *Source: IL Handbook for Practitioners Rendering Medical Services, Chapter A-200, Policy and Procedures for Medical Services, p. 38 (August 2010) & Handbook for Encounter Clinic Services pg. 17-18 (Aug. 2016). (Accessed Aug. 2016).*
Private Payers	
If an insurer provides coverage for telehealth services, then it shall not: • Require in-person contact occur between a health care provider and a patient; • Require the health care provider to document a barrier to an in-person consultation; • Require telehealth use when it is not appropriate; or • Require the use of telehealth when the patient chooses an in-person consultation *Source: SB 647 (2014) IL Insurance Code. Sec. 356z.22.*	No reference found.
Site/Transmission Fee	
No reference found.	There is reimbursement for originating site facility fees. Eligible facilities include: • Physician's office; • Podiatrist's office; • Local health departments; • Community mental health centers; • Outpatient hospitals; • Community Mental Health Providers Originating site providers who receive reimbursement for the patient's room and board are not eligible for facility fees. *Source: IL Handbook for Practitioners Rendering Medical Services, Ch. A-200, Policy and Procedures for Medical Services, p. 38 (Aug. 2010). (Accessed Aug. 2016).* *Source (Community mental health providers): IL Dept. of Healthcare and Family Svcs., Expansion of Telehealth Services, Mar. 25, 2014. (Accessed Aug. 2016).*
Miscellaneous	

Indiana

Medicaid Program: Indiana Medicaid

Program Administrator: Indiana Family and Social Services Administration

Regional Telehealth Resource Center:
Upper Midwest Telehealth Resource Center
2901 Ohio Boulevard, Ste. 110
Terre Haute, IN 47803
(855) 283-3734 ext. 232
www.umtrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Telemedicine services refer to a specific method of delivery of certain services, including medical exams and consultations, which are already reimbursed by Medicaid. Telemedicine uses videoconferencing equipment allowing a medical provider to render an exam or other service to a patient at a distant location." *Source: IN Admin. Code, Title 405, 5-38-1 (2012).* "Telehealth services mean the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across a distance." "Telemedicine services mean a specific method of delivery of services, including medical exams and consultations and behavioral health evaluations and treatment, including those for substance abuse, using videoconferencing equipment to allow a provider to render an examination or other service to a patient at a distant location. The term does not include the use of the following: (1) a telephone transmitter for transtelephonic monitoring. (2) a telephone or any other means of communication for the consultation from one (1)) provider to another provider." *Source: IN Code, 12-15-5-11.* **For Private Payer Reimbursement** "Telemedicine services" means health care services delivered by use of interactive audio, video, or other electronic media, including: • Medical exams and consultations • Behavioral health, including substance abuse evaluations and treatment • The term does not include delivery of health care services through telephone for transtelephonic monitoring; telephone or any other means of	Telehealth services are defined as the scheduled remote monitoring of clinical data through technologic equipment in the member's home. Telemedicine services refer to a specific method of delivery of certain services, including medical exams and consultations, which are already reimbursed by Medicaid. Telemedicine uses video conferencing equipment to allow a medical provider to deliver an exam or other services to a patient at a distant location. In any telemedicine service, there will be a hub site, a spoke site, an attendant to connect the patient to the specialist at the hub site, a computer or television so that the patient has real-time, interactive and face-to-face communication with the hub specialist/consultant via the interactive television technology. *Source: IN Medicaid Provider Manual. Jul. 2016. P. 843-848. (Accessed Aug. 2016).* Telemedicine refers to the use of videoconferencing equipment to allow a medical provider to render an exam or other service to a patient at distant location. *Source: Telemedicine and Telehealth Module, Feb. 26, 2016, p. 1. (Accessed Aug. 2016).*

STATE LAW/REGULATIONS	MEDICAID PROGRAM
communication for the consultation for one (1) provider to another provider. *Source: IN Code, 27-8-34 (2015) & 27-13-7-22 (2015).* "Telemedicine means the delivery of health care services using electronic communications and information technology, including: • Secure videoconferencing • Interactive audio-using store and forward technology; or • Remote patient monitoring technology; Between a provider in one location and a patient in another location. The term does not include: • Audio only communication • A telephone call • Electronic mail • An instant messaging conversation • Facsimile • Internet questionnaire • Telephone consultation • Internet consultation" *Source: IN Code, 25-1-9.5 (HB 1263 – 2016).*	
Live Video Reimbursement	
Reimbursement for live video, see Private Payer section. *Source: IN Code, 27-8-34 (2015) & 27-13-7-22 (2015).*	Indiana Code requires reimbursement for video conferencing for FQHC, Rural Health Clinic, Community Mental Health Centers, and Critical Access Hospital providers regardless of the distance between provider and patient... *Source: IN Code, 12-15-5-11.* Indiana Medicaid will reimburse the following services when provided via live video when services are medically necessary and hub and spoke are 20 miles apart: • Consultation • Office Visit • Psychotherapy • Psychiatric diagnostic interview • End-stage renal disease (ESRD) services • Pharmacologic management The hub site physician or practitioner must determine if it is medically necessary for a medical professional to be at the spoke site. For a medical professional to receive reimbursement for professional services in addition to payment for spoke services, medical necessity must be documented. If it is medically necessary for a medical professional to be with the member at the spoke site,

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	the spoke site is permitted to bill an evaluation and management code in addition to the fee for spoke services. There must be documentation in the patient's medical record to support the need for the provider's presence at the spoke site. The documentation is subject to post-payment review. ***Source (authorization): IN Admin. Code, Title 405, 5-38-1 (2012).*** ***Source (hub-spoke provider reimbursement): IN Admin. Code, Title 405, 5-38-4 (2012) & IN Medicaid Provider Manual. Jul. 2016. P. 843-848. & Telemedicine and Telehealth Module, Feb. 26, 2016, p. 1-3. (Accessed Aug. 2016)*** No reimbursement for the following: • Ambulatory surgical centers; • Outpatient surgical services; • Home health agencies or services; • Radiological services; • Laboratory services; • Long-term care facilities, including nursing facilities, intermediate care facilities, or community residential facilities for the developmentally disabled; • Anesthesia services or nurse anesthetist services; • Audiological services; • Chiropractic services; • Care coordination services; • Durable medical equipment, medical supplies, hearing aids, or oxygen; • Optical or optometric services; • Podiatric services; • Services billed by school corporations; • Physical or speech therapy services; • Transportation services; • Services provided under a Medicaid waiver. ***Source: IN Admin. Code, Title 405, 5-38-4 (2012) & IN Medicaid Provider Manual. Jul. 2016. P. 853-863. & Telemedicine and Telehealth Module, Feb. 26, 2016, p. 1. (Accessed Aug. 2016)***
Store and Forward Reimbursement	
No reimbursement for store and forward due to definition of “telemedicine services”. ***Source: IN Code, 27-8-34 (2015) & 27-13-7-22 (2015).***	Indiana Medicaid will not reimburse for store and forward services. ***Source: IN Admin. Code, Title 405, 5-38-4 (2012).*** However, there is reimbursement for store and forward technology to facilitate other reimbursable services. Separate reimbursement of the spoke-site payment is not provided for this technology. ***Source: IN Medicaid Provider Manual. Jul. 2016. P. 843-848. & Telemedicine and Telehealth Module, Feb. 26, 2016, p. 2. (Accessed Aug. 2016)***

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Remote Patient Monitoring Reimbursement	
No reimbursement for remote patient monitoring due to definition of "telemedicine services". *Source: IN Code, 27-8-34 (2015) & 27-13-7-22 (2015).*	Indiana Code requires Medicaid to reimburse providers who are licensed as a home health agency for telehealth services. *Source: IN Code, 12-15-5-11.* Indiana Medicaid will reimburse providers for telehealth services provided as home health services. Must have one of the following conditions: • Chronic obstructive pulmonary disease • Congestive heart failure • Diabetes Must initially have two or more of the following events related to one of the conditions listed above within the previous twelve months: • Emergency room visit • Inpatient hospital stay A licensed registered nurse must perform the reading of transmitted health information. *Source: IN Admin Code, Title 405, 5-16-3.1.* IN Medicaid will reimburse RPM when there is prior authorization when services are medically necessary for patients with uncontrolled chronic conditions, as evidenced by emergency room visits and inpatient hospital stays directly related to the chronic condition. A licensed RN must read the transmitted health information the day the data is received. Eligible chronic conditions include congestive heart failure, chronic obstructive pulmonary disease and diabetes. Reimbursement only available for home health agencies and members must be approved for other home health services. Other criteria apply to obtain prior authorization. *IN Medicaid Provider Manual. Jul. 2016. P. 843-848. (Accessed Aug. 2016) & Telemedicine and Telehealth Module, Feb. 26, 2016, p. 1.*
Email/Phone/FAX	
No reference found for email. No reimbursement for telephone. No reference found for FAX. *Source: IN Admin. Code, Title 405, 5-38-1 (2012).*	Telemedicine is not the use of: • Telephone transmitter for transtelephonic monitoring; or • Telephone or any other means of communication for consultation from one provider to another.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	Source: IN Medicaid Provider Manual. Jul. 2016. P. 843-848. & Telemedicine and Telehealth Module, Feb. 26, 2016, p. 1. (Accessed Aug. 2016)
Online Prescribing	
A documented patient evaluation, including history and physical evaluation adequate to establish diagnoses and identify underlying conditions or contraindications to the treatment recommended or provided, must be obtained prior to issuing e-prescriptions. *Source: IN Admin. Code, Title 844, 5-3-2 (2012).* Indiana has established a pilot program to provide telehealth services to patients in Indiana without the establishment of an in person patient-physician relationship. The pilot includes the issuance of prescription when medically necessary, with the exception of controlled substances. *Source: IN Code, 25-22.5-14.* A provider may issue a prescription via telemedicine to a patient they have not previously seen if: • The provider satisfies the applicable standard of care in the treatment of the patient • The issuance of the prescription by the provider is within the provider's scope of practice and certification • The prescription is not for a controlled substance • The prescription is not for an abortion inducing drug • The prescription is not for an ophthalmic device including glasses, contact lenses, or low vision devices. A pharmacy does not violate Indiana Rules if they fill a prescription for a controlled substance and the pharmacy is unaware that the prescription was written by a provider providing telemedicine services. *Source: IN Code, 25-1-9.5 (HB 1263 – 2016).*	No reference found.
Consent	
A health care provider (as defined in Indiana Code 16-18-2-163(a)) may not be required to obtain a separate additional written health care consent for the provision of telemedicine services. *Source: IN Code, 16-36-1-15 (2015).*	The spoke site must obtain patient consent. The consent must be maintained at the hub and spoke sites. *Source: IN Medicaid Provider Manual. Jul. 2016. P. 853-863. (Accessed Aug. 2016).*
Location	
The patient must be physically present at the spoke site and participate in the visit. *Source: IN Admin. Code, Title 405, 5-38-4 (2012).*	Indiana Code requires the amendment of the Medicaid state plan (by Dec. 1, 2013) to eliminate the current twenty mile distance restriction. *Source: IN Code, 12-15-5-11.*

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	There is reimbursement for telemedicine services only when the hub and spoke sites are greater than 20 miles apart. Telemedicine services may only be offered in an inpatient, outpatient or office setting. *Source: IN Medicaid Provider Manual. Jul. 2016. P. 843-848. (Accessed Aug. 2016).* Reimbursement for telemedicine services is available to the following providers regardless of the distance between the provider and recipient: • Federally Qualified Health Centers • Rural Health Clinics • Community mental health centers • Critical access hospitals *Source: IN Admin Code, 405 5-38-4 & Telemedicine and Telehealth Module, Feb. 26, 2016, p. 1-4.*
Cross-State Licensing	
A provider located outside Indiana may not establish a provider-patient relationship with an individual in Indiana unless the provider and the provider's employer or the provider's contractor have certified in writing to the Indiana Professional Licensing Agency that the provider agrees to be subject to the jurisdiction of the courts of law of Indiana and Indiana Substantive and Procedural Laws. This certification must be filed by a provider's employer or contractor at the time of initial certification and renewed when the provider's license is renewed. *Source: IN Code, 25-1-9.5 (HB 1263 – 2016).*	No reference found.
Private Payers	
Accident and sickness insurance (dental or vision insurance is excluded) policies and individual or group contracts must provide coverage for telemedicine services in accordance with the same clinical criteria as would be provided for services provided in person. *Source: IN Code, 27-8-34 (2015) & 27-13-7-22 (2015).*	No reference found.
Site/Transmission Fee	
No reference found.	Spoke sites are reimbursed a facility fee. *Source: IN Medicaid Provider Manual. Jul. 2016. P. 843-848. (Accessed Aug. 2016) & Telemedicine and Telehealth Module, Feb. 26, 2016, p. 1.*
Miscellaneous	
	For patients receiving ongoing telemedicine services, a physician should perform a traditional clinical evaluation at least once a year, unless otherwise stated

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	in policy. The hub physician should coordinate with the patient's primary care physician. *Source: IN Medicaid Provider Manual. Jul. 2016. P. 843-848. (Accessed Aug. 2016).*

COMMENTS: Indiana establishes a telehealth services pilot program utilizing telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, treatment, supervision and information across a distance.

Source: IN Administrative Code 844 Section 5-8-2 (2015).

Iowa

Medicaid Program: Iowa Medicaid Enterprise (IME)

Program Administrator: IA Dept. of Human Services

Regional Telehealth Resource Center:
Great Plains Telehealth Resource and Assistance Center
University of Minnesota/Institute for Health Informatics
330 Diehl Hall
505 Essex Street S.E.
Minneapolis, MN 55455
(888) 239-7092
www.gptrac.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Telemedicine means use of a telecommunications system for diagnostic, clinical, consultative, data, and educational services for the delivery of health care services or related health care activities by licensed health care professionals, licensed medical professionals, and staff who function under the direction of a physician, a licensed health care professional, or hospital, for the purpose of developing a comprehensive, statewide telemedicine network or education." *Source: IA Admin. Code, 751 7.1(8D) (2012).*	No reference found.
Live Video Reimbursement	
Department of Human Services is required to adopt rules to provide telehealth coverage under Medicaid. Such rules must provide that in-person contact between a health care professional and a patient is not required as a prerequisite for payment. *Source: IA Senate File 505 (2015).*	In person contact between a health care professional and patient is not required for payment for services otherwise covered and appropriately provided through telehealth as long as it meets the generally accepted health care practices and standards prevailing in the applicable professional community. Services provided in-person or through telehealth shall be treated as equivalent for purposes of reimbursement. *Source: IA Admin Code Sec. 441, 78.55 (249A). https://www.legis.iowa.gov/docs/iac/rule/09-30-2015.441.78.55.pdf*
Store and Forward Reimbursement	
No reference found.	No reference found.
Remote Patient Monitoring Reimbursement	
No reference found.	No reference found.
Email/Phone/FAX	
No reference found.	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Online Prescribing	
Pharmacists are prohibited from dispensing prescription drugs if the pharmacist knows or should have known that the prescription was issued solely on the basis of an Internet-based questionnaire, an Internet-based consult, or a telephone consult, and was completed without a pre-existing patient-provider relationship. ***Source: IA Admin. Code, 657 8.19(124,126,155A) (2012).*** A physician must be physically present with a woman at the time an abortion-inducing drug is provided. ***Source: IA Admin. Code, 653 13.10.***	No reference found.
Consent	
No reference found.	No reference found.
Location	
No reference found.	No reference found.
Cross-State Licensing	
Iowa adopted the Federation of State Medical Board (FSMB)'s model language for an interstate medical licensure compact. ***Source: IA Senate File 510 (2015).***	No reference found.
Private Payers	
No reference found.	No reference found.
Site/Transmission Fee	
No reference found.	No reference found.
Miscellaneous	

Comments:

Professional Board Telehealth-Specific Regulations

- IA Board of Medicine ***(Source: IA Admin Code Sec. 653.13.11)***

Kansas

Medicaid Program: Kansas Medicaid

Program Administrator: Kansas Dept. of Health and Environment

Regional Telehealth Resource Center:
Heartland Telehealth Resource Center
3901 Rainbow Blvd MS 1048
Kansas City, KS 66160
(877) 643-4872
heartlandtrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
No reference found.	"Telemedicine is the use of communication equipment to link health care practitioners and patients in different locations. This technology is used by health care providers for many reasons, including increased cost efficiency, reduced transportation expenses, improved patient access to specialists and mental health providers, improved quality of care, and better communication among providers." ***Source: KS Dept. of Health and Environment, Kansas Medical Assistance Program, Provider Manual, General Benefits, p. 2-25 (Jul. 2016). (Accessed Aug. 2016).***
Live Video Reimbursement	
No reference found.	Kansas Medicaid will reimburse for live video, for the following services: • Office visits; • Individual psychotherapy; • Pharmacological management services. The patient must be present at the originating site. ***Source: KS Dept. of Health and Environment, Kansas Medical Assistance Program, Provider Manual, General Benefits, p. 2-25 (Jul. 2016). (Accessed Aug. 2016).***
Store and Forward Reimbursement	
No reference found.	Kansas Medicaid requires the patient to be present at the originating site indicating store and forward will not be reimbursed. ***Source: KS Dept. of Health and Environment, Kansas Medical Assistance Program, Provider Manual, General Benefits, p. 2-25 (Jul. 2016). (Accessed Aug. 2016).***
Remote Patient Monitoring Reimbursement	
No reference found.	Kansas Medicaid will reimburse for home telehealth. The policy states:

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	"Home telehealth uses real-time, interactive, audio/video telecommunication equipment to monitor patients in the home setting, as opposed to a nurse visiting the home. This technology may be used to monitor the patient for significant changes in health status, provide timely assessment of chronic conditions, and provide other skilled nursing services**.** Services must be provided by a registered nurse or licensed practical nurse. Agencies may bill skilled nursing services on the same date of service as telehealth services." ***Source: Dept. of Health and Environment, Kansas Medical Assistance Program, Provider Manual, Home Health, p. 8-29 (May 2016). (Accessed Aug. 2016).*** Providers are eligible for reimbursement of home telehealth services that meet the following criteria: • Prescribed by a physician; • Considered medically necessary; • Signed beneficiary consent for telehealth services; • Skilled nursing service; • Does not exceed two visits per week for non-Home and Community Based Services patients. Prior authorization required. ***Source: KS Dept. of Health and Environment, Kansas Medical Assistance Program, Provider Manual, Home Health Agency, p. 56 (May 2016). (Accessed Aug. 2016).*** **HCBS Frail Elderly Program:** Home Telehealth is a remote monitoring system provided to a beneficiary with one or more qualifying chronic diseases. It enables the beneficiary to effectively manage the disease(s) and recognize early signs of any problematic issues so intervention can occur before his or her health declines. The provision of Home Telehealth involves beneficiary education specific to the disease(s), counseling, and nursing supervision. Providers can use telehealth to review: • Beneficiary's baseline • Survey responses • Vital sign measurements A RN or licensed practical nurse (LPN) with RN supervision must set up, supervise and provide counseling. See manual for other restrictions and documentation requirements.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	Beneficiaries can qualify for the service if they need disease management consultation and education. They must have had two or more hospitalizations (which includes ER visits) within the previous year related to the disease or be using "Money Follows the Person" (MFP) to move from a nursing facility back into the community. Beneficiaries living in an assisted living facility, residential health care facility or home plus facility are not eligible. *Source: KS Dept. of Health and Environment, Kansas Medical Assistance Program, Provider Manual, HCBS Frail Elderly, p. 8-17 (Jun. 2016). (Accessed Aug. 2016).*
Email/Phone/FAX	
No reference found.	No reimbursement for email. No reimbursement for telephone. No reimbursement for FAX. *Source: KS Dept. of Health and Environment, Kansas Medical Assistance Program, Provider Manual, General Benefits, p. 2-25 (Jul. 2016). (Accessed Aug. 2016).*
Online Prescribing	
Physicians must have a pre-existing patient-prescriber relationship. Physicians are prohibited from prescribing drugs on the basis of an internet-based questionnaire or consult, or telephone consult. *Source: KS Admin. Regs., Sec. 68-2-20 (2012).*	No reference found.
Consent	
No reference found.	Written consent for telehealth home services is required. *Source: KS Dept. of Health and Environment, Kansas Medical Assistance Program, Provider Manual, Home Health Agency, p. 67 (May 2016) & HCBS Frail Elderly, p. 8-17 (Jun. 2016). (Accessed Aug. 2016).*
Location	
No reference found.	No reference found.
Cross-State Licensing	
Recently Passed Legislation Iowa adopted the Federation of State Medical Board (FSMB)'s model language for an interstate medical licensure compact. *Source: House Bill 2615 – 2015.*	No reference found.
Private Payers	
No reference found.	No reference found.
Site/Transmission Fee	

STATE LAW/REGULATIONS	MEDICAID PROGRAM
No reference found.	No reference found.
Miscellaneous	

Kentucky

Medicaid Program: Kentucky Medicaid

Program Administrator: KY Dept. for Medicaid Services

Regional Telehealth Resource Center:
Mid-Atlantic Telehealth Resource Center
PO Box. 800711
Charlottesville, VA 22908-0711
(434) 906-4960 / (855) MATRC4U
www.matrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Telehealth means the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of health or medical data, and continuing education." ***Source: KY Revised Statutes § 310.200 & KAR Title 501, Ch. 13, Sec. 010.*** *(also see Medicaid column)*	"Telehealth consultation means a medical or health consultation, for purposes of patient diagnosis or treatment, that requires the use of advanced telecommunications technology, including, but not limited to: (a) compressed digital interactive video, audio, or data transmission; (b) clinical data transmission via computer imaging for tele-radiology or tele-pathology; and (c) other technology that facilitates access to health care services or medical specialty expertise." ***Source: KY Revised Statutes § 205.510 (2012).*** Telehealth means two-way, real time interactive communication between a patient and a physician or practitioner located at a distant site for the purpose of improving a patient's health through the use of interactive telecommunication equipment that includes, at a minimum, audio and video equipment. ***Source: KY 907 KAR 1:055E.*** "Telemedicine" means two-way, real time interactive communication between a patient and a physician or practitioner located at a distant site for the purpose of improving a patient's health through the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment. ***Source: KY 907 KAR 9:005.*** "Telehealth medical services: The originating-site or spoke site is the location of the eligible Kentucky Medicaid recipient at the time the telehealth service is being furnished via an interactive telehealth service communications system. The distant or hub site is the location of the provider and is considered the place of service. An interactive telehealth service communication system includes interactive audio and video equipment permitting two-way real time interactive communication

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	between the patient and the practitioner at the originating and distant-sites." ***Source: KY State Plan Amendment. Attachment 3.1-B. Approved 3/9/2011. (Accessed Mar. 2016).***
Live Video Reimbursement	
Kentucky law states that insurers may not deny coverage because it is "provided through telehealth and not provided through face-to-face consultation" therefore requiring reimbursement for live video. ***Source: KY Revised Statutes § 304.17A-138 (2012).*** *(See Medicaid column and "Private Payers" section)*	Live video GT modifier for "telehealth consultation" accepted by Medicaid. ***Source: KY Physician Medicaid Manual. Jun. 2016. (Accessed Aug. 2016).*** Kentucky Medicaid will reimburse for a "telehealth consultation", which includes live video. ***Source: KY Revised Statutes 205.559 (2012).*** Reimbursement shall not be denied solely because an in-person consultation between a provider and a patient did not occur. ***Source: KY Revised Statutes § 205.559 (2012).*** Except for a telehealth consultation provided by an Advanced Registered Nurse Practitioner or Community Mental Health Clinic, an amount equal to the amount paid for a comparable in-person service. ***Source: KY Admin. Regs. Title, 907, 3:170, Sec. 4(a) (2011).*** Telehealth is covered to the same extent the service and provider are covered when furnished face-to-face. Providers must be approved through the Kentucky e-Health Network Board. Must be approved member of KY telehealth network. Coverage is limited to: • Consultation • Mental health evaluation and management services • Individual and group psychotherapy • Pharmacologic management • Psychiatric/psychological/mental health diagnostic interview examinations • Individual medical nutrition services All telehealth services are subject to utilization review. Prior authorization is needed for select telehealth procedures. Eligible providers for services NOT in a Community Mental Health Center: • A psychiatrist; • A licensed clinical social worker;

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	• A psychologist; • A licensed professional clinical counselor; • A licensed marriage and family therapist; • A physician*; • An ARNP*; • Speech-language pathologist*; • Occupational therapist*; • Physical therapist*; • Licensed dietitian or certified nutritionist*; or • Registered nurse or dietician* ** Certain restrictions apply.* Eligible providers for services in a Community Mental Health Center: • A psychiatrist; • A physician; • Psychologist with a license in accordance with KRS 319.010(5); • A licensed marriage and family therapist; • A licensed professional clinical counselor; • A psychiatric medical resident; • A psychiatric registered nurse; • A licensed clinical social worker; • An advanced registered nurse practitioner; ***Source: KY State Plan Amendment. Attachment 3.1-B. Approved 3/9/2011. (Accessed Mar. 2016).*** For FQHCs and RHCs a "visit" is defined as occurring in-person or via telehealth. ***Source: KY 907 KAR 1:055.***
Store and Forward Reimbursement	
(see Medicaid column)	Kentucky reimburses for tele-radiology but there is no other reference to reimbursing for other specialties. ***Source: KY Provider Billing Instructions for Physician's Services Provider Type – 64, 65, Version 6.2, p. 41 (Feb. 16, 2016). (Accessed Mar. 2016).*** Medicaid does not cover other forms of store and forward, as a telehealth consultation requires a two-way interactive video. ***Source: KY Admin. Regs. Title, 907, 3:170, Sec. 3, 3(a) (2011).***
Remote Patient Monitoring Reimbursement	
<u>Newly Passed Legislation</u> Not later than July 1, 2017 the department must establish a pilot project which creates coverage provisions and reimbursement criteria for telemonitoring services. ***Source: KY Rev. Statute. Ch. 205. (HB 95 – 2016).***	No reference found.

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http://www.lrc.ky.gov/record/16RS/HB95/bill.pdf	
Email/Phone/FAX	
No reimbursement for email. No reimbursement for telephone. No reimbursement for FAX. *Source: KY Revised Statutes § 304.17A-138 (2012).*	No reimbursement for email. No reimbursement for telephone. No reimbursement for FAX. *Source: KY Revised Statutes § 205.559 (2012).*
Online Prescribing	
Prior to prescribing in response to any communication transmitted or received by computer or other electronic means, physicians must establish a proper physician-patient relationship. This includes: • Verification that the person requesting medication is in fact who the patient claims to be; • Establishment of a documented diagnosis through the use of accepted medical practices; • Maintenance of a current medical record. An electronic, online, or telephone evaluation by questionnaire are inadequate for the initial or any follow-up evaluation. *Source: KY Revised Statutes § 311.597 (2012).* A "good faith prior examination" (needed to establish a physician-patient relationship) can be done through telehealth. *Source: KY Rev. Statute 218A.010.* The Board of Speech Language Pathology and Audiology does not allow for the establishment of a practitioner-patient relationship via telehealth. They require an in-person meeting to occur first. A practitioner-patient relationship is required to issue a prescription. *Source: KY 201 KAR 17:110.*	No reference found.
Consent	
The provider who delivers or facilitates the telehealth service shall obtain the informed consent of the patient before services are provided. Patient consent must be obtained by: • Physicians; • Chiropractors; • Nurses; • Dentists; • Dieticians;	Before providing a telehealth consultation, providers must document written patient informed consent. This includes: • The patient may refuse the telehealth consultation at any time without affecting the right to future care or treatment, and without risking the loss or withdrawal of a benefit to which the patient is entitled; • The recipient shall be informed of alternatives to the telehealth consult;

STATE LAW/REGULATIONS	MEDICAID PROGRAM
• Pharmacist; • Psychologists; • Occupational therapists; • Behavioral analysts; • Ophthalmologi*sts;* • Physical therapists; • Speech language pathologists or audiologists; • Social workers; • Marriage/family therapists. ***Source: KY Revised Statutes § 311.5975 (2012).*** *(also see Medicaid column)* Nurses must obtain informed consent ***Source: KY 201 KAR 20:520.*** The Board of Speech Language Pathology and Audiology requires their licensees to inform the client in writing, in an initial in-person meeting, about: • The limitations of using technology in the provision of telepractice; • Potential risks to confidentiality of information due to technology in the provision of telepractice; • Potential risks of disruption in the use of telepractice; • When and how the licensee will respond to routine electronic messages; • In what circumstances the licensee will use alternative communications for emergency purposes; • Who else may have access to client communications with the licensee; • How communications can be directed to a specific licensee; • How the licensee stores electronic communications from the client; and • That the licensee may elect to discontinue the provision of services through telehealth. ***Source: KY 201 KAR 17:110.***	• The recipient shall have access to medical information resulting from the telehealth consult as provided by law; • The dissemination, storage, or retention of an identifiable recipient image or other information from the telehealth consult shall comply with all state and federal confidentiality laws and regulations; • The patient shall have the right to be informed of the parties who will be present at the spoke site and the hub site during the telehealth consult, and shall have the right to exclude anyone from either site; • The patient shall have the right to object to the videotaping of a telehealth consult. ***Source: KY Admin. Regs. Title, 907, 3:170 (2011).***
Location	
No reference found.	No reference found.
Cross-State Licensure	
A provider must be licensed in Kentucky with the exception of persons who, being nonresidents of Kentucky and lawfully licensed to practice medicine or osteopathy in their states of actual residence, infrequently engage in the practice of medicine or osteopathy within this state, when called to see or attend particular patients in consultation and association with a Kentucky-licensed physician. ***Source: KY Revised Statutes § 311.560 (2012).***	No reference found.

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Private Payers	
Payers shall not exclude services solely because the service is provided through telehealth. A health benefit plan may provide coverage for a consultation at a site not within the telehealth network at the discretion of the insurer. ***Source: KY Revised Statutes § 304.17A-138 (2012).***	No reference found.
Site/Transmission Fee	
(see Medicaid column)	No reimbursement for transmission fees. ***Source: KY Admin. Regs. Title, 907, 3:170 (2012).***
Miscellaneous	

Comments:

Professional Board Telehealth-Specific Regulations

- Speech Language Pathology and Audiology ***(Source: Title 201, Ch. 17, Sec. 110)***
- Board of Optometric Examiners ***(Source: Title 201, Ch. 5, Sec. 055)***
- Physical Therapy ***(Source: Title 201, Ch. 22, Sec. 160)***
- Psychologist ***(Source: Title 201, Ch. 26, Sec. 310)***
- Dieticians and Nutritionists ***(Source: Title 201, Ch. 33, Sec. 070)***
- Applied Behavior Analysis ***(Source: Title 201, Ch. 43, Sec. 10)***
- Nursing ***(Source: Title 201, Ch. 20, Sec. 520).***

Louisiana

Medicaid Program: Louisiana Medicaid

Program Administrator: LA Dept. of Health and Hospitals

Regional Telehealth Resource Center:
TexLa Telehealth Resource Center
3601 4th Street, Ste. 2B440
Lubbock, TX 79430
(806) 743-4440
http://www.texlatrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Telemedicine is the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data using interactive telecommunication technology that enables a health care practitioner and a patient at two locations separated by distance to interact via two-way video and audio transmissions simultaneously. Neither a telephone conversation nor an electronic mail message between a health care practitioner and patient, or a true consultation as may be defined by rules promulgated by the board pursuant to the Administrative Procedure Act, constitutes telemedicine." ***Source: LA Revised Statutes 37:1262 & LA Admin. Code 46:XLV.75.http://www.lsbme.la.gov/sites/default/files/documents/Rules/Individual%20Rules/Physicians%20Oct%202015.pdf*** Telehealth means a mode of delivering healthcare services that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management and self-management of patients at a distance from healthcare providers. Telehealth allows services to be accessed when providers are in a distant site and patients are in the originating site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers. ***Source: LA Revised Statutes HB 1280 (2014) & Title 40 Sec. 1300.383.***	"Telemedicine is the use of medical information exchanges from one site to another via electronic communications to improve a recipient's health. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient at the originating site, and the physician or practitioner at the distant site." ***Source: LA Dept. of Health and Hospitals, Professional Svcs. Provider Manual, Chapter Five of the Medicaid Svcs. Manual, p. 156 (As revised on Jul. 14, 2016). (Accessed Aug. 2016).***
Live Video Reimbursement	
Louisiana law requires reimbursement to the originating site physician for a live video consultation if he/she is physically present during the exam and interacts with the distant-site physician. *(See "Private Payers" section below)* ***Source: LA Revised Statutes 22:1821 (2012).***	Louisiana Medicaid reimburses for "services provided via an interactive audio and video telecommunications system." ***Source: LA Register, Volume 31, 2032 (2012).*** Louisiana Medicaid only reimburses the distant site

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	provider. *Source: LA Dept. of Health and Hospitals, Professional Svcs. Provider Manual, Chapter Five of the Medicaid Svcs. Manual, p. 156 (As revised on Jul. 14, 2016). (Accessed Aug. 2016).*
Store and Forward Reimbursement	
There is no reimbursement requirement based upon the definition of "telemedicine" which describes telemedicine as an interaction "via two-way video and audio transmission". *Source: LA Revised Statutes 37:1262 (2012).*	Louisiana Medicaid will not provide reimbursement for store and forward based upon the definition of "telemedicine" which describes telemedicine as including "audio and video equipment permitting two-way, real time interactive communication" therefore excluding store and forward. *Source: LA Dept. of Health and Hospitals, Professional Svcs. Provider Manual, Chapter Five of the Medicaid Svcs. Manual, p. 156 (As revised on Jul. 14, 2016). (Accessed Aug. 2016).*
Remote Patient Monitoring Reimbursement	
No reference found.	Under the Community Choices Waiver, Louisiana Medicaid will reimburse an installation fee and a monthly maintenance fee for: • TeleCare Activity and Sensor Monitoring, • Health status monitoring, and • Medication and monitoring. **Activity and Sensor Monitoring** At a minimum the system must: • Monitor the home's points of egress and entrance; • Detect falls; • Detect movement or lack of movement; • Detect whether doors are opened or closed; and • Provide a push button emergency alert system. Providers of assistive devices and medical equipment must be a licensed home health agency. Certain standards apply for the medical equipment and supplies used. Limitations • Services must be pre-approved • Services must be based on verified need. • Benefit must be determined by an independent assessment on any item that costs over $500. • All items must reduce reliance on other Medicaid state plan or waiver services • All items must meet applicable standards of manufacture, design and installation • The items must be on the Plan of Care developed by the support coordinator. A recipient is not able to receive Telecare Activity and Sensor Monitoring services and traditional PERS

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	services. Where applicable, recipients must use Medicaid State Plan, Medicare or other available payers first. *Source: LA Dept. of Health and Hospitals, Community Choices Waiver Provider Manual, Chapter Seven of the Medicaid Svcs. Manual, p. 29-30 (as revised on May 11, 2016). (Accessed Aug. 2016).*
Email/Phone/FAX	
No reimbursement for email. No reimbursement for telephone. No reference found for FAX. *Source: LA Revised Statutes 37:1262 (2012).* **Practice of Medicine** *(does not apply to reimbursement):* A physician may utilize interactive audio without video after access and review of the patient's medical records, and the physician determines that he is able to meet the same standard of care if the health care services were provided in person. *Source: LA Revised Statutes Sec. 40:1223.3 (HB 570 – 2016).*	No reference found.
Online Prescribing	
Only physicians certificated by a specialty board of the American Board of Medical Specialties or the American Osteopathic Association shall use telemedicine to prescribe amphetamines or narcotics. Telemedicine, including the issuance of any prescription via electronic means, shall be held to the same prevailing and usually accepted standards of medical practice as those in traditional, face-to-face settings. An online, electronic or written mail message, or a telephonic evaluation by questionnaire or otherwise, does not satisfy the standards of appropriate care. To establish a physician-patient relationship an in-person visit is not required if the technology is sufficient to provide the physician the pertinent clinical information. *Source: LA Admin. Code 46:XLV.75.* **Newly Passed Legislation (Now Effective)** For physicians practicing telemedicine and treating a patient at a healthcare facility that is required to be licensed according to the laws of LA and holds a current registration with the US Drug Enforcement Administration: • Physician must use the same standard of care as in person.	**Greater New Orleans Community Health Connection Provider Manual** The use of a telemedicine communications system may substitute for a face-to-face, "hands on" encounter for consultation, office visits, individual psychotherapy and pharmacologic management. *Source: LA Dept. of Health and Hospitals, Greater New Orleans Community Health Connection Provider Manual, Chapter Forty-seven of the Medicaid Svcs. Manual, p. 65 (as revised Jul. 14, 2016). (Accessed Aug. 2016).*

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• Physician must be authorized to prescribe any controlled dangerous substance without necessity of conducting an appropriate in-person patient history or physical examination. • Physician shall not be subject to any regulation prohibition or restriction on the use of telemedicine that is more restrictive than those that are otherwise applicable to their entire profession. *Source: LA Statute Sec. 1271.1 (HB 480 – 2016).* No physician practicing telemedicine can prescribe a controlled dangerous substance prior to conducting an appropriate in-person patient history or physical examination of the patient. *Source: LA Revised Statutes Sec. 1300.381 & HB 1280 (2014).*	
Consent	
Physicians must inform telemedicine patients of the relationship between the physician and patient, and the role of any other health care provider with respect to management of the patient. The patient may decline to receive telemedicine services and withdraw from such care at any time. *Source: LA Admin. Code 46:XLV.7511 (2012).*	No reference found.
Location	
No reference found.	No reference found.
Cross-State Licensing	
A telemedicine license may be issued to out-of-state physicians, as long as they hold a full and unrestricted license in another state or U.S. territory. Out-of-state telemedicine providers cannot open an office, meet with patients or receive calls from patients within Louisiana. A licensed health care provider must be in the examination room with the patient during telemedicine services. *Source: LA Revised Statutes 37:1276.1 (2012).* LA state agencies and professional boards can regulate the use of telehealth including licensing of out-of-state healthcare providers. *Source: LA Revised Statutes Sec. 1300.381 & HB 1280 (2014).*	No reference found.
Private Payers	
Reimbursement must be made to the originating site	No reference found.

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physician if he/she is physically present during the exam and interact with the distant-site physician. Originating-site physician fees shall be at least 75 percent of the normal fee for an intermediate office visit. No reference found for distant-site physician reimbursement. ***Source: LA Revised Statutes 22:1821 (2012).***	
Site/Transmission Fee	
No reference found.	No reference found.
Miscellaneous	
Louisiana law requires that a physician who uses telemedicine establish a proper physician-patient relationship. Physicians must: • Verify the identity of the patient; • Conduct an appropriate exam; • Establish a proper diagnosis; • Establish a treatment plan; • Create a written plan for follow up care. ***Source: LA Admin. Code 46:XLV.7509 (2012).***	

Comments:

Professional Board Telehealth-Specific Regulations

- Louisiana Medical Board ***(Title 46, Part XLV, Subpart 1, Subchapter C, Ch. 75)***

Louisiana has specific standards for its telemedicine physicians.

Source: LA Statute Sec. 1300.381 & House Bill 1280 (2014).

Louisiana created a Task Force on Telehealth access to advise the legislature and the Department of Health and Hospitals on policies and practices that expand access to telehealth services.

Source: LA House Concurrent Resolution 88 (2014).

Maine

Medicaid Program: MaineCare

Medicaid Program Administrator: Maine Dept. of Health and Human Services

Regional Telehealth Resource Center:
Northeast Telehealth Resource Center
11 Parkwood Drive
Augusta, ME 04330
(207) 622-7566 / (800) 379-2021
www.netrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Telemedicine, as it pertains to the delivery of health care services, means the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. 'Telemedicine' does not include the use of audio-only telephone, facsimile machine or e-mail." ***Source: ME Revised Statutes Annotated. Title 24, Sec. 4316 (2012).*** Telehealth is the use of information technology by a Health Care Provider to deliver clinical services at a distance for the purpose of diagnosis, disease monitoring, or treatment. Telehealth Services may be either telephonic or interactive (combined video/audio). ***Source: Code of ME Rules 10-144-101, Ch. 1, Sec. 4.***	Telehealth is the use of information technology by a Health Care Provider to deliver clinical services at a distance for the purpose of diagnosis, disease monitoring, or treatment. Telehealth Services may be either telephonic or interactive (combined video/audio). ***Source: MaineCare Benefits Manual, Telehealth, 10-144 Ch. 101, Ch. 1, Sec. 4. (Apr. 16, 2016). (Accessed Aug. 2016).***
Live Video Reimbursement	
Maine law requires coverage for services provided through telemedicine, which includes live video. ***Source: ME Revised Statutes Annotated. Title 24 Sec. 4316 (2012).*** ME Medicaid covers telehealth when it is medically appropriate (see Medicaid Column for details). ***Source: Code of ME Rules 10-144-101, Ch. 1, Sec. 4.*** *(See Medicaid column & "Private Payers" section)*	If the Member is eligible for the underlying covered service and providing it via telehealth is medically appropriate, the Member is eligible for telehealth services. There is a specific list of codes provided in the manual. Non-Covered services include: • Medical equipment • Personal care aide • Pharmacy services • Assistive technology services • Non-emergency medical transportation • Ambulance services • Services that require physical contact • Any service medically inappropriate for telehealth services. See manual for full list of exclusions.

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	No reimbursement for communication between health care providers. *Source: MaineCare Benefits Manual, Telehealth, 10-144 Ch. 101, Ch. 1, Sec. 4. (Accessed Aug. 2016).*
Store and Forward Reimbursement	
ME Medicaid provides coverage for telemonitoring services (which may or may not take place in real time) under certain circumstances (See Medicaid column). *Source: Code of ME Rules 10-144-101, Ch. 1, Sec. 4. http://www.maine.gov/sos/cec/rules/10/144/ch101/c1s004.docx*	Provider manual indicates coverage of "telehealth services" which is inclusive of store-and-forward, however the manual only discusses interactive telehealth, and remote patient monitoring in detail. Additionally, the manual only discusses the use of the GT modifier (live interactive video), and does not mention the GQ modifier (asynchronous). *Source: MaineCare Benefits Manual, Telehealth, 10-144 Ch. 101, Ch. 1, Sec. 4. (Accessed Aug. 2016).*
Remote Patient Monitoring Reimbursement	
ME Medicaid provides coverage for telemonitoring (see Medicaid column for details). *Source: Code of ME Rules 10-144-101, Ch. 1, Sec. 4.*	In order to be eligible for telemonitoring a member must: • Be eligible for home health services; • Have a diagnosis of a health condition requiring monitoring of clinical data at a minimum of five times per week, for at least one week; • Have had two or more hospitalizations or emergency room visits related to their diagnosis in the past calendar year or have continuously received telemonitoring services during the past calendar year and have a continued need; • Have telemonitoring services included in the Member's plan of care; • Reside in a setting suitable to support telemonitoring equipment; and • Have the physical and cognitive capacity to effectively utilize the telemonitoring equipment or have a caregiver willing and able to assist with the equipment. A physician must document that a face-to-face encounter with the member occurred before they are eligible for a home health benefit. This can occur through interactive telehealth services, but not by telephone or e-mail. Covered telemonitoring services include: • Evaluation of the member to determine if telemonitoring services are medically necessary; • Evaluation of Member to ensure cognitively and physically capable of operating equipment; • Evaluation of residence; • Education and training; • Remote monitoring and tracking of data by a RN, NP, PA or physician and response with appropriate clinical interventions;

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	• Monthly telephonic services; • Maintenance of equipment; and • Removal/disconnection of equipment ***Source: MaineCare Benefits Manual, Telehealth, 10-144 Ch. 101, Ch. 1, Sec. 4. (Accessed Aug. 2016).*** RPM is covered under Home and Community Benefits for the Elderly and for Adults with Disabilities. Services may include a range of technological options including in-home computers, sensors and video camera linked to a provider that enables 24/7 monitoring. Final approval must be obtained from the Department, Office of Aging and Disability Services while considering: • Number of hospitalizations in the past year; • Use of emergency room in the past year; • History of falls in the last six months resulting from injury; • Member lives alone or is home alone for significant periods of time; • Service access challenges and reasons for those challenges; • History of behavior indicating that a member's cognitive abilities put them at a significant risk of wandering; and • Other relevant information. ***Source: MaineCare Benefits Manual, Home and Community Benefits for the Elderly and for Adults with Disabilities, 10-144 Ch. II, Sec. 19, p. 16 (Mar. 15, 2016). (Accessed Aug. 2016).***
Email/Phone/FAX	
No reimbursement for email. No reimbursement for telephone. No reimbursement for FAX. ***Source: ME Revised Statutes Annotated. Title 24 Sec. 4316 (2012).***	No reimbursement for email. No reimbursement for telephone. No reimbursement for FAX. ***Source: Code of ME Rules. 10-144-101 (2012).*** For Indian Health Services, a second tier consultation can utilize direct email communications or telephone consultation. ***Source: MaineCare Benefits Manual, Indian Health Services, 10-144 Ch. II, p. 5 (Jan. 1, 2014). (Accessed Mar. 2016).*** Telephonic services may be reimbursed if the following conditions are met: • Interactive telehealth services are unavailable; and • A telephonic service is medically appropriate for the underlying condition. Services may not be delivered through electronic mail. ***Source: MaineCare Benefits Manual, Telehealth, 10-144 Ch. 101,***

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	Ch. 1, Sec. 4. (Accessed Aug. 2016). Telephone is also covered for: • Targeted Case Management Services for purposes of monitoring and follow up activities can take place over the telephone. • The Home and Community Benefits for the Elderly and for Adults with Disabilities for purposes of monitoring. • Behavioral Health Services for purposes of crisis resolution services. *Source: MaineCare Benefits Manual, Targeted Case Management Services, 10-144 Ch. 101, Sec. 13, p. 6 (Mar. 20, 2014). (Accessed Mar. 2016).* *Source: MaineCare Benefits Manual, Behavioral Health Services, 10-44 Ch. II, Sec. 65, p. 11 (May 24, 2016). (Accessed Aug. 2016).*
Online Prescribing	
No reference found.	Tele-pharmacy is allowed. Tele-pharmacy is a method of delivering prescriptions dispensed by a pharmacist to a remote site. Pharmacies using tele-pharmacy must follow all applicable State and Federal regulations, including use of staff qualified to deliver prescriptions through tele-pharmacy. Providers may dispense prescriptions via tele-pharmacy; pre-authorization is required. *Source: MaineCare Benefits Manual, Ch. 2, Pharmacy Services, 10-144 Chapter 101, p. 5 & 33 (Nov. 29, 2015) (accessed Aug. 2016).*
Consent	
No reference found.	Providers must deliver written educational information to patients at their visit. This information should be written at a sixth-grade comprehension level, and include the following: • Description of the telehealth equipment and what to expect; • Explanation that the use of telehealth for this service is voluntary; • Explanation that the member is able to stop the telehealth visit at any time and request a face-to-face service; • Explanation that MaineCare will pay for transportation to a distant appointment if needed; • Explanation that the Member will have access to all information resulting from the telehealth service provided by law; • HIPAA compliance information regarding the

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	telehealth encounter; • Informed of all parties who will be present at the receiving and originating site and have the right to exclude anyone from either site; and • Member has the right to object to videotaping or other recording of consult. *Source: MaineCare Benefits Manual, Telehealth, 10-144 Ch. 101, Ch. 1, Sec. 4. (Accessed Aug. 2016).* Member's record must document consent for RPM. *Source: MaineCare Benefits Manual, Home and Community Benefits for the Elderly and for Adults with Disabilities, 10-144 Ch. II, Sec. 19, p. 16 (Mar. 15, 2016). (Accessed Aug. 2016).*
Location	
No reference found.	No reference found.
Cross-State Licensing	
A physician can practice medicine in Maine through interstate telemedicine if they are licensed in the state they are providing telemedicine from, their license is in good standing, the physician does not open an office, and the physician annually registers with the board and pays a fee. *Source: 32 MSRA Sec. 3300-D.*	No reference found.
Private Payers	
Requires coverage of telemedicine services, subject to contract terms and conditions. Coverage must be provided in a manner that is consistent with coverage for in-person consultation. *Source: ME Revised Statutes Annotated. Title 24 Sec. 4316 (2012).*	No reference found.
Site/Transmission Fee	
No reference found.	A facility fee is provided to a health care provider at the originating site. When an FQHC or RHC serves as the originating site, the facility fee is paid separately from the center or clinic all-inclusive rate. *Source: MaineCare Benefits Manual, Telehealth, 10-144 Ch. 101, Ch. 1, Sec. 4. (Apr. 16, 2016). (Accessed Aug. 2016).*
Miscellaneous	
	MaineCare will pay for transportation to a distant appointment if needed. *Source: MaineCare Benefits Manual, Telehealth, 10-144 Ch. 101, Ch. 1, Sec. 4. (Apr. 16, 2016). (Accessed Aug. 2016).*

Maryland

Medicaid Program: MD Medical Assistance Program

Program Administrator: MD Dept. of Social Services

Regional Telehealth Resource Center
Mid-Atlantic Telehealth Resource Center
PO Box 800711
Charlottesville, VA 22908-0711
(434) 906-4960 / (855) MATRC4U
www.matrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Telehealth means the use of telecommunications and information technologies for the exchange of information from one site to another, for the provision of health care to an individual from a provider through hardwire or Internet connection." ***Source: MD Health Occupations Annotated Sec. 2-101 (2012).*** Telemedicine means, as it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications or electronic technology: 1. By a health care provider to deliver a health care service that is within the scope of practice of the health care provider at a site other than the site at which the patient is located; and 2. That enables the patient to see and interact with the health care provider at the time the health care service is provided to the patient. ***Source: Health General Code 15-105.2.*** "Telemedicine means the practice of medicine from a distance in which intervention and treatment decisions and recommendations are based on clinical data, documents, and information transmitted through telecommunications systems." ***Source: Code of Maryland Admin. Regs. Sec. 10.32.05.02*** "Telehealth means the delivery of medically necessary services to a patient at an originating site by distant site provider, through the use of technology-assisted communication." "Telemedicine means the delivery of medically necessary somatic services to a patient at an originating site by a distant site provider, through the use of technology-assisted communication." ***Source: Code of Maryland Admin. Regs. Sec. 10.09.49.02.***	No reference found.

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Perinatal and Neonatal Referral Center Standards: "Telemedicine" means the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service within the scope of practice of the health care provider at a site other than the site at which the patient is located, in compliance with COMAR 10.32.05.and including at least two forms of communication. ***Source: MD COMAR Sec. 30.08.12.***	
Live Video Reimbursement	
Maryland law requires private insurers to provide coverage for telemedicine services (subject to terms and conditions of contract), which includes live video. *(See "Private Payers" section).* ***Source: MD Insurance Code Annotated Sec. 15-139 (2012).*** Maryland law requires the state Medicaid program to provide coverage for live video telemedicine services (subject to terms and conditions of contract), the same as it does for private payers. Primary care providers are required to qualify as eligible telemedicine providers. The Department may require providers to submit a registration form to include information required for the processing of telemedicine claims. ***Source: House Bill 1217 – 2016.*** The Department shall grant approval to allow originating and consulting site providers to receive State and federal funds for providing telemedicine services if the telemedicine provider meets certain requirements. Telemedicine providers must be part of a private practice, hospital or other health care system. • Must be an agreement between a medical assistance-approved originating site provider and consulting provider. ***Source: Health General Code 15-105.2.*** **<u>Newly Passed Legislation (Effective Oct. 1, 2016)</u>** The Department of Health and Mental Hygiene must adopt regulations related to the scope of benefits for telehealth services. ***Source: House Bill 1217 – 2016.***	Maryland Medicaid provides a telehealth program that employs a "hub-and-spoke" model. Applies to fee for service and managed care. Communication must be in real time, and the participant must be at an originating site with a telepresenter. Covered Services - Somatic and behavioral health services: Providers must contact the participant's healthchoice MCO or Beacon Health Option with questions regarding prior authorization requirements for telehealth services. Eligible distant site provider: • Nurse midwife • Nurse practitioner • Psychiatric nurse practitioner • Physician; or • Outpatient mental health center Telehealth providers must complete an online registration. ***Source: MD Medicaid Telehealth Program. Telehealth Provider Manual. Updated May 3, 2016. Accessed Aug. 2016.*** Reimbursement for telemedicine is required by Maryland Medical Assistance if the health care service is medically necessary and provided: • For the treatment of cardiovascular disease or stroke; • In an emergency department setting; and • When an appropriate specialist is not available. ***Source: MD Insurance Code Sec. 15-105.2*** **<u>Managed Care</u>** MCOs shall provide coverage for medically necessary telemedicine services. ***Source: Code of Maryland Admin. Regs. Sec. 10.09.67.31.***

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Mental Health Eligible Services: • Diagnostic interview; • Individual therapy • Family therapy • Outpatient evaluation and management • Outpatient office consultation • Initial inpatient consultation • Emergency department services ***Source: Code of Maryland Admin. Regs. Sec. 10.09.49.05.*** Patient must be authorized to receive behavioral health treatment services through the Public Behavioral Health System, except for behavioral health services provided in a hospital emergency department. ***Source: Code of Maryland Admin. Regs. Sec. 10.09.49.05-06.*** Eligible Distant Site Providers: • Nurse midwife • Nurse practitioner • Psychiatric nurse practitioner • Physician Providers must apply to participate in the telehealth program and be approved. They also must have a written contingency plan when telemedicine is unavailable. ***Source: Code of Maryland Admin. Regs. Sec. 10.09.49.07.*** The Department may not reimburse telemedicine services by an originating and distant site provider located in different facilities in the same hospital campus. ***Source: Code of Maryland Admin. Regs. Sec. 10.09.49.11.*** The Department's contractor who operates the Maryland Public Behavioral Health System must reimburse for specialty mental health services when authorized by COMAR 10.09.49. ***Source: Code of Maryland Admin. Regs. Sec. 10.09.49.06.***	
Store and Forward Reimbursement	
No reimbursement based upon definition of "telemedicine" which describes telemedicine as "interactive". ***Source: MD Insurance Code Annotated Sec. 15-139 (2012).*** The department may provide reimbursement for services delivered through store and forward technology.	Maryland Medicaid does not cover store and forward. ***Source: MD Medicaid Telehealth Program. Telehealth Provider Manual. Updated May 3, 2016. (Accessed Aug. 2016) & Code of Maryland Admin. Regs. Sec. 10.09.49.11.***

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Source: Health General Code 15-105.2.	
Remote Patient Monitoring Reimbursement	
The department may provide reimbursement for services delivered through remote patient monitoring technology. *Source: Health General Code 15-105.2.*	No reimbursement for home health monitoring services. *Source: MD Medicaid Telehealth Program. Telehealth Provider Manual. Updated May 3, 2016. (Accessed Aug. 2016) & Code of Maryland Admin. Regs. Sec. 10.09.49.11.*
Email/Phone/FAX	
No reimbursement for email. No reimbursement for telephone. No reimbursement for FAX. *Source: MD Insurance Code Annotated Sec. 15-139 (2012) & Health General Code 15-105.2.* Telehealth also does not include a telephone conversation, email or fax between providers without interaction between the distant site provider and patient. *Source: Code of Maryland Admin. Regs. Sec. 10.09.49.11.*	No reimbursement for email. No reimbursement for telephone. No reimbursement for FAX. No reimbursement for email, phone or telephone conversations between providers. *Source: MD Medicaid Telehealth Program. Telehealth Provider Manual. Updated May 3, 2016. (Accessed Aug. 2016) & Code of Maryland Admin. Regs. Sec. 10.09.49.11.*
Online Prescribing	
A physician-patient relationship can be established through real time auditory communications or real-time visual and auditory communications. *Source: Code of Maryland Admin. Regs. Sec. 10.32.05.02*	No reference found.
Consent	
Telehealth providers must inform patients and consultants of the following: • The inability to have direct, physical contact with the patient is a primary difference between telehealth and direct in-person service delivery; • The knowledge, experiences, and qualifications of the consultant providing data and information to the provider of the telehealth services need not be completely known to and understood by the provider; • The quality of transmitted data may affect the quality of services provided by the provider; • That changes in the environment and test conditions could be impossible to make during delivery of telehealth services; Telehealth services may not be provided by correspondence only. *Source: Code of MD Reg., 10.41.06.04 (2012).* Except when providing interpretive services, the physician must obtain and document patient consent.	The originating site must obtain consent *Source: MD Medicaid Telehealth Program. Telehealth Provider Manual. Updated May 3, 2016. Accessed Aug. 2016.* Consent is required unless there is an emergency. *Code of Maryland Admin. Regs. Sec. 10.09.49.06.*

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Source: Code of Maryland Admin. Regs. Sec. 10.32.05.06	
Location	
Eligible originating sites (admin code): • College or university student health or counseling office; • Community-based substance use disorder provider; • Elementary, middle, high, or technical school with a supported nursing, counseling or medical office; • Local health department; • FQHC; • Hospital, including the emergency department; • Nursing facility; • The office of a physician, psychiatric nurse practitioner, nurse practitioner, or nurse midwife; • An opioid treatment program; • Outpatient mental health center; • Renal dialysis center; or • Residential crisis services site. When patient is in a hospital emergency department, the professional fee for the distant site provider would be covered if the distant site provider is not the physician of record or the attending physician and the initial telehealth consultation is distinct from the care provided by the physician of record or the attending physician. Distant site provider must be located within the State, the District of Columbia, or a contiguous state. *Source: Code of Maryland Admin. Regs. Sec. 10.09.49.07.*	Eligible originating sites: • College or university student health or counseling office • Community-based substance use disorder provider • Elementary, middle, high or technical school with a supported nursing, counseling or medical office • Local health department • FQHC • Hospital, including emergency department • Nursing facility • Private office • Opioid treatment program • Outpatient mental health center • Renal dialysis center; or • Residential services site *Source: MD Medicaid Telehealth Program. Telehealth Provider Manual. Updated May 3, 2016. Accessed Aug. 2016.*
Cross-State Licensing	
MD has exceptions to its MD-only licensed physicians for physicians practicing in the adjoining states of Delaware, Virginia, West Virginia, and Pennsylvania. *Source: MD Health Occupations Code Annotated Sec. 14-302 (2012).* A physician providing services through telemedicine must have a Maryland license if they are located in Maryland, or if the patient is in Maryland. *Source: COMAR 10.32.05.03*	No reference found.
Private Payers	
Requires coverage of telemedicine services, subject to contract terms and conditions. *Source: MD Insurance Code Annotated Sec. 15-139 (2012).*	No reference found.
Site/Transmission Fee	

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Originating sites are eligible for a transmission fee. *Code of Maryland Admin. Regs. Sec. 10.09.49.05.*	Originating sites may bill for a transmission fee. *Source: MD Medicaid Telehealth Program. Telehealth Provider Manual. Updated May 3, 2016. Accessed Aug. 2016.*
Miscellaneous	
Providers of health care services delivered through telemedicine must use video and audio transmission with less than a 300 millisecond delay. Other minimum technology requirements apply. *Source: Code of Maryland Admin. Regs. Sec. 10.09.49.08.* Providers may not store at originating or distant site video images or audio portion of telemedicine services for future use. *Source: Code of Maryland Admin. Regs. Sec. 10.09.49.09.* Telehealth can be used to meet network adequacy standards. *Source: MD House Bill 1318 – 2016.* **Newly Passed Legislation (Now Effective)** On or before Oct. 1, 2016, the Department of Health and Mental Hygiene, in consultation with the Maryland Health Care Commission must submit a report to the Senate Finance Committee and House Health and Government Operations Committee assessing telehealth policies of select Medicaid programs in other states, including reimbursement for telehealth services provided in a home setting and detailed planned enhancements to the Maryland Medicaid telehealth program. *Source: MD House Bill 886 – 2016.*	Technology requirements for providers: • A camera with specific resolution, focus, and zoom capabilities • Have display monitor sufficient in size • Bandwidth speed and image resolution sufficient to provide quality video • Audio equipment that ensures clear communication • Creates audio transmission with less than 300 millisecond delay Must ensure HIPAA compliance. Provider manual outlines various telehealth provider scenarios. *Source: MD Medicaid Telehealth Program. Telehealth Provider Manual. Updated May 3, 2016. Accessed Aug. 2016.*

Comments: The Maryland Health Care Commission has a Telemedicine Task Force to study the use of telehealth throughout the State.

Massachusetts

Medicaid Program: MassHealth

Program Administrator: MA Dept. of Health and Human Services

Regional Telehealth Resource Center:
Northeast Telehealth Resource Center
11 Parkwood Drive
Augusta, ME 04330
(207) 622-7566 / (800) 379-2021
www.netrc.org

Recent Policy Developments:
Massachusetts passed SB 2400 in 2012, which requires the MA Division of Insurance and Board of Registration in Medicine to review out-of-state physician issues and develop recommendations for legislation to permit use of out-of-state physicians for telemedicine.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Telemedicine as it pertains to the delivery of health care services, shall mean the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. 'Telemedicine' shall not include the use of audio-only telephone, facsimile machine or e-mail." *Source: Annotated Laws of MA. Chapter 175, Sec. 47BB.*	No reference found.
Live Video Reimbursement	
Private payers may provide coverage of telemedicine services (subject to contract terms and conditions), which includes live video. *(See "Private Payers" section).* *Source: MA Session Laws: Acts of 2012. Chapter 224, S.B. 2400.*	No reference found.
Store and Forward Reimbursement	
No reference found.	No reference found.
Remote Patient Monitoring Reimbursement	
No reference found.	In the FY 2014 State Budget, MA appropriates funds for the reimbursement of telehealth remote patient monitoring provided by home health agencies as a service to clients reimbursable through Medicaid, as long as it is for short term reimbursement. *Source: MA EOHHS and MassHealth. 4000-300.*
Email/Phone/FAX Restrictions	
No Reimbursement for email.	No reimbursement for telephone. No reference to email

STATE LAW/REGULATIONS	MEDICAID PROGRAM
No reimbursement for telephone. No reimbursement for FAX. *Source: MA Session Laws: Acts of 2012. Chapter 224, S.B. 2400.*	or fax found. *Source: Acute Outpatient Hospital Manual Transmittal Letter AOH-33. Jan. 2014; Chronic Disease and Rehabilitation Outpatient Hospital Manual Transmittal Letter COH-9. Jan. 2, 2015. (Accessed Mar. 2016).* Psychotherapy in crisis services is limited to face-to-face contacts; services via telephone are not reimbursable. *Source: Mental Health Center Manual Transmittal Letter MHC-48. 1/1/14. (Accessed Mar. 2016).*
Online Prescribing	
Prior to any e-prescribing, there must be a physician-patient relationship that conforms to certain minimum norms and standards of care, which includes taking a medical history and conducting an appropriate exam. *Source: "Internet Prescribing," MA Board of Registration in Medicine. Dec. 17, 2003. (Accessed Jul. 2015).*	No reference found.
Consent	
No reference found.	No reference found.
Location	
No reference found.	No reference found.
Cross-State Licensing	
No reference found.	No reference found.
Private Payers	
Private payers may provide coverage of telemedicine services, subject to contract terms and conditions, and must be consistent with coverage for health care services provided through in-person consultations. *Source: MA Session Laws: Acts of 2012. Chapter 224, S.B. 2400.*	No reference found.
Site/Transmission Fee	
No reference found.	No reference found.
Miscellaneous	

COMMENTS: The 2016 MA State Budget requires the health policy commission to implement a one year regional pilot program to further the development and utilization of telemedicine in the commonwealth.

Source: MA Bill H 3650 (2015).

Michigan

Medicaid Program: Michigan Medicaid

Program Administrator: Michigan Dept. of Community Health

Regional Telehealth Resource Center:
Upper Midwest Telehealth Resource Center
2901 Ohio Boulevard, Ste. 110
Terre Haute, IN 47803
(855) 283-3734 ext. 232
www.umtrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Telemedicine means the use of an electronic media to link patients with health care professionals in different locations. To be considered telemedicine, the health care professional must be able to examine the patient via a real-time, interactive audio or video, or both, telecommunications system, and the patient must be able to interact with the off-site health care professional at the time the services are provided." ***Source: MI Compiled Law Svcs. Sec. 500.3476 (2012).***	"Telemedicine is the use of telecommunication technology to connect a patient with a health care professional in a different location." ***Source: MI Dept. of Community Health, Medicaid Provider Manual, p. 1596 (Jul. 1, 2016) & MI Department of Community Health Bulletin Telemedicine. Aug. 30, 2013. (Accessed Aug. 2016).*** **Speech-Language and Audiology Services** "Telepractice is the use of telecommunications and information technologies for the exchange of encrypted patient data for the provision of speech-language and audiology services. Telepractice must be obtained through real-time interaction between the patient's physical location (patient site) and the provider's physical location (provider site)." ***Source: MI Medical Services Administration Bulletin. MSA 15-22. School based services providers and billing agents. 7/1/15. (Accessed Aug. 2016).*** **Telepractice for Behavioral Health Therapy:** Telepractice is the use of telecommunications and information technologies for the exchange of encrypted patient data for the provision of services. Telepractice must be obtained through real-time interaction between the child's physical location (patient site) and the provider's physical location (provider Site. ***Source: Dept. of Community Health, Medicaid Provider Manual, p. 461 (Jul. 1, 2016) & MI Medical Services Administration Bulletin. MSA 16-07. Updates to Provider Manual. 3/1/16. (Accessed Aug. 2016).***
Live Video Reimbursement	
Michigan law states that "contracts shall not require face-to-face contact between a health care professional and a patient for services appropriately provided through telemedicine", which includes live video.	Michigan Medicaid reimburses for the following services categories via live video: • Inpatient Consults; • Office or other outpatient consults

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Source: MI Compiled Law Services Sec. 500.3476 (2012). *(See "Private Payers" section).*	• Office or other outpatient services • Psychiatric diagnostic procedures • Subsequent hospital care • Training services, diabetes • End stage renal disease (ESRD) related services. However, there must be at least one in-person visit per month, by a physician, nurse practitioner, or physician's assistant, to examine the vascular site for ESRD services. • Behavior change intervention, individual • Behavior health and/or substance use disorder treatment • Education service, telehealth • Nursing facility subsequent care The initial visit for nursing facility services must be face-to-face. Where face-to-face visits are required, telemedicine services may be used in addition to the required face-to-face visit, but cannot be used as a substitute. • Physicians and practitioners are eligible to be distant site providers. Providers at the distant site can only bill services listed in the telemedicine services database. ***Source: Dept. of Community Health, Medicaid Provider Manual, p. 1596 (Jul. 1, 2016) & MI Department of Community Health Bulletin Telemedicine. Aug. 30, 2013. (Accessed Aug. 2016).*** **Telepractice for BHT Services** • Telepractice services must be prior authorized. Providers may arrange telepractice services for the purpose of teaching parents/guardians to provide individualized interventions to their child and to engage in behavioral health clinical observation and direction. Qualified providers include: • Board certified behavior analysts • Board certified assistant behavior analysts • Licensed psychologists • Limited licensed psychologists • Qualified behavioral health professionals Occupational, physical and speech therapists are not included in this policy. A facilitator trained in telepractice technology must be physically present with the patient. ***Source: Dept. of Community Health, Medicaid Provider Manual, p. 461 (Jul. 1, 2016) & MI Medical Services Administration Bulletin. MSA 16-07. Updates to Provider Manual. 3/1/16. (Accessed Aug. 2016).***

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	Speech-Language and Audiology Services MI Medicaid will reimburse for speech language and audiology services provided through their school based program. The patient site may be located within the school, at the patient's home or any other established site deemed appropriate by the provider. *Source: MI Medical Services Administration Bulletin. MSA 15-22. School based services providers and billing agents. 7/1/15 & MI Dept. of Community Health, Medicaid Provider Manual, p. 1672 (Jul. 1, 2016) (Accessed Aug. 2016).*
Store and Forward Reimbursement	
No reimbursement based upon definition of "telemedicine" which describes telemedicine as occurring in "real time. *Source: MI Compiled Law Svcs. Sec. 500.3476 (2012).*	Telecommunication systems using store and forward technology are not included in MI Medicaid's telemedicine policy. *Source: Dept. of Community Health, Medicaid Provider Manual, p. 1575 (Jul. 1, 2016).*
Remote Patient Monitoring Reimbursement	
No reference found.	No reference found.
Email/Phone/FAX Restrictions	
No reference found.	No reference found.
Online Prescribing	
Providers must have an existing physician-patient relationship. *Source: MI Compiled Laws Sec. 333.17751 (2012).*	No reference found.
Consent	
No reference found.	No reference found.
Location	
No reference found.	Eligible originating sites: • County mental health clinics or publicly funded mental health facilities; • Federally Qualified Health Centers; • Hospitals (inpatient, outpatient, or Critical Access Hospitals); • Physician or other providers' offices, including medical clinics; • Hospital-based or CAH-based Renal Dialysis Centers; • Rural Health Clinics; • Skilled nursing facilities; • Tribal Health Centers. *Source: MI Dept. of Community Health, Medicaid Provider Manual, p. 1596 (Jul. 1, 2016) & MI Department of Community*

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	Health Bulletin Telemedicine. Aug. 30, 2013. (Accessed Aug. 2016). **Speech-Language and Audiology Services** The patient site may be located within the school, at the patient's home or any other established site deemed appropriate by the provider for reimbursement in their school based program. *Source: MI Medical Services Administration Bulletin. MSA 15-22. School based services providers and billing agents. 7/1/15 & MI Dept. of Community Health, Medicaid Provider Manual, p. 1672 (Jul. 1, 2016) (Accessed Aug. 2016).* **Behavioral Health Therapy** Eligible patient site: • Center • Clinic • Patient's home • Any other established site deemed appropriate by the provider Room must be free of distractions. A trained facilitator must be present at the patient site. *Source: MI Medical Services Administration Bulletin. MSA 16-07. Updates to Provider Manual. 3/1/16. (Accessed Aug. 2016).*
Cross-State Licensing	
No reference found.	Telemedicine services must be provided by a health care professional who is licensed, registered or otherwise authorized to engage in his or her health care profession in the state where the patient is located. *Source: MI Medical Services Administration Bulletin. MSA 15-44. Enrollment of Psychologists, Social Workers, and Professional Counselors as Medicaid Providers. 10/30/15. (Accessed Aug. 2016).* **Behavioral Health Therapy** Must be fully licensed in MI. *Source: MI Medical Services Administration Bulletin. MSA 16-07. Updates to Provider Manual. 3/1/16. (Accessed Aug. 2016).*
Private Payers	
Contracts shall not require face-to-face contact between a health care professional and a patient for services appropriately provided through telemedicine, as determined by the insurer. Telemedicine services shall be provided by a health care professional who is licensed, registered, or otherwise authorized to engage in his or her health care profession in the state where the patient is located. Telemedicine services are subject to all terms and conditions of the contract. *Source: MI Compiled Law Services Sec. 500.3476 (2012).*	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Site/Transmission Fee	
No reference found.	Originating site may bill for a facility fee. ***Source: Dept. of Community Health, Medicaid Provider Manual, p. 32 (Jul. 1, 2016).***
Miscellaneous	
	No reimbursement for remote access for surgical procedures, and use of robotics. ***Source: Dept. of Community Health, Medicaid Provider Manual, p. 1596 (Jul. 1, 2016).***

Minnesota

Medicaid Program: Medical Assistance (MA)

Program Administrator: MN Dept. of Human Services

Regional Telehealth Resource Center:
Great Plains Telehealth Resource and Assistance Center
University of Minnesota/Institute for Health Informatics
330 Diehl Hall
505 Essex Street S.E.
Minneapolis, MN 55455
(888) 239-7092
www.gptrac.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Telemedicine" means the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. A communication between a licensed health care provider and a patient that consists solely of an e-mail or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. ***Source: MN Senate File 1458 (2015). MN Statute Sec 256B.0622, subdivision 8.***	"Telemedicine is defined as the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site." ***Source: MN Dept. of Human Services, Provider Manual, Physician and Professional Services, As revised Jul. 8, 2016. (Accessed Aug. 2016).***
Live Video Reimbursement	
Intensive Rehabilitative Mental Health Services Physician services may be billed by a psychiatrist or other health care professional to treat intensive residential treatment services. ***Source: MN Senate File 1458 (2015). MN Statute Sec 256B.0622, subdivision 8.*** *(see Medicaid column)*	Minnesota's Medical Assistance program reimburses live video for fee-for-service programs. To be eligible for reimbursement, providers must self-attest that they meet the conditions of the MHCP telemedicine policy by completing the Provider Assurance Statement for Telemedicine form. Eligible providers: • Physician • Nurse practitioner • Physician assistant • Nurse midwife

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	• Clinical nurse specialist • Registered dietitian or nutrition professional • Clinical psychologist • Clinical social worker • Dentist, dental hygienist, dental therapist, advanced dental therapist • Pharmacist • Certified genetic counselor • Podiatrist • Speech therapist • Therapist • Occupational therapist • Audiologist Examples of eligible services: • Consultations • Telehealth consults: emergency department or initial inpatient care • Subsequent hospital care services with the limitation of one telemedicine visit every 30 days per eligible provider • Subsequent nursing facility care services with the limitation of one telemedicine visit every 30 days • End-stage renal disease services • Individual and group medical nutrition therapy • Individual and group diabetes self-management training with a minimum of one hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training • Smoking cessation • Alcohol and substance abuse (other than tobacco) structured assessment and intervention services Two-way interactive video consultation may be billed when no physician is in the ER and the nursing staff is caring for the patient at the originating site. Telemedicine consults are limited to three per calendar week per patient. Payment is not available for sending materials to a recipient, other provider or facility. Non-covered services: • Electronic connections that are not conducted over a secure encrypted website as specified by the Health Insurance Portability & Accountability Act of 1996 Privacy & Security rules (e.g., Skype) • Prescription renewals • Scheduling a test or appointment • Clarification of issues from a previous visit

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	• Reporting test results • Non-clinical communication • Communication via telephone, email or facsimile ***Source: MN Dept. of Human Services, Provider Manual, Physician and Professional Services, As revised Jul. 8, 2016. (Accessed Aug. 2016).*** Some mental health services may be covered by telemedicine. ***Source: MN Dept. of Human Svcs., Provider Manual, Telemedicine Delivery of Mental Health Services, Dec. 15, 2015 (accessed Aug. 2016).*** **Individualized Education Program (IEP)** Eligible originating sites: • Home • School Telemedicine coverage applies to a child or youth who is MA eligible, has an IEP and the service provided is identified in the IEP. To be eligible for reimbursement, the school or school district must self-attest that the telemedicine services provided by the professional provider either employed by or contracted by the school meet all of the conditions of the MHCP telemedicine policy by completing the Provider Assurance Statement for Telemedicine (DHS-6806) (PDF). Eligible providers include the following: • Charter schools • Education districts • Intermediate districts • Public school districts • Tribal schools (schools that receive funding from the Bureau of Indian Affairs-BIA) • Service cooperatives • Special education cooperatives • State academies Non-Covered Services • Services that are less effective than if provided in person, face-to-face • Supervision evaluations or visits • Evaluations or assessments • Personal care assistants • Nursing services • Transportation services • Electronic connections that are conducted over a website that is not secure and encrypted as specified by the Health Insurance Portability & Accountability Act of 1996 Privacy & Security

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	rules (for example, Skype) • Prescription renewals • Scheduling a test or appointment • Clarification of issues from a previous visit • Reporting test results • Non-clinical communication • Communication via telephone, email or fax See IEP manual for specific documentation and billing requirements. ***Source: MN Dept. of Human Svcs., Provider Manual, Individualized Education Program, Feb. 9, 2016 (accessed Aug. 2016).*** Telemedicine consults shall be paid at the same rate as in-person services. ***Minnesota Source: MN Statute Sec. 256B.0625*** Non-covered Services • Teledentistry • Telemedicine for alcohol and drug abuse services ***Source (dental): MN Dept. of Human Svcs., Provider Manual, Dental Svcs. May 1, 2015 (Accessed Aug. 2016).*** ***Source (Alcohol and drug abuse): MN Dept. of Human Svcs., Provider Manual, Alcohol and Drug Abuse Svcs. Sept. 14, 2015 (Accessed Aug. 2016).***
Store and Forward Reimbursement	
(see Medicaid column)	Minnesota's Medical Assistance program reimburses for services delivered through store and forward technology. Payment will be made for only one reading or interpretation of diagnostic tests such as x-rays, lab tests, and diagnostic assessments. Payment is not available to providers for sending materials to recipients, other providers or facilities. ***Source: MN Dept. of Human Services, Provider Manual, Physician and Professional Services, As revised Jul. 8, 2016. (Accessed Aug. 2016).*** Store and forward technology includes telemedicine consults that do not occur in real time, and that do not require a face-to-face encounter with the patient for all or any part of the consult. ***Source: MN Statute Sec. 256B.0625 (2012).***
Remote Patient Monitoring Reimbursement	
No reference found.	There is reimbursement for "telehomecare" under

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	Elderly Waiver (EW) and Alternative Care (AC) programs. Not covered under PERS *Source: MN Dept. of Human Svcs., Provider Manual, Elderly Waiver (EW) and Alternative Care (AC) Program, As revised May 25, 2016, (Accessed Aug. 2016).* Prior authorization for home care services is required for all tele-home-care visits. *Source: MN Dept. of Human Svcs., Provider Manual, Home Care Svcs., As revised Jan. 23, 2015 (Accessed Aug. 2016).*
Email/Phone/FAX	
No reference found.	No reimbursement for email No reimbursement for phone No reimbursement for fax *Source: MN Dept. of Human Services, Provider Manual, Physician and Professional Services, As revised Jul. 8, 2016. (Accessed Aug. 2016).* "A communication between two physicians that consists solely of a telephone conversation is not a telemedicine consultation." *Source: MN Statute Sec. 256B.0625 (2012).* Case management for Child Welfare Case Management services is covered through telephone. *Source: MN Dept. of Human Svcs., Provider Manual, Child Welfare Case Management Services, As revised Jul. 14, 2016. (Accessed Aug. 2016).*
Online Prescribing	
A prescription or drug order is not valid unless it can be established that the prescription or order was based on a documented patient evaluation, including an examination, adequate to establish a diagnosis and identify underlying conditions and contraindications to treatment. This includes the referring provider performing an in-person examination and a consultant issuing the prescription when providing services by telemedicine. *Source: MN Statute Sec. 151.37(2012).*	No reference found.
Consent	
No reference found.	No reference found.
Location	
No reference found.	Authorized originating sites include: • Office of physician or practitioner

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	• Hospital (inpatient or outpatient) • Critical access hospital (CAH) • Rural health clinic (RHC) and Federally Qualified Health Center (FQHC) • Hospital-based or CAH-based renal dialysis center (including satellites) • Skilled nursing facility (SNF) • End-stage renal disease (ESRD) facilities • Community mental health center • Dental clinic • Residential facilities, such as a group home and assisted living • Home (a licensed or certified health care provider may need to be present to facilitate the delivery of telemedicine services provided in a private home) • School Out-of-state coverage policy applies to services provided via telemedicine. Consultations performed by providers who are not located in Minnesota and contiguous counties, require authorization prior to the service being provided ***Source: MN Dept. of Human Services, Provider Manual, Physician and Professional Services, As revised Jul. 8, 2016. (Accessed Aug. 2016).***
Cross-State Licensing	
A physician licensed in another state can provide telemedicine services to a patient in Minnesota if their license has never been revoked or restricted in any state, they agree to not open an office in Minnesota and they register with the state's board. ***Source: MN Statute Sec. 147.032(1)*** Minnesota adopted the Federation of State Medical Board (FSMB)'s model language for an interstate medical licensure compact. ***Source: MN Senate File 253 (2015). MN Statute Sec. 147.38.***	No reference found.
Private Payers	
Private payers are required to provide coverage for telemedicine in the same manner, and at the same reimbursement rate, as other services provided in person. (Applies to plans that begin on or after Jan. 1, 2017). A health carrier can establish criteria that a health care provider must meet to demonstrate the safety or efficacy of delivering a service via telemedicine. They can also require a health care provider to agree to certain documentation or billing practices to protect against fraud.	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Source: MN Senate File 1458 (2015). MN Statute Sec. 62A.672.	
Site/Transmission Fee	
No reference found.	No reference found.
Miscellaneous	
	The Chemical Dependency Continuum of Care Pilot Project is to include telehealth services to address barriers to services. *Source: MN Statute 254B.14 Sec. 13*

Mississippi

Medicaid Program: Mississippi Medicaid

Program Administrator: Mississippi Division of Medicaid

Regional Telehealth Resource Center:
South Central Telehealth Resource Center
4301 W. Markham St. #519
Little Rock, AR 72205
(855) 664-3450
learntelehealth.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Telemedicine is the practice of medicine using electronic communication, information technology or other means between a physician in one location and a patient in another location with or without an intervening health care provider. This definition does not include the practice of medicine through postal or courier services." ***Source: Code of MS Rules 50-013-2635 (2012).*** Telemedicine means the delivery of health care services such as diagnosis, consultation, or treatment through the use of interactive audio, video or other electronic media. Telemedicine must be "real-time" consultation, and it does not include the use of audio-only telephone, e-mail or facsimile. ***Source: MS Code Sec. 83-9-351.***	The Division of Medicaid defines telemedicine as a method which uses electronic information and communication equipment to supply and support health care when remoteness disconnects patients and links primary care physicians, specialists, providers, and beneficiaries which includes, but is not limited to, telehealth services, remote patient monitoring services, teleradiology services, store-and-forward and continuous glucose monitoring services. The Division of Medicaid defines telehealth services as the delivery of health care by an enrolled Medicaid provider, through a real-time communication method, to a beneficiary who is located at a different site. The interaction must be live, interactive, and audiovisual. ***Source: Code of MS Rules 23-225, Rule. 1.1 (Accessed Aug. 2016).*** Telehealth service is defined as the practice of health care delivery by a provider to a beneficiary who is under the care of a provider at a different geographical location. ***Source: State of Mississippi. State Plan Under Title XIX of the Social Security Act. Medical Assistance Program. Attachment 3.1-A. 3/31/15. (Accessed Aug. 2016).***
Live Video Reimbursement	
Mississippi Medicaid and private payers are required to provide coverage for live video consultations. ***Source: MS Code Sec. 83-9-351.*** *(also see Medicaid column)*	Medicaid covers medically necessary health services via telehealth when coverage is provided in person and is live, interactive and audiovisual. ***Source: State of Mississippi. State Plan Under Title XIX of the Social Security Act. Medical Assistance Program. Attachment 3.1A. 3/31/15. (Accessed Aug. 2016).*** There is live video reimbursement for Medicaid mental health medication evaluation and management.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	Source: Code of MS Rules 23-206, Rule. 1.9, pg. 28. Any enrolled Medicaid provider may provide telehealth services at the originating site. The following enrolled Medicaid providers may provide telehealth services at the distant site: • Physicians, • Physician assistants, • Nurse practitioners, • Psychologists, and • Licensed Clinical Social Workers (LCSW) • Licensed Professional Counselors (LPCs). ***Source: Code of MS Rules 23-225, Rule. 1.2(C). (2016).*** Real time telehealth may be used for the following monitoring services: • Assessing the need for psychotropic medication, • Prescribing medication, and • Regular periodic monitoring of the medications prescribed for therapeutic effect and medical safety. • Medication evaluation • Medication management ***Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.***
Store and Forward Reimbursement	
Private payers, MS Medicaid and employee benefit plans are required to provide coverage at the same level as in-person consultation for store-and-forward telemedicine services. A health insurance or employee benefit plan can limit coverage to health care providers in a telemedicine network approved by the plan. Patients receiving medical care through store and forward must be notified of their right to receive interactive communication with the distant site provider. Telemedicine networks unable to offer this will not be reimbursed for store and forward telemedicine services. ***Source: MS Code Sec. 83-9-353.***	Telehealth services must be live, interactive and audiovisual. ***Source: State of Mississippi. State Plan Under Title XIX of the Social Security Act. Medical Assistance Program. Attachment 3.1-A. 3/31/15. (Accessed Aug. 2016).*** There is reimbursement for tele-radiology services, however there is no reference to reimbursing for other specialties. ***Source: Mississippi Division of Medicaid. Radiology Services Provider Reference Guide, pg. 4-5. March 2013. (Accessed Aug. 2016).*** MS Medicaid is required to cover store and forward services to the same level as in-person services. ***Source: MS Code Sec. 83-9-353. (Accessed Aug. 2016).***
Remote Patient Monitoring Reimbursement	
Private payers, MS Medicaid and employee benefit plans are required to provide coverage for remote patient monitoring services for Mississippi-based telehealth programs affiliated with a Mississippi health care facility.	MS Medicaid is required to cover remote patient monitoring services. *(see State law/regulation column)* ***Source: MS Code Sec. 83-9-353. (Accessed Aug. 2016).*** The Division of Medicaid covers remote patient

STATE LAW/REGULATIONS	MEDICAID PROGRAM

A onetime telehealth installation/training fee is also reimbursed.
 	
A health insurance or employee benefit plan can limit coverage to health care providers in a telemedicine network approved by the plan.
 	
To qualify for reimbursement patients must meet all of the following criteria:
• Be diagnosed in the last 18 months with one or more chronic condition, as defined by CMS.
• Have a recent history of costly services; and
• The patient's healthcare provider recommends disease management services via remote patient monitoring.
 	
Remote patient monitoring prior authorization request form must be submitted to request telemonitoring services.
 	
The law lists specific technology requirements.
 	
Source: MS Code Sec. 83-9-353.
	monitoring of devices when medically necessary, ordered by a physician, physician assistant or nurse practitioner which includes, but not limited to:
	
	• Implantable pacemakers,
	• Defibrillators,
	• Cardiac monitors,
	• Loop recorders, and
	• External mobile cardiovascular telemetry.
	
	The Division of Medicaid covers remote patient monitoring, for disease management when medically necessary, prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO), Division of Medicaid or designee, ordered by a physician, physician assistant, or nurse practitioner for a beneficiary who meets the following criteria:
	
	• Has been diagnosed with one (1) or more of the following chronic conditions of diabetes, congestive heart failure (CHF), or chronic obstructive pulmonary disease (COPD);
	• Has had two (2) or more hospitalizations in the previous twelve (12) months for one (1) of the chronic conditions listed above;
	• Hospitalizations for two (2) different chronic conditions cannot be combined to satisfy the two (2) or more hospitalizations requirement; and
	• Is capable of using the remote patient monitoring equipment and transmitting the necessary data or has a willing and able person to assist in completing electronic transmission of data.
	
	Remote patient monitoring services must be provided in the beneficiary's private residence.
	
	Source: Code of MS Rules 23-225, Rule. 2.3. (Accessed Aug. 2016).
	
	The Division of Medicaid reimburses for remote patient monitoring:
	• Of devices when billed with the appropriate code, and
	• For disease management:
	  • A daily monitoring rate for days the beneficiary's information is reviewed.
	  • Only one (1) unit per day is allowed, not to exceed thirty-one (31) days per month.
	  • An initial visit to install the equipment and train the beneficiary may be billed as a set-up visit. Only one set-up is allowed per episode even if monitoring parameters are added after the initial set-up and installation.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	• Only one (1) daily rate will be reimbursed regardless of the number of diseases/chronic conditions being monitored. *Source: Code of MS Rules 23-225, Rule. 2.5. (Accessed Aug. 2016).*
Email/Phone/FAX	
No Email No Phone No Fax *Source: MS Code Sec. 83-9-351.*	No reimbursement for email. No reimbursement for telephone. No reimbursement for facsimile. *Source: Code of MS Rules 23-225, Rule. 1.4(C). (Accessed Aug. 2016).* Not considered telehealth: • Telephone conversations; • Chart reviews; • Electronic mail messages; • Facsimile transmission; • Internet services for online medical evaluations; or • The installation or maintenance of any telecommunication devices or systems. *Source: State of Mississippi. State Plan Under Title XIX of the Social Security Act. Medical Assistance Program. Attachment 3.1-A. 3/31/15. (Accessed Aug. 2016).* **Home and Community-Based Services & Hospice Services** MS Medicaid does not cover telephone consults. *Source: Mississippi Medicaid Provider Reference Guide, Home and Community-Based Services, Mar. 2013, pg. 1; Hospice Services, Jan. 2013, pg. 1; Family Planning Services, Jan. 2013, pg. 2. (Accessed. Aug. 2016).*
Online Prescribing	
A prescription for a controlled substance based solely on a consumer's completion of an online medical questionnaire is not a valid prescription. *Source: MS Code Annotated Sec. 41-29-137 (2012).* A health care practitioner may prescribe medication after an appropriate examination through the use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically. *Source: MS Code Sec. 83-9-351.*	An e-prescribed, telephoned or faxed prescription from the prescriber may be accepted when it is not in conflict with federal and state laws and regulations. *Source: MS. Code Ann.23-214, Rule 1.7 & Mississippi Medicaid Provider Reference Guide, Pharmacy Services, Jul. 2014, pg. 29. (Accessed Aug. 2016).*
Consent	
The physician should obtain the patient's informed consent before providing care. *Source: Code of MS Rules 50-013-2635 (2012).*	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Location	
No reference found.	Telehealth services are covered in the following originating sites: • Office of a physician or practitioner; • Outpatient Hospital (including a Critical Access Hospital (CAH)); • Rural Health Clinic (RHC); • Federally Qualified Health Center (FQHC); • Community Mental Health/Private Mental Health Centers; • Therapeutic Group Homes; • Indian Health Service Clinic; or • School-based clinic. ***Source: State of Mississippi. State Plan Under Title XIX of the Social Security Act. Medical Assistance Program. Attachment 3.1-A. 3/31/15. (Accessed Aug. 2016).***
Cross-State Licensing	
Physicians practicing telemedicine must have a Mississippi medical license. However, a valid Mississippi license is not required where the evaluation, treatment and/or medicine given by a physician outside of Mississippi is requested by a physician duly licensed to practice medicine in Mississippi, and the physician who has requested such evaluation, treatment and/or medical opinion has already established a doctor/patient relationship with the patient to be evaluated and/or treated. In order to practice telemedicine a valid "physician patient relationship" must be established. The elements of this valid relationship are: 1. verify that the person requesting the medical treatment is in fact who they claim to be; 2. conducting an appropriate examination of the patient that meets the applicable standard of care; 3. establishing a diagnosis through the use of accepted medical practices, i.e., a patient history, mental status exam, physical exam and appropriate diagnostic and laboratory testing; 4. discussing with the patient the diagnosis, risks and benefits of various treatment options to obtain informed consent; 5. insuring the availability of appropriate follow-up care; and 6. Maintaining a complete medical record available to patient and other treating health care providers. ***Source: Code of MS Rules 50-013-2635 (2012).***	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Mississippi adopted the Federation of State Medical Board (FSMB)'s model language for an interstate medical licensure compact. *Source: MS Code Sec. 73-25-101. (2016).*	
Private Payers	
Health insurance plans must provide coverage for telemedicine services to the same extent as in-person consultations. *Source: MS Code Sec. 83-9-351.* Health insurance plans are also required to provide coverage for store-and-forward and remote patient monitoring services, in accordance with certain requirements (see above store and forward & remote patient monitoring sections). *Source: MS Source: MS Code Sec. 83-9-353.*	No reference found.
Site/Transmission Fee	
The originating site is eligible to receive a facility fee. *Source: MS Code Sec. 83-9-351* *Source: MS Code Sec. 83-9-353.* RHCs acting as the originating site may receive an additional fee per completed transmission. *Source: MS Code Sec. 23-000-212.*	The Division of Medicaid reimburses the originating site the Mississippi Medicaid telehealth originating site facility fee for telehealth services per completed transmission. The following enrolled Medicaid providers are eligible to receive the originating site facility fee for telehealth services per transmission: • Office of a physician or practitioner, • Outpatient hospital, including a Critical Access Hospital (CAH), • Rural Health Clinic (RHC), • Federally Qualified Health Center (FQHC), • Community Mental Health/Private Mental Health Center, • Therapeutic Group Home, • Indian Health Service Clinic, and • School-based clinic. The telepresenter must be one of the following and physically present at all times for the originating site to receive the originating site facility fee: • Physician, • Physician assistants, • Nurse practitioners, • Psychologists, and • Licensed clinical social workers (LCSW) • Licensed Professional Counselor. *Source: Code of MS Rules 23-225, Rule. 1.5(B). (Accessed Aug. 2016).*

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	Facility fee provided. *Source: State of Mississippi. State Plan Under Title XIX of the Social Security Act. Medical Assistance Program. Attachment 4.19-B. 3/31/15. (Accessed Aug. 2016).*
Miscellaneous	
To practice telemedicine, physicians must establish a valid physician-patient relationship by the following: • Verifying the identity of the patient; • Conducting an appropriate exam that meets the applicable standard of care. This exam need not be in person if the technology is sufficient to provide the same information to the physician as if the exam had been performed face to face; • Establishing a diagnosis; • Discussing with the patient the diagnosis, and the risks and benefits of various treatment options, to obtain informed consent; • Insuring the availability of appropriate follow-up care; • Maintaining a complete medical record. *Source: Code of MS Rules 50-013-2635 (2012).* A health insurance plan may limit coverage to health care providers in a telemedicine network approved by the plan. *Source: MS Code Sec. 83-9-351.*	

Missouri

Medicaid Program: HealthNet

Program Administrator: Missouri Dept. of Social Services

Regional Telehealth Resource Center:
Heartland Telehealth Resource Center
3901 Rainbow Blvd MS 1048
Kansas City, KS 66160
(877) 643-4872
heartlandtrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
Relating to Stroke Centers "Telemedicine-the use of medical information exchanged from one (1) site to another via electronic communications to improve patient's health status. A neurology specialist will assist the physician in the center in rendering a diagnosis. This may involve a patient "seeing" a specialist over a live, remote consult or the transmission of diagnostic images and/or video along with patient data to the specialist." *Source: MO Code of State Regulation Title 19, 30-40.710.* **Newly Passed Legislation (Eff. Nov. 26, 2016)** "Telehealth" or "telemedicine", the delivery of health care services by means of information and communication technologies which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while such patient is at the originating site and the health care provider is at the distant site. Telehealth or telemedicine shall also include the use of asynchronous store-and-forward technology. *Source: MO Revised Statute Sec. 191.1145 (2016 SB 579).*	"Telehealth means the use of medical information exchanged from one (1) site to another via electronic communications to improve the health status of a patient. Telehealth means the practice of health care delivery, evaluation, diagnosis, consultation, or treatment using the transfer of medical data, audio visual, or data communications that are performed over two (2) or more locations between providers who are physically separated from the patient or from each other." *Source: MO Code of State Regulation, Title 13, 70-3.190 (2010). (Accessed Aug. 2016).* Telehealth Services are medical services provided through advanced telecommunications technology from one location to another. Medical information is exchanged in real-time communication from an originating site, where the participant is located, to a distant site, where the provider is located, allowing them to interact as if they are having a face-to-face, hands-on session. A Telehealth service requires the use of a two (2)-way interactive video technology. *Source: MO HealthNet, Provider Manual, Behavioral Services, Section 13, p. 201 (Apr. 5, 2016)* *Source: MO HealthNet, Physician Manual, Telehealth Services, p. 276 (May 18, 2016). (Accessed Aug. 2016).*
Live Video Reimbursement	
Missouri Consolidated Health Care Plan (State employees and retirees health plan) Telehealth services are covered on the same basis that the service would be covered when it is delivered in person. *Source: MO Consolidated State Reg. 22:10-3.057.*	HealthNet will reimburse for live video for medically necessary services. Eligible providers: • Physicians; • Advanced registered Nurse Practitioners, including Nurse Practitioners with a mental

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Newly Passed Legislation(Eff. Nov. 26, 2016) For the provision of telehealth services under MO HealthNet, an eligible provider includes: (1) Physicians, assistant physicians, and physician assistants; (2) Advanced practice registered nurses; (3) Dentists, oral surgeons, and dental hygienists under the supervision of a currently registered and licensed dentist; (4) Psychologists and provisional licensees; (5) Pharmacists; (6) Speech, occupational, or physical therapists; (7) Clinical social workers; (8) Podiatrists; (9) Optometrists; (10) Licensed professional counselors; and (11) Eligible health care providers under subdivisions (1) to (10) practicing in a rural health clinic, federally qualified health center, or community mental health center. *Source: MO Revised Statute Sec. 191.1145 (2016 SB 579).*	health specialty; • Psychologists. Telehealth services are limited to: • Consultation made to confirm a diagnosis; • Evaluation and management services; • A diagnosis, therapeutic or interpretive service; • Individual psychiatric or substance abuse assessment diagnostic interview examinations; or • Individual psychotherapy Reimbursement to the provider at the distant site is made at the same amount as for an in-person service. *Source (eligible providers): MO HealthNet, Provider Manual, Behavioral Services, Section 13, p. 205-206 (Apr. 5, 2016)* *Source (distant site reimbursement): MO Code of State Regulation, Title 13, 70-3.190 (2010).* *Source (psychiatrists): MO HealthNet, Community Psychiatric Rehabilitation Program Manual, Sec. 13, pg. 233-235 (Dec. 18, 2015). (Accessed Aug. 2016).* *Source: MO HealthNet, Physician Manual, Telehealth Services, p. 276 (May 18, 2016).* **Comprehensive Substance Treatment and Rehabilitation (CSTAR)**: Medication services may be provided via telehealth. *Source: MO HealthNet, Provider Manual, CSTAR, Section 13, p. 191 (Dec. 8, 2015). (Accessed Mar. 2016). (Accessed Aug. 2016).* Anesthesiologist monitoring telemetry in the operating room is a noncovered service. *Source: MO HealthNet, Physician Manual, p. 202 (May 18, 2016). (Accessed Aug. 2016).*
Store and Forward Reimbursement	
Newly Passed Legislation (Eff. Nov. 26, 2016) Reimbursement for the use of asynchronous store-and-forward technology in the practice of telehealth in the MO HealthNet program shall be allowed for orthopedics, dermatology, ophthalmology and optometry, in cases of diabetic retinopathy, burn and wound care, dental services which require a diagnosis, and maternal-fetal medicine ultrasounds. Payment cannot exceed the payment for a face-to-face consultation of the same level. The department of social services, in consultation with the departments of mental health, health and senior services, shall promulgate rules governing the use of asynchronous store-and-forward technology in the	HealthNet will not reimburse for store and forward. *Source: MO HealthNet, Provider Manual, Behavioral Services, Section 13, p. 201 (Apr. 5, 2016)* *Source: MO HealthNet, Physician Manual, Telehealth Services, p. 276 (May 18, 2016). (Accessed Aug. 2016).*

STATE LAW/REGULATIONS	MEDICAID PROGRAM
practice of telehealth in the MO HealthNet program. Such rules shall include, but not be limited to: (1) Appropriate standards for the use of asynchronous store-and-forward technology in the practice of telehealth; (2) Certification of agencies offering asynchronous store-and-forward technology in the practice of telehealth; (3) Timelines for completion and communication of a consulting provider's consultation or opinion, or if the consulting provider is unable to render an opinion, timelines for communicating a request for additional information or that the consulting provider declines to render an opinion; (4) Length of time digital files of such asynchronous store-and-forward services are to be maintained; (5) Security and privacy of such digital files; (6) Participant consent for asynchronous store-and-forward services; and (7) Payment for services by providers; except that, consulting providers who decline to render an opinion shall not receive payment under this section unless and until an opinion is rendered. ***Source: MO Revised Statute Sec. 208.670-671 (2016 SB 579).***	
Remote Patient Monitoring Reimbursement	
<u>Newly Passed Legislation</u> (Eff. Nov. 26, 2016) Subject to appropriations, the Department is required to establish a statewide program that permits reimbursement for home telemonitoring services under MO HealthNet. Eligible conditions: • Pregnancy • Diabetes • Heart disease • Cancer • Chronic obstructive pulmonary disease • Hypertension • Congestive heart failure • Mental illness or serious emotional disturbance • Asthma • Myocardial infarction; or • Stroke The beneficiary must also exhibit two or more the following risk factors: • Two or more hospitalizations in the prior twelve-month period; • Frequent or recurrent emergency department admissions; • A documented history of poor adherence to	Personal Emergency Response Systems (an electronic device that is programmed to signal a response center once the help button is activated) is available for patients at high risk of being institutionalized. ***Source: MO HealthNet, Provider Manual, Developmental Disabilities Waiver Manual, Section 13, p. 23 (Jul. 15, 2016). (Accessed Aug. 2016).***

STATE LAW/REGULATIONS	MEDICAID PROGRAM
ordered medication regimens; • A documented history of falls in the prior six-month period; • Limited or absent informal support systems; • Living alone or being home alone for extended periods of time; • A documented history of care access challenges; or • A documented history of consistently missed appointments with health care providers The program must ensure the home health agency or hospital shares telemonitoring clinical information with participant's physician. If the department finds the program is not cost effective, they may discontinue the program and stop providing reimbursement for telemonitoring services. The department may promulgate rules to implement this section. ***Source: MO Revised Statute Sec. 208.686 (2016 SB 579). http://www.senate.mo.gov/16info/pdf-bill/tat/SB579.pdf***	
Email/Phone/FAX	
No reference found.	No reimbursement for email. No reimbursement for phone. No reimbursement for fax. No reimbursement for a consultation between healthcare providers. No reimbursement for services provided via videophone. ***Source: MO HealthNet, Physician Manual, Telehealth Services, p. 276 (May 18, 2016). (Accessed Aug. 2016).***
Online Prescribing	
Prescribing or dispensing drugs without sufficient examination is prohibited. ***Source: MO Revised Statutes § 334.100 (2012).*** **<u>Newly Passed Legislation</u> (Eff. Nov. 26, 2016)** The physician-patient relationship may be established by a telemedicine encounter, if the standard of care does not require an in-person encounter, and in accordance with evidence-based standards of practice and telemedicine practice guidelines that address the clinical and technological aspects of telemedicine. In order to establish a physician-patient relationship through telemedicine: (1) The technology utilized shall be sufficient to establish an informed diagnosis as though the medical interview and physical examination has been performed in person; and	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
(2) Prior to providing treatment, including issuing prescriptions, a physician who uses telemedicine shall interview the patient, collect or review relevant medical history, and perform an examination sufficient for the diagnosis and treatment of the patient. A questionnaire completed by the patient, whether via the internet or telephone, does not constitute an acceptable medical interview and examination for the provision of treatment by telehealth. *Source: MO Revised Statute Sec. 191.1145 (2016 SB 579). http://www.senate.mo.gov/16info/pdf-bill/tat/SB579.pdf* **Newly Passed Legislation (Eff. Nov. 26, 2016)** No health care provider shall prescribe any drug, controlled substance or other treatment to a patient based solely on an evaluation over the telephone unless there is a previously established and ongoing physician-patient relationship. No health care provider shall prescribe based solely on an internet request or questionnaire. *Source: MO Revised Statute Sec. 334.108 (2016 SB 579).*	
Consent	
Services related to pregnancy Telehealth providers are required to obtain patient consent. *Source: MO Revised Statutes § 376.1900.1* **Newly Passed Legislation (Eff. Nov. 26, 2016)** Telehealth providers using asynchronous store-and-forward technology shall be required to obtain participant consent before asynchronous store-and-forward services are initiated and to ensure confidentiality of medical information. *Source: MO Revised Statute Sec. 208.671 (2016 SB 579).* If an originating site is a school, a parent or guardian must give permission for telehealth services. Advanced Practice Registered Nurses who provides nursing services under a collaborative practice arrangement must obtain informed consent. *Source: MO Code of State Rules Sec. 20, 2150-5.100 & MO Revised Statute Sec. 335.175.*	Providers must obtain written patient consent before delivery of telehealth services. *Source: MO Code of State Regulation, Title 13, 70-3.190 (2010), MO HealthNet, Provider Manual, Behavioral Services, Section 13, p. 202 (Apr. 5, 2016)* *Source: MO HealthNet, Physician Manual, Telehealth Services, p. 278 (May 18, 2016). (Accessed Aug. 2016).*
Location	
Newly Passed Legislation (Eff. Nov. 26, 2016) A telehealth eligible originating site for MO HealthNet is one of the following: (1) An office of a physician or health care provider;	Originating sites must be one of the following: • Physician or other health care provider office; • Hospital;

STATE LAW/REGULATIONS	MEDICAID PROGRAM
(2) A hospital; (3) A critical access hospital; (4) A rural health clinic; (5) A federally qualified health center; (6) A long-term care facility licensed under chapter 198; (7) A dialysis center; (8) A Missouri state habilitation center or regional office; (9) A community mental health center; (10) A Missouri state mental health facility; (11) A Missouri state facility; (12) A Missouri residential treatment facility licensed by and under contract with the children's division. Facilities shall have multiple campuses and have the ability to adhere to technology requirements. Only Missouri licensed psychiatrists, licensed psychologists, or provisionally licensed psychologists, and advanced practice registered nurses who are MO HealthNet providers shall be consulting providers at these locations; (13) A comprehensive substance treatment and rehabilitation (CSTAR) program; (14) A school; (15) The MO HealthNet recipient's home; (16) A clinical designated area in a pharmacy; or (17) A child assessment center as described in section 210.001. *Source: MO Revised Statute Sec. 191.1145 (2016 SB 579).*	• Critical Access Hospital; • Rural Health Clinic; • Federally Qualified Health Center; • Missouri state habilitation center or regional office; • Community mental health center; • Missouri state mental health facility; • Missouri state facility; *Source: MO HealthNet, Provider Manual, Behavioral Services, Section 13, p. 202 (Apr. 5, 2016)* *Source: MO HealthNet, Physician Manual, Telehealth Services, p. 276 (May 18, 2016). (Accessed Aug. 2016).*
Cross-State Licensing	
Newly Passed Legislation (Eff. Nov. 26, 2016) Health care providers must be fully licensed to practice in Missouri by their respective professional boards. Exception for the following: • Informational consultation performed by licensed out of state providers, outside the context of a contractual relationship and on an irregular or frequent basis without the expectation or exchange of direct or indirect compensation; • Furnishing health care services by a health care provider licensed and located in another state in case of an emergency or disaster, provided that no charge is made for the medical assistance; • Episodic consultation by a provider licensed and located in another state who provides such consultation services on request to a physician in Missouri. *Source: MO Revised Statute Sec. 191.1145 (2016 SB 579).*	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Private Payers	
Payers are required to provide coverage for services through telehealth, if the same service could have been provided through face to face diagnosis, consultation or treatment. *Source: MO Revised Statutes § 376.1900.1*	No reference found.
Site/Transmission Fee	
Services related to pregnancy Payers are not required to reimburse telehealth providers for site origination fees or costs for the provision of telehealth. *Source: MO Revised Statutes § 376.1900.1* **Missouri Consolidated Health Care Plan (State employees and retirees health plan)** Telehealth site origination fees or costs for the provision of telehealth services are not covered. *Source: MO Consolidated State Reg. 22:10-3.060.*	Originating sites are eligible to receive a facility fee; distant sites are not eligible. The cost of an optional telepresenter is included in the facility fee. *Source: MO Code of State Regulations, Title 13, 70 3.190 (May 31, 2011), MO HealthNet, Provider Manual, Behavioral Services, Section 13, p. 202 (Apr. 5, 2016)* *Source: MO HealthNet, Physician Manual, Telehealth Services, p. 277 (May 18, 2016). (Accessed Aug. 2016).*
Miscellaneous	
Newly Passed Legislation (Eff. Nov. 26, 2016) The legislation establishes the "Telehealth Services Advisory Committee" to advise the department of social services and propose rules regarding the coverage of telehealth services in MO HealthNet program utilizing store-and-forward technology. *Source: MO Revised Statute Sec. 208.673 (2016 SB 579).*	Special documentation requirements apply. A telehealth service must be performed on a private dedicated telecommunications line approved through the Missouri Telehealth Network (MTN). *Source: MO HealthNet, Provider Manual, Behavioral Services, Section 13, p. 202 (Apr. 5, 2016) & Physician Services, Section 13, p. 278 (May 18, 2016). (Accessed Aug. 2016).*

Montana

Medicaid Program: Montana Medicaid

Program Administrator: MT Dept. of Public Health and Human Services

Regional Telehealth Resource Center:
Northwest Regional Telehealth Resource Center
2900 12th Ave. N., Ste. 30W
Billings, MT 59101
(888) 662-5601
www.nrtrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	

Telemedicine means the use of interactive audio, video, or other telecommunications technology that is:
• Used by a health care provider or health care facility to deliver health care services at a site other than the site where the patient is located; and
• Delivered over a secure connection that complies with the requirements of HIPPA.
  • The term includes the use of electronic media for consultation relating to the health care diagnosis or treatment of a patient in real time or through the use of store-and-forward technology.
  • The term does not include the use of audio-only telephone, e-mail, or facsimile transmissions.
 	
Source: MT Code Sec. 33-22-138.
 	
Recently Passed Legislation (Currently Effective)
Telemedicine means the practice of medicine using interactive electronic communication information technology, or other means between a licensee in one location and a patient in another location with or without an intervening health care provider. Telemedicine typically involves the application of secure videoconferencing or store-and-forward technology, as defined in 33-22-138. The term does not mean an audio-only telephone conversation, an e-mail or instant messaging conversation, or a message sent by facsimile transmission.
 	
Source: MT Code Sec. 37-3-102.
	Healthy Montana Kids
	Telemedicine is "the use of a secure interactive audio and video, or other telecommunications technology by a health care provider to deliver health care services at a site other than the site where the patient is located. Does not include audio only (phone call), e-mail, and/or facsimile transmission."
	
	Source: MT Children's health Insurance Plan, Healthy Montana Kids (HMK). Evidence of Coverage (Eff. July 1, 2015), p. 10. (Accessed Mar. 2016).

Live Video Reimbursement	
Private payers are required to provide coverage for services delivered through live video, equivalent to in-	Montana Medicaid will reimburse for live video services when the consulting provider is enrolled in Medicaid.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
person coverage. Eligible providers under this law include: • Physicians • Registered professional nurse • Advanced practice registered nurse • Genetic counselor certified by the American board of genetic counseling • Diabetes educator certified by the national certification board for diabetes Eligible facilities under this law include: • Critical access hospital • Hospice • Hospital • Long-term care facility • Mental health center • Outpatient center for primary care • Outpatient center for surgical services *Source: MT Code Sec. 33-22-138.*	The requesting provider need not be enrolled in Medicaid nor be present during the telemedicine consult. *Source: MT Dept. of Public Health and Human Svcs., Medicaid and Medical Assistance Programs Manual, Physician Related Svcs., p 2.9 (Aug. 2015). (Accessed Aug. 2016).* **Healthy Montana Kids** Services provided by telemedicine are allowed. *Source: MT Children's health Insurance Plan, Healthy Montana Kids (HMK). Evidence of Coverage (Eff. July 1, 2015), p. 24. (Accessed Aug. 2016).*
Store and Forward Reimbursement	
Private payers are required to provide coverage for services delivered through store and forward technology, equivalent to in-person coverage. Eligible providers under this law include: • Physicians • Registered professional nurse • Advanced practice registered nurse • Genetic counselor certified by the American board of genetic counseling • Diabetes educator certified by the national certification board for diabetes Eligible facilities under this law include: • Critical access hospital • Hospice • Hospital • Long-term care facility • Mental health center • Outpatient center for primary care • Outpatient center for surgical services *Source: MT Code Sec. 33-22-138.*	No reference found.
Remote Patient Monitoring Reimbursement	
No reference found.	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Email/Phone/FAX	
No Email No Phone No Fax *Source: MT Code Sec. 33-22-138.*	No reimbursement for telephone services in home. *Source: MT Dept. of Public Health and Human Svcs., Medicaid and Medical Assistance Programs Manual, Audiology Svcs., p 11 (Jan. 2016); Rural Health Clinics & Federally Qualified Health Center, p. 13 (Jan. 2016); Physical Therapy, Occupational Therapy and Speech Therapy, (Jan. 2016), p. 11; Critical Access Hospital Services, (Jan. 2016), p. 22; Hospital Outpatient Services, (May 2015), p. 11; Hospital Inpatient Services, (May 2015), p. 20. (Accessed Aug. 2016).*
Online Prescribing	
No reference found.	No reference found.
Consent	
No reference found.	No reference found.
Location	
No reference found.	The place of service is considered to be the location of the provider providing the telemedicine service. *Source: MT Dept. of Public Health and Human Svcs., Medicaid and Medical Assistance Programs Manual, Physician Related Svcs., p 5.14 (Aug. 2015). (Accessed Aug. 2016).*
Cross-State Licensing	
Montana adopted the Federation of State Medical Board (FSMB)'s model language for an interstate medical licensure compact. *Source: MT House Bill 429.*	No reference found.
Private Payers	
Private payers are required to provide coverage for services delivered through telemedicine, equivalent to in-person coverage. *Source: MT Code Sec. 33-22-138.*	No reference found.
Site/Transmission Fee	
No reference found.	No reimbursement for network use charges. *Source: MT Dept. of Public Health and Human Svcs., Medicaid and Medical Assistance Programs Manual, Physician Related Svcs., pg. 21 (Aug. 2015). (Accessed Aug. 2016).* FQHCs and RHCs can bill a telehealth originating site code if applicable. *Source: MT Dept. of Public Health and Human Svcs., Medicaid and Medical Assistance Programs Manual, Rural Health Clinics & Federally Qualified Health Center, p. 5.1 (Mar. 2015). (Accessed Aug. 2016).*
Miscellaneous	

Comments:

Professional Board Telehealth-Specific Regulations

- MT Board of Speech-Language Pathology ***(MT Admin Rules, Sec. 24.222.9)***

Nebraska

Medicaid Program: Nebraska Medicaid

Program Administrator: NE Dept. of Health and Human Services

Regional Telehealth Resource Center:
Great Plains Telehealth Resource and Assistance Center
University of Minnesota/Institute for Health Informatics
330 Diehl Hall
505 Essex Street S.E.
Minneapolis, MN 55455
(888) 239-7092
www.gptrac.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
Telehealth means the use of medical information electronically exchanged from one site to another, whether synchronously or asynchronously, to aid a health care practitioner in the diagnosis or treatment of a patient. Telehealth includes services originating from a patient's home or any other location where such patient is located, asynchronous services involving the acquisition and storage of medical information at one site that is then forwarded to or retrieved by a health care practitioner at another site for medical evaluation, and telemonitoring. ***Source: NE Rev. Statute, 71-8503. (LB 1076) & LB 257 (2015).*** Telehealth consultation means any contact between a patient and a health care practitioner relating to the health care diagnosis or treatment of such patient through telehealth. ***Source: NE Rev. Statute, 71-8503. (LB 1076)***	Telehealth is a Medicaid-covered service delivered by a health care practitioner that utilize an interactive audio and video telecommunications system that permits real-time communication between the health care practitioner at the distant site and the client at the originating site. Telehealth services do not include a telephone conversation, electronic mail message, facsimile transmission between a health care practitioner and a client, a consultation between two health care practitioners and asynchronous "store and forward" technology. ***Source: NE Admin. Code Title 471, Ch. 1 & Physician Provider Handbook, Manual Letter 63-2014 (accessed Aug., 2016).***
Live Video Reimbursement	
(see Medicaid column)	For managed care plans who contract with the Department, in-person contact is not required for reimbursable services only to the extent that: • Services delivered via telehealth are covered and reimbursed under the fee-for-service program and • Managed care contracts are amended to add coverage of services delivered via telehealth Telehealth services are not covered if a child has access to a comparable service within 30 miles of his/her place of residence. Exceptions to this requirement:

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	• Children receiving behavioral health services. Reimbursement shall, at a minimum, be set at the same rate as a comparable in-person consult and the rate must not depend on the distance between the health care practitioner and the patient. NB Medicaid requires providers to be specifically enrolled as a telehealth site with Medicaid to bill for a telehealth services. A safety plan must be developed for clients, (except children receiving behavioral health services). ***Source (authorization and reimbursement): NE Revised Statutes Sec. 71-8506 (2012).*** ***Source (exceptions to 30-mile rule): NE Admin. Code Title 471, Ch. 1.*** ***Source: Physician Provider Handbook, Manual Letter 63-2014*** ***Source (Children's behavioral health): LB 556 (Recently passed, effective Aug. 30, 2013). (Accessed Aug., 2016).*** **Federally Qualified Health Centers & Rural Health Clinics** FQHC & RHC core services provided via telehealth are not covered under the encounter rate. ***Source: NE FQHC Provider Handbook, Manual Letter 11-2010 & NE RHC Provider Handbook, Manual Letter 11-2010. (Accessed Aug., 2016).*** Children's Behavioral Health A trained staff member must be immediately available to a child receiving telehealth behavioral health service. This requirement may be waived by a legal guardian. ***Source: Revised Statutes of NE. Sec. 71-8506. (Accessed Aug. 2016).*** Assertive Community Treatment (ACT) ACT Team Interventions may be provided via telehealth when provided according to certain regulations. ***Source: NE Mental Health & Substance Abuse Provider Handbook, Ch. 35 Rehabilitative Psychiatric Services, Manual Letter 89-2008. (Accessed Aug, 2016).***
Store and Forward Reimbursement	
(see Medicaid column)	Nebraska Medicaid will reimburse for tele-radiology when it meets the American College of Radiology standards for tele-radiology. There is no other reference to reimbursing for other specialties. ***Source: NE Admin. Code Title 471, Ch. 1 & Physician Provider Handbook, Manual Letter 63-2014. (Accessed Aug., 2016).***
Remote Patient Monitoring Reimbursement	

STATE LAW/REGULATIONS	MEDICAID PROGRAM
No reference found.	See “Comments” section below.
Email/Phone/FAX	
(see Medicaid column)	No reimbursement for email. No reimbursement for telephone. No reimbursement for FAX. ***Source: NE Admin. Code Title 471, Ch. 1.***
Online Prescribing	
Prescribing drugs to individuals the physician has never met, based solely on answers to questions provided by the internet, telephone, or FAX, or without first establishing a proper physician-patient relationship, is prohibited. ***Source: NE Admin. Code Title 172, Ch. 88.*** *(also see Medicaid column)*	Prescriptions over the Internet: Neither the prescribing health care practitioner service nor the pharmacy service is covered when the health care practitioner prescribing the medication has only reviewed an e-mail message or e-mail questionnaire about the client. ***Source: NE Admin. Code Title 471, Ch. 1.***
Consent	
Written patient consent required prior to any service delivery. ***Source: NE Revised Statutes Sec. 71-8505 (2012).*** *(also see Medicaid column)*	Written or email consent required before initial service delivery. Must include this information: • The patient may refuse the service at any time with no loss of future treatment or program benefits patient is otherwise entitled to;; • A list of alternative care options, including in-person services; • Confidentiality protections; • Patient access to all medical information from the consult; • Prior consent for dissemination of any client-identifiable images or information from the consult; • Patient shall be informed of all parties present at both ends of the consult, and the patient may exclude anyone from either site; • The patient may see an appropriately trained staff or employee in person immediately after the consult, or be informed ahead of time that this is not available. Sample patient consent form available in Manual Appendix. ***Source: NE Admin. Code Title 471, Ch. 1 & Physician Provider Handbook, Manual Letter 63-2014. (Accessed Aug., 2016).***
Location	
	Telehealth Site means either a health care facility enrolled with Medicaid and licensed under Neb. Rev. Stat. Section 71-2017 to 71-2029, and effective January 1, 2001, licensed under the Health Care Facility Act or a health care practitioner facility whose practitioners are

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	enrolled with Medicaid and credentialed under the Uniform Licensing Law. ***Source: NE Dept. of Health and Human Svcs., Title 471 NE Medical Assistance Svcs., p. 18 (July 11, 2009) & Physician Provider Handbook, Manual Letter 63-2014. (Accessed Aug., 2016).*** Telehealth services are not covered if the patient has access to a comparable service within 30 miles of his/her place of residence. Exceptions to this requirement: • Emergency or urgent medical situations; • When accessing in-person services at less than 30 miles poses a significant hardship on the patient, due to a medical condition or disability; • Nursing facility patients who require transportation via ambulance. • Recently Passed Legislation: Children receiving behavioral health services. ***Source (exceptions to 30-mile rule): NE Admin. Code Title 471, Ch. 1.*** ***Source (Children's behavioral health): LB 556*** Out-of-State Telehealth Services are covered: • When the distant site is located in another state and the originating site is located in Nebraska if requirements are met. • When the Nebraska client is located at an originating site in another state, whether or not the provider's distant site is located in or out of Nebraska if certain requirements are met. ***Source: NE Admin. Code Title 471, Ch. 1 & Physician Provider Handbook, Manual Letter 63-2014. (Accessed Aug., 2016).***
Cross-State Licensing	
No reference found.	Health care practitioners must be appropriately licensed, certified or registered by Nebraska. ***Source: Physician Provider Handbook, Manual Letter 63-2014. (Accessed Aug., 2016).***
Private Payers	
Private payers and self-funded employee benefit plans must provide, upon request, a description of the telehealth and telemonitoring services covered under the relevant policy. The description must include: • Description of services in telehealth and telemonitoring; • Exclusions or limitations (including limitation on transmission costs); • Requirements for licensing status;	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
• Requirements for signed written consent. *Source: LB 257 (2015).*	
Site/Transmission Fee	
(see Medicaid column)	Medicaid coverage of transmission costs is available. *Source: NE Admin. Code Title 471, Ch. 1 & Physician Provider Handbook, Manual Letter 63-2014. (Accessed Aug., 2016).* Federally Qualified Health Centers & Rural Health Clinics Telehealth transmission cost related to non-core services will be the lower of: • The provider's submitted charge; or • The maximum allowable amount *Source: NE FQHC Provider Handbook, Manual Letter 11-2010 & NE RHC Provider Handbook, Manual Letter 11-2010. (Accessed Aug., 2016).* **Managed Care** Telehealth transmission is covered as a part of the behavioral health benefits package. *Source: NE Admin. Code Title 482, 5-004.*
Miscellaneous	
Recently Passed Legislation A stroke system of care task force shall recommend eligible essential health care services for acute stroke care provided through telehealth. *Source: LB 722 (2016).*	

Comments:

NE Medicaid does provide an outpatient cardiac rehabilitation program consisting of physical exercise or conditioning and concurrent telemetric monitoring are considered a valuable therapeutic modality. When a program is provided by a hospital to its outpatients, the service is covered as an outpatient service.

Source: NE Admin. Code Title 471, Ch. 10 Hospital Services & Physician Provider Handbook, Manual Letter 48-95. (Accessed Aug., 2016).

Nevada

Medicaid Program: Nevada Medicaid

Program Administrator: Division of Health Care Financing and Policy (DHCFP)

Regional Telehealth Resource Center:
Southwest Telehealth Resource Center
PO Box 245105
Tucson, AZ 85724
(520) 626-4498
www.southwesttrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
Telehealth means the delivery of services from a provider of health care to a patient at a different location through the use of information and audio-visual communication technology, not including standard telephone, facsimile or electronic mail. *Source: NV Bill AB 292 (2015).*	"Telehealth is the use of a telecommunications system to substitute for an in-person encounter for professional consultations, office visits, office psychiatry services, and a limited number of other medical services." "Telehealth" is defined as the delivery of service from a provider of health care to a patient at a different location through the use of information and audio-visual communication technology, not including standard telephone, facsimile, or electronic mail. *Source: NV Dept. of Health and Human Svcs.,Medicaid Services Manual, Section 3400, p. 1 (Dec. 1, 2015). (Accessed Aug. 2016).*
Live Video Reimbursement	
Live video reimbursement is available, including for dental plans. See Private Payers section below. *Source: NV Bill AB 292 (2015).*	Nevada Medicaid and Nevada Check Up (NCU) program will reimburse for live video, as long as services have parity with face-to-face services and health care professionals follow Medicaid's policies for specific services they are providing. Telehealth services follow the same prior authorization requirements as services provided in person. Subsequent hospital care is limited to one telehealth visit every three calendar days. Subsequent nursing facility care is limited to one telehealth visit every 30 calendar days. Licensed Clinical Psychologists, Licensed Clinical Social Workers and clinical staff may bill and receive reimbursement for psychotherapy. End Stage Renal Disease requires at least one face-to-face visit. Smoking cessation counseling covered only for pregnant women.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	Source: NV Dept. of Health and Human Svcs., Medicaid Services Manual, Section 3403.3, p. 3-6 (Dec. 1, 2015). (Accessed Aug. 2016).
Store and Forward Reimbursement	
No reference found.	Nevada Medicaid will not reimburse for store and forward. *Source: NV Dept. of Health and Human Svcs., Medicaid Services Manual, Section 3403.4, p. 9 (Dec. 1, 2015). (Accessed Aug. 2016).*
Remote Patient Monitoring Reimbursement	
No reference found.	No reference found.
Email/Phone/FAX	
No reimbursement for email. No reimbursement for telephone. No reimbursement for FAX. *Source: NV Revised Statutes Annotated Sec. 633.165 (2012).*	No reimbursement for email. No reimbursement for telephone, except psychiatric treatment in crisis intervention. No reimbursement for FAX. *Source: NV Dept. of Health and Human Svcs., Medicaid Services Manual, Section 600, p. 10 (July 10, 2014) & NV Dept. of Health and Human Svcs., Medicaid Services Manual, Section 3403.4, p. 9 (Dec. 1, 2015). (Accessed Aug. 2016) & Nevada Dept. of Health and Human Services Billing Guidelines Telehealth Billing Instructions, p. 1 (Aug. 11, 2016).*
Online Prescribing	
A provider of health care who is located at a distant site and uses telehealth to direct or manage the care or render a diagnosis of a patient who is located in Nevada or write a treatment order or prescription for such a patient must comply with all state and federal laws that would apply if the provider was located within the state. *Source: NV Bill AB 292 (2015).* <u>Osteopathic Medicine</u> A bona fide relationship between a patient and osteopathic physician (needed for a prescription) can be established via telemedicine. *Source: NV Revised Statutes Annotated Sec. 633.165*	No reference found.
Consent	
For osteopaths, oral and written consent. Must include this information: • The patient or legal representative may withdraw consent at any time; • Potential risks, consequences and benefits of telemedicine; • Whether the osteopath has a financial interest in the web site used to engage in telemedicine, or in the products or services provided ;	

STATE LAW/REGULATIONS	MEDICAID PROGRAM
• Patient privacy and security; • The osteopath will not release any confidential medical information without written consent. *Source: NV Revised Statutes Annotated Sec. 633.165 (2012).*	
Location	
No reference found.	An originating site must be a qualified Medicaid provider and includes: • A provider's office • Critical Access Hospitals • Rural Health Clinics • Federally Qualified Health Centers • Hospitals • End State Renal Disease Facilities • Skilled Nursing Facility • Community Mental Health Centers • Indian Health Services/Tribal Organizations/Urban Indian Organizations • School-Based Health Centers • Schools • Family Planning Clinics • Public Health Clinics • Comprehensive Outpatient Rehabilitation Facilities • Community Health Clinics (State Health Division) • Special Children's Clinics • HIV Clinics • Therapy Offices • Chiropractic offices *Nevada Dept. of Health and Human Services Billing Guidelines Telehealth Billing Instructions, p.2 (Aug. 11, 2016).*
Cross-State Licensing	
A practitioner must hold a valid Nevada License or certificate to practice his or her profession before providing services via telehealth unless he or she is a provider of health care services who is providing services within the scope of his or her employment by or pursuant to a contract entered into with an urban Indian organization. *Source: NV Bill AB 292 (2015).* Nevada adopted the Federation of State Medical Boards (FSMB)"s model language for an interstate medical licensure compact. *Source: NV Bill SB 251 (2015).*	No reference found.
Private Payers	
A health plan must include coverage for services provided to an enrollee through telehealth to the same	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
extent as through provided in-person. *Source: NV Bill AB 292 (2015).*	
Site/Transmission Fee	
No reference found.	Originating site is qualified to receive a facility fee. Originating sites are considered community paramedicine services. *Nevada Dept. of Health and Human Services Billing Guidelines Provider Type 32 Billing Guide, p. 3 (July 1, 2016).* Recipient smart phones and recipient home computers cannot bill the facility fee. *Nevada Dept. of Health and Human Services Billing Guidelines Telehealth Billing Instructions, p.2 (Aug. 11, 2016).*
Miscellaneous	
Before an osteopathic physician may use telemedicine: • A bona fide relationship between the osteopathic physician and the patient must exist which must include, without limitation, a history and physical examination or consultation which occurred in person and which was sufficient to establish a diagnosis and identify any underlying medical conditions of the patient. • The osteopathic physician must obtain informed, written consent from the patient or the legal representative of the patient to engage in telemedicine with the patient. The osteopathic physician shall maintain the consent form as part of the permanent medical record of the patient. *Source: NV Revised Statutes Annotated Sec. 633.165 (2012).*	Telehealth services do not require prior authorization. However, individual services may require prior authorization, whether delivered in person or by telehealth. *Nevada Dept. of Health and Human Svcs., Medicaid Services Manual, Section 3403.8, p. 9 (Dec. 1, 2015). (Accessed Aug. 2016).*

Comments: In 2011, the Nevada Legislature defined telemedicine and established practice requirements.

Professional Board Telehealth-Specific Regulations

- Board of Occupational Therapy *(Source: LCB File No. R017-14 & Ch. 640A of NE Admin. Code)*

New Law Passed Establishing Standards for telepractice for speech language pathology and audiology.
Source: NV Bill AB 115 (2015)

New Hampshire

Medicaid Program: New Hampshire Medicaid

Program Administrator: Dept. of Health and Human Services

Regional Telehealth Resource Center:
Northeast Telehealth Resource Center
11 Parkwood Drive
Augusta, ME 04330
(207) 622-7566 / (800) 379-2021
www.netrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Telemedicine, as it pertains to the delivery of health care services, means the use of audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment. Telemedicine does not include the use of audio-only telephone or facsimile." ***Source: NH Revised Statutes Annotated, 415-J: 2 (2012).***	"Telehealth services" and the term "telemedicine" shall comply with 42 C.F.R. section 410.78 and the Centers for Medicare and Medicaid Services requirements. ***Source: NH Bill SB 112 (2015).***
Live Video Reimbursement	
New Hampshire statute states that insurers may not deny coverage for services provided through telemedicine, which includes live video. ***Source: NH Revised Statutes Annotated, 415-J: 3 (2012).*** *(See "Private Payers" section).*	Limited reimbursement for some live video services. NH Medicaid follows the reimbursement policies of Medicare. Providers who may receive reimbursement: • Physician • Nurse practitioner • Clinical nurse specialist • Nurse-midwife • Clinical psychologist • Clinical social worker • Registered dietitian or specified nutrition professional ***Source: NH Bill SB 112 (2015).***
Store and Forward Reimbursement	
No reference found.	No reimbursement for store-and-forward. ***Source: NH Bill SB 112 (2015).***
Remote Patient Monitoring Reimbursement	
No reference found.	No reference found.
Email/Phone/FAX	
No reference found for email. No reimbursement for telephone. No reimbursement for FAX.	No reimbursement for email. No reimbursement for telephone. No reimbursement for FAX.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Source: NH Revised Statutes Annotated, 415-J: 2 (2012).	*Source: NH Bill SB 112 (2015).*
Online Prescribing	
A physician-patient relationship requires an in-person exam that may take place via a face-to-face 2-way real time interactive communication. Prescribing drugs to individuals without a physician-patient relationship is prohibited, except under the following conditions: • Writing admission orders for a newly hospitalized patient; • A patient of another provider for whom the prescriber is taking call; • A prescription for a patient who has been examined by a physician assistant, nurse practitioner, or other licensed practitioner; • Medication on a short-term basis for a new patient prior to the patient's first appointment; • When providing limited treatment to a family member in accordance with the American Medical Association Code of Medical Ethics. It is unlawful to prescribe through telemedicine a controlled drug classified in schedule II through IV. A prescription of a non-opioid controlled drug classified in schedule II through IV via telemedicine shall be limited to certain practitioners who are treating a patient with whom the prescriber has an in-person practitioner-patient relationship, for purposes of monitoring or follow-up care, and who are treating patients at a state designated community mental health center or a Substance Abuse and Mental Health Services Administration-certified state opioid treatment program, and shall require an initial in-person exam by a practitioner licensed to prescribe the drug. *Source: NH Revised Statutes Annotated, Sec. 329:1-c & NH Bill SB 84 (2015) & NH Revised Statutes Annotated 22-1 (HB 1210).*	No reference found.
Consent	
No reference found.	No reference found.
Location	
No reference found in statute.	NH Medicaid follows Medicare telehealth reimbursement policies. Telehealth services may only be provided to NH Medicaid enrollees who are in a rural health professional shortage area or a county not in a Metropolitan Statistical Area. *Source: NH Bill SB 112 (2015).*
Cross-State Licensing	
Recently Passed Legislation (Eff. Jul. 4, 2016).	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
NH adopted the Federation of State Medical Board (FSMB)'s model language for an interstate medical licensure compact. *Source: NH Revised Statutes Annotated, 329:C. (HB 1665)*	
Private Payers	
Insurers may not deny coverage for services provided through telemedicine, if the services are covered through in-person consults. *Source: NH Revised Statutes Annotated, 415-J: 3 (2012).*	No reference found.
Site/Transmission Fee	
No reference found.	No reference found.
Miscellaneous	
A committee has been established to study and resolve barriers related to the use of telehealth technology in New Hampshire. The committee must report its findings by Nov. 1, 2014. *Source: NH Revised Statutes Annotated, 112:1 (HB 556).* **Recently Passed Legislation (Eff. Jul. 1, 2016).** A board of medical imaging professionals and radiation therapists shall adopt rules relative to standards of care for the practice of telemedicine or telehealth. *Source: NH Revised Statutes Annotated, 328-J (SB 330-FN).*	

Comments: As of December 1, 2013 New Hampshire Medicaid transitioned to a managed care model of administration, under three health plans. These plans each have their own telehealth coverage policy.

Source: Provider Quick Reference Guide. (Accessed Feb. 21, 2014).

New Jersey

Medicaid Program: New Jersey Medicaid

Program Administrator: New Jersey Dept. of Human Services

Regional Telehealth Resource Center
Northeast Telehealth Resource Center
11 Parkwood Drive
Augusta, ME 04330
(207) 622-7566 / (800) 379-2021
www.netrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
No reference found.	No reference found.
Live Video Reimbursement	
No reference found.	Telepsychiatry may be utilized by mental health clinics and/or hospital providers of outpatient mental health services to meet their physician related requirements including but not limited to intake evaluations, periodic psychiatric evaluations, medication management and/or psychotherapy sessions for clients of any age. Before any telepsychiatry services can be provided, each participating program must establish related policies and procedures. *Source: NJ Division of Medical Assistance and Health Services. Newsletter. Vol. 23, No. 21, December 2013 (accessed Aug. 2016).*
Store and Forward Reimbursement	
No reference found.	No reference found.
Remote Patient Monitoring Reimbursement	
No reference found	No reference found.
Email/Phone/FAX	
No reference found.	No reference found.
Online Prescribing	
No reference found.	A psychiatrist or psychiatric APN must be licensed in the State of New Jersey. *Source: NJ Division of Medical Assistance and Health Services. Newsletter. Vol. 23, No. 21, December 2013 (accessed Aug. 2016).*
Consent	
No reference found.	Informed consent is required for telepsychiatry. *Source: NJ Division of Medical Assistance and Health Services. Newsletter. Vol. 23, No. 21, December 2013 (accessed Aug. 2016).*

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Location	
No reference found.	No reference found.
Cross-State Licensing	
No reference found.	No reference found.
Private Payers	
No reference found.	No reference found.
Site/Transmission Fee	
No reference found.	No reference found.
Miscellaneous	

Comments: New Jersey's Medicaid Program is managed care, with five participating health plans. The health plans may or may not have their own telehealth related policies.

Source: NJ Medicaid & Managed Care. Division of Medical Assistance and Health Services. (Accessed Mar. 2016)

New Mexico

Medicaid Program: New Mexico Medicaid

Medicaid Program Administrator: New Mexico Human Services Dept., Medical Assistance Division (MAD)

Regional Telehealth Resource Center:
Southwest Telehealth Resource Center
PO Box 245105
Tucson, AZ 85724
(520) 626-4498
www.southwesttrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Telemedicine means the practice of medicine across state lines." ***Source: NM Administrative Code, 16.10.2.7 (2012).*** Telemedicine means the use of interactive simultaneous audio and video or store-and-forward technology using information and telecommunications technologies by a health care provider to deliver health care services at a site other than the site where the patient is located, including the use of electronic media for consultation relating to the health care diagnosis or treatment of the patient in real time or through the use of store-and-forward technology. ***Source: NM Statute. 59A-22-49.3.*** "The practice of medicine across state lines means the rendering of a written or otherwise documented medical opinion concerning diagnosis or treatment of a patient within this state, by a physician located outside this state, as a result of transmission of individual patient data by electronic, telephonic or other means from within this state, to the physician or the physician's agent, OR the rendering of treatment to a patient within this state, by a physician located outside this state, as a result of transmission of individual patient data by electronic, telephonic or other means from within this state to the physician or the physician's agent." ***Source: NM Statutes Annotated, 1978 Sec. 61-6-6 (2012).*** "Telehealth means the use of electronic information, imaging and communication technologies, including interactive audio, video and data communications as well as store-and-forward technologies, to provide and support health care delivery, diagnosis, consultation, treatment, transfer of medical data and education." ***Source: NM Statutes Annotated Sec. 24-1G-3 (2012).***	No reference found.

Live Video Reimbursement	
New Mexico statute encourages the use and reimbursement of telehealth, which includes live video. ***Source: NM Statutes Annotated, Sec. 24-25-5 (2012).*** Private payers are required to provide coverage for services delivered through live video, equivalent to in-person coverage. ***Source: NM Statute. 59A-22-49.3.*** *(also see Medicaid column)*	New Mexico Medicaid will reimburse for live video at the same rate as when the services are furnished without the use of a telecommunication system. ***Source: NM Administrative Code 8.310.2*** Telemedicine is also covered by NM Managed Care. ***Source: NM Medical Assistance Division Managed Care Policy Manual, p. 216. Mar. 3, 2015. (Accessed Aug. 2016).*** **<u>Alternative Benefits Program & Managed Care Program</u>** The benefits package includes telemedicine services. ***Source: NM Admin Code Sec. 8.309.4.16 & 8.308.9.18.*** School-based services provided via telemedicine are covered. ***Source: NM Administrative Code 8.320.6.13(H).***
Store and Forward Reimbursement	
New Mexico Statute defines telehealth as encompassing Store and Forward. ***Source: NM Statutes Annotated Sec. 24-1G-3 (2012).*** Private payers are required to provide coverage for services delivered through store and forward, equivalent to in-person coverage. ***Source: NM Statute. 59A-22-49.3.***	New Mexico Medicaid does reimburse for store and forward. To be eligible, the service must be provided through the transfer of digital images, sounds, or previously recorded video from one location to another. It does not need to occur in real time. ***Source: NM Administrative Code 8.310.2.***
Remote Patient Monitoring Reimbursement	
No reference found.	No reference found.
Email/Phone/FAX Restrictions	
No reference found.	No reference found.
Online Prescribing	
Physicians are prohibited from prescribing, dispensing or administering drugs or medical supplies to a patient when there is no established physician-patient relationship. This includes prescribing over the Internet, or via other electronic means, based solely on an online questionnaire. Physicians may prescribe online during a live video exam. The prescribing physician must: • Obtain a medical history; • Obtain informed consent; • Generate a medical record;	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
• A physical exam is recorded as appropriate by the telehealth practitioner or a practitioner such as a physician, advance practice nurse, or physician or anesthesiologist assistant; or the exam is waived when a physical exam would not normally be part of a typical physical face-to-face encounter with the patient for the services being provided. *Source: NM Statutes Annotated, 1978 Sec. 61-6-20(B).*	
Consent	
No reference found.	No reference found.
Location	
No reference found.	An interactive telehealth communication system must include both interactive audio and video, and be delivered on a real-time basis at both the originating and distant sites. The originating site can be any medically warranted site. *Source: NM Administrative Code 8.310.2.*
Cross-State Licensing	
NM issues telemedicine licenses to providers who hold a full, unrestricted license in another state and has good moral character. *Source: NM Statutes Annotated, 1978 Sec. 61-6-11.1 (Sunset date of July 1, 2016) and 16.10.2.11.* **Recently Passed Legislation (Effective July 1, 2016)** NM Board of Osteopathic Medicine will issue telemedicine license. *Source: NM Statute Chapter 61, Article 10, Sec. 19. (SB 78)*	When the originating site is in New Mexico and the distant site is outside New Mexico, the distant-site provider at the distant site must be licensed in New Mexico for telemedicine, or meet federal requirements for Indian Health Service or tribal contract facilities. *Source: NM Administrative Code 8.310.2.*
Private Payers	
Private payers are required to provide coverage for services delivered through telemedicine, consistent with in-person coverage. *Source: NM Statute. 59A-22-49.3.*	No reference found.
Site/Transmission Fee	
Indian Health Services A telemedicine facility fee is paid. Both the originating and distant sites may be IHS or tribal facilities with two different locations, or a distant site can be under contract to the IHS or tribal facility. *Source: NM Administrative Code 8.310.12.12.*	Reimbursement is made to the originating site for an interactive telehealth system fee at the lesser of the following: • Provider's billed charge; • Maximum allowed by MAD for the specific service or procedure. • A telemedicine originating-site communication fee is also covered if the eligible recipient was present at and participated in the telemedicine

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	visit at the originating site. *Source: NM Administrative Code 8.310.2.* An originating site facility fee is not payable if telemedicine is used to connect an employee or staff member of a facility to the eligible recipient being seen at the same facility. *Source: NM Register. Volume XXV, No. 20. Oct. 30, 2014.*
Miscellaneous	

Comment: New Mexico offers out of state providers a "telemedicine license" to practice within its borders.

New Mexico is also the home of Project ECHO. The project's mission is to develop the capacity to safely and effectively treat chronic, common, and complex diseases in rural and underserved areas, and to monitor outcomes of this treatment utilizing technology.

New York

Medicaid Program: New York Medicaid

Medicaid Program Administrator: New York State Dept. of Health

Regional Telehealth Resource Center
Northeast Telehealth Resource Center
11 Parkwood Drive
Augusta, ME 04330
(207) 622-7566 / (800) 379-2021
www.netrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
Related to Credentialing and Privileging health care practitioners providing telemedicine "Telemedicine means the delivery of clinical health care services by means of real time two-way electronic audio-visual communications which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient's health care, while such patient is at the originating site and the health care provider is at a distant site." *Source: NY Consolidated Law Service Public Health Sec. 2805-u.* The term "telehealth" means the use of electronic information and communication technologies by telehealth providers to deliver health care services, which shall include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a patient. Telehealth shall not include delivery of health care services by means of audio-only telephone communication, facsimile machines, or electronic messaging alone, though use of these technologies is not precluded if used in conjunction with telemedicine, store and forward technology or remote patient monitoring. *Source: NY Public Health Law Article 29 – G Section 2999-cc* Telemedicine means the use of synchronous, two-way electronic audio visual communications to deliver clinical health care services, which shall include the assessment, diagnosis, and treatment of a patient, while such a patient is at the originating site and a telehealth provider is at a distant site. *Source: NY Public Health Law Article 29 – G Section 2999-cc*	"Telemedicine is the use of interactive audio and video telecommunications technology to support "real time" interactive patient care and consultations between healthcare practitioners and patients at a distance. The distant site or "hub" is where the medical specialist providing the consultation or service is located. The originating site or "spoke" is where the referring health professional and patient are located." *Source: NY Dept. of Health, Medicaid Update, Vol. 31, Number 3, March 2015, p. 18. (Accessed Aug. 2016).* For the home telehealth program, term "telehealth" means the use of electronic information and communication technologies by telehealth providers to deliver health care services, which shall include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a patient. Telehealth shall not include delivery of health care services by means of audio-only telephone communication, facsimile machines, or electronic messaging alone, though use of these technologies is not precluded if used in conjunction with telemedicine, store and forward technology or remote patient monitoring. *Source: NY Public Health Law Article 29 – G Section 2999-cc.*
Live Video Reimbursement	
A health plan shall not exclude from coverage services that are provided via telehealth if they would otherwise	Reimbursement policy applies to fee-for-service. Managed care plans may cover telemedicine at their

STATE LAW/REGULATIONS	MEDICAID PROGRAM
be covered under a policy. Telehealth means the use of electronic information and communications technologies by a health care provider to deliver health services to an insured individual while such individual is located at a site that is different from the site where the health care provider is located. ***Source: NY Insurance Law Article 32 Section 3217-h & Article 43 Section 4306-g.***	own option and establish their own payment guidelines and structure. New York Medicaid will reimburse for live video services for medically necessary services provided to patients in: • Hospitals (emergency room, outpatient department, Inpatient) established under Article 28 of the New York Public Health Law; • Diagnostic and Treatment Centers (D&TCs) established under Article 28 of the New York Public Health Law; • FQHCs that have "opted into" NY Medicaid Ambulatory Patient Groups (APG); • Non-FQHC School Based Health Centers (SBHCs) • Practitioner offices; • Article 28 facilities providing dental services; Providers who may deliver telemedicine services include: • Physician specialists, including psychiatrists; • Certified Diabetes Educators (CDEs); • Certified Asthma Educators (CAEs or A-ECs) • Clinical Psychologists; • Dentists; • Psychiatric Nurse Practitioners; • Genetic Counselors; • Licensed Clinical Social Workers (LCSW) and Licensed Master Social Workers (LMSW) only when employed by an Article 28 clinic. LCSWs and LMSW can only provide services to Medicaid enrollees under age 21 and pregnant women up to 60 days post-partum. ***Source: NY Dept. of Health, Medicaid Update, Vol. 31, Number 3, March 2015, p. 18-19. (Accessed. Aug. 2016).*** Medicaid will cover genetic counseling services via telemedicine. ***Source: NY Dept. of Health, Medicaid Update, Vol. 31, Number 8, July 2015, p. 15. (Accessed. Aug. 2016).*** Telepsychiatric services must meet certain conditions to be eligible for Medicaid reimbursement. ***Source: NY Regulations Title 14 NYCRR Section 599.17.*** For the Home Telehealth program, a telehealth provider is: • Licensed physician • Licensed physician assistant • Licensed dentist • Licensed nurse practitioner

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	• Licensed registered professional nurse • Licensed podiatrist • Licensed optometrist • Licensed psychologist • Licensed social worker • Licensed speech language pathologist or audiologist • Licensed midwife • Certified diabetes educator • Certified asthma educator • Certified genetic counselor • Hospital • Home care services agency • Hospice • Or any other provider as determined by the Commissioner. *Source: NY Public Health Law Article 29 – G Section 2999-cc.*
Store and Forward Reimbursement	
Private payers may, but are not mandated to, reimburse for store-and forward delivered services. *Source: NY Insurance Law Article 32 Section 3217-h & NY Insurance Law Article 43 Section 4306-g.*	Store and forward is not reimbursed. *Source: NY Dept. of Health, Medicaid Update, Vol. 31, Number 3, March 2015, p. 19. (Accessed Aug. 2016).* For the home telehealth program, store and forward services may be reimbursed. *Source: NY Public Health Law Article 29 – G Section 2999-dd*
Remote Patient Monitoring Reimbursement	
Private payers may, but are not mandated to, reimburse for remote patient monitoring services. *Source: NY Insurance Law Article 32 Section 3217-h & NY Insurance Law Article 43 Section 4306-g.* Demonstration rates of payment or fees shall be established for telehealth services provided by a certified home health agency, a long term home health care program or AIDS home care program, or for telehealth services by a licensed home care services agency under contract with such an agency or program, in order to ensure the availability of technology-based patient monitoring, communication and health management. Reimbursement is provided only in connection with Federal Food and Drug Administration-approved and interoperable devices that are incorporated as part of the patient's plan of care. *Source: NY Consolidated Law Service Public Health Sec. 3614.*	For the home telehealth program, store and forward services may be reimbursed. *Source: NY Public Health Law Article 29 – G Section 2999-dd. (Accessed Aug. 2016).*
Email/Phone/FAX	
Per the definition of telehealth, health care services by	No payment for telephone.

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means of audio-only telephone communication, facsimile machines, or electronic messaging alone are not included in the definition of telehealth. The use of these technologies is not precluded if used in conjunction with telemedicine, store and forward technology or remote patient monitoring. *Source: NY Public Health Law Article 29 – G Section 2999-cc*	*Source: NY Medicaid Program. Physician Policy Guidelines. Version 2015-4. Oct. 15, 2015. P. 19. (Accessed. Aug. 2016).*
Online Prescribing	
No reference found.	No reference found.
Consent	
No reference found.	No reference found.
Location	
Originating sites are limited to: • Licensed health facilities in Articles 28 (hospitals) and 40 (hospice); • A facility as defined in Section 1.03, subdivision six of the Mental Hygiene Law which includes and place in which services for the mentally disabled are provided and includes but is not limited to a psychiatric center, development center, institute, clinic, ward, institution or building; • Private physician's or dentist's offices located in New York; • When a patient is receiving health care services by means of remote patient monitoring, the patient's place of residence located within the state of New York or other temporary location located within or outside the state of New York. *Source: NY Public Health Law Article 29 – G Section 2999-cc*	No reference found.
Cross-State Licensing	
No reference found.	No reference found.
Private Payers	
A health plan shall not exclude from coverage services that are provided via telehealth if they would otherwise be covered under a policy. Telehealth means the use of electronic information and communications technologies by a health care provider to deliver health services to an insured individual while such individual is located at a site that is different from the site where the health care provider is located. *Source: NY Insurance Law Article 32Section 3217-h & NY Insurance Law Article 43 Section 4306-g.*	No reference found.
Site/Transmission Fee	
No reference found.	Transmission fee may be billed under certain

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	circumstances. *Source: NY Dept. of Health, Medicaid Update, Vol. 31, Number 3, March 2015, p. 21. (Accessed. Aug. 2016).*
Miscellaneous	
	New York hospitals acting as originating (spoke) sites must ensure that all physicians at distant (hub) sites are appropriately credentialed and privileged. *Source: NY Dept. of Health, Medicaid Update, Vol. 31, Number 3, March 2015, p. 19. (Accessed Aug. 2016).*

Comments**:**

Telemedicine/telehealth reimbursement in managed care is optional.

A review of Web resources of 18 MMC Plans reveals policy statements of telemedicine coverage for at least the following insurance providers:

- Amerigroup New York
- BlueCross Blue Shield of Western New York
- MVP Health Plan
- United Healthcare
- Universal Community Health
- WellCare of New York

Source: Northeast Telehealth Resource Center.

North Carolina

Medicaid Program: North Carolina Medicaid

Medicaid Program Administrator: Dept. of Health and Human Services, Division of Medical Assistance

Regional Telehealth Resource Center:
Mid-Atlantic Telehealth Resource Center
PO Box 800711
Charlottesville, VA 22908-0711
(434) 906-4960 / (855) MATRC4U
www.matrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Telemedicine is the use of two-way real-time interactive audio and video between places of lesser and greater medical capability or expertise to provide and support health care, when distance separates participants who are in different geographical locations." ***Source: NC General Statute 130A-125***	"Telemedicine is the use of two-way real-time interactive audio and video between places of lesser and greater medical capability or expertise to provide and support health care, when distance separates participants who are in different geographical locations." ***Source: NC Div. of Medical Assistance, Medicaid and Health Choice Manual, Clinical Coverage Policy No: 1H, Telemedicine and Telepsychiatry, p. 1, Oct. 1, 2015. (Accessed Aug. 2016).***
Live Video Reimbursement	
The Commission is required to address follow up protocols to ensure early treatment for newborn infants diagnosed with congenital heart defects, to include telemedicine (live video). ***Source: NC General Statute 130A-125***	North Carolina Medicaid and NC Health Choice will reimburse for live video medical services and tele-psychiatry services. All of the following conditions must be met: • The beneficiary must be present at the time of consultation; • The medical examination must be under the control of the consulting provider; • The distant site of the service must be of a sufficient distance from the originating site to provide services to a beneficiary who does not have readily available access to such specialty services; and • The consultation must take place by two-way real-time interactive audio and video telecommunications system. Criteria for eligible beneficiaries: • Must be enrolled in the NC Medicaid program or NC Health Choice • Providers must verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered • The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible • For the NCHC Program, Children must be between the ages of 6-18 (one of many

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	restrictions in program) Other Limitations: • Up to three different consulting providers may be reimbursed for a separately identifiable telemedicine or telepsychiatry service per date of service • Only one facility fee is allowed per date of service per beneficiary • There is no reimbursement to the referring provider at the originating site on the same date of service unless the referring provider is billing for a separately identifiable billable service. Health records must document that all the components of the service being billed were provided • These services are subject to the same restrictions as face-to-face contacts. Special provisions apply for the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. See manual. Eligible medical providers: • Physicians; • Nurse practitioners; • Nurse midwives; • Physician's assistants. Eligible tele-psychiatry providers: • Physicians; • Advanced practice psychiatric nurse practitioners; • Advanced practice psychiatric clinical nurse specialists; • Licensed psychologists Ph.D. level; • Licensed clinical social workers (LCSW); • Community diagnostic assessment agencies. All services must be: • Medically necessary; • The procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs; • The procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; • The procedure, product, or service is furnished in a manner not primarily intended for the

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	convenience of the recipient, the recipient's caretaker, or the provider. Providers must obtain prior approval from NC Medicaid for all services delivered via telemedicine and tele-psychiatry. Providers must submit: • Prior approval request; • All health records and any other records to document that the patient has met the specific criteria for telemedicine services; ***Source: NC Div. of Medical Assistance, Medicaid and Health Choice Manual, Clinical Coverage Policy No: 1H, Telemedicine and Telepsychiatry, p. 1-7, Oct. 1, 2015. (Accessed Aug. 2016).***
Store and Forward Reimbursement	
No reference found.	North Carolina Medicaid will not reimburse for Store and Forward. ***Source: NC Div. of Medical Assistance, Medicaid and Health Choice Manual, Clinical Coverage Policy No: 1H, Telemedicine and Telepsychiatry, p. 5, Oct. 1, 2015. (Accessed Aug. 2016).***
Remote Patient Monitoring Reimbursement	
No reference found.	No reference found.
Email/Phone/FAX Restrictions	
No reference found.	No reimbursement for email. No reimbursement for telephone. No reimbursement FAX. No reimbursement for video cell phone interaction. ***Source: NC Div. of Medical Assistance, Medicaid and Health Choice Manual, Clinical Coverage Policy No: 1H, Telemedicine and Telepsychiatry, p. 4-5, Oct. 1, 2015. (Accessed Aug. 2016).***
Online Prescribing	
No reference found.	No reference found.
Consent	
No reference found.	No reference found.
Location	
No reference found.	"The distant site of the service must be of a sufficient distance from the originating site to provide services to a beneficiary who does not have readily available access to such specialty services." No reimbursement if: • The recipient is located in a jail, detention center, or prison; • The consulting provider is not a Medicaid-enrolled provider; the consulting provider does

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	not follow established criteria for the service provided. *Source: NC Div. of Medical Assistance, Medicaid and Health Choice Manual, Clinical Coverage Policy No: 1H, Telemedicine and Telepsychiatry, p. 1-7, Oct. 1, 2015. (Accessed Aug. 2016).*
Cross-State Licensing	
No reference found.	No reference found.
Private Payers	
No reference found.	No reference found.
Site/Transmission Fee	
No reference found.	Originating-site provider facility fees paid to: • Physicians; • Nurse practitioners; • Nurse midwives; • Advanced practice psychiatric nurse practitioners; • Advanced practice psychiatric clinical nurse specialists; • Licensed psychologists (Ph.D. level); • Licensed clinical social workers (LCSW); • Physician's assistants; • Hospitals (inpatient or outpatient) • Federally Qualified Health Centers; • Rural Health Clinics; • Local health departments; • Local Management Entities. No facility fees for distant-site providers. *Source: NC Div. of Medical Assistance, Medicaid and Health Choice Manual, Clinical Coverage Policy No: 1H, Telemedicine and Telepsychiatry, p. 7, Oct. 1, 2015. (Accessed Aug. 2016).*
Miscellaneous	
	The Office of Rural Health and Community Care shall oversee and monitor the establishment of a statewide telepsychiatry program. *Source: NC General Statutes Article 3, Ch. 143B, Sect. 12A.2B. (b). (Accessed Aug. 2016).* Providers must comply with the following in effect at the time the service was rendered: • All applicable agreements, federal, state and local laws and regulations including HIPAA and medical retention requirements. • All Medicaid's clinical coverage policies, guidelines, policies, provider manuals, implementation updates and bulletins published by CMS, DHHS, its divisions or its fiscal agent.

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	Source: NC Div. of Medical Assistance, Medicaid and Health Choice Manual, Clinical Coverage Policy No: 1H, Telemedicine and Telepsychiatry, p. 7, Oct. 1, 2015. (Accessed Aug. 2016).

North Dakota

Medicaid Program: North Dakota Medicaid

Medicaid Program Administrator: North Dakota Dept. of Human Services

Regional Telehealth Resource Center:
Great Plains Telehealth Resource and Assistance Center
University of Minnesota/Institute for Health Informatics
330 Diehl Hall
505 Essex Street S.E.
Minneapolis, MN 55455
(888) 239-7092
www.gptrac.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
Recently Passed Legislation (Effective Jan. 31, 2017) ***Public Employee Retirement System*** "Telehealth (1) Means the use of interactive audio, video, or other telecommunications technology that is used by a health care provider or health care facility at a distant site to deliver health services at an originating site; and that is delivered over a secure connection that complies with the requirements of state and federal laws; (2) Includes the use of electronic media for consultation relating to the health care diagnosis or treatment of a patient in real time or through the use of store - and - forward technology; (3) Does not include the use of audio - only telephone, email, or facsimile transmissions." ***Source: ND House Bill 1038 (2015), ND Statute Sec. 54-52.1-04.13.*** **Stroke system of care task force** "Telemedicine services means the use of interactive audio, video, and other electronic media used for the purpose of diagnosis, consultation, or treatment of acute stroke." ***Source: ND House Bill 1323 (2015), ND Statute Sec. 23-43-05.*** North Dakota uses federal definitions for "internet" and "practice of telemedicine" set in the Ryan Haight Online Pharmacy Consumer Protection Act of 2008. ***Source: ND Century Code, Sec. 19-02.1-15.1.*** "Telemedicine means the practice of medicine by a practitioner, other than a pharmacist, who is at a location remote from the patient, and is communicating with the patient, or health care professional who is treating the patient, using a telecommunications system." ***Source: Ryan Haight Online Pharmacy Consumer Protection Act of 2008 [Pub. L. 110-425; 21 U.S.C. 802-803].***	Telemedicine is the use of interactive audio-video equipment to link practitioners and patients at different sites. ***Source: Medicaid Medical Policy. North Dakota Department of Human Services: Policy Number NDMP-2012-0007. Telemedicine Services. (Jan. 14, 2015) (Accessed Aug. 2016).***

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Physical Therapy: "Telehealth" is the use of electronic communications to provide and deliver a host of health-related information and healthcare services, including, but not limited to physical therapy related information and services, over large and small distance. Telehealth encompasses a variety of healthcare and health promotion activities, including, but not limited to, education, advice, reminders, interventions, and monitoring of interventions. *Source: ND Admin. Code 61.5-01-02-01.*	
Live Video Reimbursement	
North Dakota's Worker Compensation Act provides reimbursement for live video. Eligible services: • Office or other outpatient visits; • New evaluation visits and established management visits; • Individual psychotherapy visits; • Pharmacologic management visits. The patient must be present and participate in the appointment. The professional fee is equal to comparable in-person services. *Source: ND Admin. Code 92-01-02-34.*	North Dakota Medicaid will reimburse for live video services as long as the patient is present during the service. Actual visual contact (face-to-face) must be maintained between practitioner and patient. Both originating-site and distant-site physicians may bill for services. There is no separate reimbursement for supplies. There is reimbursement for long-distance charges required for out-of-network sites. *Source: ND Dept. of Human Svcs., General Information For Providers, Medicaid and Other Medical Assistance Programs, p. 129 (April 2012) (Accessed Aug. 2016).* Eligible services: • New and established Office and other outpatient E/M services • Psychiatric diagnostic evaluation • Individual psychotherapy • Pharmacologic management • Speech Therapy, individual • Initial inpatient telehealth consultation Reimbursement is made only to the distant practitioner during the telemedicine session. No reimbursement is allowed to the originating site practitioner if he/she solely presents the patient to the distant site practitioner. Requires a medical professional, such as a nurse, to be present during the telehealth service; and to ensure a connection has been established with the distant physician. Out of state requests for telemedicine services require prior authorization. *Source: Medicaid Medical Policy. North Dakota Department of Human Services: Policy Number NDMP-2012-0007. Telemedicine Services. (Jan. 14, 2015) (Accessed Aug. 2016).*

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	Indian Health Services Reimbursement for telemedicine is on the same basis as those provided for face-to-face contact. *Source: ND MMIS Web Portal. Indian Health Services. April 2015. (Accessed Aug., 2016).*
Store and Forward Reimbursement	
No reference found.	North Dakota Medicaid does not reimburse for store and forward. *Source: ND Dept. of Human Svcs., General Information For Providers, Medicaid and Other Medical Assistance Programs, p. 129 (April 2012) (accessed Aug. 2016).*
Remote Patient Monitoring Reimbursement	
No reference found.	No reference found.
Email/Phone/FAX	
No reference found.	No reference found for email. No reimbursement for telephone. No reference found for FAX. *Source: ND Dept. of Human Svcs., General Information For Providers, Medicaid and Other Medical Assistance Programs, p. 126 (April 2012) (accessed Aug. 2016).*
Online Prescribing	
A valid prescription via e-prescribing means a prescription has been issued for a legitimate medical purpose, in the usual course of professional practice, by a practitioner who has first conducted an in-person medical evaluation of the patient. An in-person medical evaluation can include the referring practitioner having performed the exam, in the case of telemedicine. *Source: ND Centennial Code, Sec. 19-02.1-15.1.*	No reference found.
Consent	
No reference found.	No reference found.
Location	
No reference found.	The distant site must be a sufficient distance from the originating site to provide services to patients who do not have readily available access to such specialized services allowed/reimbursed by ND Medicaid via telemedicine. *Source: Medicaid Medical Policy. North Dakota Department of Human Services: Policy Number NDMP-2012-0007. Telemedicine Services. (Jan. 14, 2015) (Accessed Aug. 2016).*
Cross-State Licensing	
The ND Medical Board may engage in reciprocal	No reference found.

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licensing agreements with out-of-state licensing agencies, but is not required to do so. *Source: ND Century Code Sec. 43-17-21 (2012).*	
Private Payers	
No reference found.	No reference found.
Site/Transmission Fee	
Under the Worker's Compensation Act, the originating sites may receive a facility fee, not to exceed $20. *Source: ND Admin. Code 92-01-02-34.*	Reimbursement will be made to the originating site as a facility fee only in place of service office, inpatient hospital, outpatient hospital, or skilled nursing facility/nursing facility. There is no additional reimbursement for equipment, technicians or other technology or personnel utilized in the performance of the telemedicine service. *Source: Medicaid Medical Policy. North Dakota Department of Human Services: Policy Number NDMP-2012-0007. Telemedicine Services. (Jan. 14, 2015) (Accessed Aug. 2016).*
Miscellaneous	
For all policies in the Public Employees Retirement System that become effective after June 30, 2015 and don't extend passed June 30, 2017 to board shall provide coverage for telehealth services the same as in-person. The public employees' retirement system must prepare and submit for introduction a bill to the 65th legislative assembly to repeal the expiration date to the Act, and apply telehealth coverage to all group and individual insurance policies. *Source: ND House Bill 1038 (2015), ND Statute Sec. 54-52.1-04.13.*	

Ohio

Medicaid Program: Ohio Medicaid

Medicaid Program Administrator: Ohio Department of Job and Family Services

Regional Telehealth Resource Center:
Upper Midwest Telehealth Resource Center
2901 Ohio Boulevard, Ste. 110
Terre Haute, IN 47803
(855) 283-3734 ext. 232
www.umtrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"The practice of telemedicine means the practice of medicine in this state through the use of any communication, including oral, written, or electronic communication, by a physician located outside this state." ***Source: OH Revised Code Annotated, 4731.296.*** "Telehealth means the use of electronic communications to provide and deliver a host of health-related information and healthcare services, including, but not limited to physical therapy related information and services, over large and small distances." ***Source: OH Admin. Code 4755-27-01.*** Telehealth service means a health care service delivered to a patient through the use of interactive audio, video, or other telecommunications or electronic technology from a site other than the site where the patient is located. ***Source: OH Revised Code, Sec. 5164.94.*** Speech Language Pathology Telehealth means the use of telecommunications and information technologies for the exchange of information from one site to another for the provision of audiology or speech-language pathology services to an individual from a provider through hardwire or internet connection. ***Source: OH Admin. Code 4753-2-01***	Telemedicine is the direct delivery of evaluation and management (E&M) or psychiatric services to a Medicaid eligible patient via synchronous, interactive, real-time electronic communication that comprises both audio and video elements. ***Source: OH Medicaid Handbook Transmittal Letter No. 3334-15-01. Jan. 2, 2015, pg. 24 & OH Admin. Code 5160-1. (Accessed Aug. 2016).***
Live Video Reimbursement	
The department of Medicaid is required to establish standards for Medicaid payment for health care services the department determines are appropriate to be covered when provided as telehealth services. ***Source: OH Revised Code, Sec. 5164.95.***	Ohio Medicaid covers live video telemedicine. Eligible Distant Site Providers • Physicians (MD, DO) • Psychologists • Federally Qualified Health Center (medical and

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Speech Language Pathology Telehealth may be delivered through live video. *Source: OH Admin. Code 4753-2-01*	mental health) Only resident modifiers will be accepted. Providers are not eligible for payment when a Q3014 (facility fee) and a CPT code with a GQ modifier is submitted for the same patient, same date of service, and same provider. See transmittal letter for list of eligible CPT codes. *Source: OH Medicaid Handbook Transmittal Letter No. 3334-15-01, pg. 6-7. Jan. 2, 2015 & OH Admin Code 5160-1. (Accessed Aug. 2016).* Ohio Medicaid will reimburse for live video for speech therapy services in the Medicaid School Program (MSP) when provided by speech-language pathologists. *Source: OH Dept. of Job and Family Svcs., Long Term Care Services and Supports Transmittal Letter (LTCSSTL) No. 11-15, (Oct. 19, 2011.) (Accessed Aug. 2016).*
Store and Forward Reimbursement	
Speech Language Pathology Telehealth may be delivered through store and forward. *Source: OH Admin. Code 4753-2-01*	Telemedicine is defined as being "synchronous, interactive, real-time", excluding the use of store and forward technology. *Source: OH Medicaid Handbook Transmittal Letter No. 3334-15-01. Jan. 2, 2015, pg. 6-7. (Accessed Aug. 2016).*
Remote Patient Monitoring Reimbursement	
No reference found.	The home is not an acceptable place of service for either an originating or distant site. *Source: OH Medicaid Handbook Transmittal Letter No. 3334-15-01. Jan. 2, 2015, pg. 6-7. (Accessed Aug. 2016).*
Email/Phone/FAX	
No reference found.	Electronic mail, telephone and facsimile transmission are not telemedicine. *Source: OH Admin. Code 5160-1.*
Online Prescribing	
A physician shall not prescribe, dispense, or provide any dangerous drug, which is not a controlled substance, to a person who the physician has never personally physically examined and diagnosed. Eligible exceptions: • The physician is providing care in consultation with another physician, who has an ongoing professional relationship with the patient, and who has agreed to supervise the patient's use of the drug or drugs to be provided, and the	No reference found.

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physician's care of the patient meets all applicable standards of care; • In institutional settings; • On-call situations; • Cross-coverage situations; • Situations involving new patients; • Protocol situations; • Situations involving nurses practicing in accordance with standard care arrangements. *Source: OH Admin. Code 4731-11-09.*	
Consent	
Speech Language Pathology A provider is required to inform the patient of specific telehealth limitations. *Source: OH Admin. Code 4753-2-01*	The originating site is responsible for obtaining informed consent. *Source: OH Admin. Code 5160-1.*
Location	
No reference found.	When the originating site is located within a five mile radius from the distant site, providers are not eligible for reimbursement. Provider types eligible as an originating site, either using a Q3014 HCPCS code or a GQ modifier: • Primary Care Clinic • Outpatient Hospital • Rural Health Clinic (Medical) • Federally Qualified Health Clinic (Medical) • Physician • Professional Medical Group • Podiatrist • Optometrist See transmittal letter for additional billing rules. Additional place of service restrictions: • Inpatient hospital • Nursing facility • Inpatient psychiatric hospitals *Source: OH Medicaid Handbook Transmittal Letter No. 3334-15-01. Jan. 2, 2015, pg. 24-25.*
Cross-State Licensing	
Ohio issues telemedicine certificates that allow the holder to engage in the practice of telemedicine in the state. Providers with telemedicine certificates cannot practice in OH without a special activity certificate. *Source: OH Revised Code Annotated, Sec. 4731.296(C).*	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Physical Therapy Physical therapists and physical therapist assistants must hold a valid OH physical therapy license to treat a patient located in Ohio via telehealth. *Source: OH Admin. Code 4755-27-01.*	
Private Payers	
No reference found.	No reference found.
Site/Transmission Fee	
No reference found.	Originating site eligible for a facility fee using HCPCS code Q3014. See transmittal letter for additional billing rules. *Source: OH Medicaid Handbook Transmittal Letter No. 3334-15-01, pg. 24-25. Jan. 2, 2015 & OH Admin Code 5160-1. (Accessed Aug. 2016).*
Miscellaneous	

Oklahoma

Medicaid Program: SoonerCare

Medicaid Program Administrator: Oklahoma Health Care Authority

Regional Telehealth Resource Center:
Heartland Telehealth Resource Center
3901 Rainbow Blvd MS 1048
Kansas City, KS 66160
(877) 643-4872
heartlandtrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Telemedicine means the practice of health care delivery, diagnosis, consultation, treatment, including but not limited to, the treatment and prevention of strokes, transfer of medical data, or exchange of medical education information by means of audio, video, or data communications. Telemedicine is not a consultation provided by telephone or facsimile machine." ***Source: OK Statutes, Title 36, Sec. 6802.*** "Telemedicine means the practice of health care delivery, diagnosis, consultation, treatment, including but not limited to, the treatment and prevention of strokes, transfer of medical data, or exchange of medical education information by means of audio, video, or data communications. Telemedicine is not a consultation provided by telephone, facsimile machine nor does it include administrative applications such as billing, contracted services, security systems, etc." This definition excludes phone or Internet contact or prescribing and other forms of communication, such as web-based video, that might occur between parties that does not meet the equipment requirements as specified in OAC 435:10-7-13 and therefore requires an actual face-to-face encounter. ***Source: OK Admin Code Title 435:10-1-4*** **Recently Passed Legislation (Eff. Nov. 1, 2016)** Telemedicine uses audio and video multimedia telecommunication equipment which permits two-way real-time communication between a health care practitioner and a patient who are not in the same physical location. ***Source: OK Statute, Title 22, Sec. 1161.1.*** *(also see Medicaid column)*	For purposes of SoonerCare reimbursement telemedicine is the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment that occur in real-time and when the member is actively participating during the transmission. Telemedicine does not include the use of audio only telephone, electronic mail, or facsimile transmission. ***Source: OK Admin. Code Sec. 317:30-3-27 (a) & Health Care Authority, Providers, Telemedicine. (accessed Aug. 2016)***

Live Video Reimbursement	
Oklahoma statute requires coverage of telemedicine services, which includes live video, by health care service plans, disability insurer programs, workers' compensation programs, and state Medicaid managed care program contracts, subject to contract terms and conditions. ***Source: OK Statute, Title 36 Sec. 6803.*** *(see Medicaid column & "Private Payers" section)*	SoonerCare (Oklahoma's Medicaid program) reimburses for live video when: • The GT modifier is billed • Proper documentation to include services rendered, location and services provided via telemedicine is maintained OHCA has discretion and final authority to approve or deny telemedicine services based on agency and/or SoonerCare members' needs. ***Source: OK Admin. Code Sec. 317:30-3-27 & Health Care Authority, Providers, Telemedicine (accessed Aug. 2016).*** Office and outpatient visits count toward benefit limits. ***Source: OK Statute, Title 36 Sec. 6803.***
Store and Forward Reimbursement	
(see Medicaid column)	SoonerCare does not consider store and forward applications telemedicine but it may be utilized to deliver services. ***Source: OK Admin. Code Sec. 317:30-3-27(a).***
Remote Patient Monitoring Reimbursement	
No reference found.	No reference found.
Email/Phone/FAX	
No reference found for email. No reimbursement for telephone. No reimbursement for FAX. ***Source: OK Statute, Title 36 St. Sec. 6802.***	No reimbursement for email. No reimbursement for telephone. No reimbursement for FAX. ***Source: OK Admin. Code Sec. 317:30-3-27(a).***
Online Prescribing	
Telemedicine physicians who meet certain criteria are not subject to the face-to-face requirement to establish a physician-patient relationship. ***Source: OK Admin. Code Sec. 435:10-7-12.*** Prescribing or administering a drug or treatment without sufficient examination and the establishment of a valid physician-patient relationship is prohibited. ***Source: OK Statute, Title 59, Sec. 509.*** A physician-patient relationship includes an in-person patient exam. ***Source: OK Admin. Code Sec. 435:10-1-4.***	No reference found.
Consent	

STATE LAW/REGULATIONS	MEDICAID PROGRAM
(See Medicaid column)	Written consent required. ***Source: OK Admin. Code Sec. 317:30-3-27 & Health Care Authority, Providers, Telemedicine (accessed Aug. 2016).***
Location	
No reference found.	A patient may receive telemedicine services outside of Oklahoma when medically necessary. Out of state providers must comply with all laws and regulations of the provider's location, including health care and telemedicine requirements. ***Source: Health Care Authority, Providers, Telemedicine & OK Admin. Code Sec. 317:30-3-27. (Accessed Aug. 2016).***
Cross-State Licensing	
Physician treating patients in OK through telemedicine must be fully licensed in OK. ***Source: OK Admin Code Title 435:10-1-4.*** The State Board of Osteopathic Examiners has the authority to issue a telemedicine license. ***Source: OK Statute, Title 59, Sec. 633***	No reference found.
Private Payers	
Requires coverage of telemedicine services by health care service plans, disability insurer programs, workers' compensation programs, and state Medicaid managed care program contracts, subject to contract terms and conditions. ***Source: OK Statute, Title 36 Sec. 6803.***	No reference found.
Site/Transmission Fee	
(see Medicaid column)	No reference found.
Miscellaneous	
OK provides, at no cost, one telecommunications line or wireless connection for telemedicine services to the following: • Not-for-profit hospitals; • County health departments; • City-county health departments; • Federally Qualified Health Centers. ***Source: OK Statutes, Title 17 Sec. 139.109.***	

Comments: The OK Dept. of Health has begun to develop a statewide telemedicine network. ***Oklahoma Statutes, Title 63 Sec. 1-2702.***

Professional Board Telehealth-Specific Regulations

- State Board of Medical Licensure and Supervision ***(OAC 435:10-11-3)***

Oregon

Medicaid Program: Oregon Medicaid

Medicaid Program Administrator: Oregon Health Authority

Regional Telehealth Resource Center:
Northwest Regional Telehealth Resource Center
2900 12th Ave. N., Ste. 30W
Billings, MT 59101
(888) 662-5601
www.nrtrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Telemedicine means the provision of health services to patients by physicians and health care practitioners from a distance using electronic communications." ***Source: OR Revised Statutes 442.015.*** **Physical Therapy:** "Telehealth service means a physical therapy intervention, including assessment or consultation that can be safely and effectively provided using synchronous two-way interactive video conferencing, or asynchronous video communication, in accordance with generally accepted healthcare practices and standards. For purposes of these rules, 'telehealth service' also means, or may be referred to, as 'telepractice, teletherapy, or telerehab'." ***Source: OR Administrative Rule, Sec. 848-040-1080.***	"Telemedicine is the use of medical information, exchanged from one site to another, via telephonic or electronic communications, to improve a patient's health status." ***Source: OR Div. of Medical Assistance Program, Medical-Surgical Svcs. Rulebook, Div. 130, 410-130-0610, p. 69-70 (Jan. 1, 2016). (Accessed Aug, 2016).***
Live Video Reimbursement	
(See "Private Payers" section)	Oregon Medicaid will reimburse for live video when billed services comply with their billing requirements. The referring provider is not required to be present with the client for the consult. The referring provider may bill for the patient visit only if a separately identifiable visit is performed. Behavioral health services identified as allowable for telephonic delivery are listed in the fee schedule. The authority must provide coverage for telemedicine services to the same extent that the service would be covered if they were provided in person. ***Source: OR Div. of Medical Assistance Program, Medical-Surgical Svcs. Rulebook, Div. 130, 410-130-0610, p. 69-70 (Jan. 1, 2016) & Behavior Health Services Rules 410-172-0850, p. 43 (Jun. 26, 2015). (Accessed Aug. 2016).***

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Store and Forward Reimbursement	
No reference found.	**<u>Behavioral Health Services Manual:</u>** Unless specifically authorized by OAR 410-120-1200 other types of telecommunication are not covered such as images transmitted via facsimile machines and electronic mail when: • Those methods are not being used in lieu of videoconferencing, due to limited video conferencing equipment; or • Those methods and specific services are not specifically allowed pursuant to the Oregon Health Evidence Review Commission's Prioritized List of Health Services and Evidence Based Guidelines. ***Source: Behavior Health Services Rules 410-172-0850, p. 43 (Jun. 26, 2015). (Accessed Aug. 2016).***
Remote Patient Monitoring Reimbursement	
Oregon requires out of state physicians to acquire active tele-monitoring status through the Oregon Medical Board before they can perform intraoperative tele-monitoring on patients during surgery. The Administrative Code defines "tele-monitoring" as the "intraoperative monitoring of data collected during surgery and electronically transmitted to a physician who practices in a location outside of Oregon. The monitoring physician is in communication with the operation team through a technician in the operating room." Requirements: • The facility where the surgery is performed must be a licensed hospital or ambulatory surgical center; • The facility must grant medical staff membership and/or clinical privileges to the monitoring physician; • The monitoring physician must have OR active-tele-monitoring status. ***Source: OR Admin. Rules. 847-008-0023.***	No reference found.
Email/Phone/FAX	
Yes for email. Yes for telephone. No reference found for FAX. Email and telephone consults must comply with Health Service Commission guidelines. ***Source: OR Admin. Rules 410-130-0610.***	Yes for email and telephone when used for patient consulting and "when billed services comply with the practice guidelines set forth by the Health Service Commission (HSC), applicable HSC approved CPT code requirements and delivered consistent with the HSC practice guideline." Email, telephone and fax may be used when videoconferencing availability is limited.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	Source: OR Div. of Medical Assistance Programs, Medical-Surgical Svcs. Rulebook, Div. 130, 410-130-0610, p. 69-70 (Jan. 1, 2016) & Behavior Health Services Rules 410-172-0850, p. 43 (Jun. 26, 2015). (Accessed Aug., 2016).
Online Prescribing	
Practicing Across State Lines A physician must first: • Establish a physician-patient relationship; • Make a judgment based on some type of objective criteria upon which to diagnose, treat, correct or prescribe; • Act in the best interest of the patient. Writing prescriptions based only on an Internet sale or consults prohibited. *Source: OR Admin. Rules, 847-025-0000.*	No reference found.
Consent	
No reference found.	No reference found.
Location	
Plans may not distinguish between originating sites that are rural and urban in providing coverage. *Source: OR Senate Bill 144 (2015); & Revised Statutes Sec. 743A.058.*	No reference found.
Cross-State Licensing	
Out-of-state physicians may receive a license to practice across state lines in Oregon, as long as they are fully licensed in another state and meet certain requirements. *Source: OR Revised Statutes Annotated Sec. 677.139.* *(also see Medicaid column)*	The referring and evaluating practitioner must be licensed to practice medicine within the state of Oregon or within the contiguous area of Oregon and must be enrolled as a Division of Medical Assistance Programs (Division) provider. *Source: OR Administrative Regulation 410-130-0610(2)(a) & Source: OR Div. of Medical Assistance Program, Medical-Surgical Svcs. Rulebook, Div. 130, 410-130-0610, p. 68-70 (Jan. 1, 2016). (Accessed Aug. 2016).*
Private Payers	
Oregon requires coverage by health benefit plans and self-insured health plans offered through the Public Employees' Benefit Board or the Oregon Educators Benefit Board of health services that is provided using synchronous two-way interactive video conferencing, subject to contract terms and conditions. Plans may not distinguish between originating sites that are rural and urban in providing coverage. *Source: OR Senate Bill 144 (2015); & Revised Statutes Sec. 743A.058.* A health benefit plan must provide coverage in	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
connection with the treatment of diabetes if: • If coverage is provided for in-person services • The service is medically necessary; • The service relates to a specific patient; and • One of the participants in the telemedical health service is a representative of an academic health center. ***Source: OR Revised Statutes Sec. 743A.185.***	
Site/Transmission Fee	
(see Medicaid column)	Oregon Medicaid will provide transmission fees for originating sites. ***Source: OR Admin. Regulation 410-130-0610(5) & OR Div. of Medical Assistance Programs, Medical-Surgical Svcs. Rulebook, Div. 130, 410-130-0610, p. 69-70 (Jan. 1, 2016). (Accessed Aug. 2016).***
Miscellaneous	

Comments: *Professional Board Telehealth-Specific Regulations*

- Occupational Therapy ***(Source: OR Admin. Code 339-010-0006)***
- Physical Therapy ***(Source: OR Admin. Code 848-040-0180)***

Pennsylvania

Medicaid Program: Pennsylvania Medical Assistance Program (MA)

Medicaid Program Administrator: Department of Public Welfare

Regional Telehealth Resource Center:
PO Box 800711
Charlottesville, VA 22908-0711
(434) 906-4960 / (855) MATRC4U
www.matrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
No reference found.	Telemedicine is the use of real-time interactive telecommunications technology that includes, at a minimum, audio and video equipment as a mode of delivering consultation services. ***Source: PA Department of Public Welfare, Medical Assistance Bulletin 09-12-31, 31-12-31, 33-12-30, May 23, 2012 (accessed Aug. 2016).***
Live Video Reimbursement	
No reference found.	Pennsylvania Medicaid will reimburse for live video for specialty consultations. Eligible Providers (fee for service): • Physicians • Certified registered nurse practitioners • Certified nurse midwives Providers under a managed care system should contact the appropriate managed care organization. ***Source: PA Department of Public Welfare, Medical Assistance Bulletin 09-12-31, 31-12-31, 33-12-30, May 23, 2012 (accessed Aug. 2016).*** **Telepsychiatry Services** PA Medicaid will reimburse licensed psychiatrists and licensed psychologists for telepsychiatry outpatient services including: • Psychiatric diagnostic evaluations • Psychological Evaluations • Pharmacological management • Consultations (with patient/family) • Psychotherapy Providers must have documented endorsement to deliver mental services through telepsych from the county mental health program and the HealthChoices Behavioral Health Managed Care Organization, and this endorsement must be submitted to the PA Office of Mental Health and Substance Abuse Services regional

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	office for final approval. *Source: PA Department of Public Health, Medical Assistance Bulletin OMHSAS-14-01, Mar. 18, 2014 (accessed Aug. 2016).* **For FQHCs & RHCs** Telepsychiatry Services – Only applicable to Behavioral Health Managed Care delivery system claims and not fee-for-service delivery. Service is in real-time, interactive audio-video transmission and do not include phone, email or facsimile transmission. Consultation between two healthcare practitioners do not count as a qualifying service. Service providers are limited to psychologists and psychiatrists. *Source: PA PROMISe, 837 Professional/CMS-1500 Claim Form, Provider Handbook, Appendix E – FQHC/RHC. p. 10 (Apr. 22, 2014). (Accessed Aug. 2016).*
Store and Forward Reimbursement	
No reference found.	Pennsylvania Medicaid will not reimburse for store and forward. *Source: PA Department of Public Welfare, Medical Assistance Bulletin 09-12-31, 31-12-31, 33-12-30, May 23, 2012 (accessed Aug. 2016).*
Remote Patient Monitoring Reimbursement	
No reference found.	PA Medicaid fee for service does not reimburse for remote patient monitoring. However, see "Comments" section below. *Source: PA Department of Public Welfare, Medical Assistance Bulletin 09-12-31, 31-12-31, 33-12-30, May 23, 2012 (accessed Aug. 2016).*
Email/Phone/FAX	
No reference found.	No reimbursement for email. No reimbursement for telephone. No reimbursement for FAX. *Source: PA Department of Public Welfare, Medical Assistance Bulletin 09-12-31, 31-12-31, 33-12-30, May 23, 2012 (accessed Aug. 2016).*
Online Prescribing	
No reference found.	No reference found.
Consent	
No reference found.	Informed consent is required from individuals participating in any services utilizing telepsych. *Source: PA Department of Public Health, Medical Assistance Bulletin OMHSAS-14-01, Mar. 18, 2014 (accessed Aug. 2016).*
Location	
No reference found.	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Cross-State Licensing	
Pennsylvania issues extraterritorial licenses to physicians residing or practicing in an adjoining state, near the Pennsylvania boundary, and whose practice extends into Pennsylvania to practice in Pennsylvania. Pennsylvania bases the granting of this license on the availability of medical care in the area involved, and whether the adjoining state extends similar privileges to Pennsylvania physicians. ***Source: PA Statutes Annotated, Title 63 Sec. 422.34(a) and (c) (2).***	No reference found.
Private Payers	
No reference found.	No reference found.
Site/Transmission Fee	
No reference found.	Originating site may bill for facility fee. ***Source: PA Department of Public Welfare, Medical Assistance Bulletin 09-12-31, 31-12-31, 33-12-30, May 23, 2012 (accessed Aug. 2016).*** ***Source: PA Department of Public Health, Medical Assistance Bulletin OMHSAS-14-01, Mar. 18, 2014 (accessed Aug. 2016).***
Miscellaneous	

Rhode Island

Medicaid Program: Rhode Island Medical Assistance Program

Medicaid Program Administrator: Rhode Island Dept. of Human Services

Regional Telehealth Resource Center:
Northeast Telehealth Resource Center
11 Parkwood Drive
Augusta, ME 04330
(207) 622-7566 / (800) 379-2021
www.netrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
Recently Passed Legislation (Eff. June 28, 2016). "Telemedicine" means the delivery of clinical health care services by means of real time two-way electronic audiovisual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, treatment, and care management of a patient's health care while such patient is at an originating site and the health care provider is at a distant site, consistent with applicable federal laws and regulations. Telemedicine does not include an audio-only telephone conversation, email message or facsimile transmission between the provider and patient, or an automated computer program used to diagnose and/or treat ocular or refractive conditions. *Source: RI General Law, Sec. 27-81-3(12).*	No reference found.
Live Video Reimbursement	
No reference found.	No reference found.
Store and Forward Reimbursement	
No reference found.	No reference found.
Remote Patient Monitoring Reimbursement	
No reference found.	No reference found.
Email/Phone/FAX	
Recently Passed Legislation (Eff. June 28, 2016). Telemedicine does not include an audio-only telephone conversation, email message or facsimile transmission between the provider and patient. *Source: RI General Law, Sec. 27-81-3(12).*	No reference found.
Online Prescribing	
No reference found.	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Consent	
No reference found.	No reference found.
Location	
No reference found.	No reference found.
Cross-State Licensure	
RI allows physicians who have a license in good standing in another state to consult with RI licensed physicians or provide teaching assistance. Physicians not present in RI may not provide consultation to a patient without an established physician-patient relationship, unless that patient is in the physical presence of a physician licensed in RI. ***Source: RI General Law, Sec. 5-37-14.***	No reference found.
Private Payers	
Recently Passed Legislation (Effective Jan. 1, 2018) A health insurer shall not exclude a health care service for coverage solely because the health care service is provided through telemedicine and is not provided through in-person consultation or contact, subject to the terms and conditions of a telemedicine agreement between the insurer and provider. ***Source: RI General Law, Sec. 27-81-4.***	No reference found.
Site/Transmission Fee	
No reference found.	No reference found.
Miscellaneous	

South Carolina

Medicaid Program: South Carolina Medicaid

Medicaid Program Administrator: South Carolina Health and Human Services Dept.

Regional Telehealth Resource Center:
Southeast Telehealth Resource Center
PO Box 1408
Waycross, GA 31501
(888) 138-7210
www.setrc.us

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
South Carolina law addresses telemedicine under veterinary services, stating, "telemedicine is an audio, video, or data communication of medical information." *Source: SC Code Annotated Sec. 40-69-20.* **Newly Passed Legislation (Now Effective)** Telemedicine' means the practice of medicine using electronic communications, information technology, or other means between a licensee in one location and a patient in another location with or without an intervening practitioner. *Source: SC Code Annotated Sec. 40-47-20(52).*	"Telemedicine is the use of medical information about a patient that is exchanged from one site to another via electronic communications to provide medical care to a patient in circumstances in which face-to-face contact is not necessary. In this instance, a physician or other qualified medical professional has determined that medical care can be provided via electronic communication with no loss in the quality or efficacy of the care. Electronic communication means the use of interactive telecommunication equipment that typically includes audio and video equipment permitting two-way, real-time interactive communication between the patient and the physician or practitioner at the referring site. Telemedicine includes consultation, diagnostic, and treatment services." *Source: SC Health and Human Svcs. Dept., Physicians Provider Manual, p. 2-54 (Aug. 1 2016) & Local Education Manual, p. 2-8. (Jul. 1 2016).*
Live Video Reimbursement	
No reference found.	South Carolina Medicaid will reimburse for live telemedicine and tele-psychiatry. Eligible services: • Office or other outpatient visits; • Inpatient consultation; • Individual psychotherapy; • Pharmacologic management; • Psychiatric diagnostic interview examination and testing; • Neurobehavioral status examination; • Electrocardiogram interpretation and report only; Echocardiography.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	Eligible services must meet these requirements: • The medical care is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's need; • The medical care can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide. ***Source: SC Health and Human Svcs. Dept. Physicians Provider Manual, p. 2-56 (Aug. 1, 2016) & Local Education Manual, p. 2-8 to 2-14. (Jul. 1, 2016).*** These community mental health services are ineligible: • Injectables; • Nursing services; • Crisis intervention • Individual, family, group and multiple family psychotherapy • Psychological testing which require "hands-on" encounters; • Mental health assessment by non-physician; and • Service Plan Development. ***Source: SC Health and Human Svcs. Dept. Community Mental Health Services Provider Manual, p. 2-14 (Apr. 1, 2016).*** Distant site eligible, reimbursed providers: • Physicians; • Nurse practitioners. • Physician Assistants Services provided by allied health professionals are not covered. There must be a certified or licensed health care professional at the referring site to present and remain available as clinically appropriate. ***Source: SC Health and Human Svcs. Dept. Physicians Provider Manual, p. 2-55, 2-57 & 2-58 (Aug. 1, 2016) & Local Education Manual, p. 2-8 to 2-14. (Jul. 1, 2016).***
Store and Forward Reimbursement	
No reference found.	South Carolina Medicaid will not reimburse for store and forward due to the requirement that the beneficiary must be present and participating in the visit. ***Source: SC Health and Human Svcs. Dept. Physicians Provider Manual, p. 2-56 (Aug. 1, 2016) & Local Education Manual, p. 2-8 to 2-14. (Jul.1, 2016).***

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Remote Patient Monitoring Reimbursement	
No reference found.	Medicaid Home Again Program for Community Long Term Care. Medical telemonitoring will be of body weight, blood pressure, oxygen saturation, blood glucose levels, and basic hear rate information, at a minimum. Providers must meet certain conditions to participate. Community Choices waiver participants must meet the following criteria to participate: • Have a primary diagnosis of Insulin Dependent Diabetes Mellitus, Hypertension, Chronic Obstructive Pulmonary Disease and/or Congestive Heart Failure; and • History of at least two hospitalizations and/or emergency room visits in the past 12 months; and • Have a primary care physician that approves the use of telemonitoring service and is solely responsible for receiving and acting upon the information received via the service; and • Be capable of using the telemonitoring equipment and transmitting the necessary data or have an individual available to do so. Services to be provided: • Unit of service is one day of direct telemonitoring provided to/for a participant in the participant's place of residence. • The equipment must record at a minimum body weight, blood pressure, oxygen saturation, blood glucose, and basic heart rate information. Data must be transmitted electronically and any transmission costs shall be incurred by the provider of the telemonitoring service. • Daily reimbursement rate is inclusive of monitoring of data, charting data from the monthly monitoring, visits or calls made to follow up with the participants and/or caregiver, phone calls made to primary care physician(s), all installation of the equipment in the home and training on the equipment's use and care in the home, including equipment removal. • Provider shall provide telemonitoring service seven days per week for authorized time period. Other requirements on staffing, background checks, installation and equipment are required. ***Source: SC Health and Human Svcs. Dept. Community Long Term Care Provider Manual, p. 6-170 (Aug. 1, 2016).***

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Email/Phone/FAX	
No reference found.	No reimbursement for email. No reimbursement for telephone. No reimbursement for FAX. No reimbursement for video cell phone interactions. ***Source: SC Health and Human Svcs. Dept. Physicians Provider Manual, p. 2-56 (Aug. 1, 2016) & Local Education Manual, p. 2-8 to 2-14. (Jul. 1, 2016).***
Online Prescribing	
<u>Recently Passed Legislation (Eff. June 3, 2016)</u> A licensee shall not establish a physician-patient relationship by telemedicine for the purpose of prescribing medication when an in-person physical examination is necessary for diagnosis. Schedule II and Schedule III prescriptions are not permitted except for those Schedule II and Schedule III medications specifically authorized by the board, which may include, but not be limited to, Schedule II-nonnarcotic and Schedule III-nonnarcotic medications. To establish a physician-patient relationship via telemedicine, the provider must: • Comply with HIPAA • Adhere to current standards of practice • Provide an appropriate examination • Verify the identity and location of the patient • Establish a diagnosis through the use of accepted medical practices • Ensure availability of follow-up care • Prescribe within a practice setting fully in compliance with the law. Schedule II and III prescriptions are not permitted except as specifically authorized by the board. ***Source: SC Code Annotated Sec. 40-47-37.***	No reference found.
Consent	
No reference found.	No reference found.
Location	
No reference found.	Referring sites (also known as originating sites) must be located in the South Carolina Medical Service Area. Eligible originating (referring) sites: • Practitioner offices; • Hospitals (inpatient and outpatient); • Rural Health Clinics; • Federally Qualified Health Centers; • Community Mental Health Centers.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	Distant (consultant) sites must be located in the SC Medical Service Area, which is the state of SC and areas in NC and GA within 25 miles of the SC border. ***Source: SC Health and Human Svcs. Dept., Physicians Provider Manual, p. 2-54 & 2-55 (Aug. 1, 2016) & Local Education Manual, p. 2-8 to 2-14. (Jul. 2016).***
Cross-State Licensing	
The physician must be licensed in South Carolina, however they do not need to reside in South Carolina.	No reference found.
Private Payers	
No reference found.	No reference found.
Site/Transmission Fee	
No reference found.	The referring site is eligible to receive a facility fee. ***Source: SC Health and Human Svcs. Dept., Physicians Provider Manual, p. 2-58 (Aug. 1, 2016) & Local Education Manual, p. 2-8 to 2-14. (Jul. 2016).***
Miscellaneous	

Comments: In 2011, a new state law, SCSB 588, established a statewide system of stroke care. It requires the Department of Health and Environmental Control to distribute to emergency medical services providers a list of primary stroke centers, telemedicine stroke centers, and other certified programs.

Effective July 1, 2014 the South Carolina Department of Health and Human Services will implement a project to leverage the use of teaching hospitals to provide rural physician coverage, expand the use of telemedicine, and ensure targeted placement and support of adequate OB/GYN services.

Source: South Carolina Healthy Connections Medicaid, Provider Alert

South Dakota

Medicaid Program: South Dakota Medicaid

Medicaid Program Administrator: South Dakota Dept. of Social Services

Regional Telehealth Resource Center:
Great Plains Telehealth Resource and Assistance Center
University of Minnesota/Institute for Health Informatics
330 Diehl Hall
505 Essex Street S.E.
Minneapolis, MN 55455
(888) 239-7092
www.gptrac.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Telehealth services" is a home based health monitoring system used to collect and transmit an individual's clinical data for monitoring and interpretation. ***Source: SD Regulation 67:40:18.***	"Telemedicine is the use of an interactive telecommunications system to provide two-way, real-time, interactive communication between a provider and a Medicaid recipient across a distance." ***Source: SD Medical Assistance Program, Professional Svcs. Manual, p. 22 (Jan. 2016), & SD Medicaid Institutional Billing Manual, p. 26 (July 2016).***
Live Video Reimbursement	
No reference found. *(also see Medicaid column)*	South Dakota Medicaid will reimburse for the following services at the same rate as in-person services: • Patient office consultation • Inpatient hospital consultation • Pharmacologic management • Office or other outpatient visit • Diabetes outpatient self-management education services All telemedicine services must comply with South Dakota Medicaid's Out-Of-State Prior Authorization Requirements. ***Source: SD Medical Assistance Program, Professional Svcs. Manual, p. 23-24 (Jan. 2016) & SD Medicaid Institutional Billing Manual, p. 27 (July 2016). (Accessed Aug. 2016).*** ***Source (pharmacological management): SD Administrative Rules 46:20:32:08.(Jan. 2011).***
Store and Forward Reimbursement	
No reference found.	South Dakota Medicaid defines telemedicine as occurring in "real time", excluding store and forward applications. ***Source: SD Medical Assistance Program, Professional Svcs. Manual, p. 22 (Jan. 2016). (Accessed Aug. 2016).***

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Remote Patient Monitoring Reimbursement	
Office of Adult Service and Aging In-home services, which is defined as including "telehealth services", may be provided to an individual who demonstrates a need for long-term supports and services through an assessment and the following criteria: • The individual is residing at home; • The individual is age 60 or older or is age 18 or older with a disability; and • The individual is not eligible for other programs which provide the same type of service. *Source: SD Regulation 67:40:19:04.*	Please see "Comments" section below.
Email/Phone/FAX	
No reference found.	No reimbursement for phone. No reimbursement for email. No reimbursement for facsimile. *Source: SD Medical Assistance Program, Professional Svcs. Manual, p. 22 (Jan. 2016), & SD Medicaid Institutional Billing Manual, p. 27 (July 2016). (Accessed Aug. 2016).*
Online Prescribing	
No reference found.	No reference found.
Consent	
No reference found.	No reference found.
Location	
No reference found.	An originating site may not be located in the same community as the distant site. Originating sites approved for a facility fee include: • Office of a physician or practitioner • Outpatient hospital • Critical Access Hospital • Rural Health Clinic • Federally Qualified Health Center • Indian Health Services Clinic • Community Mental Health Center *Source: SD Medical Assistance Program, Professional Svcs. Manual, p. 23 (Jan. 2016). (Accessed Aug. 2016).*
Cross-State Licensing	
An applicant who holds a valid medical license issued by another state can be licensed through reciprocity in South Dakota if: • The applicant completed a residency program in the US or Canada; • Has passed one of the listed licensure examinations. (Please see rule for list);	No reference found.

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• Is in good standing with their state's professional board; and • Has completed a state and federal criminal background investigation. *Source: SD Regulation 20:78:03:12.* South Dakota adopted the Federation of State Medical Board (FSMB)'s model language for an interstate medical licensure compact. *Source: SD Senate Bill 63 (2015).*	
Private Payers	
No reference found.	No reference found.
Site/Transmission Fee	
No reference found.	Originating sites are eligible for a facility fee. Originating sites include: • Office of a physician or practitioner • Outpatient hospital • Critical Access Hospital • Rural Health Clinic • Federally Qualified Health Center • Indian Health Services Clinic • Community Mental Health Center *Source: SD Medical Assistance Program, Professional Svcs. Manual, p. 23 (Jan. 2016). (Accessed Aug. 2016).*
Miscellaneous	

COMMENTS: South Dakota's Department of Health and Human Services, Adult Services and Aging offers reimbursement for a home based monitoring system that monitors an individual's clinical data daily; such as heart rate, blood pressure, oxygen saturation, temperature, weight and can be a medication reminder depending on the unit available.

Telehealth includes equipment rental and the set up and availability of a nurse's time to monitor and provide feedback to the individual, their family, and/or consultation with the individual's physician and the Adult Services and Aging Specialist.

Source: SD Dept. of Social Services, Dept. of Adult Services & Aging, Telehealth Technology (Accessed Mar.2016).

Tennessee

Medicaid Program: TennCare
Note: TennCare is operated entirely as a managed care program.

Medicaid Program Administrator: Dept. of Human Services

Regional Telehealth Resource Center:
South Central Telehealth Resource Center
4301 W. Markham St. #519
Little Rock, AR 72205
(855) 664-3450
learntelehealth.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
Telehealth means the use of real-time interactive audio, video or other telecommunications or electronic technology by a licensed healthcare provider to deliver a healthcare service to a patient within the scope of practice of the licensed healthcare provider at a site other than the site at which the patient is located; provided, however, telehealth does not include: • An audio-only conversation between a licensed healthcare provider and a patient; • An electronic mail message between a licensed healthcare provider and a patient; or • A facsimile transmission between a licensed healthcare provider and a patient. ***Source: TN Code Annotated, Title 56, Ch. 7, Part 10.*** **Newly Passed Legislation (Now Effective)** "Telehealth" or "telemedicine" means the use of real-time audio, video, or other electronic media and telecommunications technologies that enable interaction between the healthcare services provider and the patient, or also store-and-forward telemedicine services, for the purpose of diagnosis, consultation, or treatment of a patient in another location where there may be no in-person exchange, within the scope of practice of the healthcare services provider. ***Source: TN Code Annotated, Title 56, Ch. 7, Part 10.*** Telemedicine is the practice of medicine using electronic communication, information technology or other means, between a licensee in one location and a patient in another location. Telemedicine is not an audio only telephone conversation, email/instant messaging conversation or fax. It typically involves the application or secure video conferencing or store-and-forward to provide or support healthcare delivery by replicating the	"Telehealth is the use of electronic information and telecommunication technologies to support clinical care between an individual with mental illness and/or substance abuse issues and a healthcare practitioner." "Telehealth systems provide a live, interactive audio-video communication or videoconferencing connection between the individual in need of services and the crisis service delivery system." ***Source: TN Dept. of Mental Health and Substance Abuse Svcs., p. 4, (July 2012) (Accessed Aug. 2016).***

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interaction of a traditional encounter between a provider and a patient. *Source: TN Rule Annotated, Rule 0880-02.-16.*	
Live Video Reimbursement	
Managed care organizations participating in the medical assistance program are required to provide coverage for telehealth under the same reimbursement policies that the plan permits for in-person encounters. *Source: TN Code Annotated, Title 56, Ch. 7, Part 10.* (also see Private Payer section)	TennCare will reimburse for live video for crisis-related services. *Source: TN Dept. of Mental Health and Substance Abuse Svcs., p. 4, (July 2012) (Accessed Aug. 2016).* TennCare services are offered through managed care entities. Each MCO has their own unique telehealth policy.
Store and Forward Reimbursement	
The law defines telehealth as occurring in real-time, excluding store and forward from the definition. *Source: TN Code Annotated, Title 56, Ch. 7, Part 10.*	TennCare will not reimburse for store and forward based upon definition of "telehealth systems" which describes it as "live interactive video". *Source: TN Dept. of Mental Health and Substance Abuse Svcs., p. 4, (July 2012) (Accessed Aug. 2016).*
Remote Patient Monitoring Reimbursement	
No reference found.	No reference found.
Email/Phone/FAX	
Telemedicine is not an audio only telephone conversation, email/instant messaging conversation or fax. *Source: TN Rule Annotated, Rule 0880-02.-16. http://share.tn.gov/sos/rules_filings/08-03-16.pdf.*	No reference found.
Online Prescribing	
Prior to online or telephone prescribing, providers must document and: • Perform an appropriate history and physical examination; • Make a diagnosis, consistent with good medical care; • Formulate a therapeutic plan and discuss it with the patient; • Ensure the availability for appropriate follow-up care. *Source: TN Composite Rules & Regulations 0880-02-.14.* If otherwise authorized by law, a physician may prescribe by means of telemedicine, however with respect to controlled substances, the physician must comply with requirements and guidelines set out in state and federal law.	No reference found.

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Source: TN Bill SB 1223/HB 699 (2015).	
Consent	
No reference found.	The patient must be informed and given an opportunity to request an in-person assessment before receiving a telehealth assessment. This consent must be documented in the patient's record. *Source: TN Dept. of Mental Health and Substance Abuse Svcs., p. 8, (July 2012) (Accessed Aug. 2016).*
Location	
No reference found.	No reference found.
Cross-State Licensing	
Tennessee may issue telemedicine licenses to board-certified physicians from out of state (although not required to do so). *Source: TN Code Annotated Sec. 63-6-209(b).* The Tennessee Medical Board eliminated the telemedicine license. Individuals granted a telemedicine license under the former version of the rule may apply to have the license converted to a full license. Under certain circumstances individuals who do not convert to a full license can retain their telemedicine license. *Source: TN Rule Annotated, Rule 0880-02.-16.* The TN Osteopathic Board will still issue a telemedicine license. *Source: TN Rule Annotated, Rule 1050.02.17.*	No reference found.
Private Payers	
Health insurance carriers are required to provide coverage for telehealth services on the same basis and at least at the same rate as in-person services. There can be no distinction or consideration of the geographic location, or any federal, state, or local designation or classification of the geographic area where the patient is located. *Source: TN Code Annotated, Title 56, Ch. 7, Part 10.*	No reference found.
Site/Transmission Fee	
No reference found.	No reference found.
Miscellaneous	
Teledentistry means "the delivery of dental health care and patient consultation through the use of telehealth	

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systems and technologies, including live, two-way interactions between a patient and a dentist licensed in this state using audiovisual telecommunications technology, or the secure transmission of electronic health records and medical data to a dentist licensed in this state to facilitate evaluation and treatment of the patient outside of a real-time or in-person interaction." Initial and subsequent examinations by dentists may be performed via teledentistry technology. ***Source: TN Code Annotated 976. SB 1214 (2016).***	

Texas

Medicaid Program: Texas Medicaid

Medicaid Program Administrator: Texas Health and Human Services Commission

Regional Telehealth Resource Center:
TexLa Telehealth Resource Center
3601 4th Street, Ste. 2B440
Lubbock, TX 79430
(806) 743-4440/(877) 391-0487

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Definition of telemedicine/telehealth	
Telemedicine is "the use of health care information exchanged from one site to another via electronic communications for the health and education of the individual or provider, and for the purpose of improving patient care, treatment, and services." ***Source: TX Admin. Code, Title 25 Sec. 412.303.*** "Telemedicine medical service--A health care service, initiated by a physician who is licensed to practice medicine in Texas under Title 3, Subtitle B of the Occupations Code or provided by a health professional acting under physician delegation and supervision, that is provided for purposes of patient assessment by a health professional, diagnosis or consultation by a physician, or treatment, or for the transfer of medical data, and that requires the use of advanced telecommunications technology, other than telephone or facsimile technology, including: • Compressed digital interactive video, audio, or data transmission; • Clinical data transmission using computer imaging by way of still-image capture and store and forward; and • Other technology that facilitates access to health care services or medical specialty expertise." ***Source: TX Admin. Code, Title 1 Sec. 354.1430*** **<u>Speech-Language Pathology and Audiology</u>** Telehealth is "the use of telecommunications and information technologies for the exchange of information from one site to another for the provision of speech-language pathology or audiology services to an individual from a provider through hardwire or internet connection." ***Source: TX Admin. Code, Title 22 Sec. 741.1.***	"Telehealth service" means a health service, other than a telemedicine medical service, that is delivered by a licensed or certified health professional acting within the scope of the health professional's license or certification who does not perform a telemedicine medical service and that requires the use of advanced telecommunications technology, other than telephone or facsimile technology, including: • Compressed digital interactive video, audio, or data transmission; • Clinical data transmission using computer imaging by way of still-image capture and store and forward; and • Other technology that facilitates access to health care services or medical specialty expertise. ***Source: TX Government Code, Sec. 531.001 & TX Admin. Code, Title 1 Sec. 354.1430 & TX Medicaid Telecommunication Services Handbook, pg. 6, (Jul. 2016). (Accessed Aug. 2016).*** Telemedicine is defined as a health-care service that is either initiated by a physician who is licensed to practice medicine in Texas or provided by a health professional who is acting under physician delegation and supervision. Telemedicine is provided for the purpose of the following: • Client assessment by a health professional • Diagnosis, consultation or treatment by a physician • Transfer of medical data that requires the use of advanced telecommunications technology, other than telephone or facsimile, including the following: (1) Compressed digital interactive video, audio or data transmission, (2) clinical data transmission using computer imaging by way of still-image and store and forward; and (3) Other technology that facilitates access to health-care services or medical specialty expertise.

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Telehealth services--The fitting and dispensing of hearing instruments through telepractice to a client who is physically located at a site other than the site where the provider is located. *Source: TX Admin. Code, Ch. 112, Sec.112.150. (2016).* **Occupational Therapy** Telehealth is a "mode of service delivery through the use of visual and auditory, real time interactive electronic information/communications technologies. As a mode of service delivery, telehealth is contact with the client and the occupational therapy practitioner(s). Telehealth refers only to the practice of occupational therapy by occupational therapy practitioners who are licensed by this Board with clients who are located in Texas at the time of the provision of occupational therapy services. Also may be known as other terms including but not limited to telepractice, telecare, telerehabilitation, and e-health services." *Source: TX Admin. Code, Title 40 Sec. 362.1. (2016).*	*Source: TX Admin. Code, Title 1 Sec. 354.1430 & TX Medicaid Telecommunication Services Handbook, pg. 5, (July 2016).* "Telemedicine medical service" means a health care service that is initiated by a physician or provided by a health professional acting under physician delegation and supervision, that is provided for purposes of patient assessment by a health professional, diagnosis or consultation by a physician, or treatment, or for the transfer of medical data, and that requires the use of advanced telecommunications technology, other than telephone or facsimile technology, including: • Compressed digital interactive video, audio, or data transmission; • Clinical data transmission using computer imaging by way of still-image capture and store and forward; and • Other technology that facilitates access to health care services or medical specialty expertise. *Source: TX Government Code, Sec. 531.001.* Home telemonitoring is "a health service that requires scheduled remote monitoring of data related to patient's health and transmission of the data to a licensed home health agency or a hospital". *Source: TX Government Code, Sec. 531.001.*
Live Video Reimbursement	
(see Medicaid column)	Texas Medicaid reimburses for live video for the following services: • Consultations; • Office or other outpatient visits; • Psychiatric diagnostic interviews; • Pharmacologic management; • Psychotherapy • Data transmission *Source: TX Admin. Code, Title 1, Sec. 354.1432 & TX Govt. Code Sec. 531.0216. (2016).* Telemedicine eligible distant site providers: • Physician • Certified Nutrition Specialist • Nurse Practitioner • Physician Assistant • Certified Nurse Midwife *Source: TX Medicaid Telecommunication Services Handbook, pg. 5, (Jul. 2016). (Accessed Aug. 2016).* Telehealth eligible distant site providers • Licensed professional counselors • Licensed marriage and family therapist

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	• Licensed clinical social worker • Psychologist • Licensed psychological associate • Provisionally licensed psychologist • Licensed dietician ***Source: TX Medicaid Telecommunication Services Handbook, pg. 7, (July 2016).*** Eligible originating sites (Telecommunication): • Established medical site • State mental health facility • State supported living center ***Source: TX Medicaid Telecommunication Services Handbook. P. 5-6 (July 2016).*** Telemedicine eligible originating (patient) site providers: • Physicians; • Physician assistants; • Nurse practitioners; • Clinical nurse specialists; • Outpatient providers ***Source: TX Admin Code. Title 1, Sec. 355.7001 and TX Medicaid Telecommunication Services Handbook, pg. 6 (July 2016).*** Telehealth eligible originating site presenter: • An individual who is licensed or certified in Texas to perform health care services • A qualified mental health professional A telepresenter is required at the originating site for both telemedicine and telehealth, unless the services relate to mental health. In that situation a patient-site presenter does not have to be readily available unless the client is in a danger to himself/herself or others. ***Source: TX Medicaid Telecommunication Services Handbook, pg. 8 (July. 2016).*** More than one medically necessary telemedicine or telehealth service may be reimbursed for the same date and same place of service if the services are billed by providers of different specialties. ***Source: TX Medicaid Telecommunication Services Handbook, pg. 4, (July 2016).*** There is distant-site physician reimbursement for assessment and evaluation office visit if: • A health professional under the physician's supervision is present with the patient for the visit; • The medical condition, illness, or injury for which

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	the patient is receiving the service is not likely, within a reasonable degree of medical certainty, to undergo material deterioration within the 30-day period following the visit. ***Source: TX Govt. Code Sec. 531.0217.*** Provider reimbursement must be the same as in-person services. ***Source: TX Admin. Code, Title 1 Sec. 355.7001.*** Telemedicine services are not required if an in-person consultation with a physician is reasonably available where the patient resides or works. Telemedicine providers must make a good-faith effort to identify and coordinate with existing providers, to preserve and protect existing health care systems and medical relationships in an area. With patient consent, the primary care provider must be notified of the telemedicine medical service for the purpose of sharing medical information. ***Source: TX Govt. Code Sec. 531.0217.*** Before receiving a telehealth service, the patient must receive an in-person evaluation for the same diagnosis or condition, with the exception of mental health conditions. For continued services through telehealth, a patient must receive an in-person evaluation at least once during the previous 12 months. ***Source: TX Admin. Code, Title 1, Sec. 354.1432 & TX Medicaid Telecommunication Services Handbook, pg. 6 (July 2016).***
Store and Forward Reimbursement	
(see Medicaid column)	TX Medicaid Manual states that telemedicine and telehealth services only “involve direct face-to-face interactive video communication between the client and the distant-site provider.” ***Source: TX Medicaid Telecommunication Services Handbook, pg. 4, (July 2016).*** TX Government Code includes a definition of “Telemedicine Medical Service” and “Telehealth Services” which encompasses Store and Forward, stating that it includes “clinical data transmission using computer imaging by way of still-image capture and store and forward”. ***Source: TX Government Code, Sec. 531.001.***
Remote Patient Monitoring Reimbursement	

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No reference found.	Texas Medicaid will reimburse for home telemonitoring in the same manner as their other professional services provided by a home health agency. ***Source: TX Admin Code, Title 1, Sec. 355.7001.*** Online evaluation and management for home telemonitoring services is a benefit in the office or outpatient hospital setting when services are provided by a nurse practitioner, clinical nurse specialist, physician assistant or physician provider. Data must be reviewed by a registered nurse, nurse practitioner, clinical nurse specialist, or physician assistant who is responsible for reporting data to the prescribing physician in the event of a measurement outside the established parameters. The procedure code is limited to once per seven days. Scheduled periodic reporting of client data to the physician is required. Setup and daily monitoring is reimbursed when provided by a home health agency or outpatient hospital. There must be prior authorization from TX Medicaid for home telemonitoring. Clients must be diagnosed with diabetes or hypertension and exhibit two or more risk factors (see regulations). ***Source: TX Medicaid Telecommunication Services Handbook, pg. 8-9, (July 2016).*** Home Telemonitoring is available only to patients who: • Are diagnosed with diabetes, hypertension; or • When it is determined by Texas Health and Human Services Commission to be cost effective and feasible the following conditions are also included: pregnancy, heart disease, cancer, chronic obstructive pulmonary disease, congestive heart failure, mental illness, asthma, myocardial infarction or stroke. Patients that meet the above criteria must exhibit two or more of the following risk factors: • Two or more hospitalizations in the prior 12 month period • Frequent or recurrent emergency room admissions • A documented history of poor adherence to ordered medication regimens • A documented history of falls in the prior six month period • Limited or absent informal support system • Living alone or being home alone for extended

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	periods of time; and • A documented history of care access challenges Providers must be enrolled and approved as home telemonitoring services providers. The home health agency must maintain extensive documentation in the patient's medical record. ***Source: TX Admin Code. Title 1, Sec. 354.1434 & TX Medicaid Telecommunication Services Handbook, pg. 9, (July 2016).***
Email/Phone/FAX	
For speech-language pathology and audiology, no reimbursement for correspondence only, e.g., telephone, email, or FAX, although they may be adjuncts to tele-practice. ***Source: TX Admin. Code, Title 22, Sec. 741.214. TX Admin. Code, Ch. 112, Sec.112.150. (2016).***	No reimbursement for email. No reimbursement for telephone. No reimbursement for FAX. No reimbursement for chart review. ***Source: TX Medicaid Telecommunication Services Handbook, pg. 4, (Jul. 2016).***
Online Prescribing	
Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional in-person clinical settings. Online or telephone evaluations solely by questionnaire are prohibited. ***Source: TX Admin. Code, Title 22, Sec. 174.8.*** A physician-patient relationship (needed to prescribe any dangerous drug or controlled substance) requires either an in-person exam or the patient to be located at an Established Medical Site. This does not apply for mental health services, except in cases of behavioral emergencies. ***Source: TX Admin. Code, Title 22, Part 9, Ch. 190 (Injunction filed).***	No reference found.
Consent	
Consent required prior to telemedicine or telehealth services. Either originating or distant site health professionals shall obtain this consent. For a child receiving telemedicine services in a primary school based setting, advance parent or legal guardian consent must be obtained. ***Source: TX Occupational Code Sec. 111.002. TX Admin. Code, Title 1, Sec. 354.1432. (2016).***	No reference found.

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Location	
An established medical site may include the patient's home, including a group or institutional setting, for the delivery of mental health services. If for other medical services other than mental health services, the patient's home or group or institutional setting may be an established medical site if: • A patient site presenter is present; • There is a defined physician-patient relationship • The patient site presenter has sufficient communication and remote medical diagnostic technology to allow the physician to carry out an adequate physical examination appropriate for the patient's presenting condition while seeing and hearing the patient in real time. ***Source: TX Administrative Code Sec. Title 22 Section 174.6.*** *(See Medicaid column)*	Telemedicine/Telehealth eligible originating (patient) sites: • An established medical site • A state mental health facility • State supported living centers. ***Source: TX Medicaid Telecommunication Services Handbook, pg. 5-6, (Feb. 2016). TX Admin. Code, Title 1, Sec. 354.1432. (2016).*** Services may take place in a school-based setting if: • The physician is an authorized health care provider under Medicaid; • The patient is a child who receives the service in A primary or secondary school-based setting; • The parent or legal guardian of the patient provides consent before the service is provided; and • A health professional is present with the patient during treatment. There must be a patient site presenter, with the exception of mental health services. ***Source: TX Bill HB 1878(2015); 1 TAC Sec. 355.7001; & TAC 354.1432.***
Cross-State Licensing	
A telemedicine license may be issued for out of state providers. ***Source: TX Admin. Code, Title 22, Sec. 172.12 & TX Occupation Code Section 151.056.***	No reference found.
Private Payers	
Requires coverage of telemedicine services, subject to contract terms and conditions. ***Source: TX Insurance Code Sec. 1455.004.***	No reference found.
Site/Transmission Fee	
(see Medicaid column)	Telemedicine patient site locations are reimbursed a facility fee. ***Source: TX Admin. Code, Title 1 Sec. 355.7001 & TX Medicaid Telecommunication Services Handbook, pg. 6 (Jul. 2016).***
Miscellaneous	
	Children's Health Insurance Program Allows reimbursement for live video telemedicine and telehealth services to children with special health care needs. ***Source: TX Govt. Code Sec. 531.02162***

Comments: *Professional Board Telehealth-Specific Regulations*

- TX Medical Board ***(Source: TX Admin. Code, Title 22, Part 9, Ch. 190)***
- TX Board of Speech Pathology and Audiology ***Source: TX Admin. Code, Ch. 112, Sec.112.150. (2016).***
- TX Board of Occupational Therapy Examiners ***(Source: TX Admin. Code, Title 3, Subtitle H, Ch. 372.1)***

Legislation established a pilot project to provide emergency medical services instruction and emergency prehospital care instruction through a telemedicine medical service provided by regional trauma resource centers to:

- Health care providers in rural area trauma facilities and
- Emergency medical services providers in rural areas.

Source: TX Bill HB 479 (2015)).

An e-Health Advisory Committee was established under TX Government Code Section 531.012 and is comprised of 15 members, including:

- At least one expert on telemedicine
- At least one expert on home telemonitoring services
- At least one representative of consumers of health services provided through telemedicine.

Source: TX Admin. Code, Ch. 112, Sec.351.801. (2016).

Utah

Medicaid Program: Utah Medicaid

Medicaid Program Administrator: Utah Dept. of Health

Regional Telehealth Resource Center:
Northwest Regional Telehealth Resource Center
2900 12th Ave. N., Ste. 30W
Billings, MT 59101
(888) 662-5601
www.nrtrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Digital health service means the electronic transfer, exchange, or management of related data for diagnosis, treatment, consultation, educational, public health, or other related purposes." *Source: UT Code Annotated Sec. 26-9f-102.*	Telehealth or Telemedicine is a technological method of providing auditory and visual connection between the skilled home health care nurse at a Telehealth site and the patient living in a rural Utah area. *Source: Utah Medicaid Provider Manual: Home Health Agencies, p. 18 (Jan. 2016). (Accessed Aug. 2016).* Telemedicine "is two-way, real-time interactive communication between the member and the physician or authorized provider at the distant site. This electronic communication uses interactive telecommunications equipment that includes, at a minimum, audio and video equipment." *Source: Utah Medicaid Provider Manual: Section I: General Information, p. 47 (July. 2016). (Accessed Aug. 2016).*
Live Video Reimbursement	
Providers are eligible for reimbursement under Utah's Medical Assistance Program. *Source: UT Code Annotated Sec. 26-18-13.*	Utah Medicaid covers medically necessary physician and nurse practitioner services delivered via telemedicine. Limitations: • Must be HIPAA compliant • Must comply with Utah Health Information Network Standards for Telehealth The provider at the originating site receives no additional reimbursement for the use of telemedicine. *Source: Utah Medicaid Provider Manual: Section I: General Information, p. 47 (July. 2016). (Accessed Aug. 2016).*
Store and Forward Reimbursement	
No reference found.	Utah Medicaid defines telemedicine as "two-way, real time interactive communication" excluding store and forward from the definition. **Home Health:**

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	Asynchronous transmission of telehealth data such as radiology or electrocardiogram is not a covered service for the Medicaid Telehealth home health care project. ***Source: Utah Medicaid Provider Manual: Home Health Agencies, p. 20 (Jan. 2016). (Accessed Aug. 2016).***
Remote Patient Monitoring Reimbursement	
(see Medicaid column)	**<u>Skilled Nurse Pilot Project for Patients in Rural Areas</u>** There is reimbursement in the UT Medicaid Telehealth Skilled Nurse Pilot Project for Patients in Rural Areas. Beneficiaries diagnosed with diabetes are eligible for participation. Utilization management preauthorization required. Patient eligibility requirements: • Patients diagnosed with diabetes and meets criteria (see below) • Live in a rural area • Requires two or more home care nursing visits per week • Agrees to participate in Telehealth home care services Participation Criteria: • Must be physically able to use equipment • Ability to follow directions, push two colored buttons • Hear and see • Apply the blood pressure cuff or stethoscope appropriately • Want to participate in the telehealth project • If patient is unable to use equipment, may still be included in pilot if they have a full time care giver. • Skilled nurse must determine if beneficiary care needs and quality of care delivery will be met through telehealth. The following services are covered for Telehealth home care patients: • Monitoring for compliance in taking medications, foot condition/assessment of wounds or inflamed areas, blood glucose monitoring • Education which may include a review in knowledge of the disease process, diet or nutritional counseling • Exercise and activity, diet /activity adjustment in illness/stress, medication, and glucometer use evaluation

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	• RN visits are covered for Telehealth home care reimbursement. Home health care has a four-hour limit for all education purposes, which may include some diabetes training. ***Source: Utah Medicaid Provider Manual: Home Health Agencies, p. 18-20 (Jan. 2016). (Accessed Aug. 2016).*** Home telemetry for outpatient long-term cardiac monitoring is allowed with prior authorization. Criteria include: • Must be ordered by a BC/BE neurologist • Client must have had a stroke or TIA with no identifiable cause • Client should have already had 24 hour monitoring done previously • Client should not be currently taking anti-coagulated or Warfarin for any other reason • Client should not have a known contraindication for Warfarin • Outpatient long-term cardiac monitoring may only be authorized for the 30 day test • Data from the test must be reviewed and interpreted by a BC/BE cardiologist ***Source: Utah Medicaid Provider Manual: Physician Manual, p. 65 (Jul. 2016). (Accessed Aug. 2016).*** Patients must need more than two home health agency visits per week. Telehealth home health services are limited to diabetic monitoring and education. The agency must provide at least two in-person visits per week by a home health nurse, and may use telehealth home health services only as a supplement to the in-person visits. ***Source: UT Admin. Code R414-42-3. (Accessed Aug. 2016).***
Email/Phone/FAX	
No reference found.	No reference found.
Online Prescribing	
Providers must first obtain information in the usual course of professional practice that is sufficient to establish a diagnosis, to identify conditions, and to identify potential risks to the proposed treatment. Internet-based questionnaires or interactions on toll-free telephone numbers, when there exists no other bona fide patient-practitioner relationship or bona fide referral by a practitioner involved in an existing patient-practitioner relationship, are prohibited.	No reference found.

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Source: UT Code Annotated Sec. 58-1-501.	
Consent	
No reference found.	No reference found.
Location	
No reference found.	No reference found.
Cross-State Licensing	
An out-of-state physician may practice without a Utah license if: • The physician is licensed in another state, with no licensing action pending and at least 10 years of professional experience; • The services are rendered as a public service and for a noncommercial purpose; • No fee or other consideration of value is charged, expected or contemplated, beyond an amount necessary to cover the proportionate cost of malpractice insurance; • The physician does not otherwise engage in unlawful or unprofessional conduct. *Source: UT Code Annotated Sec. 58-67-305.* A mental health therapist licensed in another state can provide short term transitional mental health therapy or transitional substance use disorder counseling remotely if: • The mental health therapist is present in the state where he/she is licensed; • The client relocates to Utah, and was a client immediately before the relocation; • The therapy or counseling is provided for a maximum of 45 days after the client relocates; • Within 10 days of the client's relocation, the mental health therapist provides a written notice to the Division of Occupational and Professional Licensing of their intent to provide therapy/counseling remotely; and • The mental health therapist does not engage in unlawful or unprofessional conduct. *Source: Laws of UT. 68-61-307* Utah adopted the Federation of State Medical Board (FSMB)'s model language for an interstate medical licensure compact. *Source: UT House Bill 121 (2015). MN Statute Sec 58-67b-101-125.*	No reference found.
Private Payers	

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No reference found.	No reference found.
Site/Transmission Fee	
No reference found.	The provider at the originating site receives no additional reimbursement for the use of telemedicine. *Source: Utah Medicaid Provider Manual: Section I: General Information, p. 47 (July. 2016). (Accessed Aug. 2016).* **Home Health Services:** No payment made for transmission expense or facility charge. *Source: Utah Medicaid Provider Manual: Home Health Agencies, p. 20 (Jan. 2016). (Accessed Aug. 2016).*
Miscellaneous	
If a hospital participates in telemedicine, it shall develop and implement policies governing the practice of telemedicine in accordance with the scope and practice of the hospital. These policies shall address security, access and retention of telemetric data, and define the privileging of all health professionals who participate in telemedicine. *Source: UT Code R432-100-33.* A Health Reform Task Force (comprised of House and Senate members) shall review and make recommendations on telehealth services. *Source: UT Code Annotated Sec. 49.1(b) HB 0036.*	

COMMENTS:

During the 2016 legislative session the Utah Education and Telehealth Network was appropriated $1,160,000 in one time funding.

Source: UT HB Bill 277 (2016).

Vermont

Medicaid Program: Vermont Medicaid

Medicaid Program Administrator: State Dept. of Vermont Health Access, under the Agency of Human Services.

Regional Telehealth Resource Center:
Northeast Telehealth Resource Center
11 Parkwood Drive
Augusta, ME 04330
(207) 622-7566 / (800) 379-2021
www.netrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Telemedicine means the delivery of health care services such as diagnosis, consultation, or treatment through the use of live interactive audio and video over a secure connection that meets Health Insurance Portability and Accountability Act (HIPAA) requirements. Telemedicine does not include the use of audio-only telephone, e-mail, or facsimile." *Source: VT Statutes Annotated, Title 8 Sec. 4100k (2012).*	Telemedicine is defined in Act 107 as "…the delivery of health care services…through the use of live interactive audio and video over a secure connection that complies with the requirements the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Telemedicine does not include the use of audio-only telephone, e-mail, or facsimile." *Source: Dept. of VT Health Access, Green Mountain Care Provider Manual, p. 105 (June 29, 2016). (Accessed Aug. 2016).*
Live Video Reimbursement	
Private payers must reimburse for live video. *Source: VT Statutes Annotated, Title 8 Sec. 4100k (2012).* **Recently Passed Legislation (Eff. July 1, 2016)** In order to facilitate the use of telemedicine in treating substance use disorder, health insurers and the Department of Vermont Health Access shall ensure that both the treating clinician and the hosting facility are reimbursed for the services rendered, unless the health care providers at both the host and service sites are employed by the same entity. *Source: VT Statutes Annotated, Title 8 Sec. 4100k No. 173 (2016).* *(See "Private Payers" section)*	Live video is reimbursed. Originating site providers are required to document the reason the service is being provided by telemedicine rather than in person. *Source: Dept. of VT Health Access, Green Mountain Care Provider Manual, p. 106 (June 29, 2016). (Accessed Aug. 2016).* Live video for the provision of primary care services outside of a health care facility will be reimbursed. Coverage shall comply with federal requirements imposed by the Center for Medicare and Medicaid Services which limits certain services and providers for reimbursement. *Source: VT Bill S. 139 (2015).*
Store and Forward Reimbursement	
Allows, but doesn't require, reimbursement for tele-ophthalmology and tele-dermatology. Allows payers to require the distant site provider to document the reason the services are being provided by store and forward.	No reimbursement for tele-ophthalmology or tele-dermatology; no reference to other store and forward technologies. *Source: Dept. of VT Health Access, Green Mountain Care Provider Manual, p. 106 (June 29, 2016). (Accessed Aug. 2016)*

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Source: VT Statutes Annotated, Title 8 Sec. 4100k (2012).	
Remote Patient Monitoring Reimbursement	
VT Medicaid is required to cover home telemonitoring services performed by home health agencies or other qualified providers for beneficiaries who have serious or chronic medical conditions. *Source: VT Statutes Annotated Title 33 Sec. 1901k).*	Home telemonitoring is a Medicaid benefit. Qualified providers are home health agencies enrolled with Vermont Medicaid. The following healthcare professionals can review data: • Registered nurse • Nurse practitioner • Clinical nurse specialist • Licensed practice nurse under supervision of RN • Physician assistant *Source: Code of VT Rules Sec. 13-170-770 & Dept. of VT Health Access, Green Mountain Care Provider Manual, p. 138-139 (June 29, 2016). (Accessed Aug. 2016)* Individuals receiving Medicaid telemonitoring must: • Have Medicaid as primary insurance or be dually eligible with non-home bound status; and • Have congestive heart failure; and • Be clinically eligible for home health services; and • Have a physician's plan of care with an order for telemonitoring services *Source: Dept. of VT Health Access, Green Mountain Care Provider Manual, p. 137 (June 29, 2016). (Accessed Aug. 2016).*
Email/Phone/FAX	
No reimbursement for email. No reimbursement for telephone. No reimbursement for FAX. *Source: VT Statutes Annotated, Title 8 Sec. 4100k (2012).*	No reimbursement for email. No reimbursement for telephone. No reimbursement for FAX. *Source: Dept. of VT Health Access, Green Mountain Care Provider Manual, p. 105 (June 29, 2016). (Accessed Aug. 2016)*
Online Prescribing	
Providers may prescribe, dispense, or administer drugs or medical supplies, or otherwise provide treatment recommendations if they first examine the patient in person or by the use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically. Treatment recommendations made via electronic means, including issuing a prescription via electronic means, shall be held to the same standards of appropriate practice as those in traditional provider-patient settings. *Source: VT Statutes Annotated, Title 18 Sec. 9361 (2012).*	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Consent	
Originating site providers must obtain consent for store and forward tele-ophthalmology or tele-dermatology. Patients will be informed of the right to receive a consult with the distant-site provider, and will receive one, upon request, either at the time of the consult, or within a reasonable time after notification of the results of the initial consult. Receiving tele-dermatology or tele-ophthalmology services by store and forward shall not preclude a patient from receiving real-time telemedicine, or face-to-face services with the distant site provider at a future date. ***Source: VT Statutes Annotated, Title 18 Sec. 9361 (2012).***	No reference found.
Location	
No reference found.	Certain primary care services may be provided outside of a health care facility. ***Source: VT Bill S. 139 (2015).***
Cross-State Licensing	
No reference found.	No reference found.
Private Payers	
Requires coverage of telemedicine services, subject to contract terms and conditions. ***Source: VT Statutes Annotated, Title 8 Sec. 4100k (2012).***	No reference found.
Site/Transmission Fee	
No reference found.	Allowed, but not required, for originating site providers. ***Dept. of VT Health Access, Green Mountain Care Provider Manual, p. 105 (June 29, 2016). (Accessed Aug. 2016).***
Miscellaneous	
Recently Passed Legislation (Eff. July 1, 2016) The Department of Vermont Health Access is required to reimburse the hosting facility for services rendered. ***Source: VT Statutes Annotated, Title 8 Sec. 4100k No. 173 (2016) http://legislature.vermont.gov/statutes/section/08/107/04100k***	The Department of Vermont Health Access and the Green Mountain Care Board is tasked with considering the implementation of pilot projects using telemedicine. Among other things, the pilot project should consider the scope of services that should be provided using telemedicine outside of a health care facility including possibly equipping home health agency nurses with tools needed to provide telemedicine during home health visits. ***Source: VT Act. No. 40 (S. 88).***

Virginia

Medicaid Program: Virginia Medicaid

Medicaid Program Administrator: State Dept. of Medical Assistance Services (DMAS)

Regional Telehealth Resource Center:
Mid-Atlantic Telehealth Resource Center
PO Box 800711
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STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
Telemedicine services means the use of electronic technology or media, including interactive audio or video for the purpose of diagnosing or treating a patient or consulting with other health care providers regarding a patient's diagnosis or treatment. 'Telemedicine services' does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire. *Source: VA Code Annotated Sec. 38.2-3418.16 & Senate Bill 1227, House Bill 2063 (2015).* "Telehealth" or "telemedicine" means the real time or near real time two-way transfer of data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment. *Source: VA Reg Text 12VAC30-121-20. (2016).*	"Telemedicine is the real-time or near real-time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment." *Source: VA Dept. of Medical Assistant Svcs., Medicaid Provider Manual, Physician/Practitioner Manual, Covered Svcs. and Limitations, p. 25 (Apr. 2, 2012). (Accessed Aug. 2016).* "Telemedicine is the real-time or near real-time exchange of information for diagnosing and treating medical conditions." *Source: VA Dept. of Medical Assistant Svcs., Medicaid Provider Manual, Psychiatric Services Provider Manual, Covered Svcs. and Limitations, p. 36 (Dec. 2, 2015) & Mental Health Clinic, p. 15 (Aug. 26, 2009). (Accessed Aug. 2016).* Telemedicine service providers provide real-time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment. *Source: Physician Provider Manual. Ch. II: Provider Participation Requirements (Jul., 18, 2014) pg. 11. (Accessed Aug. 2016).*
Live Video Reimbursement	
Virginia statute requires coverage of telemedicine (which includes live video) by private insurers, subject to their terms and conditions. *Source: VA Code Annotated Sec. 38.2-3418.16 (2012).*	Reimbursement provided subject to coverage requirements. Eligible services: • Evaluation and management • Psychiatric care • Specialty medical procedures • Speech therapy • Radiology service and procedures See Billing Instructions for complete list of eligible CPT codes.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	Eligible providers: • Physicians; • Nurse practitioners; • Nurse midwives; • Psychiatrist • Psychiatric clinical nurse specialist • Psychiatric nurse practitioner • Marriage and family therapist/counselor • School psychologist • Substance abuse practitioner • Clinical nurse specialists; • Clinical psychologists; • Clinical social workers; • Local Education Agency (billing speech therapy) • Providers must have appropriate license from the Department of Behavioral Health and Developmental Services and be enrolled with Magellan Use of telemedicine must be noted in the service documentation of the patient record. The originating site provider or designee must attend the encounter with the member, unless the encounter documentation in the patient record notes the reason staff was not present. Out-of-state physicians must enroll with DMAS contractors to utilize telemedicine in the Medicaid program. ***Source: VA Dept. of Medical Assistant Svcs., Medicaid Provider Manual, Physician/Practitioner Manual, Covered Svcs. and Limitations, p. 25 (Jul. 31, 2015) & Billing Instructions, p. 28 (Jul. 31, 2015). (Accessed Aug. 2016).*** Speech therapy reimbursement for the speech-language pathologist at the remote location and a qualified school aide with the child during the tele-practice session. ***Source: VA Dept. of Medical Assistant Svcs. Medicaid Provider Manual, Local Education Agency Provider Manual, Covered Svcs. and Limitations, p. 11 (May 12, 2014). (Accessed Aug. 2016).*** Telemedicine also available in the Governor's Access Plan for the Seriously Mentally Ill (GAP). ***Source: VA Dept. of Medical Assistant Svcs., GAP Manual, (Jan. 12, 2015). (Accessed Aug. 2016).*** For mental health clinics, providers intending to bill telemedicine services must first notify DMAS. This is a one-time activity and needs to occur at least 10 days in advance. ***Source: VA Dept. of Medical Assistant Svcs., Mental Health Clinic,***

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	Covered Services, p. 15 (Aug. 26, 2009). (Accessed Aug. 2016).
Store and Forward Reimbursement	
Medicare-Medicaid Demonstration Waiver: Participating plans shall be permitted to use telehealth in rural and urban settings and reimburse for store and forward applications. *Source: VA Reg. Text 12VAC30-121-20. (2016). (http://register.dls.virginia.gov/details.aspx?id=4766).*	Services covered include: • Radiology and radiology procedures • Diabetic retinopathy • Outpatient teledermatology *Source: VA Dept. of Medical Assistant Svcs., Medicaid Provider Manual, Billing Instructions, p. 22-24 (Jul. 31, 2015). (Accessed Aug. 2016).*
Remote Patient Monitoring Reimbursement	
Medicare-Medicaid Demonstration Waiver: Participating plans shall also have the ability to cover remote patient monitoring. *Source: VA Reg. Text 12VAC30-121-20. (2016). (http://register.dls.virginia.gov/details.aspx?id=4766).*	No reference found.
Email/Phone/FAX	
No reimbursement for email. No reimbursement for telephone. No reimbursement for FAX. *Source: VA Code Annotated Sec. 38.2-3418.16 (2012).*	No reimbursement for email. No reimbursement for telephone. No reimbursement for FAX. *Source: VA Dept. of Medical Assistant Svcs., Medicaid Provider Manual, Physician/Practitioner Manual, Covered Svcs. and Limitations, p. 19 (Jul. 31, 2015). (Accessed Aug. 2016).*
Online Prescribing	
Practitioners prescribing controlled substances must have a "bona fide" relationship with the patient. Requirements: • Obtaining a medical or drug history; • Informing the patient about the benefits and risks of the drug; • Conducting a patient exam, either physically or by the use of instrumentation and diagnostic equipment, through which images and medical records may be transmitted electronically. Additional requirements apply for the prescription of Schedule VI controlled substances via telemedicine. *Source: VA Code Annotated Sec. 54.1-3303 & Senate Bill 1227, House Bill 2063 (2015).* Also see Comment section.	No reference found.
Consent	
Informed consent must be obtained and maintained. *Source: Telemedicine Guidance. Doc. # 85-12. VA Board of Medicine.*	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Location	
No reference found.	Eligible originating sites locations: • Provider offices • Local Education Agency • Rural Health Clinics • Federally Qualified Health Centers • Hospitals • Nursing Facilities • Health Department Clinics • Renal Units • Community Services Boards • Residential Treatment Centers All listed providers are also considered eligible originating site providers. ***Source: VA Dept. of Medical Assistant Svcs., Medicaid Provider Manual, Billing Instructions, p. 25 (Jul. 31, 2015). (Accessed Aug 2016.*** Physicians may be physically located outside of VA but must be located within the continental US to deliver telemedicine services. Telemedicine out-of-state coverage does not include other out-of-state providers such as nurse practitioners. ***Source: VA Dept. of Medical Assistant Svcs., Medicaid Memo. "Updates to Telemedicine Coverage". May 13, 2014. (Accessed Aug. 2016).*** **Psychiatric Services:** Providers must by physically present in Virginia during the telemedicine encounter, until further notice from DMAS. ***Source: VA Dept. of Medical Assistant Svcs., Medicaid Provider Manual, Psychiatric Services Provider Manual, Covered Svcs. and Limitations, p. 31 (Dec. 2, 2015). (Accessed Aug. 2016).***
Cross-State Licensing	
No reference found.	Providers must be licensed in Virginia and enrolled in the state Medicaid program in which they practice medicine. ***Source: Physician Provider Manual. Ch. II: Provider Participation Requirements (Jul., 18, 2014) pg. 7. (Accessed Aug. 2016).***
Private Payers	
Requires coverage of telemedicine services, subject to contract terms and conditions. Reimbursement must be the same as in-person services. ***Source: VA Code Annotated Sec. 38.2-3418.16 (2012).***	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Site/Transmission Fee	
Reimbursement allowed, but not required. *Source: VA Code Annotated Sec. 38.2-3418.16 (2012).*	Reimburses a facility fee. *Source: VA Medicaid Provider Notice May 13, 2014. (Accessed Aug. 2016). http://www.magellanofvirginia.com/media/937360/10-21-14_telemedicine_billing_changes_email_blast.pdf*
Miscellaneous	

Comments: **Telemedicine Guidance from VA Medical Board**

- Prescribing via telemedicine is at the discretion of the prescribing practitioner.
- Informed consent must be obtained and maintained.
- See guidance for additional requirements.

Source: Telemedicine Guidance. Doc. # 85-12. VA Board of Medicine.

The Center for Telehealth of the University of Virginia and the Virginia Telehealth Network will establish a telehealth pilot program to expand access to and improve the coordination and quality of health care services in rural and medically underserved areas of the Commonwealth through the use of telemedicine services, for the purpose of providing access to health care services that would not be available to individuals in rural and medically underserved areas of the Commonwealth without the use of telehealth technology.

Source: VA Senate Bill 369. (2016). (http://lis.virginia.gov/cgi-bin/legp604.exe?161+ful+CHAP0763).

Washington

Medicaid Program: Washington Medicaid

Medicaid Program Administrator: Washington State Health Care Authority

Regional Telehealth Resource Center:
Northwest Regional Telehealth Resource Center
2900 12th Ave. N., Ste. 30W
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(888) 662-5601
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STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
Recently Passed Legislation (Effective Jan. 1, 2017) "Telemedicine means the delivery of health care services through the use of interactive audio and video technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment. For purposes of this section only, 'telemedicine' does not include the use of audio-only telephone, facsimile, or email." *Source: WA Senate Bill 5175 (2015). (Will be incorporated into Revised Code of WA Sec. 41.05, 48.43, 74.09, & 70.41.020).* "Telemedicine means the use of tele-monitoring to enhance the delivery of certain home health skilled nursing services through: • The collection of clinical data and the transmission of such data between a patient at a distant location and the home health provider through electronic processing technologies. Objective clinical data that may be transmitted includes, but is not limited to, weight, blood pressure, pulse, respirations, blood glucose, and pulse oximetry; • The provision of certain education related to health care services using audio, video, or data communication instead of a face-to-face visit." *Source: WA Admin. Code Sec. 182-551-2010.* "Telehealth means providing physical therapy via electronic communication where the physical therapist or physical therapist assistant and the patient are not at the same physical location." *Source: WA Admin. Code Sec. 246-915-187.* Telemedicine is when a health care practitioner uses	"Telemedicine is when a health care practitioner uses HIPAA-compliant interactive real-time audio and video telecommunications (including web-based applications) or store and forward technology to deliver covered services that are within his or her scope of practice to a client at a site other than the site where the provider is located." *Source: WA State Health Care Authority, Medicaid Provider Guide, Physician-Related Svcs./Health Care Professional Svcs., p. 64 (Jan. 1, 2016); School Based Health Care Services, p. 28 (May 15, 2016) (Accessed Aug. 2016)*

STATE LAW/REGULATIONS	MEDICAID PROGRAM
HIPAA-compliant, interactive, real-time audio and video telecommunications (including web-based applications) to deliver covered services that are within his or her scope of practice to a client at a site other than the site where the provider is located. Using telemedicine enables the health care practitioner and the client to interact in real-time communication as if they were having a face-to-face session. Telemedicine allows clients, particularly those in medically underserved areas of the state, improved access to essential health care services that may not otherwise be available without traveling long distances. ***Source: WA Admin. Code Sec. 182-531-1730.***	
Live Video Reimbursement	
<u>Recently Passed Legislation (Effective Jan. 1, 2017)</u> Insurers (including employee health plans and Medicaid Managed Care) must reimburse for live video, with some limitations. *(See private payer section)* ***Source: WA Senate Bill 5175 (2015). (Will be incorporated into Revised Code of WA Sec. 41.05, 48.43, & 74.09).*** Telemedicine is covered by the Department. ***Source: WA Admin. Code Sec. 182-531-0100.***	Yes, for patients with fee-for-service coverage when it is medically necessary. The referring provider is responsible for determining and documenting medical necessity. Client must be present and participating in telemedicine visit. Clients under the Family Planning, TAKE CHARGE, First Steps, and School Based Health Care Service program are also eligible for telemedicine through fee-for-service. For patients with managed care plan coverage, telehealth services will not be reimbursed separately. All services must be arranged and provided by primary care providers. It is not mandatory that the plan pay for telehealth services. WA Medicaid covers prenatal genetic counseling via telemedicine. ***Source: WA State Health Care Authority, Medicaid Provider Guide, Physician-Related Svcs./Health Care Professional Svcs., p. 74 & 165(Jan. 1, 2016). (Accessed Aug. 2016).*** Applied Behavior Analysis (ABA) for Clients Age 20 and Younger: • Eligible telemedicine services: • Program supervision when the child is present • Family training, which does not require the child's presence See ABA fee schedule for telemedicine billing instructions. ***Source: WA State Health Care Authority, Medicaid Provider Guide, Applied Behavior Analysis for Clients 20 and Younger, p. 35 (Jan. 1, 2016) & 182-531A-1200. (Accessed Aug. 2016),***
Store and Forward Reimbursement	
<u>Recently Passed Legislation (Effective Jan. 1, 2017)</u>	Store and forward is reimbursed when there is an

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Insurers (including employee health plans and Medicaid Managed Care) must reimburse for store-and forward, with some limitations. *(See private payer section)* Store and forward reimbursement is available only for covered services specified in the negotiated agreement between the health plan and health care provider. If the services are provided via store and forward, there must be an associated office visit between the patient and referring health care provider. ***Source: WA Senate Bill 5175 (2015). (Will be incorporated into Revised Code of WA Sec. 41.05, 48.43, & 74.09).***	associated office visit between the client and the referring health care provider. ***Source: WA State Health Care Authority, Medicaid Provider Guide, Physician-Related Svcs./Health Care Professional Svcs., p. 74 (Jul. 1, 2016). (Accessed Aug. 2016).***
Remote Patient Monitoring Reimbursement	
(see Medicaid column)	The Medicaid agency covers the delivery of home health services through telemedicine. Services are provided for clients who have been diagnosed with an unstable condition, and who may be at risk for hospitalization or a more costly level of care. Coverage is limited to one telemedicine interaction, per patient, per day, based on the ordering licensed practitioner's care plan. Eligible services: • Assessment and monitoring of clinical data including, but not limited to, vital signs, pain levels and other biometric measures specified in the plan of care; • Assessment of response to previous changes in the plan of care; • Detection of condition changes based on the telemedicine encounter that may indicate the need for a change in the plan of care. • Implementation of a management plan Must be provided by a Registered Nurse or Licensed Practical Nurse. The Medicaid agency does not require prior authorization for the delivery of home health services through telemedicine. ***Source: WA State Health Care Authority, Medicaid Provider Guide, Home Health Svcs. (Acute Care Svcs.), p. 26-28 (Jul. 1, 2016). (Accessed Aug 2016).*** Home health monitoring not covered in Applied Behavior

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	Analysis Program for clients Age 20 or younger. ***Source: WA State Health Care Authority, Medicaid Provider Guide, Applied Behavior Analysis for Clients 20 and Younger, p. 40 (Jul. 1, 2016). (Accessed Aug 2016).***
Email/Phone/FAX	
No reference found.	No reimbursement for email. No reimbursement for telephone. No reimbursement for FAX. ***Source: WA State Health Care Authority, Medicaid Provider Guide, Physician-Related Svcs./Health Care Professional Svcs., p. 74 (Jul. 1, 2016). (Accessed Aug. 2016).***
Online Prescribing	
The WA Medical Quality Assurance Commission has issued guidelines on the use of the Internet in medical practices. A guideline does not have the force of law, but can be considered by the Commission to be the standard of practice in the state. A documented patient evaluation, including history and physical evaluation adequate to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided, must be obtained prior to providing treatment, including issuing prescriptions, electronically or otherwise. Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in in-person settings. Treatment, including issuing a prescription, based solely on an online questionnaire or consultation does not constitute an acceptable standard of care. ***Source: Washington Medical Quality Assurance Commission, Guidelines for Appropriate Use of the Internet in Medical Practice,***	No reference found.
Consent	
No reference found.	No reference found.
Location	
<u>Recently Passed Legislation (Effective Jan. 1, 2017)</u> ***Eligible Originating Sites*** • Clinics; • Dental offices; • Home or any location determined appropriate by the individual receiving the service; • Hospitals—inpatient or outpatient;	Eligible originating sites: • Clinics • Community mental health/chemical dependency settings • Dental offices • Federally qualified health center (FQHC) • Home or any location determined appropriate by

STATE LAW/REGULATIONS	MEDICAID PROGRAM
• Neurodevelopmental centers; • Schools; • Rural health clinic; • Federally qualified health center; • Physician's or other health care provider's office; • Community mental health center/chemical dependency settings; • Skilled nursing facility; or • Renal dialysis center Originating sites may not distinguish between rural and urban originating sites. *Source: WA Senate Bill 5175 (2015). (Will be incorporated into Revised Code of WA Sec. 41.05, 48.43, & 74.09).* http://apps.leg.wa.gov/wac/default.aspx?cite=182-531-1730	the individual receiving service • Hospitals (inpatient and outpatient) • Neurodevelopmental centers • Physician or other health professional's office • Rural health clinics (RHC) • Schools • Skilled nursing facilities Originating site provider responsible for determining and documenting that telemedicine is medically necessary. *Source: WA State Health Care Authority, Medicaid Provider Guide, Physician-Related Svcs./Health Care Professional Svcs., p. 75 (Jul. 1, 2016). (Accessed Aug 2016).* When the originating site is a school, the school district must submit a claim on behalf of both the originating and distant site. *Source: WA State Health Care Authority, Medicaid Provider Guide, School Based Health Care Services, p. 27 (May 15, 2016 . (Accessed Aug. 2016).*
Cross-State Licensing	
Out-of-state, licensed practitioners may deliver telemedicine or telehealth services, as long as they do not open an office or appoint a place of meeting patients or receive calls within the state. *Source: Revised Code of WA Sec. 18.71.030 (2012).*	No reference found.
Private Payers	
Recently Passed Legislation (Effective Jan. 1, 2017) Insurers (including employee health plans and Medicaid Managed Care) must reimburse a provider for services delivered through telemedicine or store and forward if: • The plan provides coverage when provided in-person; • The health care service is medically necessary; and • The health care service is a service recognized as an essential health benefit under section 1302(b) of the federal patient protection and affordable care act. *Source: WA Senate Bill 5175 (2015). (Will be incorporated into Revised Code of WA Sec. 41.05, 48.43, & 74.09).*	No reference found.
Site/Transmission Fee	
Recently Passed Legislation (Effective Jan. 1, 2017) An originating site (other than a home) can charge a facility fee, but it is subject to a negotiated agreement between the originating site and the health plan.	Facility fees for originating sites, except inpatient hospitals. *Source: WA State Health Care Authority, Medicaid Provider*

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Source: WA Senate Bill 6519.SL (2016). (Will be incorporated into Revised Code of WA Sec. 41.05, 48.43, & 74.09).	*Guide, Physician-Related Svcs./Health Care Professional Svcs., p. 65 (Jul. 1, 2016). (Accessed Aug. 2016).*
Miscellaneous	
Physical Therapy Licensed physical therapists and physical therapist assistants may provide physical therapy via telehealth. The clinical record must indicate that the physical therapy occurred via telehealth. *Source: WA Admin. Code Sec. 246-915-187.*	

Comment: WA State requires a provider directory to be updated monthly. For each health plan, the associated provider directory must include information about available telemedicine services and specifically described for each provider.

Source: WA Admin. Code Sec. 284-43-204.

West Virginia

Medicaid Program: West Virginia Medicaid

Medicaid Program Administrator: Bureau for Medical Services, under the West Virginia Dept. of Health and Human Resources

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STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Practice of telemedicine means the practice of medicine using communication tools such as electronic communication, information technology or other means of interaction between a licensed health care professional in one location and a patient in another location, with or without an intervening health care provider, and typically involves secure real time audio/video conferencing or similar secure audio/video services, remote monitoring, interactive video and store and forward digital image or health data technology to provide or support health care delivery by replicating the interaction of a traditional in person encounter between a provider and a patient. The practice of telemedicine occurs in this state when the patient receiving health care services through a telemedicine encounter is physically located in this state." ***Source: WV Code Sec. 30-3-13.*** "Telemedicine technologies" means technologies and devices which enable secure electronic communications and information exchange in the practice of telemedicine, and typically involve the application of secure real-time audio/video conferencing or similar secure video services, remote monitoring, or store and forward digital image technology to provide or support healthcare delivery by replicating the interaction of a traditional in-person encounter between a physician or podiatrist and a patient. ***Source: WV Code Sec. 30-3-13 & 30-14-12d (SB 47 – 2016).*** **Newly Passed Legislation (Effective June 12, 2016)** "Telehealth" means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment education, care management, and self-management of a patient's health care while the	"Telehealth: The use of electronic information and telecommunications technologies to provide professional health care; is often used to connect practitioners and clinical experts in large hospitals or academic medical centers with patients in smaller hospitals or critical access hospitals which are typically located in more remote locations; and can assure that these remotely located patients enjoy the same access to potentially life-saving technologies and expertise that are available to patients in more populated parts of the country." "The telecommunication system is defined as an interactive audio and video system that permits real-time communication between the member at the originating site and the practitioner at the distant site. The telecommunication technology must allow the treating practitioner at the distant site to perform a medical examination of the member that substitutes for an in-person encounter." ***Source: WV Dept. of Health and Human Svcs. Medicaid Provider Manual, Chapter–519.17 Practitioner Services: Telehealth Services. Revised Jan. 15, 2016 (accessed Aug. 2016).***

STATE LAW/REGULATIONS	MEDICAID PROGRAM
patient is at the originating site and the health car.[i] *Source: WV Code Sec. 16-5Y-2 (SB 454—2016).*	
Live Video Reimbursement	
No reference found.	West Virginia Medicaid reimburses for a limited number of telehealth services that are provided to enrolled members by enrolled practitioners via a telecommunication system. WV Medicaid utilizes CMS guidance on Telehealth Services. Limited to specific CPT codes (not necessarily consistent with CMS reimbursement). Authorized distant site providers include: • Physicians; • Physician Assistants (PA); • Advanced Practice Registered Nurses (APRN)/Nurse Practitioners (NP) • APRN/Certified Nurse Midwife (CNM); • APRN/Clinical Nurse Specialists (CNS); • Licensed Psychologists (LP); and • Licensed Independent Clinical Social Worker (LICSW) RHCs and FQHCs are not authorized to serve as distant sites for telehealth consultations, which is the location of the practitioner, and many not bill or include the cost of a visit on the cost report. *Source: WV Dept. of Health and Human Svcs. Medicaid Provider Manual, Chapter–519.17 Practitioner Services: Telehealth Services. Revised Jan. 15, 2016 (accessed Aug. 2016).* Targeted case management can be conducted through telemedicine with the exception of the required 90 day face-to-face encounter with the targeted case manager. *Source: WV Dept. of Health and Human Svcs., Medicaid Provider Manual, Chapter 523: Targeted Case Management, p. 13 (Jul. 1, 2016).* WV Medicaid encourages providers to render services via telehealth in the Behavioral Health Clinic Services program. *Source: WV Dept. of Health and Human Services Medicaid Provider Manual, Chapter–502 Covered Services Limitations, And Exclusions For Behavioral Health Clinic Services, p. 15 (Oct. 13, 2015); Behavioral Health Rehabilitation Services, p. 13 (Jul. 1, 2014); Psychological Services, p. 9 (Apr. 1, 2015); Psychiatric Services, p. 9 (Oct. 9, 2015); Licensed Independent Clinical Social Worker, p. 8 (Jul. 1, 2015); School-Based Health Services, p. 10 (Aug. 1, 2015).*
Store and Forward Reimbursement	
No reference found.	No reimbursement. WV Medicaid only reimburses for real-time communications.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	Source: WV Dept. of Health and Human Svcs. Medicaid Provider Manual, Chapter–519.17 Practitioner Services: Telehealth Services. Revised Jan. 19, 2016 (accessed Aug. 2016).
Remote Patient Monitoring Reimbursement	
No reference found.	No reference found.
Email/Phone/FAX	
No reference found.	No reimbursement for FAX. No reimbursement for telephone. No reimbursement for email. *Source: WV Dept. of Health and Human Svcs. Medicaid Provider Manual, Chapter–519.17.2 Non-Covered Services: Telehealth Services. Revised Jan. 15, 2016 (accessed Aug. 2016).*
Online Prescribing	
A "valid patient-practitioner relationship" can be established through telemedicine in a manner approved by the appropriate board. *Source: WV Code Sec. 30-5-4.* A physician-patient relationship cannot be established through audio only communication, text communications or any combination thereof. A physician-patient relationship can be established through real-time video conferencing or store and forward (for pathology and radiology). A physician or podiatrist who solely utilizes telemedicine may not prescribe to that patient any controlled substance in Schedule II of the Uniform Controlled Substances Act. A physician or podiatrist may not prescribe any pain-relieving controlled substance listed in Schedule II through V as part of a course of treatment for chronic non-malignant pain solely based on a telemedicine encounter. *Source: WV Code Sec. 30-3-13 & 30-14-12d (SB 47 – 2016).* Prohibits providers from issuing prescriptions, via electronic or other means, for persons without establishing an ongoing physician-patient relationship, wherein the physician has obtained information adequate to support the prescription. Exceptions: • Documented emergencies; • On-call or cross-coverage situations; • Where patient care is rendered in consultation with another physician who has an ongoing relationship with the patient, and who has	No reference found.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
agreed to supervise the patient's treatment, including use of any prescribed medications. *Source: WV Code Sec. 11-1A-12.*	
Consent	
Must obtain consent. *Source: WV Code Sec. 30-3-13 & 30-14-12d (SB 47 – 2016).*	Patient consent must be obtained. *Source: WV Dept. of Health and Human Svcs. Medicaid Provider Manual, Chapter–502 Covered Svcs. Limitations, And Exclusions For Behavioral Health Clinic Services, p. 15 (Oct. 13, 2015); Behavioral Health Rehabilitation Services, p. 13 (Jul. 1, 2014); Psychological Services, p. 9 (Apr. 1, 2015); Psychiatric Services, p. 9 (Oct. 9, 2015); Licensed Independent Clinical Social Worker, p. 8 (Jul. 1, 2015); School-Based Health Services, p. 10 (Aug. 1, 2015).*
Location	
No reference found.	Authorized originating sites: • Offices of physicians or practitioners; • Private Psychological Practices; • Hospitals; • Rural Health Clinics (RHCs); • Federally Qualified Health Centers (FQHCs); • Hospital-based or CAH-based Renal Dialysis Centers (including satellites); • Skilled Nursing Facilities (SNF); and • Community Mental Health Centers (CMHC). Independent Renal Dialysis Facilities are not eligible originating sites. WV Medicaid does not limit telehealth services to members in non-metropolitan statistical professional shortage areas as defined by CMS telehealth guidance. *Source: WV Dept. of Health and Human Svcs. Medicaid Provider Manual, Chapter–519.17 Practitioner Services: Telehealth Services. Revised Jan. 15, 2016 (accessed Aug. 2016).*
Cross-State Licensing	
WV adopted the Federation of State Medical Board (FSMB)'s model language for an interstate medical licensure compact. *Source: WV House Bill 2496 (2015).* Must hold active unexpired WV license. *Source: WV Code Sec. 30-3-13 & 30-14-12d (SB 47 – 2016).*	No reference found.
Private Payers	
No reference found.	No reference found.
Site/Transmission Fee	
No reference found.	An originating site can bill for a facility fee.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	Source: WV Dept. of Health and Human Svcs. Medicaid Provider Manual, Chapter–519.17 Practitioner Services: Telehealth Services. Revised Jan. 19, 2016 (accessed Aug. 2016).
Miscellaneous	
	Additional instructions regarding telehealth standards and billing available in the following manuals: Behavioral Health Clinic (Ch. 502); Behavioral Health Rehabilitation (Ch. 503); Psychological Services (Ch. 521); Psychiatric Services (Ch. 536); Licensed Independent Clinical Social Worker (Ch. 537); School-Based Health Services (Ch. 538). Limited to specific CPT codes. ***Source: WV Dept. of Health and Human Svcs. Medicaid Provider Manual, Chapter–502 Covered Svcs., Limitations, And Exclusions For Behavioral Health Clinic Services, p. 15 (Oct. 13, 2015); Chapter 503 Behavioral Health Rehabilitation Services, p. 13 (April 25, 2016); Psychological Services, p. 9 (Apr. 1, 2015); Psychiatric Services, p. 9 (Oct. 9, 2015); Licensed Independent Clinical Social Worker, p. 8 (Jul. 1, 2015); School-Based Health Services, p. 10 (Aug. 1, 2015).***

Professional Board Regulation:

- Board of Examiners for Speech-Language Pathology and Audiology (WV Admin. Law Sec. 29-1-15)

[i] This definition is incomplete because there was an error made while drafting the legislation and it was codified into statute. The author's office has indicated that they would try to correct the error with clean-up language in the 2017 legislative session.

Wisconsin

Medicaid Program: Forward Health

Medicaid Program Administrator: Wisconsin Dept. of Health Services

Regional Telehealth Resource Center:

Great Plains Telehealth Resource and Assistance Center
University of Minnesota/Institute for Health Informatics
330 Diehl Hall
505 Essex Street S.E.
Minneapolis, MN 55455
(888) 239-7092
www.gptrac.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Telehealth" is a service provided from a remote location using a combination of interactive video, audio, and externally acquired images through a networking environment between an individual at an originating site and a provider at a remote location with the service being of sufficient audio and visual fidelity and clarity as to be functionally equivalent to face-to-face contact. "Telehealth" does not include telephone conversations or Internet-based communications between providers or between providers and individuals. ***Source: Wisconsin Statute 49.45 (29w).***	"Telemedicine services (also known as "Telehealth") are services provided from a remote location using a combination of interactive video, audio, and externally acquired images through a networking environment between a member (i.e., the originating site) and a Medicaid-enrolled provider at a remote location (i.e., distant site). The services must be of sufficient audio and visual fidelity and clarity as to be functionally equivalent to a face-to-face contact. Telemedicine services do not include telephone conversations or Internet-based communication between providers or between providers and members. ***Source: WI Forward Health, Provider Publications, Physician, pg. 132 (Published Policy Through July 31, 2016).***
Live Video Reimbursement	
(see Medicaid column)	Forward Health will reimburse for medical and mental/behavioral health services via live video. Eligible services: • Office or other outpatient services; • Office or other outpatient consults; • Initial inpatient consults; • Outpatient mental health services; • Health and behavior assessment/intervention; • End stage renal disease-related services; • Outpatient substance abuse services. Eligible providers: • Physicians and physician clinics; • Rural Health Clinics; • Federally Qualified Health Center;

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	• Physician assistants; • Nurse practitioners; • Nurse midwives; • Psychiatrists; • Ph.D. psychologists. Reimbursement is subject to the same restrictions as in-person services. Only one eligible provider may be reimbursed per member per date of service (DOS), unless it is medically necessary for the participation of more than one provider. Separate services provided by separate specialists for the same patient at different times on the same date may be reimbursed separately. Providers may receive enhanced reimbursement for pediatric services, for members 18 years old and under, and for HPSA-eligible services. HPSA-enhanced reimbursement is allowed when the patient or the provider is located in a HPSA-designated area. Out-of-state providers, except border-status providers, must obtain prior authorization (PA) before delivering services to Wisconsin Medicaid members. ***Source: WI Forward Health, Provider Publications, Physician, pg. 133-134 (Published Policy Through July 31, 2016).*** Mental health services provided through telehealth are reimbursable by the Medical Assistance program if the provider of the service satisfies the following criteria: • The provider is a certified provider of mental health services under the Medical Assistance program and is an agency that is certified by a mental health program. (Please see bill text for specific program list). • The provider and the individual providing the service comply with all Medical assistance coverage policies and standards • The provider is certified for telehealth by the department. • The individual who is providing the service is licensed or registered and in good standing with the appropriate state board. • The provider is located in the United States. The provider is not required to be located in the state. ***Source: Wisconsin Statute 49.45 (29w) (2).***
Store and Forward Reimbursement	
No reference found.	No reimbursement.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	Source: WI Forward Health, Provider Publications, Physician, pg. 135 (Published Policy Through July 31, 2016).
Remote Patient Monitoring Reimbursement	
No reference found.	No reference found.
Email/Phone/FAX	
"Telehealth" does not include telephone conversations or Internet-based communications between providers or between providers and individuals. *Source: Wisconsin Statute 94.45 (29w).*	No reimbursement for email or Internet-based communications. No reimbursement for telephone. No reference found for FAX. *Source: WI Forward Health, Provider Publications, Physician, pg. 132 (Published Policy Through July 31, 2016).*
Online Prescribing	
No reference found.	No reference found.
Consent	
No reference found.	No reference found.
Location	
No reference found.	Eligible originating sites: • Physician offices; • Hospitals (inpatient or outpatient, excluding emergency rooms); • Any other appropriate place of service with necessary equipment and staffing. *Source: WI Forward Health, Provider Publications, Physician, pg. 134-135 (Published Policy Through July 31, 2016).*
Cross-State Licensing	
WI adopted the Federation of State Medical Boards' Interstate Medical Licensure Compact. *Source: Wisconsin Statute 14.89. WI Act 116 (AB 253, 2015).*	No reference found.
Private Payers	
No reference found.	No reference found.
Site/Transmission Fee	
No reference found.	Reimbursement for originating site facility fees. Eligible originating sites: • Physician offices; • Hospitals (inpatient or outpatient, excluding emergency rooms); • Any other appropriate place of service with necessary equipment and staffing.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	The originating site may not be an emergency room. An originating site facility fee is not an RHC/FQHC service, and may not be reported as an encounter on cost reports. Any reimbursement for the originating site facility fee must be reported as a deductive value. Outpatient hospitals will receive only a facility fee. Wisconsin Medicaid will not separately reimburse the rate-per-visit for that member, unless the patient receives other covered services on the same date. Professional services provided in the outpatient hospital are separately reimbursable. ***Source: WI Forward Health, Provider Publications, Physician, pg. 134-135 (Published Policy Through July 31, 2016).***
Miscellaneous	
	Information in the physician section of the WI Forward Health Covered and non-covered services manual is repeated in the following manuals as well: • Adult Mental Health Day Treatment • Ambulatory Surgery Centers • Child/Adolescent Day Treatment • Community Support Program • Comprehensive Community Services • Crisis Intervention • End-Stage Renal Disease • Family Planning • Federally Qualified Health Centers • Hospital, Inpatient • Hospital, Outpatient • In-Home Mental Health/Substance Abuse Services • Narcotic Treatment Services • Nurse Midwife • Nursing Home • Outpatient Mental Health • Outpatient Mental Health and Substance Abuse Services • Outpatient Substance Abuse • Rural Health Clinic • Substance Abuse Day Treatment ***Source: WI Forward Health, Provider Publications, Physician, pg. 134-135 (Published Policy Through July 31, 2016).***

Wyoming

Program Name: Wyoming Medicaid

Administrator: Office of Equality Care, under the Wyoming Dept. of Health.

Regional Telehealth Resource Center:
Northwest Regional Telehealth Resource Center
2900 12th Ave. N., Ste. 30W
Billings, MT 59101
(888) 662-5601
www.nrtrc.org

STATE LAW/REGULATIONS	MEDICAID PROGRAM
Definition of telemedicine/telehealth	
"Telemedicine means the practice of medicine by electronic communication or other means from a physician in a location to a patient in another location, with or without an intervening health care provider." ***Source: WY Statutes Sec. 33-26-102.*** "Occupational therapy telehealth means the provision of occupational therapy services across a distance, using telecommunications technology for the evaluation, intervention or consultation without requiring the occupational therapist and recipient to be physically located in the same place." ***Source: WY Statutes Sec. 33-40-102.***	"Telehealth is the use of an electronic media to link beneficiaries with health professionals in different locations." This means that the patient must be able to see and interact with the off-site physician at the time services are provided via telehealth technology. ***Source: WY Dept. of Public Health Insurance, Medicaid, CMS 1500 ICD-10, p. 104 (Revised Jul. 1, 2016).***
Live Video Reimbursement	
No reference found.	Reimbursement is made for exams performed via a real-time interactive audio and video telecommunications system. The patient must be able to see and interact with the off-site practitioner during the exam. A medical professional is not required to be present with the client at the originating site unless medically indicated. Eligible providers: • Physicians; • Advanced practice nurses with a specialty of psychiatry/mental health; • Physician's assistant (billed under the supervising physician); • Psychologists and neuropsychologists; • Mental health professionals (LCSW, LPC, LMFT, LAT). • Speech therapist Provisionally licensed mental health professionals cannot bill Medicaid directly, but must provide services through a supervising provider.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	For end-stage renal disease-related services, there must be at least one in-person exam per month of the vascular access site. Quality assurance/improvement activities relative to telehealth delivered services need to be identified, documented and monitored. An evaluation process must also be instituted. Progress notes should indicate the visit took place via teleconference. *Source: WY Dept. of Public Health Insurance, Medicaid, CMS 1500 ICD-10, p. 104-107 (Jul. 1, 2016). (Accessed Aug. 2016).*
Store and Forward Reimbursement	
No reference found.	Wyoming Medicaid states that reimbursement is made for exams performed via a real-time interactive audio and video. *Source: WY Dept. of Public Health Insurance, Medicaid, CMS 1500 ICD-10, p. 105 (Jul. 1, 2016). (Accessed Aug. 2016).*
Remote Patient Monitoring Reimbursement	
No reference found.	No reference found.
Email/Phone/FAX	
No reference found.	No reimbursement for email. No reimbursement for telephone. No reimbursement for FAX. *Source: WY Dept. of Public Health Insurance, Medicaid, CMS 1500 ICD-10, p. 106 (Jul. 1, 2016). (Accessed Aug. 2016).*
Online Prescribing	
Prescribing a controlled substance through the Internet, World Wide Web or any similar proprietary or common carrier electronic system without a documented physician-patient relationship is subject to review, discipline and consequences to license. *Source: WY Statutes Annotated Sec. 33-26-402 (2012).*	No reference found.
Consent	
Written or oral consent required for physical therapy. *Source: Code of WY Rules 006-062-001 (2012).*	If the patient and/or legal guardian indicate at any point that he/she wants to stop using the technology, the service should cease immediately and an alternative appointment set up. *Source: WY Dept. of Public Health Insurance, Medicaid, CMS 1500 ICD-10, p. 107 (Jul. 1, 2016). (Accessed Aug. 2016).*
Location	
No reference found.	Eligible originating sites:

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	• Hospitals; • Physician or practitioner offices (includes medical clinics); • Psychologists or neuropsychologists offices; • Community mental health or substance abuse treatment centers (CMHC/SATC); • Advanced practice nurses with specialty of psychiatry/mental health offices; • Office of a Licensed Mental Health Professional; • Federally Qualified Health Centers; • Rural Health Clinics; • Skilled nursing facilities; • Indian Health Services Clinics; • Hospital-based or Critical Access Hospital-based renal dialysis centers (including satellites). • Development Center A medical professional is not required to be present at the originating site, unless medically indicated. Each site is able to bill their own services as long as they are an enrolled Medicaid provider (includes out-of-state Medicaid providers). *Source: WY Dept. of Public Health Insurance, Medicaid, CMS 1500 ICD-10, p. 104-105 (Jul. 1, 2016). (Accessed Aug. 2016).*
Cross-State Licensing	
WY adopted the Federation of State Medical Board (FSMB)'s model language for an interstate medical licensure compact. *Source: WY House Bill 107 (2015); WY Statute 33-26-701-703.*	No reference found.
Private Payers	
No reference found.	No reference found.
Site/Transmission Fee	
No reference found.	Yes, for originating site fees. No reimbursement for transmission fees. *Source: WY Dept. of Public Health Insurance, Medicaid, CMS 1500 ICD-10, p. 106 (Jul. 1, 2016). (Accessed Aug. 2016).*
Miscellaneous	
	No reimbursement for patient attendants who instruct the patient on the use of equipment or supervises/monitors a patient during the telehealth encounter. No reimbursement for consults between health professionals.

STATE LAW/REGULATIONS	MEDICAID PROGRAM
	Source: WY Dept. of Public Health Insurance, Medicaid, CMS 1500 ICD-10, p. 106 (Jul. 1, 2016). (Accessed Aug. 2016).

Glossary

Asynchronous (*see also Store and Forward*) technologies allow for the electronic transmission of medical information, such as digital images, documents, and pre-recorded videos. Asynchronous transmissions typically do not occur in real time, and take place primarily among medical professionals, to aid in diagnoses and medical consults, when live video or face-to-face patient contact is not necessary.

Broadband refers to the wide bandwidth characteristics of a transmission medium, and its ability to transport multiple signals and traffic types simultaneously. Broadband is often used to transmit telehealth and telemedicine services.

Centers for Medicare & Medicaid Services (CMS) is the federal agency that administers the Medicare, Medicaid and Children's Health Insurance Program.

Children's Waiver Services Program is a federal program that provides Medicaid-funded home and community-based services to children under age 18 who are eligible for, and at risk of, placement into an Intermediate Care Facility for the Mentally Retarded (ICF/MR).

Consultant Site (*see also Hub Site or Distant Site*) is the site at which the provider delivering a telehealth service is located.

Critical Access Hospital (CAH) is a rural community hospital that receives cost-based reimbursement. The reimbursement that CAHs receive is intended to improve their financial performance and reduce hospital closures.

Current Procedural Terminology (CPT) Code is a medical billing and administrative code set that describes medical, surgical, and diagnostic services. It is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations and payers for administrative, financial and analytical purposes.

Distant Site (*see also Hub Site or Consultant Site*) is the site at which the provider delivering a telehealth service is located.

Durable Medical Equipment (DME) is any medical equipment, such as wheelchairs used in the home.

Echocardiography is a sonogram of the heart.

Echography is a radiologic procedure in which deep structures of the body are recorded with ultrasonic waves.

Electrocardiogram (ECG) is a test of the electrical activity of the heart, which helps detect medical problems such as heart attacks and arrhythmias.

E-Prescribing is the act of offering medical prescriptions over the Internet. Often, e-prescriptions must be accompanied by a valid physician-patient relationship, which may or may not require a face-to-face interaction between the physician and patient, depending on the state.

Facility Fee *(see also Originating Site Fee)* is a fee paid to the originating site to compensate for the cost of facilitating a telemedicine visit.

Federally Qualified Health Centers (FQHCs) are federally designated facilities, which provide primary care and other medical services to underserved populations.

Health Professional Shortage Area (HPSA) are designated by the Health Resources and Services Administration as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), demographic (low income population) or institutional (comprehensive health center, federally qualified health center or other public facility).

Hub Site (*see also Distant Site or Consultant Site*) is the site at which the provider delivering a telehealth service is located.

Informed Consent refers to providers obtaining permission from a patient to perform a specific test, procedure, or in the case of telehealth, service delivery method. Informed consent means that the patient understands the relevant medical facts and risks involved.

Live Video Conferencing *(see also Synchronous)* refers to the use of two-way interactive audio-video technology to connect users, in real time.

Medicaid is a program that provides medical coverage for people with lower incomes, older people, people with disabilities, and some families and children. Learn more about the program in this section.provides medical coverage and long-term medical care to low-income residents. Medicaid is jointly funded by the federal government and individual states, and is administered by the states.

Medicaid Provider Manual is a document released by each state's Medicaid agency, which serves as the reference document for its Medicaid program.

Medically Underserved Area (MUA) may be a whole county or a group of contiguous counties, a group of county or civil divisions or a group of urban census tracts in which residents have a shortage of personal health services.

Medicare is a health insurance for people age 65 or older, people under 65 with certain disabilities, and people of all ages with End-Stage Renal Disease. (ESRD is permanent kidney failure requiring dialysis or a kidney transplant.)

Modifier is a two-digit code that is added to medical procedure codes, to provide additional information about the billed procedure. In some cases, addition of a modifier can directly affect payment.

Modifier GQ is the modifier for store and forward technologies.

Modifier GT is the modifier for live video conferencing.

Originating Site *(see also Spoke Site or Referring Site)* is the location of the patient receiving a telehealth service.

Originating Site Fee *(see also Facility Fee)* is a fee paid to the originating site to compensate for the cost of facilitating a telemedicine visit.

Referring Site *(see also Spoke Site or Originating Site)* is the location of the patient receiving a telehealth service.

Remote Patient Monitoring Remote patient monitoring uses telehealth technologies to collect medical data, such as vital signs and blood pressure, from patients in one location and electronically transmit that information to health care providers in a different location. The health professionals monitor these patients remotely and, when necessary, implement medical services on their behalf.

Rural Health Clinic is a clinic in a rural, medically underserved area that has a separate reimbursement structure from the standard medical office under the Medicare and Medicaid programs.

Skilled Nursing Facility (SNF) is a facility that houses chronically ill, usually elderly patients, and provides long-term nursing care, rehabilitation, and other services.

Spoke Site *(see also Originating Site or Referring Site)* is the location of the patient receiving a telehealth service.

Store and Forward **(***see also Asynchronous***)** technologies allow for the electronic transmission of medical information, such as digital images, documents, and pre-recorded videos. Asynchronous transmissions typically do not occur in real time, and take place primarily among medical professionals, to aid in diagnoses and medical consults, when live video or face-to-face patient contact is not necessary.

Synchronous *(see also Live Video Conferencing)* refers to the use of two-way interactive audio-video technology to connect users, in real time, for any type of medical service.

Tele-pharmacy involves a pharmacist in one location directing the dispensing of a prescription to another employee in a separate location.

Tele-presenter is a health professional who sits in the exam room with patients during telemedicine visits and assists the distant-site provider.

The Health Insurance Portability and Accountability Act (HIPAA) is a set of national standards, which includes security and privacy of health data for electronic health care transactions, and national identifiers for providers, health insurance plans and employers.

The program of All-Inclusive Care for the Elderly (PACE) provides comprehensive long-term services and support to Medicaid and Medicare beneficiaries.

Transmission Fee is a fee paid to telemedicine providers for the cost of telecommunications transmission.

October 11, 2016

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Center for Connected Health Policy

The National Telehealth Policy Resource Center

CCHP October Newsletter:

Telehealth Policy Updates

New Federal Legislation Incorporates Telehealth

Last month two federal pieces of legislation incorporated the use of telehealth as a way to expand access to care. The first bill, S. 3435, the Craig Thomas Rural Hospital and Provider Equity Act of 2016, would amend Title XVIII of the Social Security Act to protect and preserve access of Medicare beneficiaries in rural areas to health care providers under the Medicare program. Among the bill's various components, it

seeks to facilitate the provision of telehealth across state lines by mandating that the Secretary of Health and Human Services consult with representatives of States, physicians, health care practitioners and patient advocates to encourage and facilitate the adoption of provisions allowing for multistate practitioner practice across state lines.

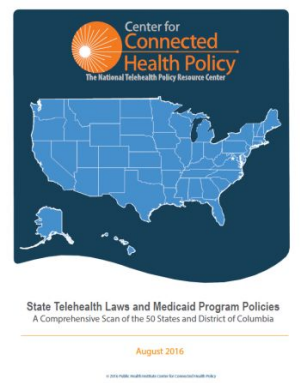
The second bill, HR 6101 was introduced by Representative Black and is titled the ACO Improvement Act of 2016. Section two of the bill aims to move participating entities from volume to value. As a part of this initiative, the bill recognizes the ability of telehealth to improve care coordination and allows an ACO to be granted a waiver from the current restrictions in 1834(m) of the Social Security Act. Specifically, the waiver would exempt participating ACOs from the limitations on originating sites (including geographic and facility type restrictions) and on the use of store-and-forward technologies. Other restrictions on telehealth, such as limitations on eligible providers and service restrictions would still apply.

Telehealth Recognized as Strategy to Help Meet Network Adequacy Standards

Last month Oregon's Department of Consumer and Business Services passed new network adequacy standards for insurers in the state of Oregon offering individual or small group health benefit plans, requiring annual reports to establish network adequacy. These reports are now required to include how the insurer is using telemedicine, telehealth or other technology to meet those network adequacy standards. This follows the passage of recent legislation in California which allows for the use of alternative modalities for accessing care, including telemedicine to be accounted for in meeting those requirements of Medicaid managed care compliance. As telehealth is increasingly recognized as an avenue to achieve network adequacy, these policies factoring in telehealth into network adequacy assessments may become more common.

CCHP's 50 State Reimbursement Policies Report Now Available Online

An update to the fourth edition of the Center for Connected Health Policy's (CCHP) State Telehealth Laws and Reimbursement Policies Report was released last month and is now available online. CCHP's report is the most comprehensive report on state telehealth laws, regulations and Medicaid policies available and contains the most current and up to date information for all 50 states and the District of Columbia. The full report is available at no cost to the public on CCHP's website, which also includes a state-by-state interactive map to more easily access this information.

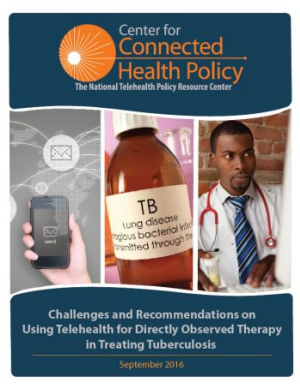


The report found that over the past six months there has been a slight uptake in Medicaid policy allowing for store-and-forward as well as remote patient monitoring reimbursement, although live video reimbursement continues to far exceed both. A few significant findings include:

- Forty-eight states and Washington DC provide reimbursement for some form of live video in Medicaid fee-for-service.
- Twelve states provide reimbursement for store-and-forward.
- Nineteen state Medicaid programs provide reimbursement for remote patient monitoring (RPM).
- Thirty-five jurisdictions have laws that govern private payer telehealth reimbursement policies (an increase of five states from July 2015).

Visit CCHP's website to download a copy of the infograph, factsheet or a full PDF version of State Telehealth Laws and Reimbursement Policies Report. Or use CCHP's interactive state policy map to conduct specific searches. All of these materials can be located on CCHP's website.

CCHP Report on eDOT for TB Treatment Reveals Challenges and Opportunities



Last week the Center for Connected Health Policy released a report summarizing the challenges and making recommendations on using telehealth for Directly Observed Therapy (eDOT) in treating tuberculosis (TB). Funded by the California Health Care Foundation, CCHP examined potential barriers to employing technology to deliver DOT in treating TB in the state of California, while the University of California, San Diego (UCSD) conducted a study exploring the efficacy of eDOT.

CCHP's report concluded that eDOT shows great promise in medication adherence and patient acceptance due to the flexibility offered by the technology. Concerns centered on technology failures, privacy and security issues, reimbursement and lack of guidelines or materials for effectively building an eDOT program. To address the barriers to utilizing eDOT in TB patients, CCHP recommended that the CDC update their DOT guidelines to include eDOT, and that additional guidelines be developed to address HIPAA, privacy, security, and confidentiality concerns when utilizing eDOT. CCHP also noted the need for Medi-Cal to provide reimbursement for eDOT and eliminate some of the existing barriers to utilizing telehealth such as expanding the list of eligible providers for reimbursement through telehealth to include community health workers and/or public health nurses (who most commonly administer DOT treatment), and expand the eligible locations for reimbursement to allow for the home to qualify when a healthcare provider is not present. CCHP also recommended that more studies be conducted on other infectious diseases in addition to TB, such as HIV/AIDS.

To learn more about the project, and about the findings of CCHP and UCSD's studies, view the full report.

Calendar of Events

2016 American Public Health Association Annual Conference

October 29 - November 2, 2016; Denver, CO

Come hear CCHP's Senior Policy Associate, Mei Kwong, speak at this year's APHA conference in Denver, Colorado. Ms. Kwong will be speaking at the Pre-Confernce session titled *"Leveraging Telehealth Technologies to Extend the Reach and Effectiveness of Public Health Practice"* on October 29th at 9:00 a.m. During this session we examine how telehealth can increase our capacity to effectively deliver the "Ten Essential Public Health Services", improve access to healthcare services and patient education resources in underserved areas, and enhance communication and collaboration among all of healthcare. This course will introduce concepts in telehealth and public health, dive into the fundamentals of telehealth program development, and explore current and future policy implications. For more information, or to register for this conference, please visit the APHA website.

In addition, Ms. Kwong will also be speaking at the following APHA 2016 Sessions:

October 31, 2016; 12:30 pm – 2:00 pm – Health Disparities, Mental Health and Health Technology; Ms. Kwong will be speaking about "Utilization of connected health technologies to treat tuberculosis: Policy Challenges and Opportunities".

November 2, 2016; 8:30 am – 10:00 am – Advances in Telemedicine/Telehealth, Health IT Applications, Registries and Consumer Mobile Apps; Ms. Kwong will be speaking about "Challenges to using telehealth in public health: Policy, regulatory and legal barriers".

Click Here

To find out about telehealth related laws, regulations and Medicaid programs in your state!

Would you like to register to receive CCHP's monthly newsletter? Sign up here!

The Center for Connected Health Policy (CCHP) is a public interest nonprofit organization that develops and advances telehealth policy solutions to promote improvements in health and health care systems.

In its work as the federally designated National Telehealth Policy Resource Center, CCHP provides technical assistance to twelve regional telehealth resource centers nationwide. This project is made possible by Grant #G22RH30365 from the Office of the Advancement of Telehealth, Health Resources and Services Administration, Department of Health and Human Services.

CCHP is a program of the Public Health Institute and was created in 2008 by the California Health Care Foundation, who remains as its lead funder.

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You are receiving this email because you expressed an interest in learning more about telehealth and the work CCHP is completing.

Our mailing address is:
Center for Connected Health Policy
1331 Garden Highway
Sacramento, CA 95833

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You can update your preferences or unsubscribe from this list

UNFINISHED BUSINESS & RULES

Secretary of State

NOTICE OF PROPOSED RULEMAKING HEARING*

A Statement of Need and Fiscal Impact accompanies this form

FILED
8-25-16 11:35 AM
ARCHIVES DIVISION
SECRETARY OF STATE

Oregon Board of Dentistry — 818
Agency and Division — Administrative Rules Chapter Number

Stephen Prisby — (971) 673-3200
Rules Coordinator — Telephone

Oregon Board of Dentistry, 1500 SW 1st Ave., Suite 770, Portland, OR 97201
Address

RULE CAPTION

Adopts, amends and repeals multiple rules in the Dental Practice Act.

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

Hearing Date	Time	Location	Hearings Officer
10-20-16	7:00 p.m.	1500 SW 1st Ave., Suite 620, Portland, 97201	Board President

RULEMAKING ACTION

Secure approval of rule numbers with the Administrative Rules Unit prior to filing.

ADOPT:
818-001-0083 Relief from Public Disclosure
818-005-0050 Criminal Records Check for Employees, Volunteers and Applicants
818-012-0032 Diagnostic Records
818-042-0112 Expanded Functions Preventative Dental Assistants (EFPDA)
818-042-0113 Certification - Expanded Function Preventative Dental Assistants (EFPDA)

AMEND:
818-001-0082 Access to Public Records
818-001-0087 Fees
818-005-0035 Contesting a Fitness Determination
818-012-0005 Scope of Practice
818-012-0010 Unacceptable Patient Care
818-012-0030 Unprofessional Conduct
818-012-0040 Infection Control Guidelines
818-012-0060 Failure to Cooperate with Board
818-012-0070 Patient Records
818-021-0011 Application for License to Practice Dentistry without Further Examination
818-021-0025 Application for License to Practice Dental Hygiene without Further Examination
818-021-0026 State and Nationwide Criminal Background Checks, Fitness Determinations
818-026-0030 Requirement for Anesthesia Permit, Standards and Qualifications of an Anesthesia Monitor
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818-026-0080 Standards Applicable When a Dentist Performs Dental Procedures and a Qualified Provider Induces Anesthesia
818-026-0110 Office Evaluations
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818-042-0020 Dentist and Dental Hygienist Responsibility
818-042-0050 Taking of X-Rays-Exposing of Radiographs
818-042-0070 General Anesthesia Permit
818-042-0115 Expanded Functions-Certified Anesthesia Dental Assistant
818-042-0120 Certification by Credential
818-042-0130 Application for Certification by Credential

REPEAL:
818-005-0000 Definitions
818-005-0005 Employee Applicant/Employee
818-005-0011 Criminal Records Check Required
818-005-0015 Criminal Records Check Process

818-005-0021 Potentially Disqualifying Crimes
818-005-0025 Final Fitness Determination
818-005-0030 Incomplete Fitness Determination
818-005-0045 Record Keeping, Confidentiality

RENUMBER: Secure approval of new rule numbers with the Administrative Rules Unit prior to filing.

AMEND AND RENUMBER: Secure approval of new rule numbers with the Administrative Rules Unit prior to filing.

Statutory Authority:
181.534, 181A.195, 670.260, 676.185, 676.190, 676.195, 676.200, 679.010, 679.020, 679.025, 679.060, 679.090, 679.115, 679.120, 679.140, 679.160, 679.170, 679.250, 679.535, 680.050, 680.072, 680.075, 680.082, 680.100, 680.150, 680.200, 680.205.

Other Authority:

Statutes Implemented:
ORS 181.534, 181A.195, 183.325-183.355, 183.400, 679.250, 679.255, 680.150, 680.200, 680.205.

RULE SUMMARY

The Board is adopting OAR 818-001-0083 Relief from Public Disclosure. The addition of 818-001-0083 is to be in compliance with HB 4095 (2016) to clarify when a licensee can request relief from public disclosure.

The Board is adopting OAR 818-005-0050 Criminal Records Check for Employees, Volunteers and Applicants. The addition of 818-005-0050 is required by House Bill 3168 (2013) and House Bill 2250 (2015), which gave the Department of Administrative Services (DAS) authority to adopt statewide administrative rules for criminal background checks and required other agencies to repeal or amend existing rules as needed in order to be consistent with the statewide rules.

The Board is adopting OAR 818-012-0032 Diagnostic Records. The addition of 818-012-0032 is to clarify the fees for digital patient records and how long the licensee has to release the digital patient records.

The Board is adopting OAR 818-042-0112 Expanded Functions Preventative Dental Assistants (EFPDA). The addition of 818-042-0112 is to add a new category of dental assistant.

The Board is adopting OAR 818-042-0113 Certification - Expanded Function Preventative Dental Assistants (EFPDA). The addition of 818 -042-0113 is to add new duties for this level of expanded function dental assistants.

The Board is amending 818-001-0082 Access to Public Records. The amendment to 818-001-0082 is to clarify that public records requests must be in writing.

The Board is amending 818-001-0087 Fees. The amendment to 818-001-0087 is to clarify that the fee is for a background check and not for the permit itself.

The Board is amending 818-005-0035 Contesting a Fitness Determination. The amendment to 818-005-0035 is to correct a numbering and grammatical error in the rule.

The Board is amending 818-012-0005 Scope of Practice. The amendment to 818-012-0005 is to add the provision for dentists to utilize dermal fillers to treat a condition within the scope of the practice of dentistry and add 4 additional hours to education requirement.

The Board is amending 818-012-0010 Unacceptable Patient Care. The amendment to 818-012-0010 is to clarify that failure to determine and document dental justification prior to ordering a Cone Beam CT series documentation with a field greater than 10x10 cm for patients under 20 years of age, and for failure to advise a patient of any treatment complications or treatment outcomes.

The Board is amending 818-012-0030 Unprofessional Conduct. The amendment to 818-012-0030 is to clarify that duplicates of radiographs must be same quality as originals, to update the language as it pertains to substance use disorder, and to add additional language for what may be considered unprofessional conduct.

The Board is amending 818-012-0040 Infection Control Guidelines. The amendment to 818-012-0040 is to bring the rule in compliance with ORS 679.535.

The Board is amending 818-012-0060 Failure to Cooperate with Board. The amendment to 818-012-0060 is to include failure to attend a Board requested investigative interview and failure to fully cooperate in any way with the Board to the language of the rule.

The Board is amending 818-012-0070 Patient Records. The amendment to 818-012-0070 is to clarify that all licensees are required to prepare and maintain an accurate record and adding that the patient record must include documentation of informing patient of treatment outcomes. The Board is also adding that a licensee must notify the Board within 14 days of transferring patient records.

The Board is amending 818-021-0011 Application for License to Practice Dentistry without Further Examination. The amendment to 818-021-0011 is to clarify that teaching clinical dentistry at a CODA accredited dental school can count towards the 3,500 clinical practice hours.

The Board is amending 818-021-0025 Application for License to Practice Dental Hygiene without Further Examination. The amendment to 818-021-0025 is to clarify that 3,500 clinical teaching hours must be in a CODA accredited dental hygiene program.

The Board is amending 818-021-0026 State and Nationwide Criminal Background Checks, Fitness Determinations. The amendment to 818-021-0026 is required by House Bill 3168 (2013) and House Bill 2250 (2015), which gave the Department of Administrative Services (DAS) authority to adopt statewide administrative rules for criminal background checks and required other agencies to repeal or amend existing rules as needed in order to be consistent with the statewide rules.

The Board is amending 818-026-0030 Requirement for Anesthesia Permit, Standards and Qualifications of an Anesthesia Monitor. The amendment to 818-026-0030 is to clarify that in addition to the BLS for Health Care Providers certificate or equivalent, dentist permit holders who induce moderate, deep or general anesthesia must also hold an ACLS and/or PALS certificate, or whichever is appropriate for the patient being sedated.

The Board is amending 818-026-0050 Minimal Sedation Permit. The amendment to 818-026-0050 is to clarify the rule and add to dentist, "dentist permit holder".

The Board is amending 818-026-0060 Moderate Sedation Permit. The amendment to 818-026-0060 is to clarify the rule and add to dentist, "dentist permit holder" and to clarify that the Certified Anesthesia Assistant is certified by the Oregon Board of Dentistry.

The Board is amending 818-026-0065 Deep Sedation. The amendment to 818-026-0065 is to clarify the rule and add to dentist, "dentist permit holder" and to clarify that the Certified Anesthesia Assistant is certified by the Oregon Board of Dentistry.

The Board is amending 818-026-0070 General Anesthesia Permit. The amendment to 818-026-0070 is to clarify the rule and add to dentist, "dentist permit holder" and to clarify that the Certified Anesthesia Assistant is certified by the Oregon Board of Dentistry.

The Board is amending 818-026-0080 Standards Applicable When a Dentist Performs Dental Procedures and a Qualified Provider Induces Anesthesia. The amendment to 818-026-0080 is to clarify that the qualified anesthesia provider who induces moderate sedation, deep sedation and general anesthesia has to monitor the patient's condition until the patient is discharged.

The Board is amending 818-026-0110 Office Evaluations. The amendment to 818-026-0110 is to clarify the rule and add to dentist, "dentist permit holder".

The Board is amending 818-035-0040 Expanded Functions of Dental Hygienists. The amendment to 818-035-0040 is add that upon successful completion of a course of instruction approved by the Oregon Health Authority a dental hygienist may purchase epinephrine and administer epinephrine in case of an emergency.

The Board is amending 818-042-0020 Dentist and Dental Hygienist Responsibility. The amendment to 818-042-0020 is to clarify that a dental hygienist may supervise one or more dental assistants at a time, and allows an Expanded Practice Dental Hygienist to hire and supervise one or more dental assistant at a time.

The Board is amending 818-042-0050 Taking of X-Rays- Exposing of Radiographs. The amendment to 818-042-0050 is to clarify that a dental hygienist can authorize an assistant to take radiographs.

The Board is amending 818-042-0070 Expanded Functions Dental Assistants (EFDA). The amendment to 818-042-0070 is to clarify that when an EFDA polishes the coronal surfaces with a brush or rubber cup, the patient must be checked by a dental hygienist or dentist prior to being discharged.

The Board is amending 818-042-0115 Expanded Functions - Certified Anesthesia Dental Assistant. The amendment to 818-042-0115 is to clarify that only a Certified Anesthesia Assistant by the Oregon Board of Dentistry can perform certain procedures.

The Board is amending 818-042-0120 Certification by Credential. The amendment to 818-042-0120 is to add an additional category of expanded functions to the certification by credentials pathway.

The Board is amending 818-042-0130 Application for Certification by Credential. The amendment to 818-042-0130 is to allow an additional category of expanded functions dental assistants to apply for certification by credentials.

The Board is repealing 818-005-0000 Definitions. Removal of 818-005-0000 is required by House Bill 3168 (2013) and House Bill 2250 (2015), which gave the Department of Administrative Services (DAS) authority to adopt statewide administrative rules for criminal background checks and required other agencies to repeal or amend existing rules as needed in order to be consistent with the statewide rules.

The Board is repealing 818-005-0005 Employee Applicant/Employee. The repeal of 818-005-0005 is required by House Bill 3168 (2013) and House Bill 2250 (2015), which gave the Department of Administrative Services (DAS) authority to adopt statewide administrative rules for criminal background checks and required other agencies to repeal or amend existing rules as needed in order to be consistent with the statewide rules.

The Board is repealing 818-005-0011 Criminal Records Check Required. The repeal of 818-005-0011 is required by House Bill 3168 (2013) and House Bill 2250 (2015), which gave the Department of Administrative Services (DAS) authority to adopt statewide administrative rules for criminal background checks and required other agencies to repeal or amend existing rules as needed in order to be consistent with the statewide rules.

The Board is repealing 818-005-0015 Criminal Records Check Process. The repeal of 818-005-0015 is required by House Bill 3168 (2013) and House Bill 2250 (2015), which gave the Department of Administrative Services (DAS) authority to adopt statewide administrative rules for criminal background checks and required other agencies to repeal or amend existing rules as needed in order to be consistent with the statewide rules.

The Board is repealing 818-005-0021 Potentially Disqualifying Crimes. The repeal of 818-005-0021 is required by House Bill 3168 (2013) and House Bill 2250 (2015), which gave the Department of Administrative Services (DAS) authority to adopt statewide administrative rules for criminal background checks and required other agencies to repeal or amend existing rules as needed in order to be consistent with the statewide rules.

The Board is repealing 818-005-0025 Final Fitness Determination. The repeal of 818-005-0025 is required by House Bill 3168 (2013) and House Bill 2250 (2015), which gave the Department of Administrative Services (DAS) authority to adopt statewide administrative rules for criminal background checks and required other agencies to repeal or amend existing rules as needed in order to be consistent with the statewide rules.

The Board is repealing 818-005-0030 Incomplete Fitness Determination. The repeal of 818-005-0030 is required by House Bill 3168 (2013) and House Bill 2250 (2015), which gave the Department of Administrative Services (DAS) authority to adopt statewide administrative rules for criminal background checks and required other agencies to repeal or amend existing rules as needed in order to be consistent with the statewide rules.

The Board is repealing 818-005-0045 Record Keeping, Confidentiality. The repeal of 818-005-0045 is required by House Bill 3168 (2013) and House Bill 2250 (2015), which gave the Department of Administrative Services (DAS) authority to adopt statewide administrative rules for criminal background checks and required other agencies to repeal or amend existing rules as needed in order to be consistent with the statewide rules.

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

10-20-2016 4:00 p.m.	Stephen Prisby	stephen.prisby@state.or.us
Last Day *(m/d/yyyy)* and Time for public comment	Rules Coordinator Name	Email Address

*The Oregon Bulletin is published on the 1st of each month and updates the rule text found in the Oregon Administrative Rules Compilation.

Secretary of State

STATEMENT OF NEED AND FISCAL IMPACT

A Notice of Proposed Rulemaking Hearing accompanies this form.

FILED
8-25-16 11:35 AM
ARCHIVES DIVISION
SECRETARY OF STATE

Oregon Board of Dentistry — 818

Agency and Division — Administrative Rules Chapter Number

Adopts, amends and repeals multiple rules in the Dental Practice Act.

Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of:

OARS:

ADOPT:
818-001-0083 Relief from Public Disclosure
818-005-0050 Criminal Records Check for Employees, Volunteers and Applicants
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818-005-0005 Employee Applicant/Employee
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818-005-0015 Criminal Records Check Process
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818-005-0025 Final Fitness Determination
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818-005-0045 Record Keeping, Confidentiality

Statutory Authority:

181.534, 181A.195, 670.260, 676.185, 676.190, 676.195, 676.200, 679.010, 679.020, 679.025, 679.060, 679.090, 679.115, 679.120,

679.140, 679.160, 679.170, 679.250, 679.535, 680.050, 680.072, 680.075, 680.082, 680.100, 680.150, 680.200, 680.205.

Other Authority:

Statutes Implemented:
ORS 181.534, 181A.195, 183.325-183.355, 183.400, 679.250, 679.255, 680.150, 680.200, 680.205.

Need for the Rule(s):
The addition of 818-001-0083 is required by House Bill 4095 (2016) to clarify when a licensee can request relief from public disclosure.

The addition of 818-005-0050 is required by House Bill 3168 (2013) and House Bill 2250 (2015), which gave the Department of Administrative Services (DAS) authority to adopt statewide administrative rules for criminal background checks and required other agencies to repeal or amend existing rules as needed in order to be consistent with the statewide rules.

The addition of 818-012-0032 is to clarify the fees for digital patient records and how long the licensee has to release the digital patient records.

The addition of 818-042-0112 is to add a new category of dental assistant.

The addition of 818-042-0113 is to add new duties for this level of expanded function dental assistants.

The amendment to 818-001-0082 is to clarify that public records requests must be in writing.

The amendment to 818-001-0087 is to clarify that the fee is for a background check and not for the permit itself.

The amendment to 818-005-0035 is to correct a numbering and grammatical error in the rule.

The amendment to 818-012-0005 is to add the provision for dentists to utilize dermal fillers to treat a condition within the scope of the practice of dentistry and add 4 hours to education requirement.

The amendment to 818-012-0010 is to clarify that failure to determine and document dental justification prior to ordering a Cone Beam CT series documentation with a field greater than 10x10 cm for patients under 20 years of age, and for failure to advise a patient of any treatment complications or treatment outcomes.

The amendment to 818-012-0030 is to clarify duplicates of radiographs must be same quality as originals, to update the language as it pertains to substance use disorder, and to add additional language for what may be considered unprofessional conduct.

The amendment to 818-012-0040 is to be bring the rule in compliance with ORS 679.535.

The amendment to 818-012-0060 is to include failure to attend a Board requested investigative interview or for failure to fully cooperate in any way with the Board.

The amendment to 818-012-0070 is to clarify that all licensees are required to prepare and maintain an accurate record and adding that the patient record must include documentation of informing patient of treatment outcomes. The Board is also adding that a licensee must notify the Board within 14 days of transferring patient records.

The amendment to 818-021-0011 is to clarify that teaching clinical dentistry at a CODA accredited dental school can count towards the 3,500 clinical practice hours.

The amendment to 818-021-0025 is to clarify that 3,500 clinical teaching hours must be in a CODA accredited dental hygiene program.

The amendment to 818-021-0026 is required by House Bill 3168 (2013) and House Bill 2250 (2015), which gave the Department of Administrative Services (DAS)authority to adopt statewide administrative rules for criminal background checks and required other agencies to repeal or amend existing rules as needed in order to be consistent with the statewide rules.

The amendment to 818-026-0030 is to clarify that in addition to the BLS for Health Care Providers certificate or equivalent, dentist permit holders who induce moderate, deep or general anesthesia must also hold an ACLS and/or PALS certificate whichever is appropriate for the patient being sedated.

The amendment to 818-026-0050 is to clarify the rule and add to dentist, "dentist permit holder".

The amendment to 818-026-0060 is to clarify the rule and add to dentist, "dentist permit holder" and to clarify that the Certified Anesthesia Assistant is certified by the Oregon Board of Dentistry.

The amendment to 818-026-0065 is to clarify the rule and add to dentist, "dentist permit holder" and to clarify that the Certified Anesthesia Assistant is certified by the Oregon Board of Dentistry.

The amendment to 818-026-0070 is to clarify the rule and add to dentist, "dentist permit holder" and to clarify that the Certified Anesthesia Assistant is certified by the Oregon Board of Dentistry.

The amendment to 818-026-0080 is to clarify that the qualified anesthesia provider who induces moderate sedation, deep sedation and general anesthesia has to monitor the patient's condition until the patient is discharged.

The amendment to 818-026-0110 is to clarify the rule and add to dentist, "dentist permit holder".

The amendment to 818-035-0040 is to add that upon successful completion of a course of instruction approved by the Oregon Health Authority a dental hygienist may purchase epinephrine and administer epinephrine in case of an emergency.

The amendment to 818-042-0020 is to clarify that a dental hygienist may supervise one or more dental assistants at a time, and allows an Expanded Practice Dental Hygienist to hire and supervise one or more dental assistant at a time.

Documents Relied Upon, and where they are available:

The Oregon Board of Dentistry has a website at www.Oregon.gov/dentistry where all documents related to the dental practice act are posted.

ORS Chapter 181A is available at www.oregonlegislature.gov/bills_laws/ors/ors181A.html

OAR Chapter 125 division 007 is available at www.arcweb.sos.state.or.us/pages/rules/oars_100/oar_125/125_007.html

ORS Chapter 676 is available at www.oregonlegislature.gov/bills_laws/ors/ors676.html

Fiscal and Economic Impact:

It is not possible to estimate the exact number of small businesses, as the majority of dental practices are considered small businesses. Some licensees may see a small increase in costs to be in compliance with rule changes.

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):

It is not possible to estimate the exact number of small businesses, as the majority of dental practices are considered small businesses. Some licensees may see a small increase in costs to be in compliance with rule changes.

2. Cost of compliance effect on small business (ORS 183.336):

a. Estimate the number of small business and types of businesses and industries with small businesses subject to the rule:

It is not possible to estimate the exact number of small businesses, as the majority of dental practices are considered small businesses. Some licensees may see a small increase in costs to be in compliance with rule changes.

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:

Some licensees may see a small increase in costs to be in compliance with rule changes.

c. Equipment, supplies, labor and increased administration required for compliance:

Some licensees may see a small increase in costs to be in compliance with rule changes.

How were small businesses involved in the development of this rule?

Dentists who are owners of dental practices assisted in the review and writing of the rules as members of the Oregon Board of Dentistry (OBD) Rules Oversight Committee and the Anesthesia Committee. Professional association representatives are also members of the OBD Rules Oversight Committee and participated in the drafting of the proposed rules and amendments.

Administrative Rule Advisory Committee consulted?: No

If not, why?:

Board of Dentistry Committees did not previously review changes to Division 5 OARs (but reviewed all other proposed rule changes) because Division 5 rule changes are due to Department of Administrative Services' rule changes implemented due to legislation - HB 3168 (2013) and HB 2250 (2015). The Board of Dentistry's Committees would not be able to amend or prevent them from going into effect.

10-20-2016 4:00 p.m.	Stephen Prisby	stephen.prisby@state.or.us
Last Day (m/d/yyyy) and Time for public comment	Printed Name	Email Address

Oregon
Kate Brown, Governor

Board of Dentistry
1500 SW 1st Ave. Ste 770
Portland, OR 97201-5837
(971) 673-3200
Fax: (971) 673-3202

Memorandum

To: Attendees of OBD public rulemaking hearing on October 20, 2016 @ 7 pm.

From: Stephen Prisby, Executive Director

Re: Oregon Medical Board Conference Room – Suite 620 access

The Crown Plaza closes the 1st floor lobby/access at 6:00 p.m.
The building must be accessed on the 2nd floor. There is a security desk/ guard that may require you to sign in with and show I.D.
The parking garage is directly across the street from our building (The Crown Plaza).
The access is via two walkways on the 2nd floor. If you walk up to the building there are stairs that take you to the second floor.

The rulemaking hearing is being held in the Oregon Medical Board's Conference room on the 6th floor.

Please contact the OBD if you have any questions. Thank you.

OREGON BOARD OF DENTISTRY
RULEMAKING HEARING

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818-042-0130	Application for Certification by Credential

October 20, 2016
7:00 p.m.
1500 SW 1st Ave. 6th floor
Medical Board - Conference Room
Portland, OR 97201

DIVISION 1

PROCEDURES

818-001-0082

Access to Public Records

(1) Public records not exempt from disclosure may be inspected during office hours at the Board office upon reasonable notice.

(2) Copies of public records not exempt from disclosure may be purchased **upon receipt of a written request**. The Board may withhold copies of public records until the requestor pays for the copies.

(3) The Board establishes the following fees:

(a) $25 per hour for the time required to locate and remove non-public records or for filling special requests;

(b) Up to ten (10) pages at no cost; more than 10 pages, $0.50 for each page plus postage necessary to mail the copies;

(c) $0.10 per name and address for computer-generated lists on paper or labels; $0.20 per name and address for computer-generated lists on paper or labels sorted by specific zip code;

(d) Data files on diskette or CD:

(A) All Licensed Dentists -- $50;

(B) All Licensed Dental Hygienists -- $50;

(C) All Licensees -- $100.

(e) $60 per year for copies of minutes of all Board and committee meetings;

(f) Written verification of licensure -- $2.50 per name; and

(g) Certificate of Standing -- $20.

Stat. Auth.: ORS 183, 192, 670 & 679

Stats. Implemented: ORS 192.420, 192.430 & 192.440

OAR 818-001-0083

Relief from Public Disclosure

Upon the receipt of a written request of an individual who has been disciplined by the Oregon Board of Dentistry, the Board shall remove from its website, and other publicly accessible print and electronic publications under the Board's control, all information related to disciplining the individual under ORS 679.140 and any findings and conclusions made by the Board during the disciplinary proceeding, if:

(1) The request is made 10 years or more after the date on which any disciplinary sanction ended;

(2) The individual was not disciplined for financially or physically harming a patient as determined by the Board;

(3) The individual informed the Board of the matter for which the individual was disciplined before the Board received information about the matter or otherwise had knowledge of the matter;

(4) The individual making the request, if the individual is or was a licensee, has not been subjected to other disciplinary action by the Board following the imposition of the disciplinary sanction; and

(5) The individual fully complied with all disciplinary sanctions imposed by the Board.

818-001-0087

Fees

(1) The Board adopts the following fees:

(a) Biennial License Fees:

(A) Dental —$390;

(B) Dental — retired — $0;

(C) Dental Faculty — $335;

(D) Volunteer Dentist — $0;

(E) Dental Hygiene —$230;

(F) Dental Hygiene — retired — $0;

(G) Volunteer Dental Hygienist — $0.

(b) Biennial Permits, Endorsements or Certificates:

(A) Nitrous Oxide Permit — $40;

(B) Minimal Sedation Permit — $75;

(C) Moderate Sedation Permit — $75;

(D) Deep Sedation Permit — $75;

(E) General Anesthesia Permit — $140;

(F) Radiology — $75;

(G) Expanded Function Dental Assistant — $50;

(H) Expanded Function Orthodontic Assistant — $50;

(I) Instructor Permits — $40;

(J) Dental Hygiene Restorative Functions Endorsement — $50;

(K) Restorative Functions Dental Assistant — $50;

(L) Anesthesia Dental Assistant — $50;

(M) Dental Hygiene, Expanded Practice Permit — $75;

(N) Non-Resident Dental ~~Permit~~ **Background Check** - $100.00;

(c) Applications for Licensure:

(A) Dental — General and Specialty — $345;

(B) Dental Faculty — $305;

(C) Dental Hygiene — $180;

(D) Licensure Without Further Examination — Dental and Dental Hygiene — $790.

(d) Examinations:

(A) Jurisprudence — $0;

~~(B) Dental Specialty:~~

~~(i) If only one candidate applies for the exam, a fee of $2,000.00 will be required at the time of application; and~~

~~(ii) If two candidates apply for the exam, a fee of $1,000.00 will be required at the time of application; and~~

~~(iii) If three or more candidates apply for the exam, a fee of $750.00 will be required at the time of application.~~

(e) Duplicate Wall Certificates — $50.

(2) Fees must be paid at the time of application and are not refundable.

(3) The Board shall not refund moneys under $5.01 received in excess of amounts due or to which the Board has no legal interest unless the person who made the payment or the person's legal representative requests a refund in writing within one year of payment to the Board.

Stat. Auth.: ORS 679 & 680

Stats. Implemented: ORS 293.445, 679.060, 679.115, 679.120, 679.250, 680.050, 680.075, 680.200 & 680.205

DIVISION 5

CRIMINAL RECORDS CHECK AND FITNESS DETERMINATION RULES

~~818-005-0000~~

~~Definitions~~

~~As used in OAR Chapter 818, Division 005, unless the context of the rule requires otherwise, the following definitions apply:~~

~~(1) Conviction: A final judgment on a verdict or finding of guilty, a plea of guilty, a plea of nolo contendere (no contest); or any determination of guilt entered by a court of law against an employee applicant/employee in a criminal case, unless that judgment has been reversed or set aside by a subsequent court decision.~~

~~(2) Criminal Offender Information: Records and related data as to physical description and vital statistics; fingerprints received and compiled by the Oregon State Police, Bureau of Criminal Identification, for purposes of identifying criminal offenders and alleged offenders; and records of arrests and the nature and disposition of criminal charges, including sentencing, confinement, parole, and release.~~

~~(3) Crime Relevant to a Fitness Determination: A crime listed or described in OAR 818-005-0020.~~

~~(4) Criminal Records Check: One or more of the following processes used to check the criminal history of an employee applicant/employee:~~

~~(a) A name-based check of criminal offender information conducted through use of the Law Enforcement Data System (LEDS) maintained by the Oregon State Police, in accordance with the rules adopted and procedures established by the Oregon State Police (LEDS Criminal Records Check);~~

~~(b) A check of Oregon criminal offender information through fingerprint identification, conducted by the Oregon State Police at the Board's request (Oregon Criminal Records Check); or~~

~~(c) A nationwide check of federal criminal offender information through fingerprint identification, conducted by the Oregon State Police through the Federal Bureau of Investigation at the Board's request (Nationwide Criminal Records Check).~~

~~(5) Denied: A fitness determination by the Board pursuant to a final fitness determination under OAR 818-005-0025 that the subject individual is not fit to be an employee, volunteer, contractor, or vendor in a position covered by OAR 818-005-0025.~~

~~(6) False Statement: In association with an activity governed by these rules, an employee applicant/ employee either:~~

~~(a) Provided the Board with materially false information about the employee applicant's/employee's criminal history, such as, but not limited to, materially false information about employee applicant/employee or conviction record; or~~

~~(b) Failed to provide to the Board information material to determining employee applicant's/employee's criminal history.~~

~~(7) Fitness Determination: A determination made by the Board pursuant to the process established in OAR 818-005-0025 that an employee applicant/ employee is or is not fit to be a Board employee, volunteer, contractor, or vendor.~~

~~(8) Employee applicant/employee: An individual identified in OAR 818-005-0025 as someone from whom the Board may require a criminal records check.~~

~~Stat. Auth: ORS 181.534, 676.303 & 679.253~~

~~Stats. Implemented: ORS 676.303 & 181.534~~

~~Hist.: OBD 4-2011, f & cert. ef. 11-15-11~~

~~**818-005-0005**~~

~~**Employee Applicant/Employee**~~

~~The Board may require an Employee Applicant/Employee to complete a criminal records check pursuant to these rules if the person:~~

~~(1)(a) Is employed by or applying for employment with the Board; or~~

~~(b) Provides services or seeks to provide services to the Board as a volunteer, contractor, or vendor; and~~

~~(2) Is, or will be, working or providing services in a position in which the person:~~

~~(a) Provides information technology services and has control over, or access to, information technology systems that would allow the person to harm the information technology systems or the information contained in the systems; or~~

~~(b) Accesses information, that state or federal laws, rules or regulations prohibit disclosing or define as confidential.~~

~~Stat. Auth: ORS 181.534, 676.303 & 679.253~~

~~Stats. Implemented: ORS 676.303 & 181.534~~

~~Hist.: OBD 4-2011, f & cert. ef. 11-15-11~~

~~**818-005-0011**~~

~~**Criminal Records Check Required**~~

~~The Board may conduct, or request the Oregon State Police to conduct, a criminal records check when:~~

~~(1) An individual meets the definition of an employee applicant/employee; or~~

~~(2) Required by federal law or regulation, by state or administrative rule, or by contract or written agreement with the Board.~~

~~Stat. Auth: ORS 181.534, 676.303 & 679.253~~

~~Stats. Implemented: ORS 676.303 & 181.534~~

~~Hist.: OBD 4-2011, f & cert. ef. 11-15-11~~

~~**818-005-0015**~~

~~**Criminal Records Check Process**~~

~~(1) Disclosure of Information by employee applicant/employee.~~

~~(a) Preliminary to a criminal records check, an employee applicant/employee shall complete and sign the Oregon Board of Dentistry Criminal Records Request form and, if requested by the Board, a fingerprint card within three business days of having received the card. The Oregon Board of Dentistry Criminal Records Request form shall require the following information: name, birth date, Social Security Number, driver's license or identification card number, prior residency in other states, and any other identifying information deemed necessary by the Board. The Oregon Board of Dentistry Criminal Records Request form may also require details concerning any circumstance listed in OAR 818-005-0020(1).~~

~~**Note**: The Board may extend the deadline for good cause.~~

~~(b) The Board may require additional information from the employee applicant/employee as necessary to complete the criminal records check and fitness determination, such as, but not limited to, proof of identity; or additional criminal, judicial, or other background information.~~

~~(2) When the Board determines under OAR 818-005-0005 that a criminal records check is required, the Board may request or conduct a LEDS Criminal Records Check, an Oregon Criminal Records Check, a Nationwide Criminal Records Check, or any combination thereof.~~

~~Stat. Auth: ORS 181.534, 676.303 & 679.253~~

~~Stats. Implemented: ORS 676.303 & 181.534~~

~~Hist.: OBD 4-2011, f & cert. ef. 11-15-11~~

~~**818-005-0021**~~

~~**Potentially Disqualifying Crimes**~~

~~(1) Crimes Relevant to a Fitness Determination:~~

~~(a) All felonies;~~

~~(b) All misdemeanors;~~

~~(c) Any Federal crime, United States Military crime or international crime.~~

~~(2) Evaluation Based on Oregon and Other Laws. An authorized designee shall evaluate a crime on the basis of Oregon laws and, if applicable, Federal laws or the laws of any other jurisdiction in which a criminal records check indicates an employee applicant/employee may have committed a crime, as those laws are in effect at the time of the fitness determination.~~

~~(3) Expunged Juvenile Record. Under no circumstances shall an employee applicant/employee subject individual be denied under these rules on the basis of the existence or contents of a juvenile record that has been expunged pursuant to ORS 419A.260 and 419A.262.~~

~~Stat. Auth: ORS 181.534, 676.303 & 679.253~~

~~Stats. Implemented: ORS 676.303 & 181.534~~

~~Hist.: OBD 4-2011, f & cert. ef. 11-15-11~~

~~**818-005-0025**~~

~~**Final Fitness Determination**~~

~~(1) If the Board elects to conduct a criminal records check, the Board shall make a fitness determination about an employee applicant/employee based on information provided by the employee applicant/employee under OAR 818-005-0005, the criminal records check(s) conducted, and any materially false statements made by the employee applicant/employee.~~

~~(2) In making a fitness determination about an employee applicant/employee, the Board shall also consider the factors in subsections (a), (b), and (c) below in relation to information provided by the employee applicant/employee under OAR 818-005-0015, any LEDS report or criminal offender information obtained through a criminal records check, and other information known by the Board. To assist in considering these factors, the Board may obtain any other information deemed relevant, from the employee applicant/employee or any other credible source, including law enforcement and criminal justice agencies or courts within or outside of Oregon. To acquire other criminal offender information from the employee applicant/employee, the Board may request to meet with the employee applicant/employee and may request to receive written materials or~~

~~authorization to obtain other relevant information, from employee applicant/employee. The employee applicant/employee shall meet with the Board when requested and provide additional information or authorization within a reasonable period of time, as arranged with the Board. The Board's final fitness determination regarding an employee applicant/employee will include considerations of:~~

~~(a) Potentially disqualifying crimes or conditions and any mitigating circumstances including, but not limited to:~~

~~(A) False Statement. Any materially false statements made by the employee applicant/employee to the Board;~~

~~(B) Sex Offender. The employee applicant/employee is registered, or is required to register, as a sex offender in Oregon or any other jurisdiction;~~

~~(C) Warrants. An outstanding warrant against the employee applicant/employee for any crime in any jurisdiction;~~

~~(D) Deferred Sentence, Diversion Program, Parole or Probation. The employee applicant/employee has a deferred sentence, conditional discharge, is participating in a diversion program, or has not completed a required diversion program or any condition of post-prison supervision, parole or probation, for any potentially disqualifying crime;~~

~~(E) Parole or Probation Violation. A post-prison supervision, parole or probation violation for any potentially disqualifying crime; or~~

~~(F) Unresolved Arrests, Charges or Indictments. An unresolved arrest, charge, or a pending indictment, for a potentially disqualifying crime.~~

~~(b) Evaluating any potentially disqualifying crime or condition identified in this subsection (a), the department shall consider:~~

~~(A) The nature of the crime;~~

~~(B) The facts that support the conviction or pending indictment or that indicate the making of a false statement;~~

~~(C) The relevancy, if any, of the crime or the false statement to the specific requirements of the employee applicant's/employee's present or proposed position, services, or employment.~~

~~(c) Intervening circumstances, when applicable, relevant to the responsibilities of the employment or services, including, but not limited to:~~

~~(A) The passage of time since the commission or alleged commission of a crime identified under subsection (a);~~

~~(B) The age of the employee applicant/employee at the time of the commission or alleged commission of a crime identified under subsection (a);~~

~~(C) The likelihood of a repetition of offenses or of the commission of another crime;~~

~~(D) The subsequent commission of another crime;~~

~~(E) Whether a conviction identified under subsection (a) has been set aside and the legal effect of setting aside the conviction; and~~

~~(F) A recommendation of an employer.~~

~~(3) If an employee applicant/employee refuses to consent to a criminal records check, including fingerprint identification, the Board shall deny the employment of the employee applicant/employee or deny any applicable position or authority to provide services. A person may not appeal any determination made based on a refusal to consent.~~

~~(4) If an employee applicant/employee is denied as not fit, the subject individual may not be employed by the Board, or provide services as a volunteer, contractor, or vendor.~~

~~(5) A final fitness determination is a final order of the Board unless the affected employee applicant/employee appeals by requesting either a contested case hearing as provided by OAR 818-005-0035.~~

~~(6) The Board shall inform the employee applicant/employee who has been determined not to be fit on the basis of a criminal records check, via courier, or registered or certified mail to the most current address provided by the employee applicant/employee, of such disqualification.~~

~~Stat. Auth: ORS 181.534, 676.303 & 679.253~~

~~Stats. Implemented: ORS 676.303 & 181.534~~

~~Hist.: OBD 4-2011, f & cert. ef. 11-15-11~~

~~**818-005-0030**~~

~~**Incomplete Fitness Determination**~~

~~(1) The Board will close a fitness determination as incomplete when:~~

~~(a) Circumstances change so that a person no longer meets the definition of an "employee applicant/employee" under OAR 818-005-0005;~~

~~(b) The employee applicant/employee does not provide materials or information under OAR 818-015-0015(1)(a) within the time frames established under that rule;~~

~~(c) The Board cannot locate or contact the employee applicant/employee;~~

~~(d) The Board applicant/employee fails or refuses to cooperate with the Board's attempts to acquire other relevant information under OAR 818-005-0015(1)(b);~~

~~(e) The Board determines that the employee applicant/employee is not eligible or not qualified for the position for a reason unrelated to the fitness determination process; or~~

~~(f) The position is no longer open.~~

~~(2) An employee applicant/employee does not have a right to a contested case hearing under OAR 818-005-0035(2).~~

~~Stat. Auth: ORS 181.534, 676.303 & 679.253~~

~~Stats. Implemented: ORS 676.303 & 181.534~~

~~Hist.: OBD 4-2011, f & cert. ef. 11-15-11~~

818-005-0035

Contesting a Fitness Determination

(1) This rule sets forth a contested case hearing process by which a subject individual may appeal a fitness determination made under OAR 818-005-00~~25~~**50** that he or she is fit or not fit to be a Board employee, volunteer, contractor, or vendor.

(2) The Attorney General's Model Rules of Procedure, OAR 137-003-0001 through 137-003-0092, apply unless the Board refers the matter to the Office of Administrative Hearings to assign an Administrative Law Judge. If the Board refers the matter to the Office of Administrative Hearings, 137-003-0501 through 137-003-0700 shall apply.

(3) Process.

(a) To request a contested case hearing, the employee applicant/employee or the employee applicant/employee individual's legal representative must submit a written request to the Executive Director of the Board. To be timely, the request must be received by the Executive Director of the Board within 21 business days of the postmark of the fitness determination notification letter.

(b) A contested case hearing shall be conducted by an Administrative Law Judge appointed by the Office of Administrative Hearings once a timely request has been received by the Board as outlined in section (3)(a).

(4) The Administrative Law Judge will establish the time and place of the hearing. Notice of the hearing shall be served on the Board or designee and participants at least ten working days in advance of the hearing date.

(5) No Public Attendance. Contested case hearings on fitness determinations are closed to non-participants.

(6) A fitness determination made under OAR 818-005-00~~25~~**50** becomes final when:

(a) A timely request for hearing is not filed; or

(b) A party withdraws a hearing request, notifies the Board or the Administrative Law Judge that

the party will not appear, or fails to appear for the hearing.

(7) The Administrative Law Judge will issue a proposed order following a hearing. Exceptions, if any, must be received by the Board within 10 working days after the service of the proposed order.

(8) An employee applicant/employee currently employed by the Board who is denied as unfit pursuant to a final fitness determination may appeal the fitness determination either under the contested case process made available by this rule or through a process available under applicable personnel rules, policies and collective bargaining agreements. An employee applicant's/employee's decision to appeal a fitness determination through applicable personnel rules, policies, and collective bargaining agreements is an election of remedies as to the rights of the individual with respect to the fitness determination and is a waiver of the contested case process made available by this rule.

(9) The only remedy that may be awarded is a determination that the employee applicant/employee is fit or not fit. Under no circumstances shall the Board be required to place an employee applicant/employee in any position, nor shall the Board be required to accept services or enter into a contractual agreement with a**n** employee applicant/employee.

(10) An employee applicant/employee may not use the appeals process established by this rule to challenge the accuracy or completeness of information provided by the Oregon State Police, the Federal Bureau of Investigation, or agencies reporting information to the Oregon State Police or the Federal Bureau of Investigation. To challenge the accuracy or completeness of information identified in this section ~~(10)~~, a**n** employee applicant/employee may use any process made available by the agency that provided the information.

(11) Appealing a fitness determination, challenging criminal offender information with the agency that provided the information, or requesting a new criminal records check and re-evaluation of the original fitness determination will not delay or postpone the Board's hiring process or employment decisions.

(12) Alternative Process. An employee currently employed by the Board may choose to appeal a fitness determination either under the process made available by this rule or through a process made available by applicable personnel rules, policies and collective bargaining provision. A subject individual's decision to appeal a fitness determination through applicable personnel rules, polices and collective bargaining provisions is an election of remedies as to the rights of the individual with respect to the fitness determination and is a waiver of the contested case process made available by this rule.

(13) The only remedy that may be awarded is a determination that the employee is fit or not fit.

Under no circumstances shall the Board be required to place an employee in any position, or shall the Board be required to accept services or enter into a contractual agreement with an employee.

Stat. Auth: ORS 181.534, 676.303 & 679.253
Stats. Implemented: ORS 676.303 & 181.534

~~**818-005-0045**~~
~~**Record Keeping, Confidentiality**~~
~~Any information obtained in the criminal records check is confidential. The Board must restrict the dissemination of information obtained in the criminal records check. Only those persons, as identified by the Board, with a demonstrated and legitimate need to know the information, may have access to criminal records check records.~~

~~Stat. Auth.: ORS 181.534, 676.303 & 679.253~~
~~Stats. Implemented: ORS 676.303 & 181.534~~
~~Hist.: OBD 4-2011, f & cert. ef. 11-15-11~~

818-005-0050
Criminal Records Check for Employees, Volunteers and Applicants
(1) The Board may require a criminal records check and fitness determination for Board employees, volunteers or applicants for employment with the Board.
(2) Criminal records checks and fitness determinations are conducted pursuant to ORS 181A.170 to 181A.215 and OAR 125-007-0200 to 125-007-0310.
(a) To complete the criminal records check and fitness determination, the Board may require additional information from the employee, volunteer or applicant, such as, but not limited to, proof of identity or additional criminal, judicial or other background information.
(b) If the employee, volunteer or applicant has potentially disqualifying criminal offender information, the Board will consider factors listed in ORS 181A.195 before making a fitness determination.
(c) An approved fitness determination does not guarantee employment.
(d) An incomplete fitness determination does not entitle the employee, volunteer or applicant the right to appeal under OAR 125-007-0300.
(3) Pursuant to ORS 181A.195, ORS 676.175, and OAR 125-007-0310, information

obtained in the criminal records check is confidential and will not be disseminated by the Board except to persons with a demonstrated and legitimate need to know the information.

(4) The Board may charge a fee to the employee, volunteer or applicant for the criminal records check. The fee will not exceed the fee charged the Board by the OSP and the FBI to obtain such information.

Stat. Auth.: ORS 181A.195, 676.303

Stats. Implemented: ORS 181A.170, 181A.195, 181A215, 676.175, 676.303, 679.250

DIVISION 12

STANDARDS OF PRACTICE

818-012-0005

Scope of Practice

(1) No dentist may perform any of the procedures listed below:

(a) Rhinoplasty;

(b) Blepharoplasty;

(c) Rhydidectomy;

(d) Submental liposuction;

(e) Laser resurfacing;

(f) Browlift, either open or endoscopic technique;

(g) Platysmal muscle plication;

(h) Otoplasty;

(i) Dermabrasion;

~~(j) Lip augmentation;~~

(j) ~~(k)~~ Hair transplantation, not as an isolated procedure for male pattern baldness; and

(k) ~~(l)~~ Harvesting bone extra orally for dental procedures, including oral and maxillofacial procedures.

(2) Unless the dentist:

(a) Has successfully completed a residency in Oral and Maxillofacial Surgery accredited by the American Dental Association, Commission on Dental Accreditation (CODA), ~~and~~

~~(b) Has successfully completed a clinical fellowship, of at least one continuous year in duration, in esthetic (cosmetic) surgery recognized by the American Association of Oral and Maxillofacial Surgeons or by the American Dental Association Commission on Dental Accreditation~~, or

(b) ~~(c)~~ Holds privileges either:

(A) Issued by a credentialing committee of a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to perform these procedures in a hospital setting; or

(B) Issued by a credentialing committee for an ambulatory surgical center licensed by the State of Oregon and accredited by either the JCAHO or the Accreditation Association for Ambulatory Health Care (AAAHC).

(3) A dentist may utilize Botulinum Toxin Type A **and dermal fillers** to treat a condition that is within the scope of the practice of dentistry after completing a minimum of ~~16~~ **20** hours in a hands on clinical course(s)**, which includes both Botulimum Toxin Type A and dermal fillers, and** ~~**in which**~~ the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP).

Stat. Auth.: ORS 679 & 680

Stats. Implemented: ORS 679.010(2), 679.140(1)(c), 679.140(2), 679.170(6) & 680.100

818-012-0010

Unacceptable Patient Care

The Board finds, using the criteria set forth in ORS 679. 140(4), that a licensee engages in or permits the performance of unacceptable patient care if the licensee does or permits any person to:

(1) Provide treatment which exposes a patient to risk of harm when equivalent or better treatment with less risk to the patient is available.

(2) Fail to seek consultation whenever the welfare of a patient would be safeguarded or advanced by having recourse to those who have special skills, knowledge and experience; provided, however, that it is not a violation of this section to omit to seek consultation if other competent licensees in the same locality and in similar circumstances would not have sought such consultation.

(3) Fail to provide or arrange for emergency treatment for a patient currently receiving treatment.

(4) Fail to exercise supervision required by the Dental Practice Act over any person or permit any person to perform duties for which the person is not licensed or certified.

(5) Render services which the licensee is not licensed to provide.

(6) Fail to comply with ORS 453.605 to 453.755 or rules adopted pursuant thereto relating to the use of x-ray machines.

(7) Fail to maintain patient records in accordance with OAR 818-012-0070.

(8) Fail to provide goods or services in a reasonable period of time which are due to a patient pursuant to a contract with the patient or a third party.

(9) Attempt to perform procedures which the licensee is not capable of performing due to

physical or mental disability.

(10) Perform any procedure for which the patient or patient's guardian has not previously given informed consent provided, however, that in an emergency situation, if the patient is a minor whose guardian is unavailable or the patient is unable to respond, a licensee may render treatment in a reasonable manner according to community standards.

(11) Use the behavior management technique of Hand Over Mouth (HOM) without first obtaining informed consent for the use of the technique.

(12) Use the behavior management technique of Hand Over Mouth Airway Restriction (HOMAR) on any patient.

(13) Fail to determine and document a dental justification prior to ordering a Cone Beam CT series with field greater than 10x10 cm for patients under 20 years of age where pathology, anatomical variation or potential treatment complications would not be otherwise visible with a Full Mouth Series, Panoramic or Cephalometric radiographs.

(14) Fail to advise a patient of any treatment complications or treatment outcomes.

Stat. Auth.: ORS 679 & ORS 680

Stats. Implemented: ORS 679.140(1)(e), ORS 679.140(4) & ORS 680.100

Unprofessional Conduct

818-012-0030

~~The Board finds that in addition to the conduct set forth in ORS 679.140(2), a licensee engages in unprofessional conduct if the licensee does or permits any person to:~~ **The Board finds that in addition to the conduct set forth in ORS 679.140(2), unprofessional conduct includes, but is not limited to, the following in which a licensee does or knowingly permits any person to:**

(1) Attempt to obtain a fee by fraud**,** or misrepresentation.

(2) Obtain~~ing~~ a fee by fraud**,** or misrepresentation.

(a) A licensee obtains a fee by fraud if the licensee ~~obtains a fee by~~ knowingly mak~~ing~~**es,** or permit~~ting~~**s** any person to make**,** a material, false statement intending that a recipient**,** who is unaware of the truth**,** rely upon the statement.

(b) A licensee obtains a fee by misrepresentation if the licensee obtains a fee through making or permitting any person to make a material, false statement.

(c) Giving cash discounts and not disclosing them to third party payers is not fraud or

misrepresentation.

(3) Offer rebates, split fees, or commissions for services rendered to a patient to any person other than a partner, employee, or employer.

(4) Accept rebates, split fees, or commissions for services rendered to a patient from any person other than a partner, employee, or employer.

(5) Initiate, or engage in, with a patient, any behavior with sexual connotations. The behavior can include but is not limited to, inappropriate physical touching; kissing of a sexual nature; gestures or expressions, any of which are sexualized or sexually demeaning to a patient; inappropriate procedures, including, but not limited to, disrobing and draping practices that reflect a lack of respect for the patient's privacy; or initiating inappropriate communication, verbal or written, including, but not limited to, references to a patient's body or clothing that are sexualized or sexually demeaning to a patient; and inappropriate comments or queries about the professional's or patient's sexual orientation, sexual performance, sexual fantasies, sexual problems, or sexual preferences.

(6) Engage in an unlawful trade practice as defined in ORS 646.605 to 646.608.

(7) Fail to present a treatment plan with estimated costs to a patient upon request of the patient or to a patient's guardian upon request of the patient's guardian.

(8) Misrepresent any facts to a patient concerning treatment or fees.

(9)(a) Fail to provide a patient or patient's guardian within 14 days of written request:

(A) Legible copies of records; and

(B) Duplicates of study models**,** ~~and~~radiographs **of the same quality as the originals, and** photographs ~~or legible copies thereof~~ if the**y** ~~radiographs, photographs or study models~~ have been paid for.

(b) The **licensee** ~~dentist~~ may require the patient or guardian to pay in advance a fee reasonably calculated to cover the costs of making the copies or duplicates. The **licensee** ~~dentist~~ may charge a fee not to exceed $30 for copying 10 or fewer pages of written material and no more than $0.50 per page for pages 11 through 50 and no more than $0.25 for each additional page (including records copied from microfilm), plus any postage costs to mail copies requested and actual costs of preparing an explanation or summary of information, if requested. The actual cost of duplicating ~~x-rays~~ **radiographs** may also be charged to the patient. Patient records or summaries may not be withheld from the patient because of any prior unpaid bills, except as provided in (9)(a)(B) of this rule.

(10) Fail to identify to a patient, patient's guardian, or the Board the name of an employee, employer, contractor, or agent who renders services.

(11) Use prescription forms pre-printed with any Drug Enforcement Administration number, name of controlled substances, or facsimile of a signature.

(12) Use a rubber stamp or like device to reproduce a signature on a prescription form or sign a blank prescription form.

(13) Order drugs listed on Schedule II of the Drug Abuse Prevention and Control Act, 21 U.S.C. Sec. 812, for office use on a prescription form.

(14) Violate any Federal or State law regarding controlled substances.

(15) Becomes addicted to, or dependent upon, or abuses alcohol, illegal or controlled drugs, or mind altering substances**, or practice with an untreated substance use disorder diagnosis that renders the licensee unable to safely conduct the practice of dentistry or dental hygiene.**

(16) Practice dentistry or dental hygiene in a dental office or clinic not owned by an Oregon licensed dentist(s), except for an entity described under ORS 679.020(3) and dental hygienists practicing pursuant to ORS 680.205(1)(2).

(17) Make an agreement with a patient or person, or any person or entity representing patients or persons, or provide any form of consideration that would prohibit, restrict, discourage or otherwise limit a person's ability to file a complaint with the Oregon Board of Dentistry; to truthfully and fully answer any questions posed by an agent or representative of the Board; or to participate as a witness in a Board proceeding.

(18) Fail to maintain at a minimum a current BLS for Healthcare Providers certificate or its equivalent. (Effective January 2015).

(19) Conduct unbecoming a licensee or detrimental to the best interests of the public, including conduct contrary to the recognized standards of ethics of the licensee's profession or conduct that endangers the health, safety or welfare of a patient or the public.

(20) Knowingly deceiving or attempting to deceive the Board, an employee of the Board, or an agent of the Board in any application or renewal, or in reference to any matter under investigation by the Board. This includes but is not limited to the omission, alteration or destruction of any record in order to obstruct or delay an investigation by the Board, or to omit, alter or falsify any information in patient or business records.

(21) Knowingly practicing with a physical or mental impairment that renders the Licensee unable to safely conduct the practice of dentistry or dental hygiene.

(22) Take any action which could reasonably be interpreted to constitute harassment or retaliation towards a person whom the licensee believes to be a complainant or witness.

Stat. Auth.: ORS 679 & 680

Stats. Implemented: ORS 679.140(1)(c), 679.140(2), 679.170(6) & 680.100

818-012-0032

Diagnostic Records

1) Licensees shall provide duplicates of physical diagnostic records that have been paid for to patient or patient's guardian within 14 days of written request.

(A) Physical records include silver emulsion radiographs, physical study models, paper charting and chart notes.

(B) Licensees may require the patient or patient's guardian to pay in advance the fee reasonably calculated to cover costs of making the copies or duplicates.

(1) Licensee may charge a fee not to exceed $30 for copying 10 or fewer pages of written material and no more than $0.50 per page for 11-50 and no more than $0.25 for each additional page, including cost of microfilm plus any postage costs to mail copies requested and actual costs of preparing an explanation or summary of information, if requested. The actual costs of duplicating radiographs may also be charged to the patient.

(2) Licensees shall provide duplicates of digital patient records within 5 clinical days of written request by the patient or patient's guardian.

(A) Digital records include any patient diagnostic image, study model, test result or chart record in digital form.

(B) Licensees may require the patient or patient's guardian to pay for the typical retail cost of the digital storage device, such as a CD, thumb drive, or DVD as well as associated postage.

(C) Licensees shall not charge any patient or patient's guardian to transmit requested digital records over email if total records do not exceed 25 Mb.

(D) A clinical day is defined as a day during which the dental clinic treated scheduled patients.

(E) Licensees may charge up to $5 for duplication of digital records up to 25Mb and up to $30 for more than 25Mb.

(F) Any transmission of patient records shall be in compliance with the Health Insurance Portability and Accountability Act (HIPAA Act) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act).

(G) Duplicated digital records shall be of the same quality as the original digital file.

(3) If a records summary is requested by patient or patient's guardian, the actual cost of creating this summary and its transmittal may be billed to the patient or patient's guardian.

818-012-0040

Infection Control Guidelines

In determining what constitutes unacceptable patient care with respect to infection control, the Board may consider current infection control guidelines such as those of the Centers for Disease Control and Prevention and the American Dental Association.

(1) Additionally, licensees must comply with the following requirements:

(**a**) (~~1~~)Disposable gloves shall be worn whenever placing fingers into the mouth of a patient or when handling blood or saliva contaminated instruments or equipment. Appropriate hand hygiene shall be performed prior to gloving.

(**b**) (~~2~~)Masks and protective eyewear or chin-length shields shall be worn by licensees and other dental care workers when spattering of blood or other body fluids is likely.

(**c**)(~~3~~) Between each patient use, instruments or other equipment that come in contact with body fluids shall be sterilized.

(**d**) (~~4~~)Environmental surfaces that are contaminated by blood or saliva shall be disinfected with a chemical germicide which is mycobactericidal at use.

(**e**)(~~5~~) Impervious backed paper, aluminum foil, or plastic wrap may be used to cover surfaces that may be contaminated by blood or saliva and are difficult or impossible to disinfect. The cover shall be replaced between patients.

(**f**) (~~6~~)All contaminated wastes and sharps shall be disposed of according to any governmental requirements.

(2) Dentists must comply with the requirement that heat sterilizing devices shall be tested for proper function by means of a biological monitoring system that indicates micro-organisms kill each calendar week in which scheduled patients are treated. Testing results shall be retained by the **dentist** ~~licensee~~ for the current calendar year and the two preceding calendar years.

Stat. Auth.: ORS 679.120, 679.250(7), **679.535,** 680.075 & 680.150

Stats. Implemented: ORS 679.140, 679.140(4) & 680.100

818-012-0060

Failure to Cooperate with Board

(1) No licensee shall:

(~~1~~**a**) Fail to report to the Board violations of the Dental Practice Act.

(~~2~~**b**) Use threats or harassment to delay or obstruct any person in providing evidence in any investigation, contested case, or other legal action instituted by the Board.

(~~3~~**c**) Discharge an employee based primarily on the employee's attempt to comply with or aid in the compliance with the Dental Practice Act.

(~~4~~**d**) Use threats or harassment to obstruct or delay the Board in carrying out its functions under the Dental Practice Act.

(~~5~~**e**) Deceive or attempt to deceive the Board with respect to any matter under investigation including altering or destroying any records.

(~~6~~**f**) Make an untrue statement on any document, letter, or application submitted to the Board.

(~~7~~**g**) Fail to temporarily surrender custody of original patient records to the Board when the Board makes a written request for the records. For purposes of this rule, the term records includes, but is not limited to, the jacket, treatment charts, models, radiographs, photographs, health histories, billing documents, correspondence and memoranda.

(h) Fail to attend a Board requested investigative interview or failure to fully cooperate in any way with an ongoing Board investigation.

(2) No ~~person~~ **applicant** shall:

(~~8~~**a**) Deceive or attempt to deceive the Board with respect to any matter under investigation including altering or destroying any records.

(~~9~~**b**) Make an untrue statement on any document, letter, or application submitted to the Board.

(c) Fail to fully cooperate with the Board during the course of an investigation, including but not limited to, waiver of confidentiality privileges, except attorney-client privilege.

Stat. Auth.: ORS 679 & 680

Stats. Implemented: ORS 679.060(4), 679.170(5), 679.250(8), 679.290, 679.310(1), 680.050(4) & 680.100

818-012-0070

Patient Records

(1) Each licensee shall have prepared and maintained an accurate record for each person receiving dental services, regardless of whether any fee is charged. The record shall contain the name of the licensee rendering the service and include:

(a) Name and address and, if a minor, name of guardian;

(b) Date description of examination and diagnosis;

(c) An entry that informed consent has been obtained and the date the informed consent was obtained. Documentation may be in the form of an acronym such as "PARQ" (Procedure, Alternatives, Risks and Questions) or "SOAP" (Subjective Objective Assessment Plan) or their equivalent.

(d) Date and description of treatment or services rendered;

(e) Date ~~and~~**,** description **and documentation of informing the patient** of treatment complications **or treatment outcomes**;

(f) Date and description of all radiographs, study models, and periodontal charting;

(g) Health history; and

(h) Date, name of, quantity of, and strength of all drugs dispensed, administered, or prescribed.

(2) Each ~~dentist~~ **licensee** shall have prepared and maintained an accurate record of all charges and payments for services including source of payments.

(3) Each ~~dentist~~ **licensee** shall maintain patient records and radiographs for at least seven years from the date of last entry unless:

(a) The patient requests the records, radiographs, and models be transferred to another ~~dentist~~ **licensee** who shall maintain the records and radiographs;

(b) The ~~dentist~~ **licensee** gives the records, radiographs, or models to the patient; or

(c) The ~~dentist~~ **licensee** transfers the ~~dentist's~~ **licensee's** practice to another ~~dentist~~ **licensee** who shall maintain the records and radiographs.

(4) When changing practice locations, closing a practice location or retiring, each licensee must retain patient records for the required amount of time or transfer the custody of patient records to another licensee licensed and practicing dentistry in Oregon. Transfer of patient records pursuant to this section of this rule must be reported to the Board in writing within 14 days of transfer, but not later than the effective date of the change in practice location, closure of the practice location or retirement. Failure to transfer the custody of patient records as required in this rule is unprofessional conduct.

(5) Upon the death or permanent disability of a licensee, the administrator, executor, personal representative, guardian, conservator or receiver of the former licensee must notify the Board in writing of the management arrangement for the custody and transfer of patient records. This individual must ensure the security of and access to patient records by the patient or other authorized party, and must report arrangements for permanent custody of patient records to the Board in writing within 90 days of the death of the licensee.

Stat. Auth.: ORS 679

Stats. Implemented: ORS 679.140(1)(e) & ORS 679.140(4)

DIVISION 21

EXAMINATION AND LICENSING

818-021-0011

Application for License to Practice Dentistry Without Further Examination

(1) The Oregon Board of Dentistry may grant a license without further examination to a dentist who holds a license to practice dentistry in another state or states if the dentist meets the requirements set forth in ORS 679.060 and 679.065 and submits to the Board satisfactory evidence of:

(a) Having graduated from a school of dentistry accredited by the Commission on Dental Accreditation of the American Dental Association; or

(b) Having graduated from a dental school located outside the United States or Canada, completion of a predoctoral dental education program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association or completion of a postdoctoral General Dentistry Residency program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association, and proficiency in the English language; and

(c) Having passed the dental clinical examination conducted by a regional testing agency or by a state dental licensing authority; and

(d) Holding an active license to practice dentistry, without restrictions, in any state; including documentation from the state dental board(s) or equivalent authority, that the applicant was issued a license to practice dentistry, without restrictions, and whether or not the licensee is, or has been, the subject of any final or pending disciplinary action; and

(e) Having conducted licensed clinical practice in Oregon, other states or in the Armed Forces of the United States, the United States Public Health Service or the United States Department of Veterans Affairs for a minimum of 3,500 hours in the five years immediately ~~prior~~ **preceding** ~~to~~ application. **Licensed clinical practice could include hours devoted to teaching by dentists employed by a dental education program in a CODA accredited dental school, with verification from the dean or appropriate administration of the institution documenting the length and terms of employment, the applicant's duties and responsibilities, the actual hours involved in teaching clinical dentistry, and any adverse**

actions or restrictions; and

(f) Having completed 40 hours of continuing education in accordance with the Board's continuing education requirements contained in these rules within the two years immediately preceding application.

(2) Applicants must pass the Board's Jurisprudence Examination.

(3) A dental license granted under this rule will be the same as the license held in another state; i.e., if the dentist holds a general dentistry license, the Oregon Board will issue a general (unlimited) dentistry license. If the dentist holds a license limited to the practice of a specialty, the Oregon Board will issue a license limited to the practice of that specialty. If the dentist holds more than one license, the Oregon Board will issue a dental license which is least restrictive.

Stat. Auth.: ORS 679

Stats. Implemented: ORS 679.060, 679.065, 679.070, 679.080 & 679.090

818-021-0025

Application for License to Practice Dental Hygiene Without Further Examination

(1) The Oregon Board of Dentistry may grant a license without further examination to a dental hygienist who holds a license to practice dental hygiene in another state or states if the dental hygienist meets the requirements set forth in ORS 680.040 and 680.050 and submits to the Board satisfactory evidence of:

(a) Having graduated from a dental hygiene program accredited by the Commission on Dental Accreditation of the American Dental Association; or

(b) Having graduated from a dental hygiene program located outside the United States or Canada, completion of not less than one year in a program accredited by the Commission on Dental Accreditation of the American Dental Association, and proficiency in the English language; and

(c) ~~Evidence of~~ ~~h~~**Having** passed the clinical dental hygiene examination conducted by a regional testing agency or by a state dental or dental hygiene licensing authority; and

(d) Holding an active license to practice dental hygiene, without restrictions, in any state; including documentation from the state dental board(s) or equivalent authority, that the applicant was issued a license to practice dental hygiene, without restrictions, and whether or not the licensee is, or has been, the subject of any final or pending disciplinary action; and

(e) Having conducted licensed clinical practice in Oregon, in other states or in the Armed Forces

of the United States, the United States Public Health Service, the United States Department of Veterans Affairs~~, or teaching all disciplines of clinical dental hygiene at a dental hygiene education program accredited by the Commission on Dental Accreditation of the American Dental Association~~ for a minimum of 3,500 hours in the five years immediately preceding application. **Licensed clinical practice could include hours devoted to teaching by** ~~For~~ dental hygienists employed by a **CODA accredited** dental hygiene program **with verification** ~~documentation~~ from the dean or appropriate administration of the institution **documenting the** ~~regarding~~ length and terms of employment, the applicant's duties and responsibilities, the actual hours involved in teaching ~~all disciplines of~~ clinical dental hygiene, and any adverse actions or restrictions; and

(f) Having completed 24 hours of continuing education in accordance with the Board's continuing education requirements contained in these rules within the two years immediately preceding application.

(2) Applicants must pass the Board's Jurisprudence Examination.

Stat. Auth.: ORS 680

Stats. Implemented: ORS 680.040, 680.050, 680.060, 680.070 & 680.072

818-021-0026

State and Nationwide Criminal Background Checks, Fitness Determinations

(1) The Board requires fingerprints of all applicants for a dental or dental hygiene license to determine the fitness of an applicant. **The purpose of this rule is to provide for the reasonable screening of dental and dental hygiene applicants and licensees in order to determine if they have a history of criminal behavior such that they are not fit to be granted or hold a license that is issued by the Board.**~~These will be provided on prescribed forms provided by the Board. Fingerprints may be obtained at a law enforcement office or at a private service. The Board will submit fingerprints to the Oregon State Police for checks against state and national data sources. Any original fingerprint cards will subsequently be destroyed by the Oregon State Police.~~

(2)~~(2)~~ These rules are to be applied when evaluating the criminal history of all licensees and applicants for a dental or dental hygiene license and for conducting fitness determinations **consistent with the outcomes provided in OAR 125-007-0260.**

~~based upon such history. The fact that the applicant has cleared the criminal history check does not guarantee the granting of a license.~~

~~(3) Except as otherwise provided in section (1) in making the fitness determination the Board shall consider:~~

(3) Criminal records checks and fitness determinations are conducted according to ORS 181A.170 to 181A.215, ORS 670.280 and OAR 125-007-0200 to 127-007-0310.

(a) The Board will request the Oregon Department of State Police to conduct a state and nationwide criminal records check. Any original fingerprint cards will subsequently be destroyed.

(b) All background checks must include available state and national data, unless obtaining one or the other is an acceptable alternative.

(c) The applicant or licensee must disclose all arrests, charges, and convictions regardless of the outcome or date of occurrence. Disclosure includes but is not limited to military, juvenile, expunged, dismissed or set aside criminal records.

(4) If the applicant or licensee has potentially disqualifying criminal offender information, the Board will consider the following factors in making a fitness determination:

(a) The nature of the crime;

(b) The facts that support the conviction or pending indictment or that indicates the making of the false statement;

(c) The relevancy, if any, of the crime or the false statement to the specific requirements of the subject individual's present or proposed position, services, employment, license, or permit; and

(d) Intervening circumstances relevant to the responsibilities and circumstances of the position, services, employment, license, or permit. Intervening circumstances include but are not limited to:

(A) The passage of time since the commission of the crime;

(B) The age of the subject individual at the time of the crime;

(C) The likelihood of a repetition of offenses or of the commission of another crime:

(D) The subsequent commission of another relevant crime;

(E) Whether the conviction was set aside and the legal effect of setting aside the conviction; and

(F) A recommendation of an employer.

(e) Any false statements or omissions made by the applicant or licensee; and

(f) Any other pertinent information obtained as part of an investigation.

(5) The Board will make a fitness determination consistent with the outcomes provided in OAR 125-007-0260.

(a) A fitness determination approval does not guarantee the granting or renewal of a license.

(b) An incomplete fitness determination results if the applicant or licensee refuses to consent to the criminal history check, refuses to be fingerprinted or respond to written correspondence, or discontinues the criminal records process for any reason. Incomplete fitness determinations may not be appealed.

(6)~~(4)~~ The Board may require fingerprints of any licensed Oregon dentist or dental hygienist, who is the subject of a complaint or investigation for the purpose of requesting a state or nationwide criminal records background check.

(7)~~(5)~~ All background checks shall be requested to include available state and national data, unless obtaining one or the other is an acceptable alternative.

(8)~~(6)~~ Additional information required. In order to conduct the Oregon and National Criminal History Check and fitness determination, the Board may require additional information from the licensee/applicant as necessary, such but not limited to, proof of identity; residential history; names used while living at each residence; or additional criminal, judicial or other background information.

(9)~~(7)~~ Criminal offender information is confidential. Dissemination of information received ~~under HB 2157~~ **may be disseminated** ~~is~~ only to people with a demonstrated and legitimate need to know the information. The information is part of the investigation of an applicant or licensee and as such is confidential pursuant to ORS 676.175(1).

(10)~~(8)~~ The Board will permit the individual for whom a fingerprint-based criminal records check was conducted, to inspect the individual's own state and national criminal offender records and, if requested by the individual, provide the individual with a copy of the individual's own state and national criminal offender records.

(11)~~(9)~~ The Board shall determine whether an individual is fit to be granted a license or permit, based on **fitness determinations**~~the criminal records background check~~, on any false statements made by the individual regarding criminal history of the individual, or any refusal to submit or consent to a criminal records check including fingerprint identification, and any other pertinent information obtained as a part of an investigation. If an individual is determined to be unfit, then the individual may not be granted a license or permit. The Board may make fitness determinations conditional upon applicant's acceptance of probation, conditions, or limitations, or other restrictions upon licensure.

~~(10) The Board may consider any conviction of any violation of the law for which the court could impose a punishment and in compliance with ORS 670.280. The Board may also consider any arrests and court records that may be indicative of a person's inability to perform as a licensee with care and safety to the public.~~

(12)~~(11) If an~~ **An** applicant or licensee **may appeal a final fitness determination pursuant to OAR 125-007-0300.** ~~is determined not to be fit for a license or permit, they are entitled to a contested case process pursuant to ORS 183.414 - 183.470.~~ Challenges to the accuracy of completeness of **criminal history** information **must be made in accordance with OAR 125-007-0030(7).** ~~provided by the Oregon State Police, Federal Bureau of Investigation and agencies reporting information must be made through the Oregon State Police, Federal Bureau of Investigation, or reporting agency and not through the contested case process pursuant to ORS 183.~~

~~(12) If the applicant discontinues the application process or fails to cooperate with the criminal history check process, then the application is considered incomplete.~~

Stat. Auth.: ORS 679 & 680, 181A.195, 181A215, 676.303

Stats. Implemented: ORS 181A.195, 181A.215, 676.303, 183, 670.280, 679.060, 679.115, 679.140, 679.160, 680.050, 680.082 & 680.100

DIVISION 26

ANESTHESIA

818-026-0030

Requirement for Anesthesia Permit, Standards and Qualifications of an Anesthesia Monitor

(1) A permit holder who administers sedation shall assure that drugs, drug dosages, and/or techniques used to produce sedation shall carry a margin of safety wide enough to prevent unintended deeper levels of sedation.

(2) No licensee shall induce central nervous system sedation or general anesthesia without first having obtained a permit under these rules for the level of anesthesia being induced.

(3) A licensee may be granted a permit to administer sedation or general anesthesia with documentation of training/education and/or competency in the permit category for which the licensee is applying by any one the following:

(a) Initial training/education in the permit category for which the applicant is applying shall be completed no more than two years immediately prior to application for sedation or general anesthesia permit; or

(b) If greater than two years but less than five years since completion of initial training/education, an applicant must document completion of all continuing education that would have been required for that anesthesia/permit category during that five year period following initial training; or

(c) If greater than two years but less than five years since completion of initial training/education, immediately prior to application for sedation or general anesthesia permit, current competency or experience must be documented by completion of a comprehensive review course approved by the Board in the permit category to which the applicant is applying and must consist of at least one-half (50%) of the hours required by rule for Nitrous Oxide, Minimal Sedation, Moderate Sedation and General Anesthesia Permits. Deep Sedation and General Anesthesia Permits will require at least 120 hours of general anesthesia training.

(d) An applicant for sedation or general anesthesia permit whose completion of initial training/education is greater than five years immediately prior to application, may be granted a sedation or general anesthesia permit by submitting documentation of the requested permit level from another state or jurisdiction where the applicant is also licensed to practice dentistry or dental hygiene, and provides documentation of the completion of at least 25 cases in the

requested level of sedation or general anesthesia in the 12 months immediately preceding application; or

(e) Demonstration of current competency to the satisfaction of the Board that the applicant possesses adequate sedation or general anesthesia skill to safely deliver sedation or general anesthesia services to the public.

(4) Persons serving as anesthesia monitors in a dental office shall maintain current certification in Health Care Provider Basic Life Support (BLS)/Cardio Pulmonary Resuscitation (CPR) training, or its equivalent, shall be trained in monitoring patient vital signs, and be competent in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. (The term "competent" as used in these rules means displaying special skill or knowledge derived from training and experience.)

~~**(5) A licensee holding an anesthesia permit shall at all times hold a current Health Care Provider BLS/CPR level certificate or its equivalent, or a current Advanced Cardiac Life Support (ACLS) Certificate or Pediatric Advanced Life Support (PALS) Certificate, whichever is appropriate for the patient being sedated.**~~

(**5) A licensee holding a nitrous or minimal sedation permit, shall at all times maintain a current BLS for Health Care Providers certificate or its equivalent.**

(6) A licensee holding an anesthesia permit for moderate sedation, deep sedation or general anesthesia at all times maintains a current BLS for Health Care Providers certificate or its equivalent, and a current Advanced Cardiac Life Support (ACLS) Certificate or Pediatric Advanced Life Support (PALS) Certificate, whichever is appropriate for the patient being sedated. If a licensee permit holder sedates only patients under the age of 12, only PALS is required. If a licensee permit holder sedates only patients age 12 and older, only ACLS is required. If a licensee permit holder sedates patients younger than 12 years of age as well as older than 12 years of age, both ACLS and PALS are required. For licensees with a moderate sedation permit only, successful completion of the American Dental Association's course *"Recognition and Management of Complications during Minimal and Moderate Sedation"* at least every two years may be substituted for ACLS, but not for PALS.

(a) Advanced Cardiac Life Support (ACLS) and or Pediatric Advanced Life Support (PALS) do not serve as a substitute for Health Care Provider Basic Life Support (BLS).

(7)~~(6)~~ When a dentist utilizes a single dose oral agent to achieve anxiolysis only, no anesthesia permit is required.

(8)~~(7)~~ The applicant for an anesthesia permit must pay the appropriate permit fee, submit a completed Board-approved application and consent to an office evaluation.

(9)~~(8)~~ Permits shall be issued to coincide with the applicant's licensing period.

Stat. Auth.: ORS 679 & 680

Stats. Implemented: ORS 679.250

818-026-0050

Minimal Sedation Permit

Minimal sedation and nitrous oxide sedation.

(1) The Board shall issue a Minimal Sedation Permit to an applicant who:

(a) Is a licensed dentist in Oregon;

(b) Maintains a current BLS for Healthcare Providers certificate or its equivalent; and

(c) Completion of a comprehensive training program consisting of at least 16 hours of training and satisfies the requirements of the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students (2007) at the time training was commenced or postgraduate instruction was completed, or the equivalent of that required in graduate training programs, in sedation, recognition and management of complications and emergency care; or

(d) In lieu of these requirements, the Board may accept equivalent training or experience in minimal sedation anesthesia.

(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedures and during recovery:

(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;

(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient’s airway, quickly alter the patient’s position in an emergency, and provide a firm platform for the administration of basic life support;

(c) A lighting system which permits evaluation of the patient’s skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;

(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;

(e) An oxygen delivery system with adequate full facemask and appropriate connectors that is

capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;

(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;

(g) Sphygmomanometer, stethoscope, pulse oximeter, and/or automatic blood pressure cuff; and

(h) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives and anticonvulsants.

(3) Before inducing minimal sedation, a dentist **permit holder** who induces minimal sedation shall:

(a) Evaluate the patient;

(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian;

(c) Certify that the patient is an appropriate candidate for minimal sedation; and

(d) Obtain written informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient's record.

(4) No permit holder shall have more than one person under minimal sedation at the same time.

(5) While the patient is being treated under minimal sedation, an anesthesia monitor shall be present in the room in addition to the treatment provider. The anesthesia monitor may be the dental assistant. After training, a dental assistant, when directed by a dentist **permit holder**, may administer oral sedative agents or anxiolysis agents calculated and dispensed by a dentist **permit holder** under the direct supervision of a dentist **permit holder**.

(6) A patient under minimal sedation shall be visually monitored at all times, including recovery phase. The dentist **permit holder** or anesthesia monitor shall monitor and record the patient's condition.

(7) The patient shall be monitored as follows:

(a) Color of mucosa, skin or blood must be evaluated continually. Patients must have continuous monitoring using pulse oximetry. The patient's response to verbal stimuli, blood pressure, heart rate, and respiration shall be monitored and documented if they can reasonably be obtained.

(b) A discharge entry shall be made by the dentist **permit holder** in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.

(8) The dentist **permit holder** shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:

(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;

(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;

(c) The patient can talk and respond coherently to verbal questioning;

(d) The patient can sit up unaided;

(e) The patient can ambulate with minimal assistance; and

(f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.

(g) A dentist **permit holder** shall not release a patient who has undergone minimal sedation except to the care of a responsible third party.

(9) Permit renewal. In order to renew a Minimal Sedation Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent. In addition, Minimal Sedation Permit holders must also complete four (4) hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current BLS for Healthcare Providers certificate, or its equivalent, may not be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

Stat. Auth.: ORS 679

Stats. Implemented: ORS 679.250(7) & 679.250(10)

818-026-0060

Moderate Sedation Permit

Moderate sedation, minimal sedation, and nitrous oxide sedation.

(1) The Board shall issue or renew a Moderate Sedation Permit to an applicant who:

(a) Is a licensed dentist in Oregon;

(b) In addition to a current BLS for Healthcare Providers certificate or its equivalent, either maintains a current Advanced Cardiac Life Support (ACLS) certificate and/or a Pediatric

Advanced Life Support (PALS) certificate, whichever is appropriate for the patient being sedated. ~~Successful completion of a board approved course on minimal/moderate sedation at least every two years may be substituted for ACLS, but not for PALS;~~ and

(c) Satisfies one of the following criteria:

(A) Completion of a comprehensive training program in enteral and/or parenteral sedation that satisfies the requirements described in Part V of the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students (2007) at the time training was commenced.

(i) Enteral Moderate Sedation requires a minimum of 24 hours of instruction plus management of at least 10 dental patient experiences by the enteral and/or enteral-nitrous oxide/oxygen route.

(ii) Parenteral Moderate Sedation requires a minimum of 60 hours of instruction plus management of at least 20 dental patients by the intravenous route.

(B) Completion of an ADA accredited postdoctoral training program (e.g., general practice residency) which affords comprehensive and appropriate training necessary to administer and manage parenteral sedation, commensurate with these Guidelines.

(C) In lieu of these requirements, the Board may accept equivalent training or experience in moderate sedation anesthesia.

(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedures and during recovery:

(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;

(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;

(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;

(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;

(e) An oxygen delivery system with adequate full face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;

1122 (f) A nitrous oxide delivery system with a fail-safe mechanism that will insure
1123 appropriate continuous oxygen delivery and a scavenger system;
1124 (g) A recovery area that has available oxygen, adequate lighting, suction and electrical
1125 outlets. The recovery area can be the operating room;
1126 (h) Sphygmomanometer, precordial/pretracheal stethoscope, capnograph, pulse oximeter,
1127 oral and nasopharyngeal airways, larynageal mask airways, intravenous fluid administration
1128 equipment, automated external defibrillator (AED); and
1129 (i) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to
1130 the drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines,
1131 antihypertensives and anticonvulsants.
1132 (3) No permit holder shall have more than one person under moderate sedation,
1133 minimal sedation, or nitrous oxide sedation at the same time.
1134 (4) During the administration of moderate sedation, and at all times while the patient is under
1135 moderate sedation, an anesthesia monitor, and one other person holding a current BLS for
1136 Healthcare Providers certificate or its equivalent, shall be present in the operatory, in addition
1137 to the dentist **permit holder** performing the dental procedures.
1138 (5) Before inducing moderate sedation, a dentist **permit holder** who induces moderate
1139 sedation shall:
1140 (a) Evaluate the patient and document, using the American Society of Anesthesiologists
1141 Patient Physical Status Classifications, that the patient is an appropriate candidate for
1142 moderate sedation;
1143 (b) Give written preoperative and postoperative instructions to the patient or, when
1144 appropriate due to age or psychological status of the patient, the patient's guardian; and
1145 (c) Obtain written informed consent from the patient or patient's guardian for the
1146 anesthesia.
1147 (6) A patient under moderate sedation shall be visually monitored at all times, including the
1148 recovery phase. The dentist **permit holder** or anesthesia monitor shall monitor and record the
1149 patient's condition.
1150 (7) The patient shall be monitored as follows:
1151 (a) Patients must have continuous monitoring using pulse oximetry, and End-tidal CO2
1152 monitors. Patients with cardiovascular disease shall have continuous electrocardiograph
1153 (ECG) monitoring. The patient's blood pressure, heart rate, and respiration shall be recorded
1154 at regular intervals but at least every 15 minutes, and these recordings shall be documented
1155 in the patient record. The record must also include documentation of preoperative and

postoperative vital signs, all medications administered with dosages, time intervals and route of administration. If this information cannot be obtained, the reasons shall be documented in the patient's record. A patient under moderate sedation shall be continuously monitored and shall not be left alone while under sedation;

(b) During the recovery phase, the patient must be monitored by an individual trained to monitor patients recovering from moderate sedation.

(8) A dentist **permit holder** shall not release a patient who has undergone moderate sedation except to the care of a responsible third party.

(a) When a reversal agent is administered, the dentist **permit holder** shall document justification for its use and how the recovery plan was altered.

(9) The dentist **permit holder** shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:

(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;

(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;

(c) The patient can talk and respond coherently to verbal questioning; (d) The patient can sit up unaided;

(e) The patient can ambulate with minimal assistance; and

(f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.

(10) A discharge entry shall be made by the dentist **permit holder** in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.

(11) After adequate training, an assistant, when directed by a dentist **permit holder**, may dispense oral medications that have been prepared by the dentist permit holder for oral administration to a patient under direct supervision. **Pursuant to OAR 818-042-0115 a Certified Anesthesia Dental Assistant, when directed by a dentist permit holder, may** introduce additional anesthetic agents into an infusion line under the direct ~~visual~~ supervision of a dentist **permit holder**.

(12) Permit renewal. In order to renew a Moderate Sedation Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent; a current Advanced Cardiac Life Support (ACLS) certificate and/or a current Pediatric Advanced Life Support (PALS) certificate; Successful completion of a board approved course on minimal/moderate sedation at least every two years may be substituted for ACLS,

but not for PALS; and must complete 14 hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current ACLS or PALS certification or successful completion of the American Dental Association's course "Recognition and Management of Complications during Minimal and Moderate Sedation" may be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021- 0060.

Stat. Auth.: ORS 679

Stats. Implemented: ORS 679.250(7) & 679.250(10)

818-026-0065

Deep Sedation

Deep sedation, moderate sedation, minimal sedation, and nitrous oxide sedation.

(1) The Board shall issue a Deep Sedation Permit to a licensee who holds a Class 3 Permit on or before July 1, 2010 who:

(a) Is a licensed dentist in Oregon; and

(b) In addition to a current BLS for Healthcare Providers certificate or its equivalent, maintains a current Advanced Cardiac Life Support (ACLS) certificate and/or a Pediatric Advanced Life Support (PALS) certificate, whichever is appropriate for the patient being sedated.

(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedures and during recovery:

(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;

(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;

(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;

(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;

1224 (e) An oxygen delivery system with adequate full face mask and appropriate connectors that
1225 is capable of delivering high flow oxygen to the patient under positive pressure, together with
1226 an adequate backup system;
1227 (f) A nitrous oxide delivery system with a fail-safe mechanism that will insure
1228 appropriate continuous oxygen delivery and a scavenger system;
1229 (g) A recovery area that has available oxygen, adequate lighting, suction and electrical
1230 outlets. The recovery area can be the operating room;
1231 (h) Sphygmomanometer, precordial/pretracheal stethoscope, capnograph, pulse oximeter,
1232 electrocardiograph monitor (ECG), automated external defibrillator (AED), oral and
1233 nasopharyngeal airways, laryngeal mask airways, intravenous fluid administration
1234 equipment; and
1235 (i) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to
1236 the drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines,
1237 antihypertensives and anticonvulsants.
1238 (3) No permit holder shall have more than one person under deep sedation, moderate
1239 sedation, minimal sedation, or nitrous oxide sedation at the same time.
1240 (4) During the administration of deep sedation, and at all times while the patient is under deep
1241 sedation, an anesthesia monitor, and one other person holding a current BLS for Healthcare
1242 Providers certificate or its equivalent, shall be present in the operatory, in addition to the
1243 dentist **permit holder** performing the dental procedures.
1244 (5) Before inducing deep sedation, a dentist **permit holder** who induces deep sedation shall:
1245 (a) Evaluate the patient and document, using the American Society of Anesthesiologists Patient
1246 Physical Status Classifications, that the patient is an appropriate candidate for deep sedation;
1247 (b) Give written preoperative and postoperative instructions to the patient or, when
1248 appropriate due to age or psychological status of the patient, the patient's guardian; and
1249 (c) Obtain written informed consent from the patient or patient's guardian for the anesthesia.
1250 (6) A patient under deep sedation shall be visually monitored at all times, including the
1251 recovery phase. The dentist **permit holder** or anesthesia monitor shall monitor and record the
1252 patient's condition.
1253 (7) The patient shall be monitored as follows:
1254 (a) Patients must have continuous monitoring using pulse oximetry, electrocardiograph
1255 monitors (ECG) and End-tidal CO2 monitors. The patient's heart rhythm shall be continuously
1256 monitored and the patient’s blood pressure, heart rate, and respiration shall be recorded at
1257 regular intervals but at least every 5 minutes, and these recordings shall be documented in the

patient record. The record must also include documentation of preoperative and postoperative vital signs, all medications administered with dosages, time intervals and route of administration. If this information cannot be obtained, the reasons shall be documented in the patient's record. A patient under deep sedation shall be continuously monitored;

(b) Once sedated, a patient shall remain in the operatory for the duration of treatment until criteria for transportation to recovery have been met.

(c) During the recovery phase, the patient must be monitored by an individual trained to monitor patients recovering from deep sedation.

(8) A dentist **permit holder** shall not release a patient who has undergone deep sedation except to the care of a responsible third party. When a reversal agent is administered, the dentist **permit holder** shall document justification for its use and how the recovery plan was altered.

(9) The dentist **permit holder** shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:

(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;

(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;

(c) The patient can talk and respond coherently to verbal questioning;

(d) The patient can sit up unaided;

(e) The patient can ambulate with minimal assistance; and

(f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.

(10) A discharge entry shall be made by the dentist **permit holder** in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.

(11) ~~After adequate training, an~~ **Pursuant to OAR 818-042-0115 a Certified Anesthesia Dental A**~~a~~ssistant, when directed by a dentist **permit holder**, may administer oral sedative agents calculated by a dentist **permit holder** or introduce additional anesthetic agents into an infusion line under the direct visual supervision of a dentist

(12) Permit renewal. In order to renew a Deep Sedation Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent; a current Advanced Cardiac Life Support (ACLS) certificate and/or a current Pediatric Advanced Life Support (PALS) certificate; and must complete 14 hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical

emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current ACLS and/or PALS certificates may be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

Stat. Auth.: ORS 679
Stats. Implemented: ORS 679.250(7) & 679.250(10)

818-026-0070
General Anesthesia Permit

General anesthesia, deep sedation, moderate sedation, minimal sedation and nitrous oxide sedation.
(1) The Board shall issue a General Anesthesia Permit to an applicant who:
(a) Is a licensed dentist in Oregon;
(b) In addition to a current BLS for Healthcare Providers certificate or its equivalent, maintains a current Advanced Cardiac Life Support (ACLS) certificate and/or a Pediatric Advanced Life Support (PALS) certificate, whichever is appropriate for the patient being sedated, and
(c) Satisfies one of the following criteria:
(A) Completion of an advanced training program in anesthesia and related subjects beyond the undergraduate dental curriculum that satisfies the requirements described in the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students (2007) consisting of a minimum of 2 years of a postgraduate anesthesia residency at the time training was commenced.
(B) Completion of any ADA accredited postdoctoral training program, including but not limited to Oral and Maxillofacial Surgery, which affords comprehensive and appropriate training necessary to administer and manage general anesthesia, commensurate with these Guidelines.
(C) In lieu of these requirements, the Board may accept equivalent training or experience in general anesthesia.
(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedure and during recovery:
(a) An operating room large enough to adequately accommodate the patient on an

operating table or in an operating chair and to allow an operating team of at least three individuals to freely move about the patient;

(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;

(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;

(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;

(e) An oxygen delivery system with adequate full face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;

(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;

(g) A recovery area that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area can be the operating room;

(h) Sphygmomanometer, precordial/pretracheal stethoscope, capnograph, pulse oximeter, electrocardiograph monitor (ECG), automated external defibrillator (AED), oral and nasopharyngeal airways, laryngeal mask airways, intravenous fluid administration equipment; and

(i) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, intravenous medications for treatment of cardiac arrest, narcotic antagonist, antihistaminic, antiarrhythmics, antihypertensives and anticonvulsants.

(3) No permit holder shall have more than one person under general anesthesia, deep sedation, moderate sedation, minimal sedation or nitrous oxide sedation at the same time.

(4) During the administration of deep sedation or general anesthesia, and at all times while the patient is under deep sedation or general anesthesia, an anesthesia monitor, and one other person holding a current BLS for Healthcare Providers certificate or its equivalent, shall be present in the operatory in addition to the dentist **permit holder** performing the dental procedures.

(5) Before inducing deep sedation or general anesthesia the dentist **permit holder** who induces deep sedation or general anesthesia shall:

1359 (a) Evaluate the patient and document, using the American Society of Anesthesiologists
1360 Patient Physical Status Classifications, that the patient is an appropriate candidate for general
1361 anesthesia or deep sedation;
1362 (b) Give written preoperative and postoperative instructions to the patient or, when
1363 appropriate due to age or psychological status of the patient, the patient's guardian; and
1364 (c) Obtain written informed consent from the patient or patient's guardian for the anesthesia.
1365 (6) A patient under deep sedation or general anesthesia shall be visually monitored at all
1366 times, including recovery phase. A dentist **permit holder** who induces deep sedation or
1367 general anesthesia or anesthesia monitor trained in monitoring patients under deep sedation or
1368 general anesthesia shall monitor and record the patient's condition on a contemporaneous
1369 record.
1370 (7) The patient shall be monitored as follows:
1371 (a) Patients must have continuous monitoring of their heart rate, heart rhythm, oxygen
1372 saturation levels and respiration using pulse oximetry, electrocardiograph monitors (ECG) and
1373 End-tidal CO2 monitors. The patient's blood pressure, heart rate and oxygen saturation shall
1374 be assessed every five minutes, and shall be contemporaneously documented in the patient
1375 record. The record must also include documentation of preoperative and postoperative vital
1376 signs, all medications administered with dosages, time intervals and route of administration.
1377 The person administering the anesthesia and the person monitoring the patient may not leave
1378 the patient while the patient is under deep sedation or general anesthesia;
1379 (b) Once sedated, a patient shall remain in the operatory for the duration of treatment
1380 until criteria for transportation to recovery have been met.
1381 (c) During the recovery phase, the patient must be monitored, including the use of pulse
1382 oximetry, by an individual trained to monitor patients recovering from general
1383 anesthesia.
1384 (8) A dentist **permit holder** shall not release a patient who has undergone deep sedation or
1385 general anesthesia except to the care of a responsible third party. When a reversal agent is
1386 administered, the dentist **permit holder** shall document justification for its use and how the
1387 recovery plan was altered.
1388 (9) The dentist **permit holder** shall assess the patient's responsiveness using preoperative
1389 values as normal guidelines and discharge the patient only when the following criteria are
1390 met:
1391 (a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;
1392 (b) The patient is alert and oriented to person, place and time as appropriate to age

and preoperative psychological status;
(c) The patient can talk and respond coherently to verbal questioning;
(d) The patient can sit up unaided;
(e) The patient can ambulate with minimal assistance; and
(f) The patient does not have nausea or vomiting and has minimal dizziness.
(10) A discharge entry shall be made in the patient's record by the dentist **permit holder** indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.
(11) ~~After adequate training, an~~ **Pursuant to OAR 818-042-0115 a Certified Anesthesia Dental A**~~a~~ssistant, when directed by a dentist **permit holder**, may introduce additional anesthetic agents to an infusion line under the direct visual supervision of a dentist **permit holder**.
(12) Permit renewal. In order to renew a General Anesthesia Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent; a current Advanced Cardiac Life Support (ACLS) certificate and/or a current Pediatric Advanced Life Support (PALS) certificate; and must complete 14 hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current ACLS and/or PALS certificates may be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

Stat. Auth.: ORS 679
Stats. Implemented: ORS 679.250(7) & 679.250(10)

818-026-0080
Standards Applicable When a Dentist Performs Dental Procedures and a Qualified Provider Induces Anesthesia

(1) A dentist who does not hold an anesthesia permit may perform dental procedures on a patient who receives anesthesia induced by a physician anesthesiologist licensed by the

Oregon Board of Medical Examiners, another Oregon licensed dentist holding an appropriate anesthesia permit, or a Certified Registered Nurse Anesthetist (CRNA) licensed by the Oregon Board of Nursing.

(2) A dentist who does not hold a Nitrous Oxide Permit for nitrous oxide sedation may perform dental procedures on a patient who receives nitrous oxide induced by an Oregon licensed dental hygienist holding a Nitrous Oxide Permit.

(3) A dentist who performs dental procedures on a patient who receives anesthesia induced by a physician anesthesiologist, another dentist holding an anesthesia permit, a CRNA, or a dental hygienist who induces nitrous oxide sedation, shall maintain a current BLS for Healthcare Providers certificate, or its equivalent, and have the same personnel, facilities, equipment and drugs available during the procedure and during recovery as required of a dentist who has a permit for the level of anesthesia being provided.

(4) A dentist, a dental hygienist or an Expanded Function Dental Assistant (EFDA) who performs procedures on a patient who is receiving anesthesia induced by a physician anesthesiologist, another dentist holding an anesthesia permit or a CRNA shall not schedule or treat patients for non emergent care during the period of time of the sedation procedure.

(5) Once anesthetized, a patient shall remain in the operatory for the duration of treatment until criteria for transportation to recovery have been met.

(6) The qualified anesthesia provider who **induces moderate sedation, deep sedation or general anesthesia shall monitor the patient's condition** until the patient is discharged and record the patient's condition at discharge in the patient's dental record as required by the rules applicable to the level of anesthesia being induced. The anesthesia record shall be maintained in the patient's dental record and is the responsibility of the dentist who is performing the dental procedures.

(7) A dentist who intends to use the services of a qualified anesthesia provider as described in section 1 above, shall notify the Board in writing of his/her intent. Such notification need only be submitted once every licensing period.

Stat. Auth.: ORS 679

Stats. Implemented: ORS 679.250(7) & (10)

818-026-0110

Office Evaluations

(1) By obtaining an anesthesia permit or by using the services of a physician anesthesiologist,

CRNA, an Oregon licensed dental hygienist **permit holder** or another dentist **permit holder** to administer anesthesia, a licensee consents to in-office evaluations by the Oregon Board of Dentistry, to assess competence in central nervous system anesthesia and to determine compliance with rules of the Board.

(2) The in-office evaluation may include, but is not limited to:

(a) Observation of one or more cases of anesthesia to determine the appropriateness of technique and adequacy of patient evaluation and care;

(b) Inspection of facilities, equipment, drugs and records; and

(c) Confirmation that personnel are adequately trained, hold a current BLS for Healthcare Providers certificate, or its equivalent, and are competent to respond to reasonable emergencies that may occur during the administration of anesthesia or during the recovery period.

(3) The evaluation shall be performed by a team appointed by the Board and shall include:

(a) A permit holder who has the same type of license as the licensee to be evaluated and who holds a current anesthesia permit in the same class or in a higher class than that held by the licensee being evaluated.

(b) A member of the Board's Anesthesia Committee; and

(c) Any licensed dentist, deemed appropriate by the Board President, may serve as team leader and shall be responsible for organizing and conducting the evaluation and reporting to the Board.

(4) The Board shall give written notice of its intent to conduct an office evaluation to the licensee to be evaluated. Licensee shall cooperate with the evaluation team leader in scheduling the evaluation which shall be held no sooner than 30 days after the date of the notice or later than 90 days after the date of the notice.

Stat. Auth.: ORS 679 & 680

Stats. Implemented: ORS 679.250(7) & (10)

DIVISION 35

DENTAL HYGIENE

818-035-0040

Expanded Functions of Dental Hygienists

(1) Upon completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course of instruction approved by the Board, a dental hygienist who completes a Board approved application shall be issued an endorsement to administer local anesthetic agents and local anesthetic reversal agents under the general supervision of a licensed dentist. Local anesthetic reversal agents shall not be used on children less than 6 years of age or weighing less than 33 pounds.

(2) Upon completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course of instruction approved by the Board, a dental hygienist may administer nitrous oxide under the indirect supervision of a licensed dentist in accordance with the Board's rules regarding anesthesia.

(3) Upon completion of a course of instruction approved by the Oregon Health Authority, Public Health Division, a dental hygienist may purchase epinephrine and administer epinephrine in an emergency.

Stat. Auth.: ORS 679 & 680

Stats. Implemented: ORS 679.025(2)(j) & 679.250(7)

DIVISION 42

DENTAL ASSISTING

818-042-0020

Dentist and Dental Hygienist Responsibility

(1) A dentist is responsible for assuring that a dental assistant has been properly trained, has demonstrated proficiency, and is supervised in all the duties the assistant performs in the dental office. Unless otherwise specified, dental assistants shall work under indirect supervision in the dental office.

(2) A dental hygienist who works under general supervision may supervise ~~a~~ dental assistant**s** in the dental office if the dental assistant**s** ~~is~~ **are** rendering assistance to the dental hygienist in providing dental hygiene services and the dentist is not in the office to provide indirect supervision. A dental hygienist with an Expanded Practice Permit may hire and supervise ~~a~~ dental assistant**s** who will render assistance to the dental hygienist in providing dental hygiene services.

(3) The supervising dentist or dental hygienist is responsible for assuring that all required licenses, permits or certificates are current and posted in a conspicuous place.

(4) Dental assistants who are in compliance with written training and screening protocols adopted by the Board may perform oral health screenings under general supervision.

Stat. Auth.: ORS 679 & 680

Stats. Implemented: ORS 679.025(2)(j) & 679.250(7)

818-042-0050

Taking of X-Rays — Exposing of Radiographs

(1) A dentist may authorize the following persons to place films, adjust equipment preparatory to exposing films, and expose the films under general supervision:

(a) A dental assistant certified by the Board in radiologic proficiency; or

(b) A radiologic technologist licensed by the Oregon Board of Medical Imaging and certified by

the Oregon Board of Dentistry (OBD) who has completed ten (10) clock hours in a Board approved dental radiology course and submitted a satisfactory full mouth series of radiographs to the OBD.

(2) A dentist or dental hygienist may authorize a dental assistant who has completed a course of instruction approved by the Oregon Board of Dentistry, and who has passed the written Dental Radiation Health and Safety Examination administered by the Dental Assisting National Board, or comparable exam administered by any other testing entity authorized by the Board, or other comparable requirements approved by the Oregon Board of Dentistry to place films, adjust equipment preparatory to exposing films, and expose the films under the indirect supervision of a dentist, dental hygienist, or dental assistant who holds an Oregon Radiologic Proficiency Certificate. The dental assistant must successfully complete the clinical examination within six months of the dentist **or dental hygienist** authorizing the assistant to take radiographs.

Stat. Auth.: ORS 679

Stats. Implemented: ORS 679.025(2)(j) & 679.250(7)

818-042-0070

Expanded Function Dental Assistants (EFDA)

The following duties are considered Expanded Function Duties and may be performed only after the dental assistant complies with the requirements of 818-042-0080:

(1) Polish the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis to remove stains **providing the patient is checked by a dentist or dental hygienist after the procedure is performed, prior to discharge**;

(2) Remove temporary crowns for final cementation and clean teeth for final cementation;

(3) Preliminarily fit crowns to check contacts or to adjust occlusion outside the mouth;

(4) Place temporary restorative material (i.e., zinc oxide eugenol based material) in teeth providing that the patient is checked by a dentist before and after the procedure is performed;

(5) Place and remove matrix retainers for alloy and composite restorations;

(6) Polish amalgam or composite surfaces with a slow speed hand piece;

(7) Remove excess supragingival cement from crowns, bridges, bands or brackets with hand instruments providing that the patient is checked by a dentist after the procedure is performed;

(8) Fabricate temporary crowns, and temporarily cement the temporary crown. The cemented crown must be examined and approved by the dentist prior to the patient being released;

(9) Under general supervision, when the dentist is not available and the patient is in discomfort, an EFDA may recement a temporary crown or recement a permanent crown with temporary cement for a patient of record providing that the patient is rescheduled for follow-up care by a licensed dentist as soon as is reasonably appropriate; and

(10) Perform all aspects of teeth whitening procedures.

Stat. Auth.: ORS 679 & 680

Stats. Implemented: ORS 679.020, 679.025 & 679.250

818-042-0112

Expanded Function Preventive Dental Assistants (EFPDA)

The following duties are considered Expanded Function Preventive Duties and may be performed only after the dental assistant complies with the requirements of 818-042-0113:

(1) Polish the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis to remove stains providing the patient is checked by a dentist or dental hygienist after the procedure is performed, prior to discharge.

818-042-0113

Certification — Expanded Function Preventive Dental Assistants (EFPDA)

The Board may certify a dental assistant as an expanded function preventive dental assistant:

(1) By credential in accordance with OAR 818-042-0120, or

(2) If the assistant submits a completed application, pays the fee and provides evidence of;

(a) Certification of Radiologic Proficiency (OAR 818-042-0060); and satisfactory completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association; or

(b) Certification of Radiologic Proficiency (OAR 818-042-0060); and passage of the Oregon Basic or Certified Preventive Functions Dental Assistant (CPFDA) examination, and the Expanded Function Dental Assistant examination, or equivalent successor examinations, administered by the Dental Assisting National Board, Inc. (DANB), or any

other testing entity authorized by the Board; and certification by an Oregon licensed dentist that the applicant has successfully polished the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis to remove stains on six patients.

818-042-0115

Expanded Functions — Certified Anesthesia Dental Assistant

(1) A dentist holding the appropriate anesthesia permit may verbally authorize a Certified Anesthesia Dental Assistant**, who possesses a Certified Anesthesia Dental Assistant certificate from the Oregon Board of Dentistry** to:

(a) Administer medications into an existing intravenous (IV) line of a patient under sedation or anesthesia under direct visual supervision.

(b) Administer emergency medications to a patient in order to assist the licensee in an emergent situation under direct visual supervision.

(2) A dentist holding the appropriate anesthesia permit may verbally authorize a Certified Anesthesia Dental Assistant to dispense to a patient, oral medications that have been prepared by the dentist and given to the anesthesia dental assistant by the supervising dentist for oral administration to a patient under Indirect Supervision.

Stat. Auth.: ORS 679

Stats. Implemented: ORS 679.020(1), 679.025(1) & 679.250(7)

818-042-0120

Certification by Credential

(1) Dental Assistants who wish to be certified by the Board in Radiologic Proficiency or as Expanded Function Dental Assistants, ~~or as~~ Expanded Function Orthodontic Dental Assistants**, or as Expanded Function Preventive Dental Assistants** shall:

(a) Be certified by another state in the functions for which application is made. The training and certification requirements of the state in which the dental assistant is certified must be substantially similar to Oregon's requirements; or

(b) Have worked for at least 1,000 hours in the past two years in a dental office where such employment involved to a significant extent the functions for which certification is sought; and

(c) Shall be evaluated by a licensed dentist, using a Board approved checklist, to assure that the assistant is competent in the expanded functions.

(2) Applicants applying for certification by credential in Radiologic Proficiency must obtain

certification from the Oregon Health Authority, Center for Health Protection, Radiation Protection Services, of having successfully completed training equivalent to that required by OAR 333-106-0055 or approved by the Oregon Board of Dentistry.

Stat. Auth.: ORS 679

Stats. Implemented: ORS 679.020, 679.025 & 679.250

818-042-0130

Application for Certification by Credential

An applicant for certification by credential shall submit to the Board:

(1) An application form approved by the Board, with the appropriate fee;

(2) Proof of certification by another state and any other recognized certifications (such as CDA or COA certification) and a description of the examination and training required by the state in which the assistant is certified submitted from the state directly to the Board; or

(3) Certification that the assistant has been employed for at least 1,000 hours in the past two years as a dental assistant performing the functions for which certification is being sought.

(4) If applying for certification by credential as an EFDA**,** ~~or~~ EFODA **or EFPDA**~~,~~ certification by a licensed dentist that the applicant is competent to perform the functions for which certification is sought; and

(5) If applying for certification by credential in Radiologic Proficiency, certification from the Oregon Health Authority, Center for Health Protection, Radiation Protection Services, or the Oregon Board of Dentistry, that the applicant has met that agency's training requirements for x-ray machine operators, or other comparable requirements approved by the Oregon Board of Dentistry.

Stat. Auth.: ORS 679

Stats. Implemented: ORS 679.020, 679.025 & 679.250

Rulemaking Hearing Testimony
Received by 10/13/2016

Juan Yepes, D.D.S., M D , M P H , DrPH, Indiana University, School of Dentistry, Department of Pediatric Dentistry – OAR 818-012-0010(13)
Stephen Bush – Permanente Dental Associates, PC – Regarding OAR 818-012-0010(14)
Adam Fox, D.M.D. – Regarding OAR 818-012-0060
Bruce Sellers, D.M.D. – Regarding OAR 818-012-0070(e)
Ivan Wolthuis, D.M.D. – Regarding OAR 818-026 & OAR 818-042-0112
Christopher Swisher, D.D.S. – Regarding OAR 818-042-0112

IUPUI

DEPARTMENT OF
PEDIATRIC DENTISTRY

SCHOOL OF DENTISTRY
Indiana University
Indianapolis

RECEIVED
OCT 13 2016
Oregon Board
of Dentistry

October 13, 2016

Attn: President Julie Ann Smith, DDS, MD, MCR
Oregon Board of Dentistry
1500 SW 1st Avenue, Suite # 770
Portland, OR 97201

Reference: CBCT Guidelines Rule

Dear Dr. Smith

My name is Juan F. Yepes. I am an associate professor in the Department of Pediatric Dentistry at Indiana University, Indianapolis. I have postgraduate training in oral radiology (University of Iowa), oral medicine (University of Pennsylvania), and pediatric dentistry (University of Kentucky). My doctoral degree (University of Kentucky) is in epidemiology. I spent the last 5 years of my academic career in the field of radiation safety and children, as you know, the most radiosensitive population.

The advantages that volumetric imaging (CBCT) bring to the practice of dentistry are **undebatable**. However, the implications in terms of radiation are in the frontline of our profession. The public is well informed about the delicate balance between necessary radiation for diagnostic purposes and the long term effects of radiation, especially in children (NY Times, November 22 2010. http://www.nytimes.com/2010/11/23/us/23scan.html?_r=0). The American Academy of Oral and Maxillofacial Radiology in a position statement about the use of CBCT in orthodontics concluded that there is not clear evidence to support the routine use of CBCT for standard orthodontic diagnosis and treatment planning (Oral Surg Oral Med Oral Pathol Oral Radiolo 2013; 116:238-257). A robust evidence base-dentistry literature came to the conclusion that up to today, there is little evidence for improved diagnostic efficacy of CBCT over alternative radiographic examinations.

The current proposed rule to the Oregon Board of Dentistry, to include a statement to take out the routine use of CBCT in orthodontics and particular in children is aligned with the

Riley Hospital for Children Suite 4205 Indianapolis, IN 46202-5200 317 944-9604 fax 317 948-0760

current national campaign of the Alliance for Radiation Safety in Pediatric Imaging (www.imagegently.org) and endorsed by the American Dental Association. I deeply support the proposed rule, always with the frame of "justification" as the reason to prescribe a particular imaging technique, including CBCT.

Thank you for your time reading this letter,

Sincerely yours,

Juan F. Yepes DDS, MD, MPH, MS, DrPH
Diplomate ABOM, ABDPH, and ABPD
Active member AAOMR, AAOM, AAPD, ADA
Associate Professor of Pediatric Dentistry
Department of Pediatric Dentistry
James Whitcomb Riley Hospital for Children
Indiana University School of Dentistry
705 Riley Hospital Drive, RM 4205
Indianapolis, IN 46202
Office: (317)944-9601
Fax: (317)948-0760
jfyepes@iupui.edu

From: Stephen X. Bush [mailto:Stephen.C.Bush@kp.org]
Sent: Tuesday, October 11, 2016 2:12 PM
To: OBD Info
Subject: Comment to proposed 10/20/16 rulemaking

Comment to Oregon Board of Dentistry ("Board") Proposed Rule-Making
Hearing Date: October 20, 2016, 7pm

To: Hearing Officer & Board President Julie Ann Smith, DDS, MD, MCR
Oregon Board of Dentistry

From: Stephen C. Bush, Director of Legal Services & Government Relations
Permanente Dental Associates, PC

Proposed Rule:

818-012-0010
Unacceptable Patient Care

The Board finds, using the criteria set forth in ORS 679. 140(4), that a licensee engages in or permits the performance of unacceptable patient care if the licensee does or permits any person to:
***
(14) Fail to advise a patient of any treatment complications or treatment outcomes.

Comment:

Requesting that implementation of proposed OAR 818-012-0010(14) be delayed for a two-year period while the Oregon Legislature considers adopting a legal privilege substantially similar to the one for Oregon Medical Board licensees at ORS 677.082, and which would prohibit dentists' statements of regret or apology to their patients from being used against them in lawsuits.

Background & Assessment
Unlike licensees of the Oregon Medical Board (OMB), Oregon dentists are not afforded any kind of statutory privilege protection when disclosing an error or complication in dental treatment. Privileging statements of apology or regret – limiting the use of such statements in litigation – encourages transparency around clinical errors and adverse events. The resulting transparency enhances patient care, improves patient safety and maintains the relationship of provider/patient instead of plaintiff/defendant.

Currently, there are five Oregon healthcare license types (MDs, DOs, DPMs, PAs & LAcs, all of whose licenses are governed by the Oregon Medical Board) which may make statements of apology or regret to patients without fear of those statements being used against them in lawsuits:

ORS 677.082 – Expression of regret or apology

(1) For the purposes of any civil action against a person licensed by the Oregon Medical Board or a health care institution, health care facility or other entity that employs the person or grants the person privileges, any expression of regret or apology made by or on behalf of the person, the institution, the facility or other entity, including an expression of regret or apology that is made in writing, orally or by conduct, does not constitute an admission of liability.

(2) A person who is licensed by the Oregon Medical Board, or any other person who makes an expression of regret or apology on behalf of a person who is licensed by the Oregon Medical

> Board, may not be examined by deposition or otherwise in any civil or administrative proceeding, including any arbitration or mediation proceeding, with respect to an expression of regret or apology made by or on behalf of the person, including expressions of regret or apology that are made in writing, orally or by conduct.

A broad coalition of dental care organizations and dentists practicing in Oregon – including the Oregon Dental Association – has recently begun working toward a statutory legal privilege permitting Oregon dentists and possibly other healthcare licensees to disclose errors and adverse outcomes without fear of those statements being used in lawsuits. Without a safe space for healthcare professionals to be transparent with their patients about clinical errors and adverse events, an opportunity is lost to improve patient care and safety for the public.

For all of these reasons, we respectfully request that the Board delay implementation of proposed OAR 818-012-0010(14) so that the Legislature can consider a statutory privilege for dentists' statements of apology or regret.

Please contact the undersigned if I can provide any further information. I look forward to appearing before the Board at the October 20th rule-making hearing and discussing this proposed rule.

Thank you.

Stephen Bush, JD
Director, Legal Services & Government Relations
PDA MSO, LLC | Permanente Dental Associates, PC
500 NE Multnomah Street
Portland, OR 97232
Phone: 503-813-2724 | Cell: 971-221-6615
Please send PDFs in lieu of faxing
Email: Stephen.C.Bush@kp.org

Administrative Assistant -- Meaghan Madden
Email: Meaghan.L.Madden@kp.org
Phone: 503-813-3040(49-3040)

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From: Adam Fox
To: OBD Info
Subject: Fw: Important Information - Announcements (Draft for Licensees)
Date: Friday, August 26, 2016 2:13:30 PM

Hello:

I find the language of "818-012-0060 Failure to Cooperate with Board....Fail to attend a Board requested investigative interview or failure to fully cooperate in 676 any way with an ongoing Board investigation." to be too general, too broad and too open to interpretation.

I live in Medford, if the Board wanted to interview me tomorrow, and I had patients scheduled that would be an undo burden on me. Also, I've heard of the Board making some strange and arduous requests. I am uncomfortable allowing such sweeping language into the Dental Practice Act. "Failure to comply in any way" gives a LOT of power to the Board.

Thank you,

Adam Fox DMD

----- Forwarded Message -----
From: Oregon Board of Dentistry - Mailing List <MailingLists@oregondentistry.org>
To:
Cc: Ingrid Nye <Ingrid.Nye@state.or.us>; Haley Huntington <Haley.Huntington@state.or.us>; Teresa Haynes <Teresa.Haynes@state.or.us>
Sent: Friday, August 26, 2016 1:25 PM
Subject: Important Information - Announcements (Draft for Licensees)

Oregon
Kate Brown, Governor

Board of Dentistry
1500 SW 1st Ave. Ste 770
Portland, OR 97201-5837
(971) 673-3200
Fax: (971) 673-3202

August 26, 2016

Dear Licensees:

Notice of Public Rulemaking Hearing October 20, 2016

At its August 19, 2016 meeting, the Board approved holding a public rulemaking hearing on October 20, 2016 at 7 p.m. to review 39 proposed rule changes. The Board welcomes feedback and comments from all interested parties, whether in person at the public rulemaking hearing or through correspondence. You may submit your comments to information@oregondentistry.org or mail them to the Board's mailing address. The latest we can accept your feedback by correspondence is at 4 p.m. on October 20th. The notice and proposed rule changes can be viewed at this

link. **Notice of Proposed Rulemaking Hearing and Proposed Rule Changes**

The Board will be voting on amending the rules at its regularly scheduled Board meeting on October 21.

Dental Hygiene Renewal Reminder – Expiration Date September 30, 2016

This reminder is for dental hygienists whose licenses expire on September 30, 2016 to renew their dental hygiene licenses. Renewal postcards were mailed July 15, 2016 to those hygienists with an expiration date of September 30, 2016. If you have not renewed your dental hygiene license as of yet, following is the link to do so:

https://hrlb.oregon.gov/obd/renewals/index.asp

If you do not plan on renewing your dental hygiene license, please let us know.

Your opinion matters. Please complete our Customer Satisfaction Survey at
http://obd.oregonsurveys.com

From:	Bruce
To:	OBD Info
Subject:	Regarding the change of 818-012-0070-e
Date:	Thursday, September 22, 2016 9:36:59 AM

To whom it may concern,

While all changes proposed by the board seemed valid and in many cases just a point of wording, I write this e-mail regarding the change proposed of 818-012-0070-e in which the board proposes the following wording:

> Date and**,** description **and documentation of informing the patient** of treatment complications **or treatment outcomes**;

I am asking for further clarification on how this differs from discussing the RISKS when PARQing with a patient? If this is in fact different, could the board cite an example of that they would like to see? If this is in fact covered under the Risks discussed in PARQ, then perhaps the wording could be changed to "Date, description and documentation of informing the patient of treatment complications or treatment outcomes, if not already reviewed under PARQ"

The board's help in clarifying this matter is appreciated.

Thank you.

Dr. Bruce Sellers
Neighborhood Dentistry
A place of welcome for your kids
1109 Liberty Circle S
Salem, OR 97306
Office: 503-363-8466
www.kidsdentistsalem.com

From: Dr. Ivan Wolthuis [mailto:doctorivan@sweethomedental.com]
Sent: Monday, August 29, 2016 5:26 PM
To: OBD Info
Subject: Proposed changes to practice act

To Whom It May Concern,

As I review the proposed changes, I can't help but wonder what the thought processes were behind the changes. In particular the following:

1. Why are dentists and hygienists now being referred to as "dentist permit holders," "hygienist permit holders," and even "licensed dental permit holders?"
2. Why the creation of a new class of dental assistants known as "Expanded Function Preventive Dental Assistants (EFPDA)?"

I take lots of continuing education and strive to be provide "evidence based" dental care to my patients. So often, I wonder if portions of the practice act are driven more by special interests and their lobbyists. For the benefit of the entire dental profession here in Oregon, I think that further explanations for why the changes are proposed would be very beneficial. Due to travel distance and busy schedules, attending the meetings is not exactly practical or possible. Could there be more of an online forum or newsletter to encourage more participation by the professionals you are writing rules for? I might enjoy being more involved.

Respectfully,

Ivan H. Wolthuis, DMD, MAGD

From:	Chris Swisher
To:	Oregon Board of Dentistry - Mailing List; conor mcnulty; Austin Bruce W
Cc:	Ingrid Nye; Haley Huntington; Teresa Haynes
Subject:	Re: Important Information - Announcements (Draft for Licensees)
Date:	Friday, August 26, 2016 6:59:03 PM
Attachments:	image001.jpg

Expanded Function Preventative Dental Assistant is a vaguely defined category that will be made to appease the corporate dental offices and insurance companies that use a capitation payment system. There should be considerable discussion regarding this category. It will continue to devalue dentistry much similar to what corporate dentistry and large capitation systems have already done, but to such a great extent, that it may be difficult to reestablish dental care as something more a smear of Silver Diamine Fluoride on teeth 3-4 times a year at school...

On Fri, Aug 26, 2016 at 1:25 PM, Oregon Board of Dentistry - Mailing List <MailingLists@oregondentistry.org> wrote:

cid:image001.jpg@01D0EADF.847A0460

August 26, 2016

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If you do not plan on renewing your dental hygiene license, please let us know.

Your opinion matters. Please complete our Customer Satisfaction Survey at

http://obd.oregonsurveys.com

--
" think differently "

CORRESPONDENCE

From: gamdmd@peak.org
To: Teresa Haynes; Stephen Prisby
Subject: Re: OBD Memo Surgeon General Pledge
Date: Thursday, August 25, 2016 11:57:55 AM
Attachments: image007.png

Hello you guys,

Isn't it interesting that the OR Legislature in all their wisdom a few years ago required all Health practitioners to take their online course in pain management and then required the OBD to verify compliance. Seems as though as I remember it the course was all about insuring that no Oregonian ever experience pain. And now an authority on even a higher plateau has asked us all to join in a pledge to try to eliminate the abuse of opiods. Some of us fully expected this to be the consequence of the requirement of the law. Another example of a law that resulted in significant consequences that were unintended and another reason to really examine the introduction of rules that while seemingly well intended very likely will result in consequences that were not foreseen by the promoters of the rule and that never were intended.

Years certainly do help in seeing more clearly the folly of our ways. Have a great day.

George McCully

From: "Oregon Board of Dentistry - Mailing List" <MailingLists@oregondentistry.org>
Cc: "Stephen Prisby" <Stephen.Prisby@state.or.us>, "Teresa Haynes" <Teresa.Haynes@state.or.us>
Sent: Thursday, August 25, 2016 8:28:04 AM
Subject: OBD Memo Surgeon General Pledge

Oregon
Kate Brown, Governor

Board of Dentistry
1500 SW 1st Ave. Ste 770
Portland, OR 97201-5837
(971) 673-3200
Fax: (971) 673-3202

To: OBD Licensees
From Oregon Board of Dentistry
Date: August 25, 2016
Subject: The Surgeon General is calling on us to lead

Dear Colleague,

Today, the U.S. Surgeon General is taking historic action by sending a personal letter to more than 2.3 million health care practitioners and public health leaders. He is seeking our help to address the prescription opioid crisis. We want to make sure you see his letter, a copy of which we have included below. Please take a moment to read it. Then go to www.TurnTheTideRx.org/join to join with clinicians from across the country in a simple but powerful movement to end this epidemic.

Read the letter. Take the pledge. And spread the word.

Together, we can save countless lives. We can lead the way. We can #TurnTheTide.

Dear Colleague,

I am asking for your help to solve an urgent health crisis facing America: the opioid epidemic. Everywhere I travel, I see communities devastated by opioid overdoses. I meet families too ashamed to seek treatment for addiction. And I will never forget my own patient whose opioid use disorder began with a course of morphine after a routine procedure.

It is important to recognize that we arrived at this place on a path paved with good intentions. Nearly two decades ago, we were encouraged to be more aggressive about treating pain, often without enough training and support to do so safely. This coincided with heavy marketing of
opioids to doctors. Many of us were even taught – incorrectly – that opioids are not addictive when prescribed for legitimate pain.

The results have been devastating. Since 1999, opioid overdose deaths have quadrupled and opioid prescriptions have increased markedly – almost enough for every adult in America to have a bottle of pills. Yet the amount of pain reported by Americans has not changed. Now,

nearly 2 million people in America have a prescription opioid use disorder, contributing to increased heroin use and the spread of HIV and hepatitis C.

I know solving this problem will not be easy. We often struggle to balance reducing our patients' pain with increasing their risk of opioid addiction. But, as clinicians, we have the unique power to help end this epidemic. As cynical as times may seem, the public still looks to our profession for hope during difficult moments. This is one of those times.

That is why I am asking you to pledge your commitment to turn the tide on the opioid crisis. Please take the pledge. Together, we will build a national movement of clinicians to do three things:

First, we will educate ourselves to treat pain safely and effectively. A good place to start is this pocket guide with the CDC Opioid Prescribing Guideline. Second, we will screen our patients for opioid use disorder and provide or connect them with evidence-based treatment. Third, we can shape how the rest of the country sees addiction by talking about and treating it as a chronic illness, not a moral failing.

Years from now, I want us to look back and know that, in the face of a crisis that threatened our nation, it was our profession that stepped up and led the way. I know we can succeed because health care is more than an occupation to us. It is a calling rooted in empathy, science, and service to humanity. These values unite us. They remain our greatest strength.

Thank you for your leadership.

Vivek Murthy

Graham D. Shea, DDS
4012 Oak St.
San Marcos, TX 78666
503-318-1996
gckshea@yahoo.com
LinkedIn: www.linkedin.com/in/grahamdsheaoregon/

26 August 2016

Dear Oregon Board of Dentistry:

After receiving the latest email regarding the Surgeon General's plea to curb opioid abuse and the addiction epidemic, I was struck with a severe case of the "ironies." A number of years ago (2009) the Oregon Board of Dentistry made it clear that all practitioners of dentistry must take a Pain Management Course, available in person or online, in order to maintain Oregon licensure.

In that Course, it was stated that a dentist in compliance with the ethical standard of care will ensure the patient of record shall be treated for acute and chronic pain.

http://www.oregon.gov/oha/OHPR/PMC/pages/index.aspx

818-021-0060
Continuing Education — Dentists

> (5) All dentists licensed by the Oregon Board of Dentistry will complete a one-hour pain management course specific to Oregon provided by the Pain Management Commission of the Oregon Health Authority. All applicants or licensees shall complete this requirement by January 1, 2010 or within 24 months of the first renewal of the dentist's license.

Because I worked for Kaiser Permanente, in their usual way of embellishing OBD Rules to meet their Human Resources criteria of scrutiny of their providers, the Pain Management guidelines became a dictum of expected treatment protocols, not guidelines within the judgment and best practices of each provider. Therefore, the Pain Management Course became either a forced dictation to prescribe for pain medications which may not be what a given practitioner believes is best for their patients. But the OBD Pain Management Course support also became a tool to punitively address a provider if it was deemed they over prescribed a particular medication (very subjective). It all depended on the way the winds blew within the Permanente Dental Associate/Kaiser Permanente Dental Care Program administration, and the Kaiser Pharmacy Review Board. In other words, if they didn't like a provider, this Course outline became a tool to use for or against the best judgments of a dental provider – not what this Pain Management Course was intended for.

Needless to say, this was one of many ways the HR and non-dental administrators exercised Kaiser's dictation of dental care for the patients…wholly against the fact that it is the individual dentist who hold the license, and the care is not to be in the hands of a corporate standard.

All this is to say I find it interesting the Oregon Board of Dentistry made the Pain Management Course a requirement for licensure just in 2009-2010, and now the web link to

the Pain Management Couse, in the shadow of the Surgeon General's Letter about the epidemic abuse of opioids, is no longer available? Which way do you want it?

From the first inception of the Pain Management Course requirement, I had reservations. I saw it as a potential dictation to be used by Kaiser Permanente, as well as the Board of Dentistry, to judge my beliefs, skills, and knowledge in acute and chronic pain management and hold me to a standard to which I would not always see fit to treat my patients…that is, use opioids and treat acute pain aggressively.

Fast forward to our current epidemic, and the Surgeon General's belief that he needs to address every provider who prescribes and treats patients in pain, and I see we have a problem in what everyone is doing. I have long held that opioids were highly over prescribed, lacked effectiveness, and created a toxic social and real medical dilemma that we are now seeing come to fruition. Yet I was held to the standard to prescribe, lest I be undertreating and neglecting my patients! Seriously?

Thank you for the joining of the Surgeon General's bandwagon, but I saw this coming way before 2009 when I "had" to take the course. Dentists became the patsy, the "hit" used when an abuser was told "no" by their medical providers…feign a toothache and demand meds. If a dentist refused, at least at Kaiser, they were brought to investigation that they were refusing treatment. This is unethical on Kaiser's part, yet the Board of Dentistry has NO jurisdiction over a corporation that hold jobs hostage via dictating care. It is crap.

So I continue to limit my opioid prescription to very specific cases, and have to constantly defend myself in the public's eye as they expect "something stronger." I hate the battle! We have a bunch of pill popping users out there that the Surgeon General is right in saying the medical community has been a part of the creation of the problem, but must be also a solution. I fail to see how this was not on the Board of Dentistry's radar far before 2009 when it adopted a mandatory course that spoke almost oppositely to the Surgeon General's letter.

I am disgusted with how dentistry has evolved since dental school graduation in 1990. This political game is but one more reason to always be paranoid I can never treat my patients in their best interest, without some rule or mandate that screams contradiction. I lost/quit my job of 17 years at Kaiser for these very reasons, plus they suck as a company in employee support, and they are laughing at the Board. If only they could be regulated and investigated…they'd be done tomorrow. But further, I did not agree with the tone of the day in 2009 that I was forced to treat pain aggressively or face either abandonment issues, or insufficient care charges because of the medications I chose to prescribe.

I do hope the Oregon Board of Dentistry lands on a practical and thought out note in this matter…a problem was created, supported, and now being pleaded to be solved. It will not be easy.

Regards,
Graham D. Shea, DDS

P.S., I have had discussions with Darryl Ross and Paul Kleinstub in the past when I was still employed by Permanente Dental Associate (ended 2013) regarding care issues dictated by their corporation who was neither regulated by the Board of Dentistry nor the Oregon

Insurance Commission. It leaves practitioners holding the bag with regards to how KP/PDA plays their so-called "evidence-based," research driven, cutting edge leadership in dental care. Bullshit. Please do not give Kaiser bullets for their guns to crucify good dentists in the name of the almighty buck. And this goes for the corporate schlocky chains springing up like malignancies all over the states. These outfits use Board Rules out of context to control providers who need jobs but are driven to practice outside their envelopes of ethical and moral boundaries.

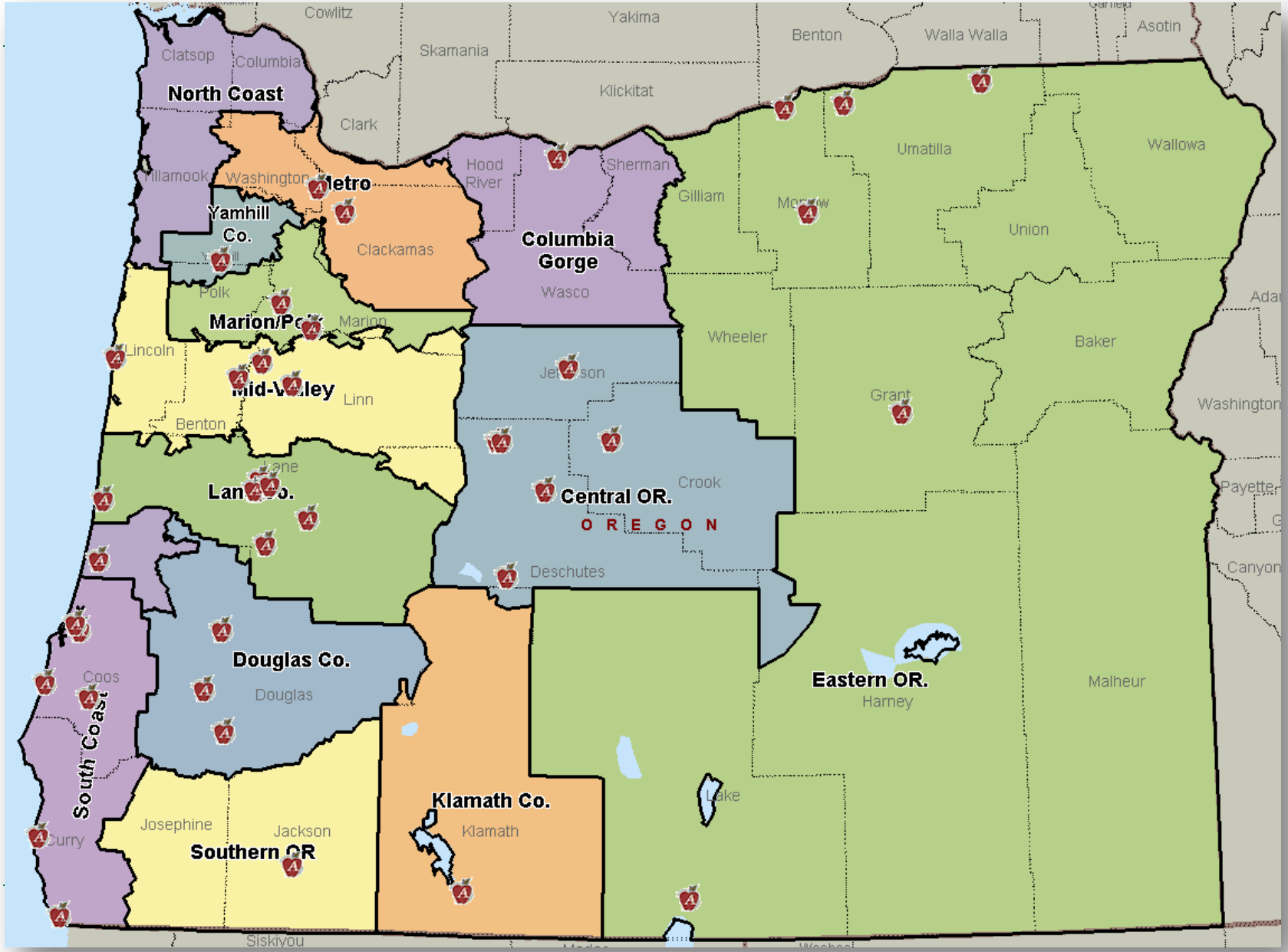
I worked briefly with Daniel Blickenstaff at PCC Dental Hygiene and Assisting Program at Sylvania. I respect his take on things. Do this thing right.

OTHER ISSUES

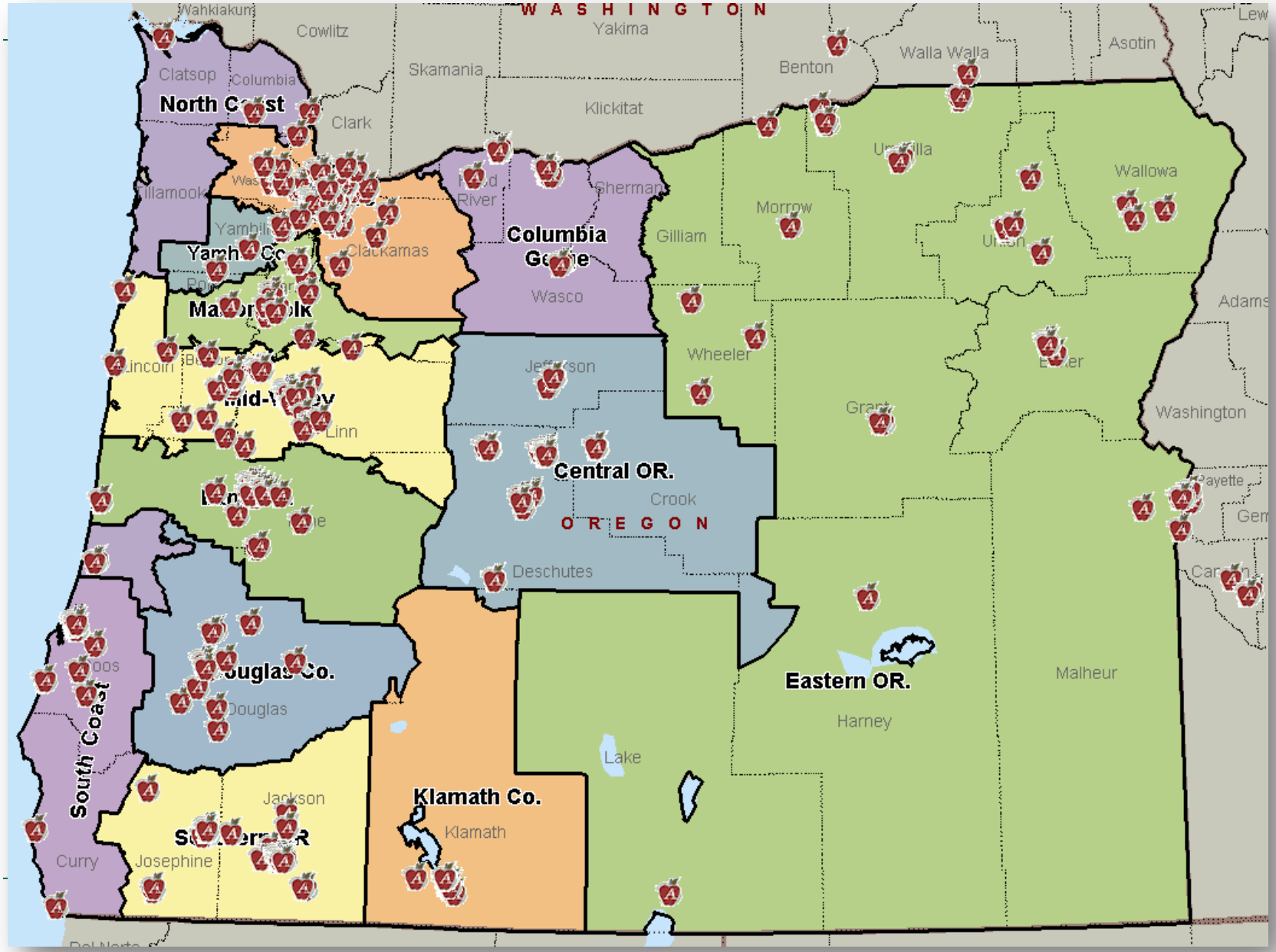
Oregon Board of Dentistry Presentation

By: R. Mike Shirtcliff, DMD
President
mikes@advantagedental.com

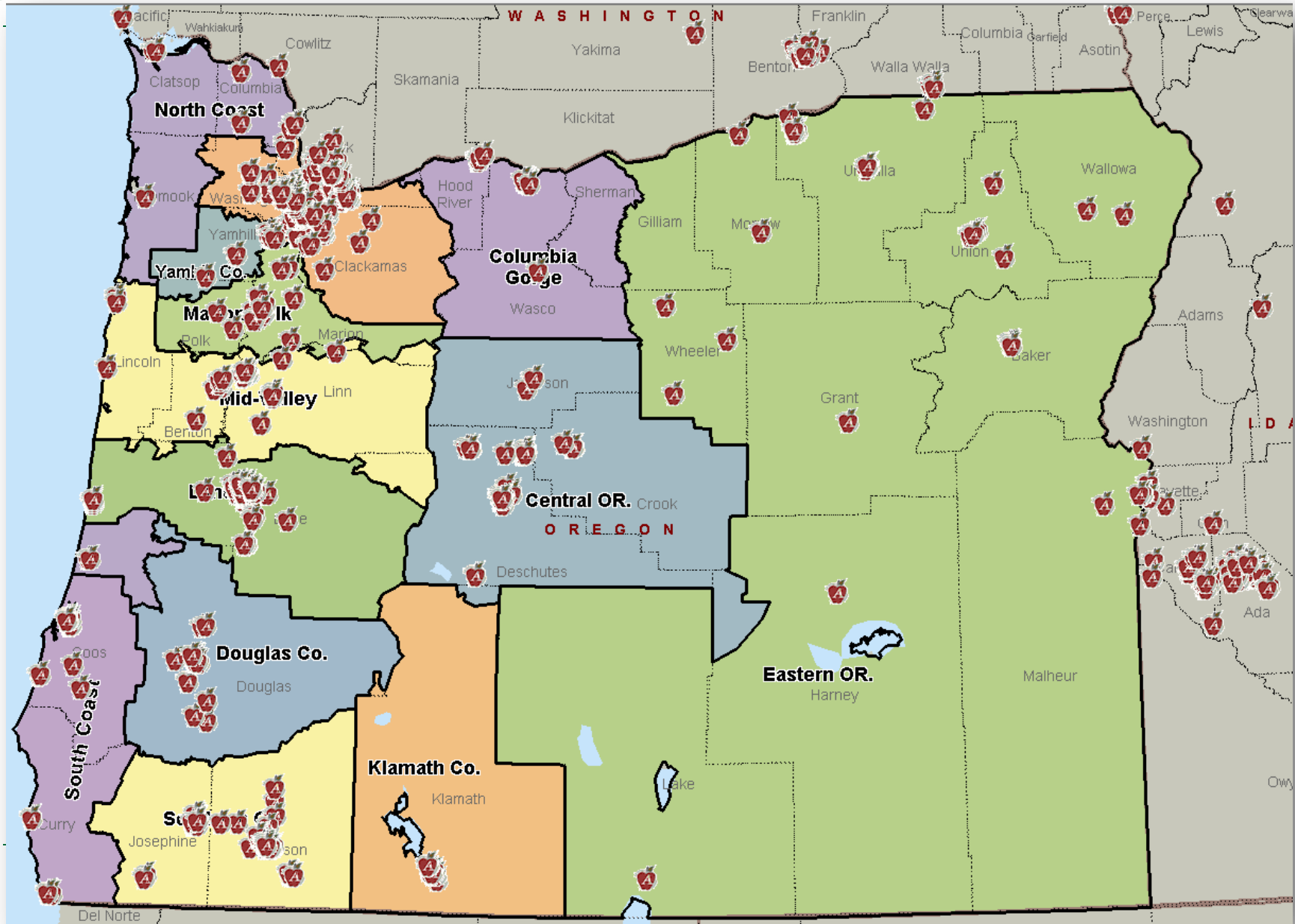
Advantage Dental Clinic Locations



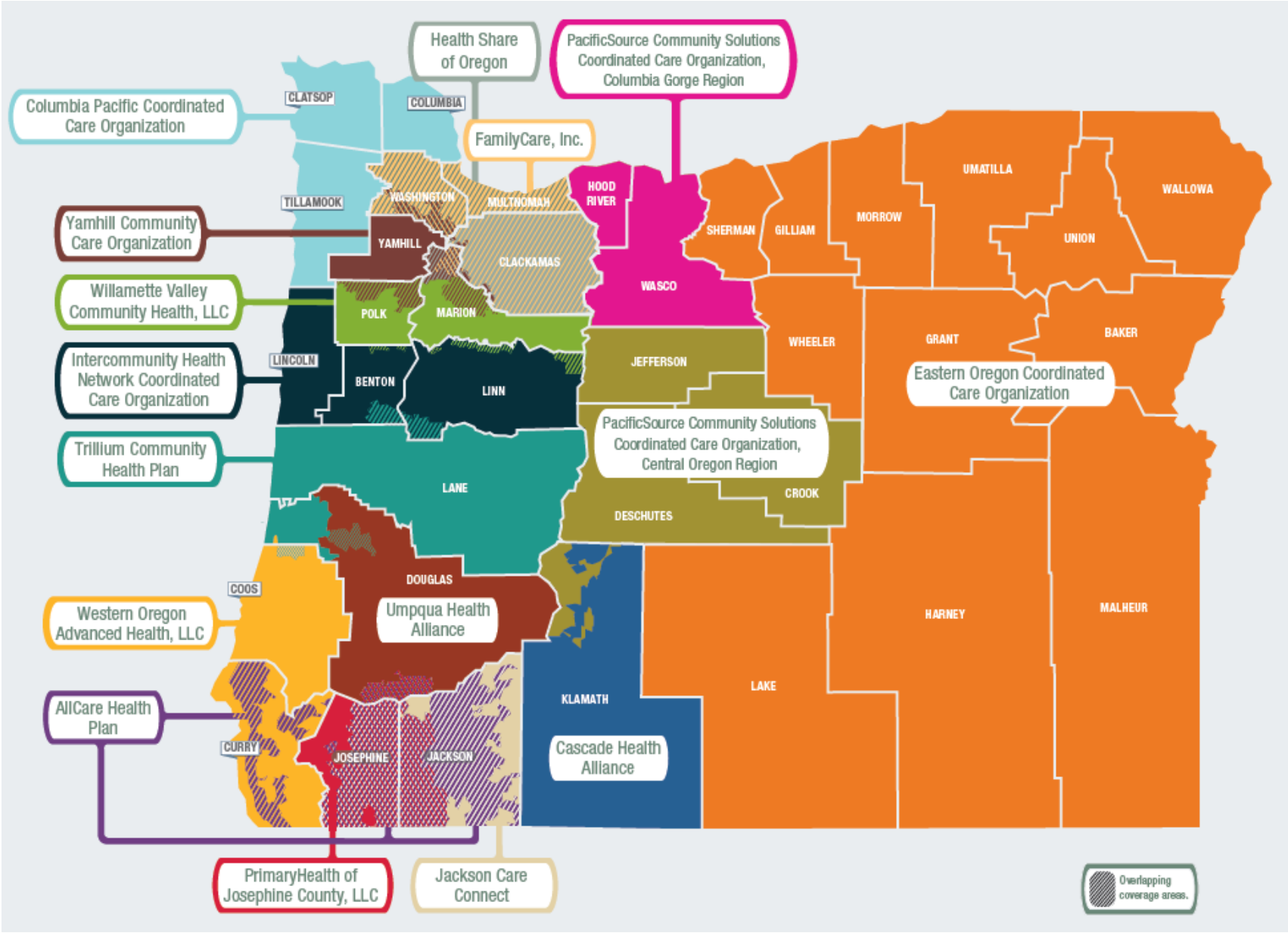
OHP Contracted Provider Offices



Commercial Provider Offices



Coordinated Care Organization Service Areas



CCO/DCO Relationships

CCO	Contracted DCOs
AllCare (ACHP)	Advantage Dental, Capitol Dental, ODS, & Willamette Dental
Cascade Health Alliance (CHA)	Advantage Dental & Capitol Dental
Columbia Pacific CCO (CPCC)	Advantage Dental, Capitol Dental, ODS, & Willamette Dental
Eastern Oregon CCO (EOCC)	Advantage Dental, Capitol Dental, & ODS
FamilyCare, Inc. (FCI)	Access Dental, Advantage Dental, Capitol Dental, CareOregon, Family Dental, ODS, & Willamette Dental
HealthShare of Oregon (HSO)	Access Dental, Advantage Dental, Capitol Dental, CareOregon, Family Dental, Kaiser, ODS, & Willamette Dental
InterCommunity Health Network (IHN)	Advantage Dental, Capitol Dental, ODS, & Willamette Dental
Jackson Care Connect (JCC)	Advantage Dental, Capitol Dental, ODS, & Willamette Dental
PacificSource Central Oregon (PSCS)	Advantage Dental, Capitol Dental, ODS, & Willamette Dental
PacificSource Columbia Gorge (PSGC)	Advantage Dental, Capitol Dental, & ODS
Primary Health of Josephine County (PHJC)	Advantage Dental, Capitol Dental, ODS, & Willamette Dental
Trillium (TCHP)	Advantage Dental, Capitol Dental, ODS, & Willamette Dental
Umpqua Health Alliance (UHA)	Advantage Dental & Willamette Dental
Western Oregon Advanced Health (WOAH)	Advantage Dental
Willamette Valley Community Health (WVCH)	Advantage Dental, Capitol Dental, ODS, & Willamette Dental
Yamhill CCO (YCCO)	Advantage Dental, Capitol Dental, & ODS

OHP Enrollment by CCO- 2016

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
ACHP	20,513	20,873	21,534	20,991	20,959	20,615	20,192	20,043
CHA	12,778	13,140	13,213	12,812	12,695	12,460	12,142	12,160
CPCC	5,134	5,225	5,245	5,049	5,037	4,934	4,821	4,730
EOCC	38,965	39,828	40,428	39,088	39,083	38,379	37,345	36,642
FCI	13,214	13,729	14,046	13,796	13,751	13,565	13,161	13,243
HSO	11,687	12,145	12,355	12,174	12,347	12,120	11,939	11,938
IHN	17,669	18,392	18,953	18,507	19,449	18,509	17,963	17,771
JCC	12,603	12,905	13,101	12,883	13,083	12,846	12,505	12,424
NWD	24,074	24,677	25,309	24,643	24,638	23,678	23,098	23,043
PHJC	4,609	4,640	4,668	4,454	4,412	4,289	4,173	4,087
PSCS	41,575	42,264	42,663	41,217	41,058	40,024	38,809	38,054
PSGC	7,514	7,660	7,746	7,424	7,493	7,336	7,173	7,065
TCHP	48,312	48,783	49,392	47,538	46,981	44,325	37,785	37,954
UHA	23,993	24,307	24,505	23,913	23,880	23,577	23,183	23,006
WOAH	21,334	21,759	21,935	21,358	21,297	20,986	20,590	20,521
WVCH	16,490	16,909	17,106	16,575	16,715	16,559	16,224	16,252
YCCO	9,175	9,611	10,026	10,020	10,301	10,253	9,967	10,032
Total	329,639	336,847	342,225	332,442	333,179	324,455	311,070	308,965

Advantage Enrollment/CCO Enrollment

	Advantage Aug-16	CCO* Aug-16	Advantage Percent
ACHP	20,043	49,186	41%
CHA	12,160	17,353	70%
CPCC	4,730	25,784	18%
EOCC	36,642	46,452	79%
FCI	13,243	123,587	11%
HSO	11,938	223,623	5%
IHN	17,771	55,750	32%
JCC	12,424	30,163	41%
NWD	23,043	55,533	41%
PHJC	4,087	11,230	36%
PSCS	38,054	49,745	76%
PSGC	7,065	12,253	58%
TCHP	37,954	93,249	41%
UHA	23,006	25,596	90%
WOAH	20,521	20,207	102%
WVCH	16,252	97,909	17%
YCCO	10,032	24,475	41%
Total	308,965	962,095	32%

* - Source OHP Coordinated Care enrollment report for 8/16/2016 - includes all benefit types CCOA, CCOB, CCOE, and CCO G) regardless of benefit package

Advantage Dental Grievance Process

- Upon receipt of an expression of dissatisfaction by a member to an Advantage Customer Service Representative, the member is offered a complaint form, or if the member desires to make a verbal complaint, the Customer Service Representative will fill out a verbal complaint form on behalf of the member.
  - Within five (5) days of receipt of the complaint, the Case Management Department will either 1) make a decision on the complaint and notify the member, or 2) notify the member in writing that a delay of up to 30 calendar days is necessary to resolve the grievance.
- Upon receipt of the complaint Advantage Dental's Grievance Coordinator will:
  - Investigate by contacting the member, Advantage Dental Clinical/Administrative staff and others as necessary (primary care physician, mental health worker, etc.)
  - Gather all supporting documentation and submit for review by Advantage Dental's Dental Director or President.
  - Complete any follow up requested by Advantage Dental's Dental Director or President while working with the member to ensure a satisfactory resolution.
  - Keep a complete and accurate record of all steps taken and all documentation submitted during the grievance process.
- Upon completion of the grievance, a follow up letter will be sent to the member explaining what steps were taken to resolve their complaint. If the member is dissatisfied with the resolution, the member may present their grievance to the Governor's Advocacy Office.
- All grievances are submitted to the Quality Improvement Committee for review on a bimonthly basis. The QI Committee reviews the grievances for quality of care issues, access issues, etc. and looks for any trends.

PREDICT

Population-centered

Risk-based

Evidence-based

Dental **I**nter-professional **C**are **T**eam

PREDICT

- PREDICT is designed to test the effectiveness of new delivery and payment systems for improving dental care and oral health.
  - Changes in the delivery system
    - Aggressive outreach and screening
    - Risk-based primary and secondary preventive care
    - Seamless referral for curative care
    - Expanded case management
  - Pay for performance metrics

PREDICT

- PREDICT is a three-year grant project that is a collaboration between University of Washington and Advantage.

- University of Washington will use Advantage's Expanded Practice Dental Hygienists (EPDH) to evaluate the effectiveness of utilizing EPDHs in providing oral health care in community settings.

PREDICT Study Counties

- **Intervention (PREDICT):**
- Deschutes
- Douglas
- Jackson-Josephine
- Klamath
- Morrow
- Wasco

- **Control:**
- Coos
- Crook
- Curry
- Grant
- Jefferson
- Lake
- Lincoln
- Umatilla

Expanded Practice Permit Dental Hygienist

- Board of Dentistry reclassifies LAP to Expanded Practice Permit Dental Hygienist (EPDH)
  - Scope of Practice
  - Set parameters of where an EPDH may perform services on patients without dental supervision
  - Adopted requirement that hygienists enter into a written collaborative agreement
    - In a format approved by the Board of Dentistry
    - Must be with a licensed dentists

Expanded Practice Permit Dental Hygienist

- **May perform all services within the scope of practice of a dental hygiene without the supervision of a dentist to:** *See ORS 680.205 for complete list.*
  - Patients or residents at defined facilities or programs who, due to age, infirmity or disability, are unable to receive regular dental hygiene treatment.
  - Adults who are homebound.
  - Nursing homes and resident care type facilities
  - Mental health residential programs administered by OHA,
  - Correctional type facilities.
  - Public and nonprofit community health clinics.
  - Students or enrollees of nursery schools/day care programs and their siblings under 18 years of age, Job Corps and other similar employment training facilities, primary and secondary schools, including private schools and public charter schools, and persons entitled to benefits under the Women, Infants and Children Program.
  - Patients in hospitals, medical clinics, medical offices or offices operated or staffed by nurse practitioners, physician assistants or midwives.
  - Patients whose income is less than the federal poverty level and low-income persons (200% of FPL)
  - Other populations that the Oregon Board of Dentistry determines are underserved or lack access to dental hygiene services.

Expanded Practice Permit Dental Hygienist

- Unless otherwise specified in the Collaborative Agreement,
  - At least once each calendar year, a EPDH must refer patient to a dentist to treat the patient
  - EPDH must note in chart that patient was referred to dentist
- Collaborative Agreement must set forth scope of EPDH practice regarding:
    - Administering local anesthesia
    - Administering temporary restorations without excavation
    - Prescribing prophylactic antibiotics and nonsteroidal anti-inflammatory drugs and
    - Referral parameters
  - When these services are authorized by a licensed dentist, the EPDH shall document in patient's chart the name of the collaborating dentist and date of collaborative agreement.

EPDH Scope of Practice

No Collaborative Agreement

- An expanded practice dental hygienist may render all services within the scope of practice of dental hygiene, as defined in ORS 679.010, without the supervision of a dentist and as authorized by the expanded practice dental hygienist permit.

With a Collaborative Agreement

- Administer of local anesthesia
- Administer temporary restorations without excavation.
- Prescribing prophylactic antibiotics and non-steroidal anti-inflammatory drugs
- Overall dental risk assessment and referral parameters

Oregon Board of Dentistry. Application for Dental Hygiene Expanded Practice Permit. Accessed: March 8, 2016
http://www.oregon.gov/dentistry/forms/hygiene/expandedpracticepermit_pathway1.pdf

Questions?

Commission on Dental Accreditation

VIA ELECTRONIC MAIL: STEPHEN.PRISBY@STATE.OR.US

September 29, 2016

Mr. Stephen Prisby
Executive Director
Oregon Board of Dentistry
1500 SW 1st Ave., Ste. 770
Portland, OR 97201

Dear Mr. Prisby:

RE: ***State Board Participation on Accreditation Site Visits***

This letter is to notify you that the institution(s) listed below have indicated a willingness to have a representative of the state board participate in the Commission on Dental Accreditation's 2016 on-site evaluations of the following dental and allied dental education program(s):

Allied Education Site Visits:

Portland Community College
Portland, OR
November 1-3, 2017

Advanced Dental Education Site Visits:

Oregon Health and Science University School of Dentistry
Portland, OR
April 20, 2017

Appointment Process and Reimbursement: In accordance with the attached policy statement for state board participation on site visit teams, the state board of dentistry is requested to submit the names of ***two*** representatives who are ***current members*** of the board for each site visit listed. The Commission will then ask the institution to select ***one*** individual to participate on the visit. You will be notified when the institution has selected a representative. Prior to the visit, the representative will receive an informational packet from the Commission and the self-study document from the institution. The state board is responsible for reimbursing its representative for expenses incurred during a site visit.

Confirmation of State Board Participation Form (to be returned): Each program that has elected to invite the board of dentistry is identified on the attached Confirmation of State Board Participation Form(s). The board of dentistry is requested to complete this form, as described above.

Please note: The Confirmation of State Board Participation Form(s) must be returned by the due date indicated on each form, whether or not the State Board is participating in the site visit However, if communication is not received from the state board by this date, it will be assumed that the state board is unable to participate on the site visit.

Conflicts of Interest: When selecting its representatives, the state board should consider possible conflicts of interest. These conflicts may arise when the representative has a family member employed by or affiliated with the institution; or has served as a current or former faculty member, consultant, or in some other official capacity at the institution. Please refer to the enclosed policy statements for additional information on conflicts of interest.

Time Commitment: **It is important that the selected representative be fully informed regarding the time commitment required**. In addition to time spent reviewing program documentation in advance of the visit, the representative should ideally be available the evening before the visit to meet with the Commission's site visit team. Only one state board representative may attend each site visit to ensure that continuity is maintained; the representative is expected to be present for the entire visit.

Confidentiality and Distribution of Site Visit Reports: Please note that, as described in the enclosed documents, state board representatives attending CODA site visits must consider the program's self-study, site visit report, and all related accreditation materials confidential. Release of the self-study, report, or other accreditation materials to the public, including the state board, is the prerogative of the institution sponsoring the program. **State Board representatives who attend a site visit will be requested to sign a confidentiality agreement. If the confidentiality agreement is not signed, the individual will not be allowed to attend the site visit.**

If the Commission can provide further information regarding its site visit evaluation process, please contact Ms. Malinda Little at 1-800-621-8099 extension 2675 or littlem@ada.org or Ms. Sheron Parkman at 1-800-621-8099 extension 2668 or parkmans@ada.org. Thank you in advance for your efforts to facilitate the board's participation in the accreditation process.

Sincerely,

Sherin Tooks

Dr. Sherin Tooks
Director
Commission on Dental Accreditation

ST/gm

cc: Dr. Catherine Horan, Manager, Predoctoral Dental Education, Commission on Dental Accreditation (CODA)
Ms. Jennifer Snow, Manager, Advanced Specialty Education, CODA
Ms. Peggy Soeldner, Manager, Postdoctoral General Dentistry Education, CODA
Ms. Patrice Renfrow, Manager, Allied Education Programs, CODA

Ms. Alyson Ackerman, Manager, Allied Program Reviews, CODA
Ms. Catherine Baumann, Manager, Advanced Specialty Education, CODA
File

Enclosures: CODA Confirmation of State Board Participation Form(s)
Policy on State Board Participation and Role During a Site Visit
Policy on Conflict of Interest
Policy on Public Disclosure and Confidentiality

Commission on Dental Accreditation
Confirmation of State Board Participation
on Dental Education Site Visits

Name of Institution: _____

Program(s) to be Evaluated: _____

Dates of Site Evaluation: _____

To aid the Commission on Dental Accreditation in preparing for the site evaluation noted above, please check the appropriate statements and complete the information requested **by October 31, 2016* or call if additional time is needed.**

_____ The State Board is unable to participate in the site evaluation.

_____ The State Board wishes to participate in the site evaluation and submits the following names of current Board members for the institution's consideration.

Name:	_____	Name:	_____
Address:	_____	Address:	_____
City:	_____	City:	_____
State/Zip:	_____	State/Zip:	_____
Phone:	_____	Phone:	_____
Fax:	_____	Fax:	_____
E-Mail:	_____	E-Mail:	_____

Signature _____

Name (Print/Type): _____

Title: _____

Phone: _____ Fax: _____ Date: _____ E-Mail: _____

Return by fax to: 1-312-587-5121

Attn: Ms. Malinda Little, Site Visit Coordinator
Ms. Sheron Parkman, Site Visit Coordinator
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois 60611

***If a response is not received by the date indicated above, it will be presumed that the State Board is unable to participate.**

Revised 09/2016

POLICY ON STATE BOARD PARTICIPATION DURING SITE VISITS

It is the policy of the Commission on Dental Accreditation that the state board of dentistry is notified when an accreditation visit will be conducted in its jurisdiction. The Commission believes that state boards of dentistry have a legitimate interest in the accreditation process and, therefore, strongly urges institutions to invite a current member of the state board of dentistry to participate in Commission site visits. The Commission also encourages state boards of dentistry to accept invitations to participate in the site visit process.

If a state has a separate dental hygiene examining board, that board will be contacted when a dental hygiene program located in that state is site visited. In addition, the dental examining board for that state will be notified.

The following procedures are used in implementing this policy:

1. Correspondence will be directed to an institution notifying it of a pending accreditation visit and will include a copy of Commission policy on state board participation. The institution is urged to invite the state board to send a current member. The Commission copies the state board on this correspondence.
2. The institution notifies the Commission of its decision to invite/not invite a current member of the state board. If a current member of the state board is to be present, s/he will receive the same background information as other team members.
3. If it is the decision of the institution to invite a member of the state board, Commission staff will contact the state board and request the names of at least two of its current members to be representatives to the Commission.
4. The Commission provides the names of the two state board members, to the institution. The institution will be able to choose one of the state board members. If any board member is unacceptable to the institution, the Commission must be informed in writing.
5. The state board member, if authorized to participate in the site visit by the institution, receives the self-study document from the institution and background information from the Commission prior to the site visit.
6. The state board member must participate in all days of the site visit, including all site visit conferences and executive sessions.
7. In the event the chair of the site visit committee determines that a vote is necessary to make a recommendation to the Commission, only team members representing the Commission will be allowed to vote.
8. The state board reimburses its member for expenses incurred during the site visit.

The following statement was developed to assist state board members by clearly indicating their role while on-site with an accreditation team and what they may and may not report following a site visit. The statement is used on dental education, advanced dental education and allied dental education site visits. The state board member participates in an accreditation site visit in order to develop a better understanding of the accreditation site visit process and its role in ensuring the competence of graduates for the protection of the public. The dental, advanced dental and allied dental education programs are evaluated utilizing the Commission's approved accreditation standards for each respective discipline.

The state board member is expected to be in attendance for the entire site visit, including all scheduled conferences and during executive sessions of the visiting committee. While on site the state board member:

- provides assistance in interpreting the state's dental practice act and/or provides background on other issues related to dental practice and licensure within the state.
- on allied dental education visits: assists the team in assessing the practice needs of employer-dentists

in the community and in reviewing those aspects of the program which may involve the delegation of expanded functions.

- on dental school visits: functions primarily as a clinical site visitor working closely with the clinical specialist member(s) who evaluate the adequacy of the preclinical and clinical program(s) and the clinical competency of students.

Following the site visit, state board members may be asked to provide either a written or oral report to their boards. Questions frequently arise regarding what information can be included in those reports while honoring the Agreement of Confidentiality that was signed before the site visit. The following are some general guidelines:

- What You May Share: Information about the Commission's accreditation standards, process and policies
- What You May Not Share:
  - The school's self-study;
  - Previous site visit reports and correspondence provided to you as background information;
  - Information revealed by faculty or students/residents during interviews and conferences;
  - The verbal or written findings and recommendations of the visiting committee; and
  - Any other information provided in confidence during the conduct of an accreditation visit.

The Commission staff is available to answer any questions you may have before, during or after a site visit.

Revised: 7/09, 1/00; Reaffirmed: 8/10, 7/07, 7/04, 7/01, 12/82, 5/81, 12/78, 12/75; Adopted: 8/86

Tab 7 **Dr. Gary Ostenson – Request for Periodontal Research Group to be recognized as a Dental Study Group**

679.050 Nonresident dentists giving or receiving instruction; hospital permits. (1) If a reputable and duly licensed practitioner in dentistry of another state or country is asked to appear and demonstrate, receive or give instruction in the practice of dentistry before any qualified dental college or dental organization or dental study group recognized by the Oregon Board of Dentistry, the secretary of the board shall issue on written request of an authorized officer of such college or dental organization or dental study group, without fee, a permit for such purpose. A permit shall be issued upon such terms as the board shall prescribe.

(2) If a reputable and duly licensed practitioner in dentistry of another state has been granted staff privileges, either limited, special or general, by any duly licensed hospital in this state, the secretary of the board shall issue on written request and verification of an authorized officer of such hospital, a permit for such nonresident practitioner to practice dentistry in said hospital. [Amended by 1963 c.284 §4; 1965 c.122 §3; 1967 c.282 §1; 1973 c.390 §2; 2013 c.114 §2]

818-001-0020 (14) "Dental Study Group" as used in ORS 679.050, OAR 818-021-0060 and OAR 818-021-0070 is defined as a group of licensees who come together for clinical and non-clinical educational study for the purpose of maintaining or increasing their competence. This is not meant to be a replacement for residency requirements.

Dr. Gary Ostenson would like the Board to recognized Periodontal Reseach Group as a "Dental Study Group" so that their organizaion can request nonresident permits for dentists who are licensed in another state or country to appear and demonstrate, receive or give instruction in the practice of dentistry.

Dear Oregon Board of Dentistry,

(to Teresa Haynes Regarding out of state permits and validation of our study club Columbia Periodontal Research Group).

Originally Columbia Periodontal Research Group was started by Dr. Fred Bremner in 1976 in conjunction with OHSU continuing education department and Oregon AGD. The group has always been a mix of dentists from Washington and Oregon, with most being members of the Academy of General Dentistry. In 2002, Dr. Brad McAllister took over as the head mentor. Our study club moved to the new dental school when it opened.

Our membership varies from 10-15 dentists with their assistants and hygienists also present. At this time we only have 3 Washington licensed dentists. It is a participation study club with 1.5 hours of lecture and clinical surgeries following.

Some of the lectures are as follows:

1. Periodontal plastic surgery(connective tissue grafts and free gingival grafts).
2. Extraction socket grafting
3. Implant surfaces and implant designs
4. Crown lengthening

Upon request I can send you copies of these lecture outlines.

Please grant us the 3 temporary Oregon out of state licenses, so we can continue participation in this valuable study club.

Thank you,

Dr. Gary Ostenson

NEWSLETTERS & ARTICLES OF INTEREST

HealthProCHOICES

A newsletter for participants in the Health Professionals' Services Program (HPSP)

September 2016

"Suffering has been stronger than all other teaching, and has taught me to understand what your heart used to be. I have been bent and broken, but—I hope—into a better shape." - Charles Dickens

Holiday Travel

The holidays are quickly approaching. Please remember that we require two weeks notice of travel plans so we can identify testing sites. Remember that we need zip codes and dates of travel. Also, please remember to carry your paper chain of custody forms with you on your travels. Get your requests in early if you have already made your holiday plans.

Florence's Lamp: Support for Chemically Dependent Nurses

Florence's Lamp has changed from weekly meetings to once a month. Meetings are the first Tuesday of the month at 5 p.m. Phone: Kay (503-644-3012) or Eunice (503-538-9850). St Barnabas House, 2025 SW Vermont, Terwilliger Exit from I-5 near Bertha in house next to the church. Open to RNs and LPNs.

Monitoring Portal

The new RBH Monitoring Portal was introduced in May. Several of you are using the new Monitoring Portal www.rbhmonitoring.com. As a reminder, the Portal provides the daily check-in feature, a log of your daily check-ins, the ability to submit an e-request for additional paper toxicology forms (CCFs), current Account Balance, and list of your Testing Facilities. If you have any questions, please contact your agreement monitor.

**** All Data Current As Of Yesterday**

Is a Test Required Today?

Click here to check for required testing today.

Check Now

Daily Check-Ins

Check In Type	Check In Date	Test Scheduled?
Phone Call	05-May-2016	No
Phone Call	04-May-2016	Yes
Phone Call	03-May-2016	No
Phone Call	02-May-2016	No
Phone Call	30-Apr-2016	No
Phone Call	29-Apr-2016	No
Phone Call	28-Apr-2016	No
Phone Call	27-Apr-2016	No

1 2 3 4 5 > >>

COC Request Form

Quantity Needed and Comments

Send COC Form to address on file ? ☐

Address: [redacted]

Submit

Account

Balance*: $ 0.00

Description	Amount	Date
MEDTOX 96123/B Medtoxpro 2 + ETG	$ 70.30	04-26-2016
MEDTOX 87606/C ETG Only	$ 52.56	04-08-2016
MEDTOX 87606/C ETG Only	$ 52.56	03-19-2016
MEDTOX 87606/C ETG Only	$ 52.56	02-25-2016
MEDTOX 96123/B Medtoxpro 2 + ETG	$ 70.30	02-08-2016
MEDTOX 87606/C ETG Only	$ 52.56	01-22-2016

1 2 3 4 5 > >>

**A negative balance indicates a credit on account*

Testing Facilities

Name	Address	Phone	Sat Hours
CHEMICAL TESTING - Eugene	2025 W. 12TH AVE Eugene, OR 97402	(541) 686-2550	0900-1200
CHEMICAL TESTING - SPRINGFIELD - Springfield	1293 18TH ST Springfield, OR 97477	(541) 744-2550	CLOSED
LEGACY CENTRAL LAB - Portland	1225 NE 2nd Avenue, 1st Floor Portland, OR 97232	(503) 413-5113	0800-1630
LEGACY HEALTH SYSTEMS - NEWPORT - Newport	1010 S.W. COAST HWY STE 104 Newport, OR 97365	(541) 265-8810	CLOSED

Reliant Behavioral Health (RBH)

RBH
www.RBHHealthPro.com

HPSP: 888.802.2843
www.RBHHealthPro.com

Falling Into a New Workout

As the Weather Cools, Make Changes to Stay Active

Those long, active summer days have drawn to a close, but that's no reason to let your workout routines go into hibernation.

"Think of autumn as the start of a fresh new fitness season. Take advantage of the brisk temperatures to re-energize your commitment to a healthful lifestyle," says Kathie Davis, executive director of IDEA: The Health and Fitness Source, based in San Diego.

Start by writing down what you've accomplished in your fitness program so far and what you want to achieve in the future. Include long-range, broad objectives, such as maintaining a healthy weight, along with some short-term goals that will help you reach them.

As autumn days get shorter, "scheduling workouts can become more difficult, especially if you prefer to exercise outdoors, says Wayne L. Westcott, Ph.D., author of "Strength Training Past 50."

Instead of struggling to beat the clock, Dr. Westcott suggests "get more bang for the buck by choosing activities that give you the same fitness benefits in a shorter amount of time." If you usually take a one-hour brisk walk, for instance, run for a half-hour, instead.

If you decide to work out indoors, don't expect to duplicate your outdoor routine. "Sustained activity in a gym lacks the variety you get outside," says Dr. Westcott. "If you spend an hour riding a bike on a beautiful country road, it goes by in a flash. If you spent an hour on a stationary bike in the gym, you'd go nuts."

To keep yourself entertained indoors, plan a workout that includes short periods of several different activities. Try 20 minutes on the stationary bicycle, 20 on the rowing machine and 20 on the stair climber.

Here are other ideas to help you make an active transition from summer to autumn exercise.

Get organized
Autumn brings lots of new demands on time, especially if you're involved in community activities or have children in school. Protect your workout by setting a definite time and place, then scheduling other activities around that.

Seal the commitment by arranging to work out with a friend or personal trainer. Or join a group of people who walk, run or cycle at a regular time and place.

Catch the back-to-school spirit
Sign up for a class in a physical activity you've always wanted to learn.

Winterize your equipment
If you change your workout conditions, you may need to change your shoes, outerwear or other equipment, as well.

Maintain your skills
Tennis and swimming transfer easily indoors, but if golf or baseball is your sport, it may be harder to find winter opportunities to play. Keep in shape by choosing workouts that mimic motions used in your sport and keep those muscles strong and flexible.

Sign up for a bad-weather backup
Don't let rain or snow give you an excuse to skip a workout. Arrange for an indoor location before you need it. Join a health club, buy a video or investigate local mall-walking opportunities.

Find new opportunities to be active
Take the stairs instead of the elevator; park in the lot farthest away; and take a quick walk around the block at lunchtime. "Get more exercise in winter, not less," says Dr. Westcott. "You'll feel better all over. And there's no more effective way to fight the winter doldrums than by staying active and fit."

Upcoming Opportunities

IDAA Annual Meeting 2017 – Salt Lake City, UT. August 2-6, 2017 at the Snowbird Resort. Find more information at www.idaa.org.

Sante Center for Healing is offering Maintaining Proper Boundaries course in Argyle, TX. The course will be offered November 9-11, 2016. Visit http://www.santecenter.com/professionals-program/ for more information.

Oregon's Health System Transformation Quarterly Legislative Report

Q1 2016

Published September 1, 2016

Oregon Health Authority

About this Report

Welcome to the first quarterly report to the Legislature on Oregon's Health System Transformation progress in Q1 2016 (January—March).

This report was developed to address legislatively-established reporting requirements for health system transformation and coordinated care organizations (CCOs).[1]

On a quarterly basis, this report will provide updates on the Oregon Health Plan population and CCOs' efforts to further the transformation of our health system.

For questions or comments about this report, or to request this publication in another format or language, please contact the Oregon Health Authority Director's Office at:

503.947.2340 or
OHA.DirectorsOffice@state.or.us

We welcome your ideas for report improvements.

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[1]Requirements include Senate Bill 1580 (2012), Oregon Revised Statutes 414.620 and 414.629, and House Bill 3650 (2011), which established Oregon's Integrated and Coordinated Health Care Delivery System in which CCOs are used to improve health, improve quality, access, and health outcomes.

Cover image courtesy of United Way of the Lower Mainland. This image was not modified from its original format. License available online at: https://creativecommons.org/licenses/by-nc/2.0/legalcode

Executive Summary

Director's Message

As Oregonians, we all want to see the results of our investment in Health System Transformation and Medicaid expansion, as well as our progress toward the triple aim of better health, better care, and lower costs. Key elements of Oregon's health system transformation include:

- Using best practices to manage and coordinate care
- Shared responsibility for health
- Transparency in price and quality
- Measuring performance
- Paying for outcomes and health
- A sustainable rate of growth

Each of these elements individually and collectively produces better health outcomes for Oregonians at lower prices.

We have much to be proud of now that ninety-five percent of Oregonians have health insurance. Health coverage is a significant driver in providing preventive, appropriate, and timely access to health care, and Oregon has successfully taken on approximately 400,000 new Medicaid enrollees, while keeping the cost of health care within our 3.4 percent annual average growth rate. We have accomplished a tremendous amount in the past year.

Additionally, Oregon's approach to monitoring performance has been recognized nationally as a model for other states. Our CCO and hospital performance metrics effectively ensure system accountability for quality and outcomes, while rewarding and replicating success.

Next steps in what we call Health System Transformation 2.0 (HST 2.0) include:

- Focusing on accelerating quality and integration for our behavioral health system
- Integrating population health through public health modernization
- Continuing to move to value-based payments for incentivizing health outcomes
- Maintaining a financially sustainable model

Thank you for your role in Oregon's success. We welcome your comments on this report and your commitment to the work ahead in HST 2.0.

Lynne Saxton, Director
Oregon Health Authority

Executive Summary

Oregon Health Plan Demographics

Early estimates of Oregon's Medicaid expansion projected more than 240,000 newly eligible Oregonians, and 20,000 previously eligible Oregonians would enroll in the Oregon Health Plan.[2] In actuality:

- Medicaid enrollment increased by approximately 400,000 individuals since the Affordable Care Act expansion took effect January 2014, bringing enrollment to approximately 1.1 million Oregonians. This increase has changed the Oregon Health Plan population to include more adult members, with children ages 0-18 now representing 40 percent of OHP, in contrast to 60 percent in 2013. CCOs responded to the significant enrollment growth while also improving quality, as indicated by the annual performance metrics.

- Almost 90 percent of the Medicaid population eligible for enrollment in CCOs are enrolled. Of the remaining individuals not enrolled, many have exemptions such as dual enrollment in Medicare and other third party resources. OHA is exploring options for more of these individuals to be served by CCOs.

- 57,015 individuals are enrolled in Citizen Alien Waived Emergent Medical, or CAWEM, a benefit which provides emergency medical assistance and coverage for pregnant women that does not require proof of citizenship for Oregon residents who meet financial criteria.

CCO Performance on Quality Metrics

Oregon has demonstrated that when CCOs have a meaningful percentage of their payment at risk for performance, they achieve performance improvement and affect transformative change.

- OHA just completed the third year of its incentive payment program with CCOs to encourage performance improvements. For measurement year 2015, four percent ($168 million) of total capitation payments were distributed to CCOs based on quality measures performance. Fifteen of the 16 CCOs earned 100 percent of the possible funds.

- CCOs continue to reduce emergency department visits and preventable visits to hospitals, as well as maintaining and expanding member enrollment in patient-centered primary care homes. Avoidable emergency department visits have decreased by 50 percent since 2011. Further improvement is needed in measures for substance use disorders, and tobacco / smoking cessation.

Member Satisfaction

- OHA monitors member satisfaction through the standard Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and through complaints and grievances. 2015 survey results indicate CCOs are focused on improving health plan customer service; however, further improvement is necessary in making written or online information available to members about their health plans.

- In the first quarter of 2016, most complaints (43 percent) were related to access to care or interactions with providers or their health plan (31 percent). Ninety-seven percent of complaints received in Q1 were resolved.

[2] Estimated Financial Effects of Expanding Oregon's Medicaid Program under the Affordable Care Act (2014-2020), 2013 http://www.shadac.org/publications/estimated-financial-effects-expanding-oregons-medicaid-program-under-affordable-care

Executive Summary

Health Disparities

CCOs are contractually required to focus on how they will reduce health disparities and advance health equity for culturally and socially diverse communities.

- CCOs are fully engaged in improving health equity, with a focus on health literacy and cultural competency. CCO activities include financial support for health equity coalitions, engaging community advisory councils (CACs) in equity work, and reviewing data to identify disparities and develop equity strategies.

- Nine CCOs met their Transformation Plan benchmarks regarding health disparities in 2013-2015, and nine met benchmarks in cultural competency. OHA monitors Transformation Plans and provides technical assistance.

Finance

OHA pays CCOs a monthly capitation payment to manage and deliver health care for OHP members. Approximately 77 percent of OHP expenditures are distributed as capitation payments to CCOs—a total of $4.9 billion in CY 2015. Overall, CCOs are in good financial standing and exceed minimum net worth requirements.

In 2014, with the expansion of the Medicaid program, CCO membership increased more than 70 percent. At the time, this expansion population was largely unknown and assumed to have more health care concerns than the previous population; CCO payments were set assuming higher costs. However, this population was not as costly in 2014 as previously assumed; therefore, CCOs realized an increased operating margin in 2014.

The statewide composite operating margin was over 7 percent in 2014, with CCO increases fluctuating between less than 1 and 21 percent. In 2015, the composite CCO statewide operating margin was 5 percent, with CCO operating margins ranging from less than a 1 percent loss to over 18 percent. The statewide operating margin is closer to the national average of 4 to 5 percent. It should be noted that the state's sustainability threshold of 3.4 percent relates to the annual rate of growth in health care costs, not operating margins.

Patient-Centered Primary Care Homes

The adoption of patient-centered primary care homes is integral to transforming the health system, with their patient and family-centered approach to all aspects of care, wellness, and prevention. Oregon expects CCOs to work with their contracted providers to attain highest levels of PCPCH certification.

- Today, about two-thirds of all primary care clinics in the state are recognized PCPCHs. As of December 2015, all CCOs had at least 70 percent of their members enrolled in PCPCHs.
- Senate Bill 231, passed in 2015, requires OHA and the Department of Consumer and Business Services (DCBS) to report on the percentage of medical spending allocated to primary care for CCOs and select commercial plans. In 2014 CCOs allocated 13 percent of their total medical spending to primary care on average. Two-thirds of primary care spending by CCOs was non-claims based. These are payments to providers intended to incentivize efficient care delivery, reward achievement of quality or cost-savings goals, and build primary care infrastructure and capacity. This was the first year of reporting; comparative data will be available in future years.
- A Multi-Payer Primary Care Payment Reform collaborative is working to sustain and improve primary care statewide with expected recommendations to the Oregon Health Policy Board.

Executive Summary

Evaluations

Early findings from Oregon's State Innovation Model (SIM) grant evaluation show that CCOs and other payers initially focused on integration and care coordination as part of health system transformation. They were less focused on alternate payment methodologies, health information technology, and the health care workforce.

The Hospital Transformation Performance Program (HTPP) evaluation found that the first two years of the hospital incentive metrics program has increased collaboration between hospitals and CCOs, and has helped most hospitals with their quality improvement efforts.

Local Governance

Each Coordinated Care Organization's Community Advisory Council(s) advise and make recommendations on the strategic direction of their organization. Community Advisory Councils (CACs) are comprised of local community members and the majority is to be made up of Oregon Health Plan members.

- CCOs are required to have at least one CAC which helps ensure the CCO is addressing the health needs of CCO members and the community. CAC strengths include helping break down silos to address social factors that influence health and improving diversity within community-CCO partnerships.

- CACs struggle to achieve majority consumer membership and diverse representation.

More information on CACs is available online at https://www.oregon.gov/oha/OHPB/Pages/cac.aspx.

Eligibility and Enrollment

For OHA Member Services, the first quarter of this year marked the launch of a new eligibility system, a restart to the coverage renewal process, and a focus on reducing the application backlog. For the first time, using the new Medicaid system OregONEligibility (ONE), call center staff were able to process an application and tell a member they had benefits before the call ended. ONE has improved efficiency for members and will continue to improve our member services response.

OHA also resumed renewals (that is, members renewing their Oregon Health Plan eligibility for continued enrollment) in February; renewals had previously been paused while OHA transitioned to the ONE system. Of the more than 116,000 memberships up for renewal, 59 percent of members renewed their applications within the 60-day timeline.

Administrative Rules

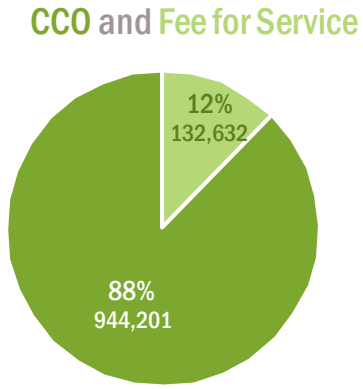
This section of the report summarizes five new administrative rules and eight amendments to existing rules related to CCOs. Of these rule changes, six were challenging and generated debate as evidenced by public comment, including rules related to prescription prior authorizations, enrollment criteria for children in foster care, enrollment criteria for non-hospital births, and the rules process for flexible services.

Oregon Health Plan Demographics

Medicaid enrollment has continued to grow since the 2014 Expansion, with total enrollment reaching just over 1.1 million members in early 2016. The majority of Medicaid members are enrolled in coordinated care organizations (CCOs).

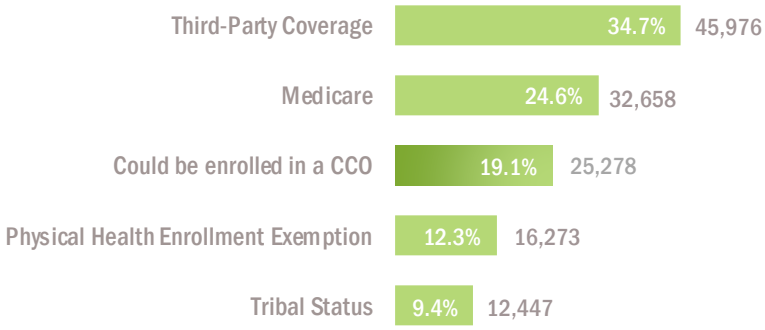
Oregon Health Plan Enrollment (March 2016)

Non-OHP Enrollment is 80,730



Fee For Service Detail (March 2016)

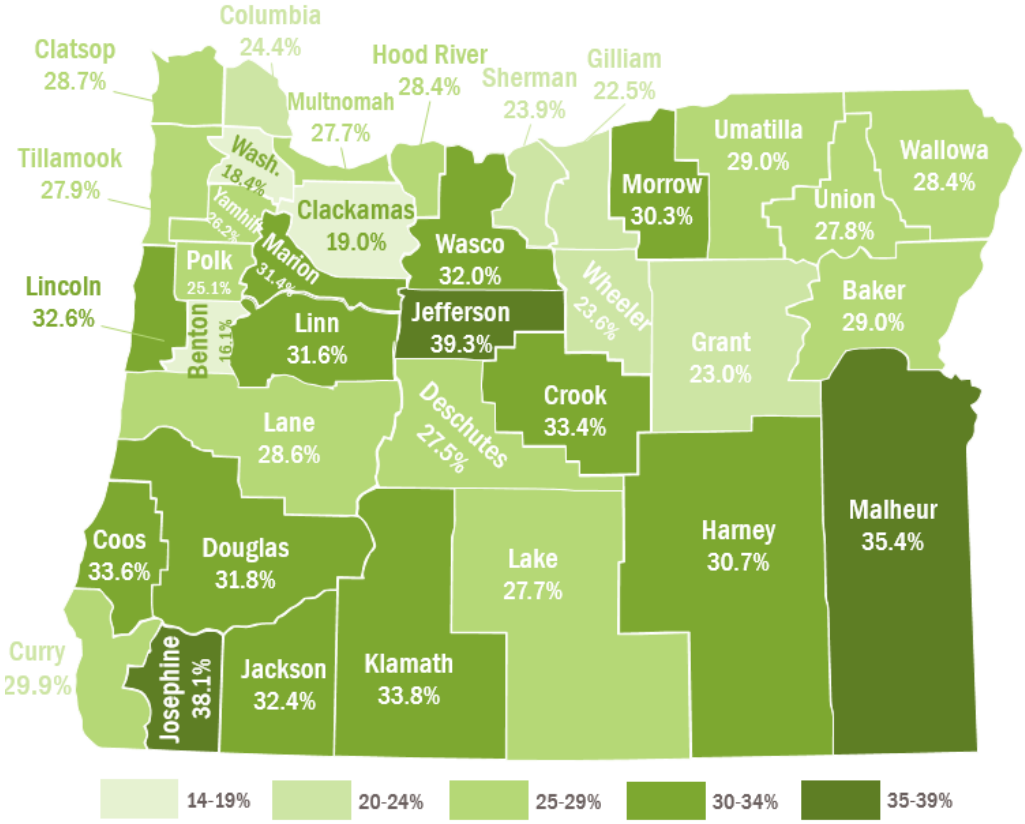
Clients with:



CCO counts include members enrolled in the Program of All-Inclusive Care for the Elderly (PACE). Non-OHP includes 57,015 individuals who are enrolled in Citizen Alien Waived Emergent Medical (CAWEM), a benefit that provides emergency medical assistance and pregnancy coverage that does not require proof of citizenship for Oregon residents who meet financial eligibility criteria, and Medicare premium program groups.

Percentage of Oregon's population enrolled in OHP, by county

March 2016



Definitions:

Oregon Health Plan (OHP)
Oregonians who receive comprehensive Medicaid benefits.

Non-OHP
Oregonians who receive Medicaid benefits, but are not eligible to receive the comprehensive OHP benefits package. This may include clients who receive CAWEM, senior drug plan, or members who also receive Medicare (dual eligible).

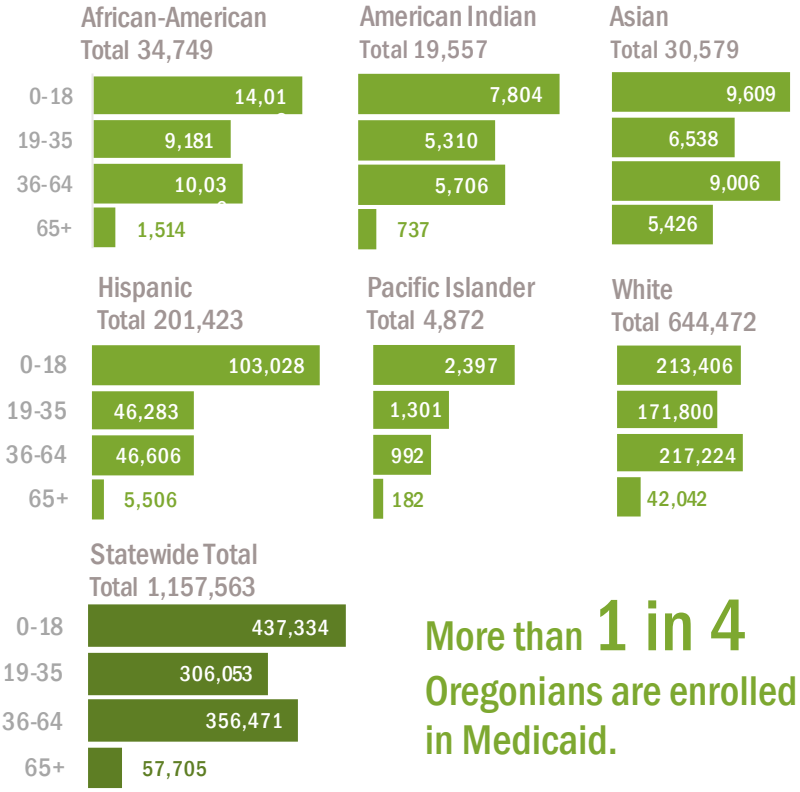
Fee For Service
OHP members who are not enrolled in a CCO or other managed care organization. Sometimes referred to as "Open Card"

Oregon Health Plan Demographics

OHP and Oregon Populations, by Race and Ethnicity

The racial and ethnic makeup of the Oregon Health Plan population differs from Oregonians overall, but has remained fairly consistent despite the inclusion of new members following the Medicaid expansion in 2014.

OHP Enrollment by Race/Ethnicity and Age, March 2016



More than **1 in 4** Oregonians are enrolled in Medicaid.

- Data are missing are for 9.1 percent of the population, and 10.0 percent are categorized "unknown/other." Thus, percentages do not add to 100.
- Missing data are where the race/ethnicity fields are blank on the member's enrollment file; unknown / other is used when member information is provided, but is not clear or does not align with existing categories.
- Race and ethnicity are collected separately, but reported together here. For example, an individual who indicates they are both White (race) and Hispanic/Latino (ethnicity) is counted as Hispanic/Latino. An individual who indicates that they are Native American (race) and non-Hispanic (ethnicity) is counted as Native American.

Oregon Overall: Source, 2010 US Census

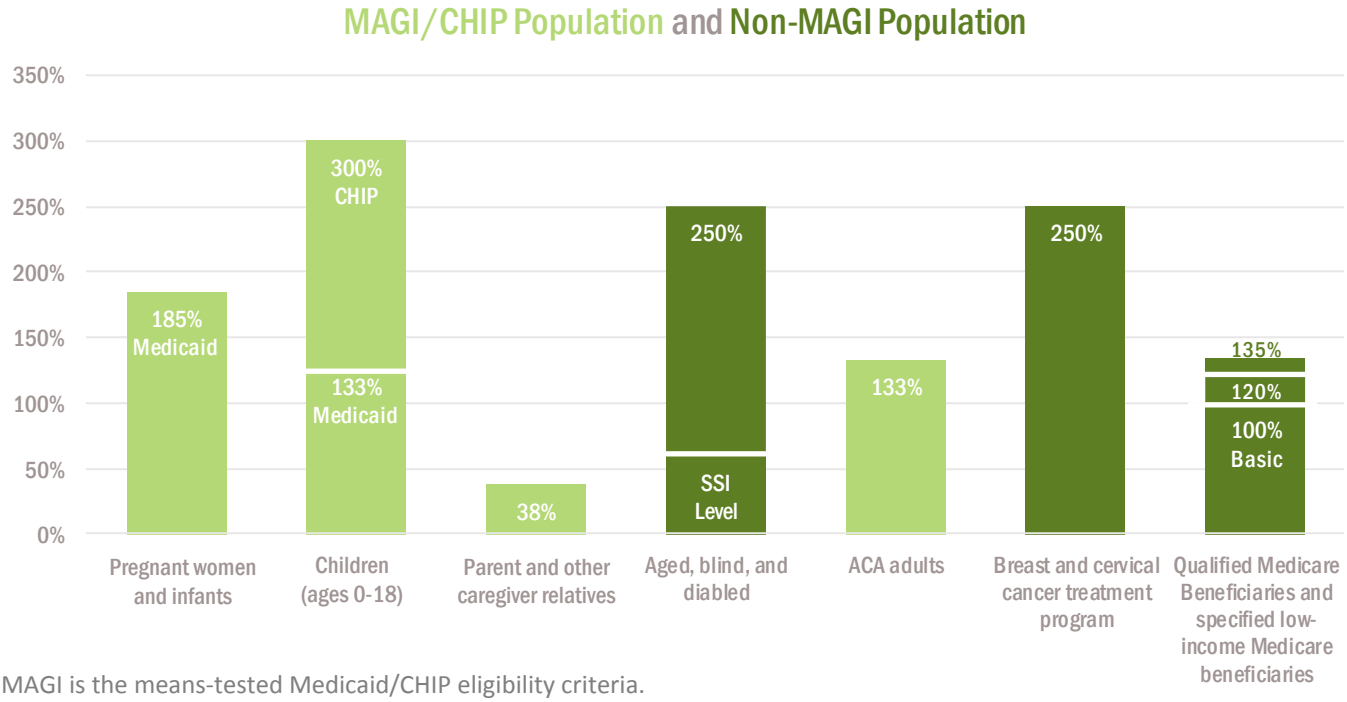
Oregon Health Plan Demographics

Oregon Health Plan, by Eligibility Group

To qualify for the Oregon Health Plan, individuals and families must meet income and residency requirements. Oregonians may also qualify based on age and disability status.

- **Adults**: OHP is available to adults who earn up to 138 percent of the Federal Poverty Level (FPL). That's about $16,300 a year for a single person, or $33,500 a year for a family of four.
- **Children:** OHP is available to children and adolescents (0-18) whose family earns up to 300 percent FPL. That's about $48,000 a year for a family of two, or $72,900 a year for a family of four.

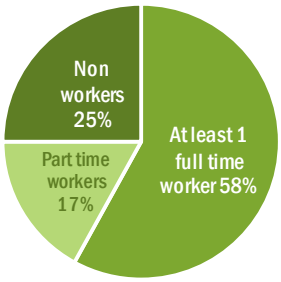
Approximate Federal Poverty Level (FPL) for Medicaid eligibility groups in 2015



MAGI is the means-tested Medicaid/CHIP eligibility criteria.
Non-MAGI has other eligibility criteria in addition to the means test.

Oregon Health Plan, by Employment Status

According to a 2015 analysis from the Kaiser Commission on Medicaid and the Uninsured, three-quarters of non-elderly Oregon Health Plan population are employed either full time or part time.* This is similar to the national average.



*http://kff.org/medicaid/state-indicator/distribution-by-employment-status-4/

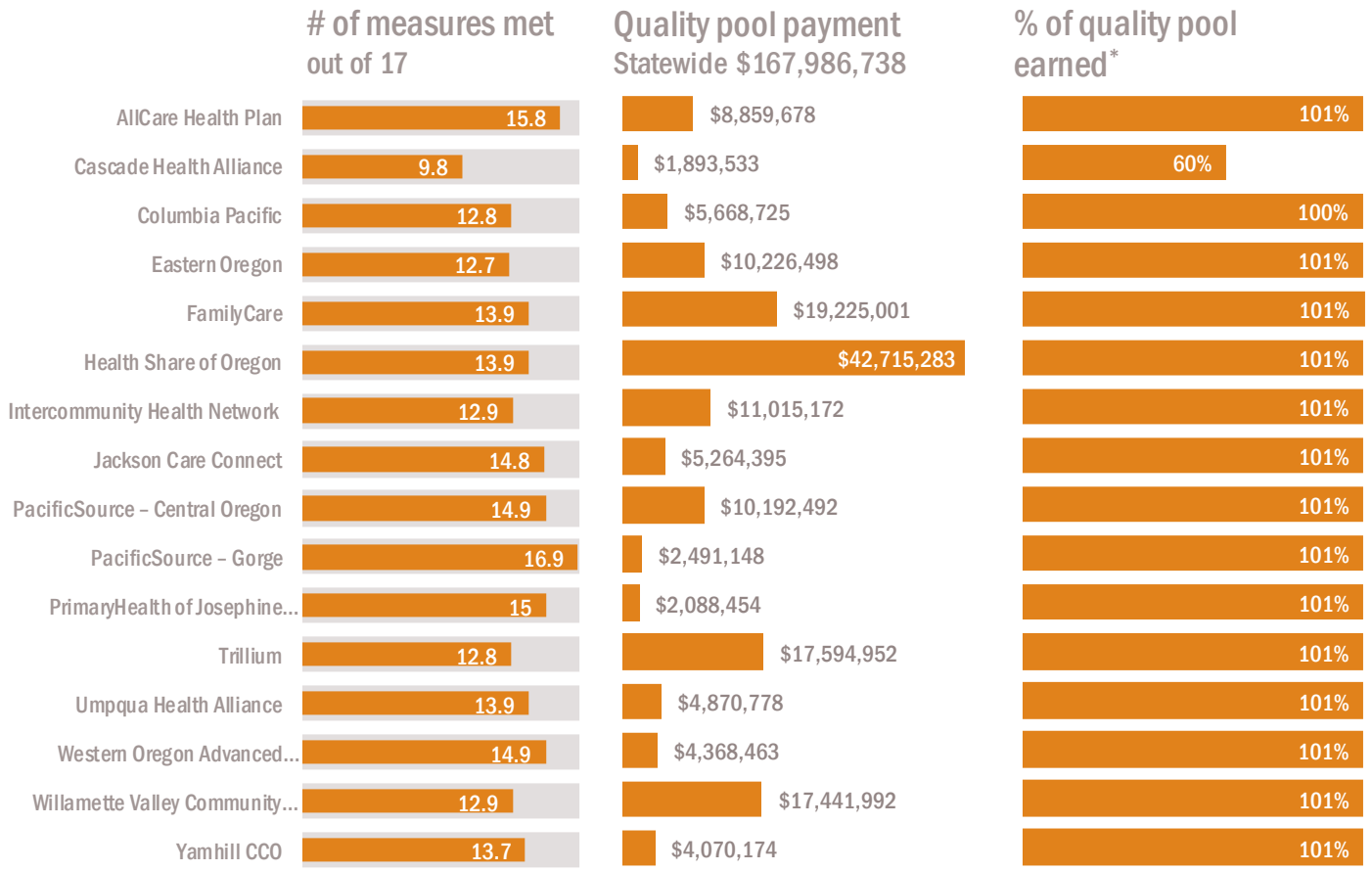
CCO Performance on Quality Metrics

2015 is the third year in which the Oregon Health Authority distributed bonus payments from a 'quality pool' to CCOs that met benchmarks or demonstrated certain improvements on a set of 17 measures. The 2015 quality pool was four percent of monthly payments to CCOs, totaling $168 million.

Quality pool dollars are distributed based on the number of measures met and CCO size (number of members). In 2015, 15 of the 16 CCOs earned 100 percent of the quality pool funds they were eligible for by meeting 12 of 16 measures, and having at least 60 percent of their members enrolled in a patient-centered primary care home (the 17th measure). The remaining CCO met eight of the measures and had at least 60 percent of their members enrolled in a PCPCH and earned 60 percent of the quality pool funds for which they were eligible. CCOs are contractually required to distribute their quality pool funds to the provider networks, and many run their own incentive programs.

Oregon's coordinated care model, which CCOs are implementing, continues to demonstrate improvements in a number of areas, such as reductions in emergency department visits, and increases in dental sealants and alcohol and drug screening. These improvements help support Oregon's achievement of the Triple Aim: better health, better care, and lower costs.

CCO Performance and Payments, CY 2015



*Funds from CCOs not earning 100% were redistributed based on CCO performance on four selected measures, resulting in CCOs earning more than 100% of their own quality pool totals. See Appendix for link to the full 2015 CCO Metrics report.

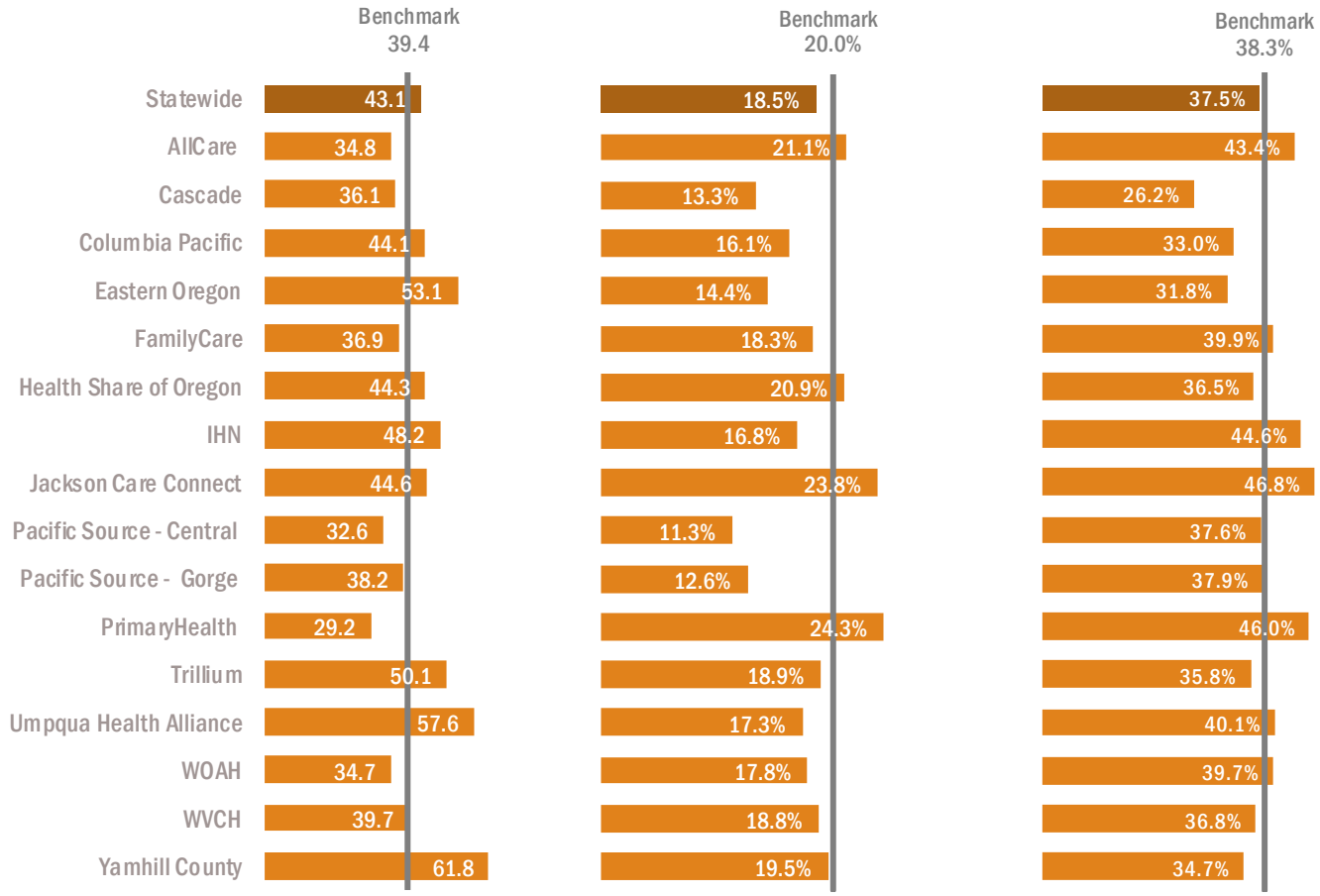
CCO Performance on Quality Metrics

The graphs below show a selection of quality measures, statewide and by CCO compared against the benchmark, for calendar year 2015. The full CY 2015 CCO Metrics report includes results for all measures reported at the state level, by CCO, and by race/ethnicity where available. http://www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx

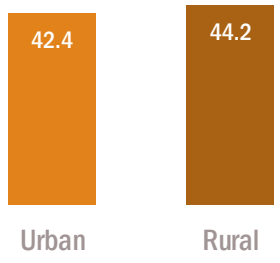
Emergency Dept. utilization, 2015
Lower is better. Per 1,000 member months.

Dental sealants, 2015
Ages 6-9. Higher score is better.

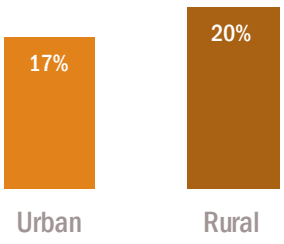
Initiation of alcohol or drug treatment, 2015
Higher score is better.



ED utilization, statewide



Dental sealants, statewide



While we see improvement in reducing emergency department utilization since 2011 baseline, there are still areas in need of attention, including initiation of treatment for those newly diagnosed with substance use disorders.

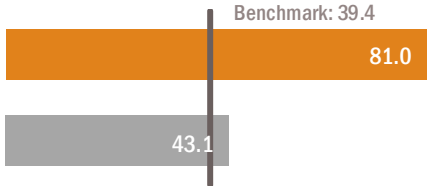
CCO Performance on Quality Metrics

The graphs below show a selection of 2015 quality measures for OHP members with disability, mental health diagnoses, and severe and persistent mental illness (SPMI) indicated in the orange bars compared to OHP members statewide (grey bars). The dark line indicates the benchmark for each measure. See Appendix for a link to the full 2015 metrics report.

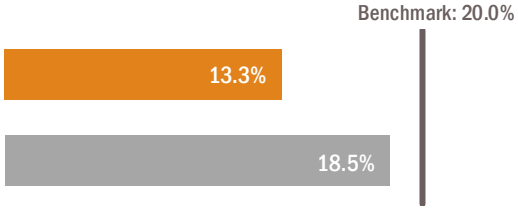
Members with disability, mental health diagnoses, and SPMI used the emergency department at much higher rates than the statewide average. Children with disability were less likely to receive dental sealants, and children in DHS custody who had mental health diagnoses were less likely to receive health assessments than other children. Effective contraceptive use among women at risk of unintended pregnancy was lower among women with disability, but higher among women with mental health diagnoses.

With disability

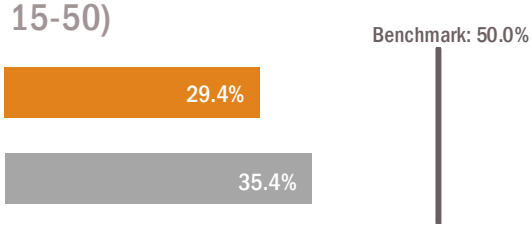
Emergency department utilization (per 1,000 member months)



Dental sealants (ages 6-14)

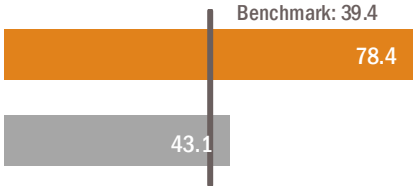


Effective contraceptive use (ages 15-50)

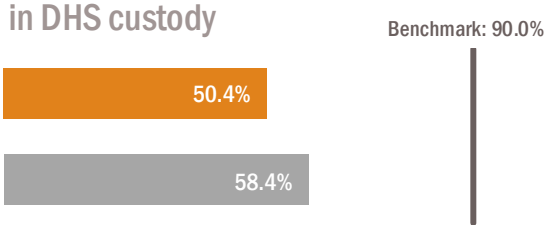


With mental health diagnoses

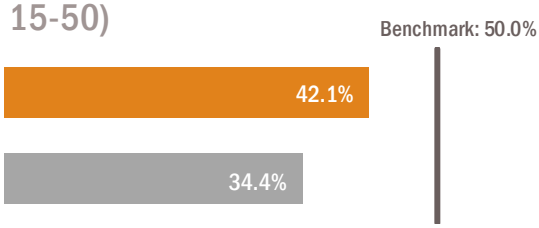
Emergency department utilization (per 1,000 member months)



Health assessments for children in DHS custody

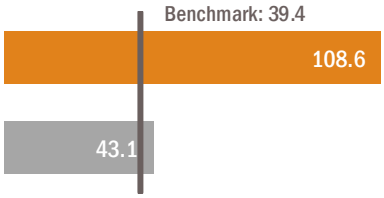


Effective contraceptive use (ages 15-50)

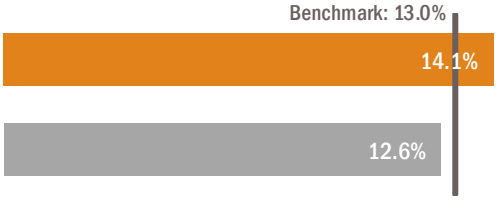


With severe and persistent mental illness

Emergency department utilization (per 1,000 member months)



Screening, brief invervention, and referral to treatment (ages 18+)



Member Satisfaction

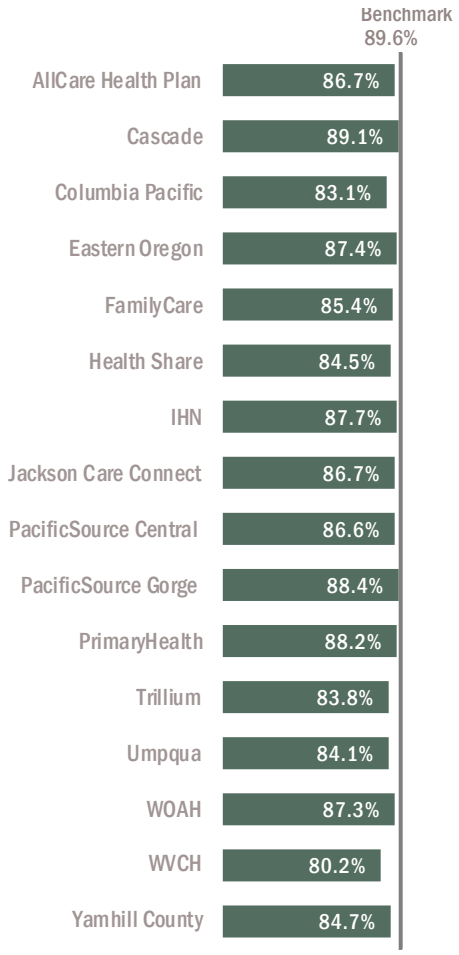
The Oregon Health Authority values Oregon Health Plan member experience as an essential measure of health system transformation success. Accordingly, OHA monitors and evaluates OHP member experience and satisfaction in a number of ways.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

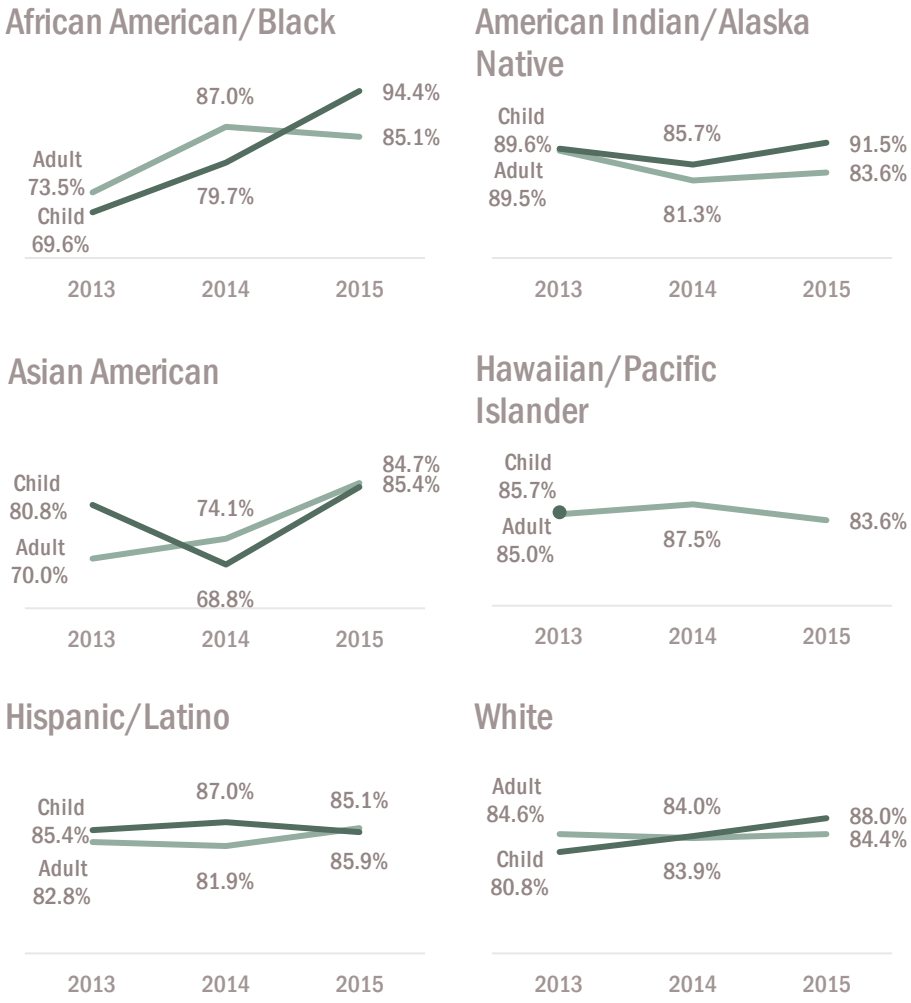
OHA administers the CAHPS survey every year. This survey covers topics that are important to OHP members and focuses on aspects of care that members are best qualified to assess. Results of the survey allow OHA and CCOs to evaluate how well they are meeting members' expectations, encourage accountability, and help inform action plans.

CAHPS data are used in the CCO incentive measure Satisfaction with Health Plan Customer Service composite, which is based on two questions: In the last six months, how often has your health plan's customer service 1) given you the information or help you needed? 2) treated you with courtesy and respect? Data are reported for "usually" and "always" responses.

2015 member satisfaction by CCO



Member satisfaction by race/ethnicity



Results for Hawaiian/Pacific Islander children not available in 2014-2015 due to small denominators (n<30)

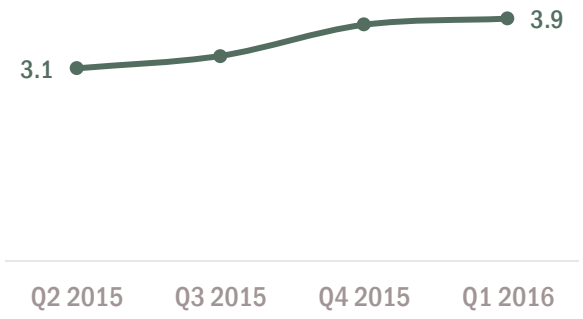
Satisfaction with Health Plan Customer Service is highly correlated with how members rate their health care, which is highly correlated with access to care, and how members rate their personal doctor.

Member Satisfaction

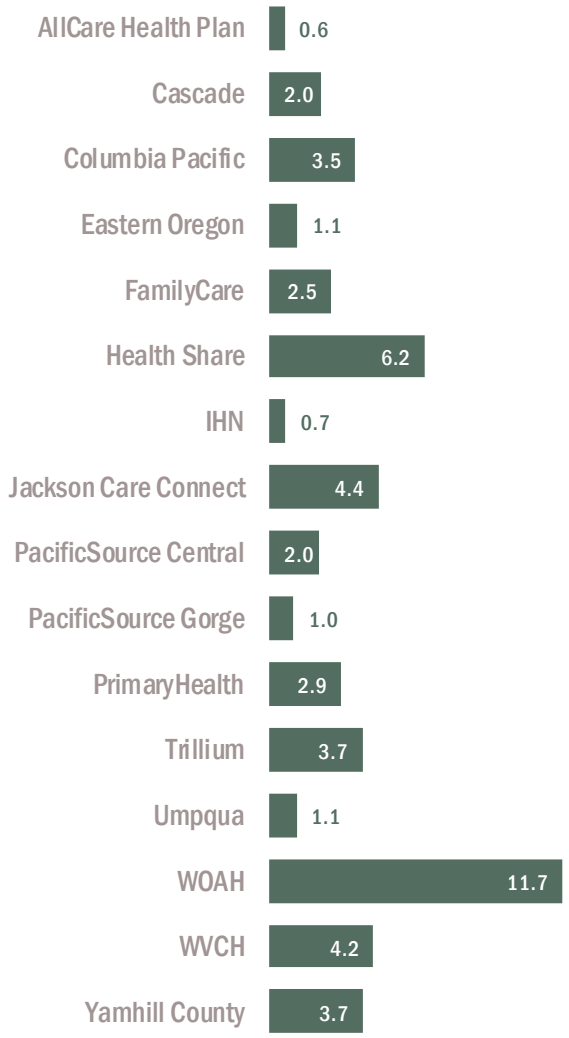
Complaint and Grievance Reporting

The CAHPS survey is a requirement of Oregon's 1115 Demonstration Waiver. In addition, the Waiver requires reporting on six categories of complaints and grievances: Access to Providers and Services, Interaction with Provider of Plan, Consumer Rights, Clinical Care, Quality of Services, and Client Billing Issues.

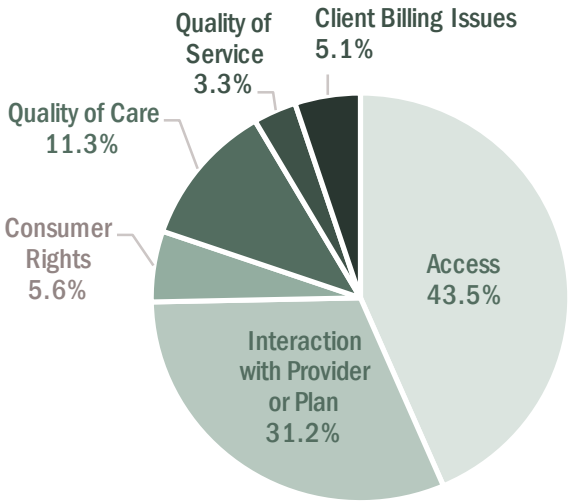
Complaints increased each quarter
per 1,000 members



Complaints varied by CCO, Q1 2016
per 1,000 members



Most Q1 2016 complaints were about access to care or interaction with provider.



In Q1 2016,
97.4%
of complaints were resolved.

Complaint and grievance information is reported individually by each CCO; complaints and grievances received directly by OHA from Open Card OHP members are tracked separately by OHA. Appeals of coverage denials, or Notices of Action (NOAs) are also captured and reported separately from complaint and grievance information. Summaries of complaint, grievance, appeal trends and interventions are included in the Oregon Health Plan Section 1115 Quarterly Report.

Health Disparities

Transformation Plans

CCO transformation plans, as required by contract, include eight transformational elements; three elements specifically require CCOs to address improving member engagement, cultural competency, and health disparities. CCOs identify their own objectives and set benchmarks for transformation plan elements; these are reviewed and approved by OHA. Each of the following activities is reflected in the transformation plans for at least half of the CCOs:

- Providing cultural competency, cultural diversity, and/or health equity trainings for their clinic and provider networks;
- Reviewing and revising member materials for appropriate health literacy; and
- Analyzing, reporting, and disseminating their quality performance measure data stratified by member demographics, such as race, ethnicity, language, age, gender, and disability.

OHA provided each CCO with suggested technical assistance available from the Transformation Center and the Office of Equity and Inclusion to help meet equity-related transformation plan goals.

CCOs meeting Transformation Plan Benchmarks in 2013-2015	Member Engagement	Cultural Competency	Health Disparities
AllCare Health Plan	No	No	Yes
Columbia Pacific CCO	Yes	No	No
Eastern Oregon	Yes	No	Yes
FamilyCare	Yes	Yes	No
Health Share of Oregon	Yes	No	Yes
Intercommunity Health Network	Yes	No	Yes
Jackson Care Connect	Yes	Yes	No
PacificSource—Central	Yes	Yes	Yes
PacificSource—Gorge	Yes	Yes	Yes
PrimaryHealth of Josephine County	Yes	Yes	Yes
Trillium Community Health Plan	Yes	No	No
Umpqua Health Alliance	Yes	Yes	Yes
Western Oregon Advanced Health	Yes	Yes	No
Willamette Valley Community Health	Yes	Yes	Yes
Yamhill CCO	Yes	Yes	No

Cascade Health Alliance's Transformation Plan is excluded from this summary, as their Exhibit K report was not included in their CCO contract until October 2013.

Finance

CCO Profile

Although all of Oregon's 16 CCOs are community-based in terms of local governance, they exist under a wide variety of legal and corporate structures. All of the CCOs generally fit into one of the following corporate structures: Taxable Publicly Traded Corporation; Taxable Private Corporation; Tax-exempt Charitable Organization – 501(c)(3); Tax-exempt Non-Charitable Organization – 501(c)(4); Limited Liability Corporation – LLC. Within those general structures, there are also variations within each CCO. The table below describes the corporate structure of each CCO:

CCO	Corporate Status	Parent / Owner
AllCare CCO	Private corporation single owner	Mid Rogue AllCare Health Assurance, Inc. (multiple shareholders)
Cascade Health Alliance	LLC single owner	Cascade Comprehensive Care, Inc. (multiple shareholders)
Columbia Pacific	LLC single owner	CareOregon 501(c)(3)
Eastern Oregon CCO	LLC multiple owners	Owners include both for profit and not for profit organizations
FamilyCare	501(c)(4)	
Health Share of Oregon	501(c)(3)	
Intercommunity Health Plans	501(c)(4)	Samaritan Health Services, Inc. 501(c)(3)
Jackson County CCO	LLC single owner	CareOregon 501(c)(3)
PacificSource Community Solutions - Central	Private corporation single owner	PacificSource (not for profit holding company)
PacificSource Community Solutions - Gorge	Private corporation single owner	PacificSource (not for profit holding company)
PrimaryHealth of Josephine County	LLC single owner	Grants Pass Management Services (multiple shareholders)
Trillium Community Health Plan	Publicly traded corporation	Agate Resources, Inc./Centene Corp. (publicly traded on NYSE)*
Umpqua Health Alliance (DCIPA)	LLC single owner	Architrave Health, LLC (two owners)
Western Oregon Advanced Heatlh	LLC multiple owners	Owners include both for profit and not for profit organizations
Willamette Valley Community Health	LLC multiple owners	Owners include both for profit and not for profit organizations
Yamhill Community Care	501(c)(3)	

* Agate Resources, Inc. was acquired by Centene Corporation (a publicly held corporation traded on the NYSE) as of 9/1/2015.

Finance

OHA tracks two key metrics each quarter: the CCOs' operating margin and total margin (which includes the impact of non-operating income and expenses as well as income taxes). Operating margin is calculated by dividing operating income by total operating revenue, resulting in a percentage.

On a statewide basis, CCO operating margins for 2013 aggregated to approximately 3 percent with the highest margin being approximately 8 percent. With the expansion of the Medicaid program in 2014, CCO membership increased more than 70 percent. The 2014 rates developed for the new expansion population (referred to as ACA population) were calculated with little to no historical cost data. The general assumption was that the ACA population would consist of individuals who had more health care concerns than the current Medicaid population, as well as pent-up demand from uninsured individuals, and rates were paid based on these assumptions. In reality, the new ACA members who joined the CCOs were younger and healthier, which resulted in generally higher CCO operating margins for 2014.

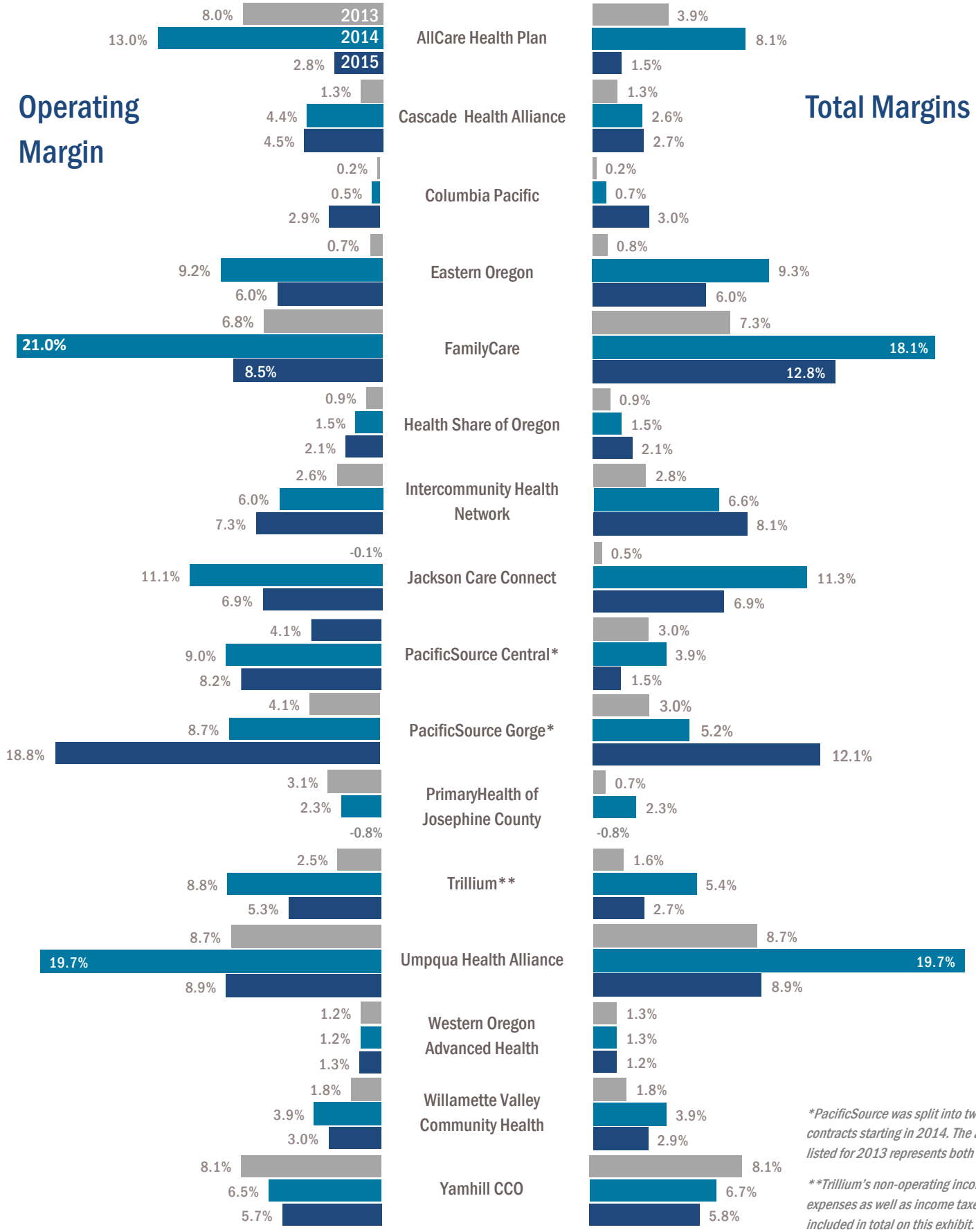
By early 2015, OHA had adequate emerging experience (claims information) to begin to quantify the true underlying cost of the ACA population. In cooperation with CMS, OHA retained an external actuarial firm (Optumas), redeveloped the 2015 rates, and changed the rate development methodology to better align the CCOs' population risk to their capitation rate. The redeveloped rates were retroactively applied to the CCOs' 2015 rates, which resulted in generally lower operating margins for the year.

CCO Operating and Total Margins

	Operating Margin $ millions			Total Margin** $ millions		
	2013	2014	2015	2013	2014	2015
Allcare Health Plan, Inc.	$ 8.8	$ 27.3	$ 6.3	$ 4.3	$ 17.0	$ 3.4
Cascade Health Alliance	$ 0.4	$ 2.1	$ 3.6	$ 0.4	$ 1.2	$ 2.1
Columbia Pacific	$ 0.1	$ 0.6	$ 4.4	$ 0.1	$ 0.8	$ 4.4
Eastern Oregon	$ 0.7	$ 18.4	$ 15.6	$ 0.8	$ 18.5	$ 15.6
FamilyCare	$ 11.3	$ 85.5	$ 46.4	$ 12.1	$ 73.5	$ 69.4
Health Share of Oregon	$ 4.8	$ 14.5	$ 22.5	$ 4.8	$ 14.5	$ 22.6
Intercommunity Health Network	$ 3.4	$ 15.2	$ 20.5	$ 3.5	$ 16.8	$ 22.8
Jackson Care Connect	$ -	$ 13.8	$ 9.9	$ 0.3	$ 14.1	$ 9.9
PacificSource Comm. Solutions - Central*	$ 5.6	$ 19.6	$ 22.2	$ 4.1	$ 8.4	$ 4.1
PacificSource Comm. Solutions - Gorge*	NA	$ 4.4	$ 12.3	NA	$ 2.6	$ 7.9
Primary Health Josephine Co	$ 0.7	$ 1.0	$ (0.4)	$ 0.2	$ 1.0	$ (0.4)
Trillium Comm. Health Plan***	$ 2.4	$ 36.4	$ 36.2	$ 0.3	$ 22.6	$ 22.4
Umpqua Health Alliance	$ 5.8	$ 23.0	$ 10.8	$ 5.8	$ 23.0	$ 10.8
Western Oregon Advanced Health	$ 0.6	$ 1.2	$ 1.4	$ 0.6	$ 1.2	$ 1.4
Willamette Valley Community Health	$ 3.5	$ 14.1	$ 13.4	$ 3.5	$ 14.1	$ 12.7
Yamhill County Care Organization	$ 3.7	$ 5.3	$ 6.1	$ 3.8	$ 5.5	$ 6.2
Consolidated Total	$ 51.8	$ 282.4	$ 231.2	$ 44.6	$ 234.8	$ 215.3

*PacificSource was split into two contracts starting in 2014. The amount listed for 2013 represents both CCOs. ** Total Margin includes the impact of non-operating income and expenses as well as income taxes. ***Trillium's non-operating income and expenses as well as income taxes are included in total on this exhibit.

CCO Operating and Total Margins (operating income as percentage of revenue)



**PacificSource was split into two contracts starting in 2014. The amount listed for 2013 represents both CCOs.*

***Trillium's non-operating income and expenses as well as income taxes are included in total on this exhibit.*

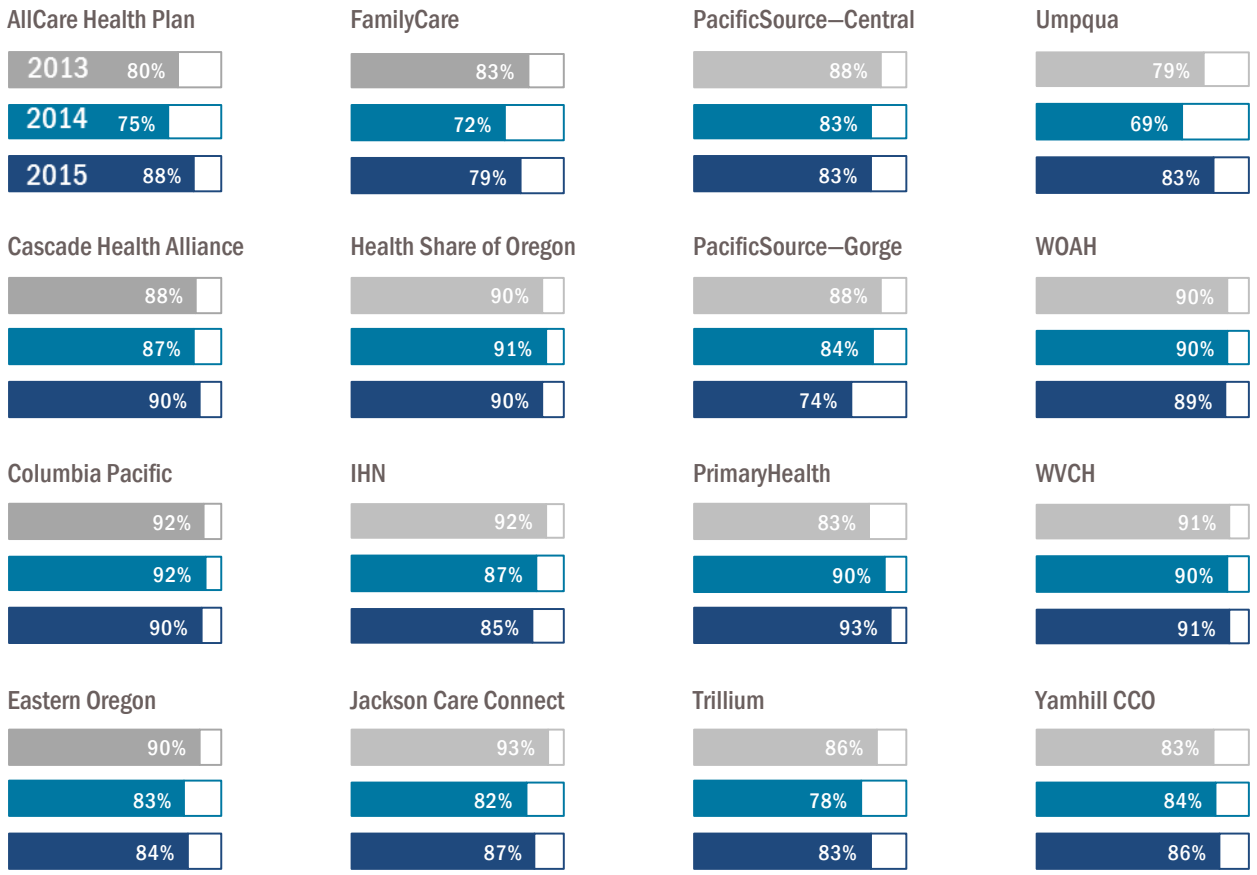
Finance

Member Services Ratio / Medical Loss Ratio

CCO Member Services Ratio (MSR) is a key financial metric that calculates the costs of services a CCO provided to its members (both medical and non-medical such as flexible services) as a percentage of total revenue. Member service expenditures are reported to OHA on the CCOs' Financial Statements, submitted on a quarterly basis.

Closely correlated to the MSR is the Medical Loss Ratio (MLR), which is a term used within the insurance industry and by the Centers for Medicare & Medicaid Services (CMS). The MLR is calculated using the MSR as the starting point and then allows certain defined administrative services to be included in the calculation, such as Health Care Quality Improvement Expenses, and starting in 2017, Fraud Prevention Expenses. Under new CMS Rules for Medicaid Managed Care Organizations, all CCOs must meet a minimum MLR of 85 percent in 2018. Oregon first adopted a minimum MLR requirement in 2014 with the ACA expansion and has developed a phased approach to achieve all of the CMS requirements for MLR in 2018.

Below is a table that displays each CCO's Member Services Ratio for the past three years:



Data Source: Data in this section are drawn from annual audited financial statements as prepared by an independent accounting firm. CCOs submit these annual statements after the close of the year. It is important to note that the financial statements follow generally accepted accounting principles (GAAP), which could include accrued contingencies and reserves per each CCO's individual financial reporting and business model.

Finance

Capitalization

CCOs are paid monthly capitation payments, commonly referred to as per member per month (pmpm) payments, to manage and deliver health care for the CCO's membership. CCOs have flexibility in allocating the capitation revenues, determining how best to purchase and coordinate their members care.

The increased membership resulting from ACA expansion in 2014 led to increased net worth and higher restricted reserve requirements. CCOs are currently required to maintain a net worth level of five percent of their average annual revenue (a rolling average of the past four quarters' revenue) as a minimum amount of operating capital.

See the table on the next page for CCOs' net assets in total compared to their required net worth, and reported by member. This allows for normalization between large and small CCOs.

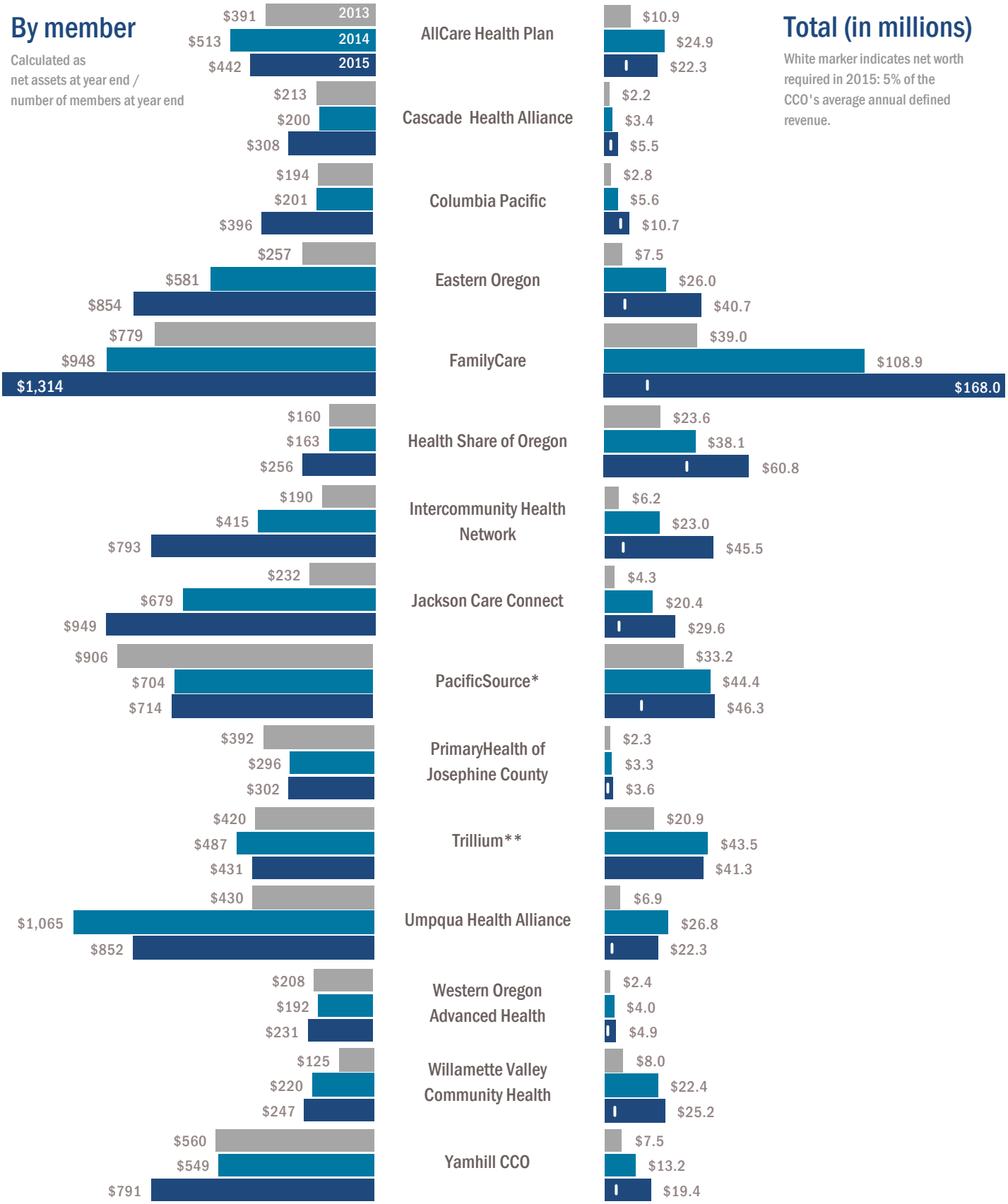
Partially as a result of the increase in CCO enrollment with the expansion of Medicaid, CCOs built up operating capital and realized a sharp increase in cash and investments between 2013 and 2014. This increase continued between 2014 and 2015 (see table below).

In 2014, CCOs realized a sharp increase in cash and investments, primarily due to the increased investment from Medicaid expansion.

Cash and Investments (in millions)	2013	2014	2015	Trend
Allcare Health Plan, Inc.	$12.5	$39.1	$33.5	
Cascade Health Alliance	$6.2	$14.0	$28.8	
Columbia Pacific	$2.8	$7.1	$13.8	
Eastern Oregon	$16.6	$52.2	$69.8	
Family Care	$60.3	$197.8	$292.1	
Health Share of Oregon	$23.9	$41.2	$55.5	
Intercommunity Health Network	$32.2	$80.7	$94.0	
Jackson Care Connect	$4.3	$8.5	$16.8	
PacificSource Comm. Solutions*	$26.3	$54.5	$62.8	
Primary Health Josephine Co	$4.4	$4.8	$4.1	
Trillium Comm. Health Plan	$54.7	$112.7	$131.3	
Umpqua Health Alliance	$14.1	$51.5	$60.5	
Western Oregon Advanced Health	$2.8	$5.8	$8.1	
Willamette Valley Community Health	$8.9	$27.8	$22.0	
Yamhill County Care Organization	$9.1	$19.5	$25.9	
Consolidated Total	$279.1	$717.1	$919.1	

**Note that while PacificSource has two contracts, one for Columbia Gorge and one for Central Oregon, only one corporate balance sheet is provided; financial data presented here represent PacificSource Community Solutions combined.*

Finance: Net assets by CCO, 2013-2015



* PacificSource has two contracts, one for Columbia Gorge and one for Central Oregon. Only one corporate balance sheet is provided; financial data presented here are combined.

**Trillium financial statements filed through Department of Community and Business Services with financial oversight based on NAIC oversight requirements.

Finance

Rate Development

In 2015, OHA engaged Optumas, an external actuarial firm, to re-examine the methodology for developing CCO capitation payment rates and subsequently re-developed the 2015 CCO rates. The updated regional methodology matches payment to risk and meets applicable CMS and Actuarial standards. The 2015 and 2016 CCO rates were developed using this updated rate methodology.

OHA is currently developing the 2017 CCO rates with the same rate methodology. During this process, some CCOs reported significant increases in per member spending from 2014 to 2015. Optumas reviewed the drivers of this growth and found in some cases it was due to increased reimbursement and payout of surpluses to providers as incentives. Other factors included high pharmacy cost trends and increased small/rural hospital costs.

In order to continue to contain costs to 3.4% annual growth, OHA developed a policy to evaluate the high growth rate from 2014 to 2015 related to CCO business decisions. In summary, the policy makes no reimbursement adjustments for CCOs that are at a reasonable growth rate; however, for CCOs that were outliers above the sustainable rate of growth and had increased reimbursement from 2014 to 2015, adjustments were made to claim-level reimbursement and/or incentives.

This means the financial information that informs the rate process is being adjusted. Actual rates have not been completed at the time this report was published. OHA is working closely with Optumas to finalize trend assumptions and complete the development of the 2017 rates.

Risks and Pressures

The Medicaid program and CCOs are facing a number of financial pressures. Nationally, pharmaceutical costs continue to rise rapidly. Although these increases are in specialty drugs and breakthrough therapies, the increase is impacting generic drug costs as well. In a recent review of cost reports, CCOs are seeing increases in drug costs of between 20 and 30 percent.

Similarly, the costs of new treatments and expanded benefits covered through the Oregon Health Plan (OHP) adds financial pressure to CCOs. There has been significant attention on the coverage of Hepatitis C treatment for OHP members in stage 3 and 4. CCOs received a rate adjustment in 2015 and 2016 to cover these added costs; however, CCOs had varying levels of utilization in 2015 due to different prior authorization (PA) criteria. OHA has undergone a robust review process to align PA criteria for these drugs.

CCOs have implemented new benefits as of July 2016 including: expanded dental benefits for adults, a change in guidance covering back-pain through more alternative approaches and less reliance on opioid drugs, and the addition of Applied Behavioral Analysis (commonly referred to as “ABA”) as a treatment for some autistic children.

OHA continues to partner with CCOs to ensure our annual health care cost growth rate does not exceed 3.4 percent.

Patient-Centered Primary Care Homes (PCPCH)

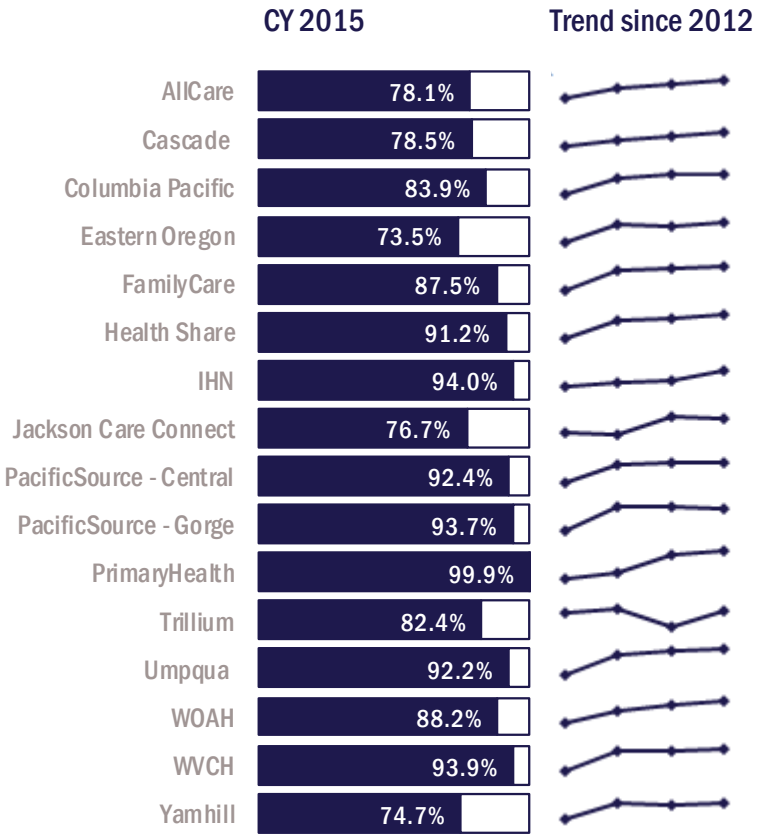
PCPCHs across Oregon

The adoption of PCPCHs is integral to transforming the health system, with their patient- and family-centered approach to all aspects of care, wellness, and prevention. Although the PCPCH program has been operational less than five years, about two-thirds of all primary care clinics in the state are recognized PCPCHs.

As of March 2016, more than 620 clinics had been recognized as a PCPCH, with the majority reaching Tier 3 recognition, the highest level possible. Seven practices have been awarded 3 STAR designation for implementing advanced PCPCH model measures that further health system transformation.

Recognized PCPCHs by tier, March 2016

Percent of CCO members enrolled in PCPCHs



2017 PCPCH standards:

Accelerate integration, engagement, and quality

In January 2017, the PCPCH program will implement revised PCPCH standards based on the recommendations of the PCPCH Standards Advisory Committee. Notable changes include:

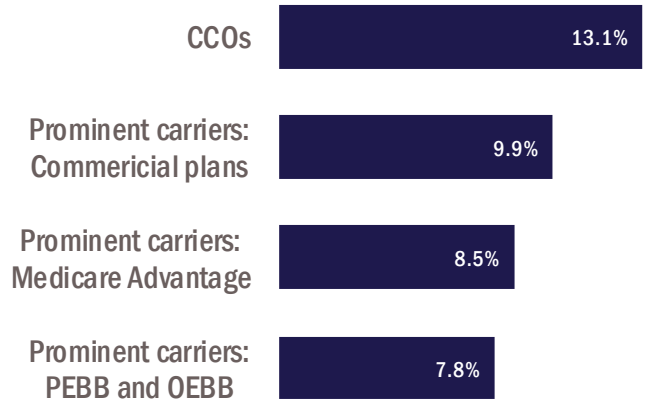
- An improved framework for behavioral and physical health care integration in a PCPCH. Mandated by SB 832, this work will help break down barriers to integrated care.
- Greater engagement with patients by requiring PCPCHs to survey their patient population at least once every two years about their experience of care.
- A greater emphasis on a PCPCH's use of data to identify areas of improvement and implement quality improvement processes.
- Two new levels of PCPCH recognition to encourage and support continued transformation for the most advanced practices.

Primary Care Transformation

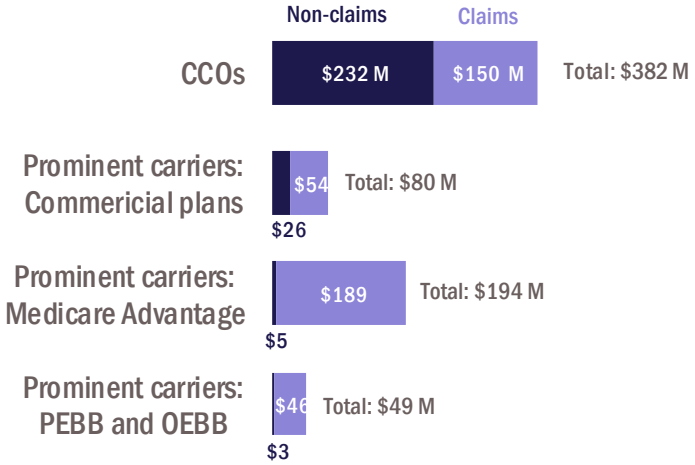
Primary Care Spending

Senate Bill 231 (2015) requires the Oregon Health Authority and the Department of Consumer and Business Services to report on the percentage of medical spending allocated to primary care for CCOs, health plans contracted by the Public Employees' Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB), and prominent carriers (those health insurers with annual premium income of $200 million or more). See Appendix for a link to the full report from Feb2016.

In 2014, CCOs allocated 13% of total medical spending to primary care on average



In 2014, CCOs spent $232 million on primary care through non-claims based payments



Non-claims-based payments are payments to health care providers intended to incentivize efficient care delivery, reward achievement of quality or cost-saving goals, and build primary care infrastructure and capacity.

Comprehensive Primary Care Plus (CPC+)

CPC+ is a regionally based, multi-payer advanced primary care medical home model offering an innovative payment structure to improve healthcare quality and delivery. It is a five year federal program that will bring significant Medicare dollars to Oregon. CPC+ begins Jan 2017 in 20 regions across the country with up to 5,000 practices, 20,000 physicians, and 25 million patients.

Oregon has 65 practices that have been participating in the first Comprehensive Primary Care initiative, bringing Medicare enhanced payments into Oregon to support primary care. CPC brought in $12 million of additional funding paid directly to primary care practices.

CPC+ accepted payers (CCO only)

AllCare	ColumbiaPacific	EOCCO
FamilyCare	Health Share*	Jackson
PacificSource - Central	PacificSource - Gorge	Primary Health
Umpqua	WOAH	WVCH
Yamhill		

*Three of the four Health Share risk-accepting entities (RAEs) were accepted.

Oregon was just accepted as a CPC+ region, which brings enhanced Medicare dollars in state, increases the number of participating practices, and bolsters our efforts to move from fee-for-service to a system that pays for outcomes.

Evaluations

Under the current Medicaid demonstration waiver, OHA has engaged external evaluators to assess OHA and CCOs' activities aimed at transforming Oregon's Medicaid delivery system. See Appendix for links to full reports.

Waiver Midpoint Evaluation

This evaluation, conducted by Mathematica Policy Research (MPR), assessed the extent to which OHA and CCOs supported and implemented activities to transform Medicaid, and provided insight into transformation areas where CCOs focused their efforts (based on CCO self-assessment).

Midpoint Evaluation Findings

- Significant changes appeared to be concentrated in primary care improvements.
- Start-up phase of CCOs did not reflect significant transformation findings.

MPR found few statistically significant changes associated with the introduction of CCOs, with significant changes concentrated in the area of improving primary care. Primary care is a foundational element of transformation, with a focus on prevention, case management, and care coordination delivered through team-based care.

The analysis included a limited timeframe (only the first 15 months of CCO experience) and did not have a comparison group. The evaluation may have only reflected where CCOs devoted their attention during their start-up phases.

Patient-Centered Primary Care Home (PCPCH) Evaluation

Key Findings

- PCPCHs showed significant increases in preventive procedures and decreases in specialty visits compared to non-PCPCHs.
- PCPCHs showed significant decreases in primary care visit and specialty office visit expenditures compared to non-PCPCHs.

In 2013 Portland State University evaluated whether utilization and expenditures changed for patients served in PCPCHs compared to non-PCPCH practices in the first year following PCPCH recognition.

Findings are consistent with the expectation that PCPCHs should emphasize primary care utilization over specialty care when appropriate. Researchers are building on this project and a new report will be published in fall 2016.

Hospital Transformation Performance Program (HTPP) Evaluation

This evaluation estimated the impact of the HTPP on hospital performance, quality improvement activities, and collaboration with CCOs.

All CCO representatives interviewed reported that HTPP has increased collaboration between hospitals and CCOs and nearly all hospitals reported that HTPP has helped their quality improvement efforts and programs.

Key Findings

- Hospitals have increased outreach to primary care for emergency department (ED) use and alcohol and substance use screening in the ED.
- Hospitals that increased collaboration with CCOs experienced statistically significant improvement on select measures.

Local Governance

Community Advisory Councils

COOs are required to have at least one Community Advisory Council (CAC), which meets regularly to ensure the CCO is addressing the health needs of the CCO members and the community. Representation is made up of members of each community of each county served, must include a majority of consumers and representation from each county government in the service area.

CAC strengths include driving partnerships between CCOs and communities on diverse projects, including those that address social factors that influence health, and giving Medicaid members a voice in setting CCO priorities. CAC challenges include achieving majority consumer membership and more diverse representation, specifically from Hispanic/Latinos.

The Transformation Center is supporting CCOs in recruiting CAC members with a customizable public service announcement in English and Spanish, a toolkit for CAC member recruitment, and assistance with CCO marketing and outreach materials.

Community Health Improvement Plans

All 16 CCOs have completed a Community Health Improvement Plan (CHIP), a document that must be updated at least every five years. CACs play an integral part in developing these plans by providing a local community perspective to improving community health. A 2014 review of CHIP development found CCOs included a diverse range of stakeholders in the process, and over 80 percent of CCOs focused on (1) improving integration of services; (2) primary care, behavioral health, and oral health; and (3) addressing promotion of health, prevention, and early intervention in treatment.

Coordination with Local Public Health

CCOs are contractually required to collaborate with local public health authorities (LPHAs) in a number of areas, including health promotion and prevention, and addressing disparities, although they are not required to have a formal contract or memorandum of understanding. Most CCOs have a close working relationship with their LPHAs.

OHA also provides competitive grants to 10 CCO and 23 LPHAs to work collaboratively to improve community health. Recipients must demonstrate that a local consortium of at least one CCO and one LPHA exists. Not all CCOs applied.

Community Prevention Program grants support evidence-based population and clinical interventions that align with community priorities.

Health Share	Multnomah, Clackamas, Washington
IHN	Benton, Lincoln, Linn
AllCare, Jackson, and PrimaryHealth	Jackson, Josephine
Eastern Oregon	Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wheeler

Sustainable Relationships for Community Health grants build local systems to prevent and manage chronic diseases

FamilyCare	Clackamas
ColumbiaPacific	The Public Health Foundation of Columbia County
IHN	Benton, Lincoln, Linn
Cascade	Klamath
Trillium	Lane

Eligibility and Enrollment

OHA maintains a close working relationship with the Department of Consumer and Business Services (DCBS) to ensure cross-agency collaboration between Qualified Health Plan Marketplace and Medicaid operations.

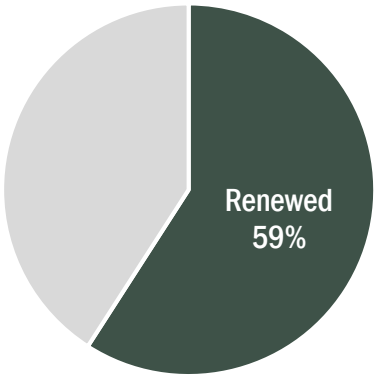
Areas of collaboration include coordination with HealthCare.gov to ensure that there is no "wrong door" for applications, and the implementation of OHA's new Medicaid eligibility and enrollment system, OregONEligibility (ONE), which began operations in December 2015. OHA's goal is to give Oregonians a better customer experience when they apply for coverage and benefits, through an easier, automated process.

Renewals and Closures

Members can renew their Oregon Health Plan eligibility by submitting an online PDF or paper application, or applying by phone. Members have approximately 60 days to respond to a renewal notice before their benefits are closed.

In 2015 OHA received approval from the Centers for Medicare and Medicaid Services to pause renewals for 90 days while OHA transitioned to the ONE eligibility system. Renewals resumed in February 2016. Starting in September, OHA is working to make renewals easier for members by sending a prepopulated renewal form.

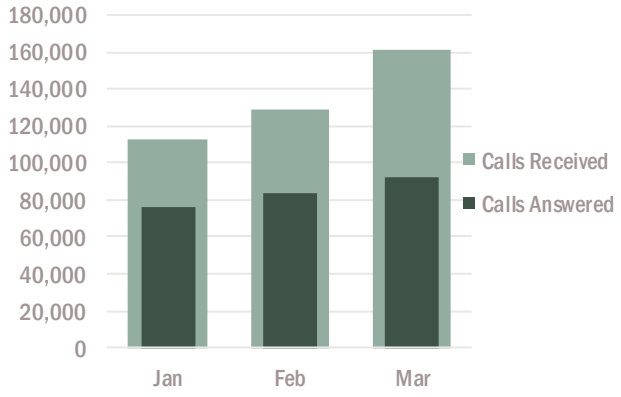
Of 116,660 memberships up for renewal, 59 percent of members renewed within 60 days.



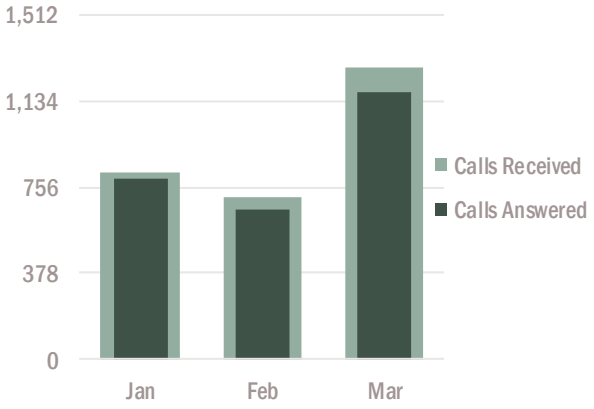
Outreach and Education

OHA and DCBS are currently coordinating their outreach and education efforts, including partnering to provide a network of community partner organizations with more than 800 enrollment assisters capable of helping and enrolling both qualified health plan and Medicaid eligible individuals, and coordinating call center operations and information.

Calls to OHA's Call Center have risen each month in Q1 2016



Calls to the Marketplace have also increased in Q1 2016



Administrative Rules: Changes related to CCOs

Rule Number and Name	Description	Effective Date	Rulemaking Action	Con-cerns?
OAR 410-141-3110 Substance Use Disorder Provider, Treatment and Facility Certification and Licensure	Rule addresses Substance Use Disorder (SUD) Provider, Treatment and Facility Certification and Licensure for the coordinated care organizational framework.	07/01/16	New Rule	No
OAR 410-141-3262 Requirements for CCO Appeal	Clarification has been provided in the Grievance System rule language for a standard appeal request for CCO members: a verbal appeal request must be followed by a written request.	07/01/16	Amendment	No
OAR 410-141-3070 Preferred Drug List Requirements	Rule language revisions clarify the pharmacy pre-authorization timelines and align prescription (Rx) prior authorization (PA) timeframes also stated in OAR 410-141-3420. *Concerns:* • Anticipated Rx PA language from CMS for 2017 • CCOs want to align language with Medicare Advantage requirements to align business practices *Resolution:* Avoid rework—CCOs and OHA agreed to follow CMS 2017 Rx PA requirements.	07/01/16	Amendment	Yes
OAR 410-141-3420 Billing and Payment — repeal of OAR 410-141-0420	Rule changes to provide guidance for CCOs, MHOs, and DCOs in single rule set: • Clarifies the 4-month billing requirement; • Specifies separate plan type requirements as applicable; • Aligns the pharmacy pre-authorization timeline with 410-141-3070 Preferred Drug Requirements—see above; • Updates claim submission timeframes with federal requirements and 2016 contracts; • Clarifies school-based health service considerations; and • Updates A and B hospital payment methodology language to align with current practices. *Concerns & Resolution:* See above re: OAR 410-141-3070. OAR 410-141-0240 was repealed as duplicate	07/01/16	Amendment and Repeal	Yes
OAR 410-141-3060 Enrollment; OAR 410-141-3080 Disenrollment	Rule changes were made as a result of public comment and OHA policy decisions re: consideration of non-hospital birth enrollment and disenrollment criteria, enrollment for children in DHS custody, and general housekeeping changes. *Concerns:* • CCOs and other contractors feel the enrollment of women not meeting non-hospital delivery criteria is adverse selection; they oppose CCO enrollment for these women. • Children are auto enrolled into dental and mental health CCOs, with manual enrollment for physical health. Requested auto-enrollment into physical health also. *Resolution:* No changes to current rule language made to address DHS custody auto enrollment; agency will review processes for all children in Child Welfare custody.	06/28/16	Amendment	Yes

Administrative Rules: Changes related to CCOs

Rule Number and Name	Description	Effective Date	Rulemaking Action	Concerns?
OAR 410-141- 3345 General Financial Reporting and Financial Solvency Matters; Transition	Expands the number of reports DCBS filers need to complete and submit to OHA so that they are filing reports with both agencies.	01/01/16	Amendment	No
OAR 410-141-3150 Flexible Services	Applying a new title, definition and rule structure *Concerns and resolution:* CCOs and other contractors felt OHA did not listen to public comment provided; advocates were interested in recourse for members through the complaints and grievance system. OHA sent a letter clarifying that all comments were held until completion of flexible services waiver discussion with CMS, then the rule will be re-opened / comments considered. Rule provides recourse for members.	01/01/16	New Rule	Yes
OAR 410-141-3267 CCO/OHA Dispute Resolution	Creates a rule structure for the CCO/OHA Dispute Resolution process within the CCO environment.	01/01/16	New Rule	Yes
OAR 410-141-3040 CCO Service Area Change	Creates a rule structure for the service area change process within the CCO environment. *Concerns and resolution*: CCOs felt OHA did not listen to concerns related to rule design; OHA held multiple Rule Advisory Committee meetings, leadership reviewed concerns.	01/07/16	New Rule	Yes
OAR 410-141-0520 Prioritized List of Health Services	The Authority is temporarily amending 410-141-0520, the approved Health Evidence Review Committee Prioritized List of Health Services and incorporating interim modifications made October 1 with the biennial changes for January 1, 2016-December 31, 2017.	01/01/16	Amendment	No
All Primary Care Case Manager (PCCM) and Primary Case Manager (PCM) rules and references.	As of Nov. 1, 2012, PCM/PCCMs are no longer receiving new patients and OHA contracts ran out. Clients were enrolled in CCOs and there are no any longer clients enrolled in this program.	12/10/15	Repeal of rules and deletion of term use	No
OAR 410-141-0000 Acronyms and Definitions - housekeeping changes) / OAR 410-141-3000 Definitions refer to OAR 410-141-0000	Migrate applicable rule definitions from 141 Administrative Rules to 120 General Rules. The CCO contract will be synchronized in the 2017 contract	10/01/15	Amendment	No
OAR 410-141-3066 CCO Enrollment Requirements for Temporary Out-of-Area Behavioral Health Treatment Service	Framework for CCO member enrollment for adults and young adults receiving temporary out-of-area behavioral health treatment services. This also integrates the rule for substance use disorder treatment services, 410-141-3065, which will be repealed.	09/01/15	New Rule	No
OAR 410-141-0300 / OAR 410-141-3300 / OAR 410-141-0280 / OAR 410-141-3280 /	Updates and aligns OHP member educational / information rules affecting members and potential members.	04/15/15	Amendment	No

Appendix: Additional Transformation Reporting

This appendix summarizes OHA reports on health system transformation topics and provides links to full reports for additional information.

Oregon Health Plan Demographics

OHA publishes a suite of Oregon Health Plan demographic, enrollment, and eligibility reports every month. http://www.oregon.gov/oha/healthplan/pages/reports.aspx. Select by report type.

CCO Performance on Quality Metrics

CCO metrics are reported semi-annually, with quality pool payment reporting each June. http://www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx

Member Satisfaction

- CAHPS survey data are published annually. Statewide and by CCO reports ("banner books") are available. http://www.oregon.gov/oha/analytics/Pages/CAHPS.aspx
- OHP member complaints and grievance data are reported quarterly; Summaries of compliant, grievance, appeal trends and interventions are all included in OHA's quarterly waiver reports. Select by report type "quarterly" http://www.oregon.gov/oha/healthplan/pages/reports.aspx.

Health Disparities

- Race, Ethnicity, Language and Disability (REAL-D) uniform standards for data collection, 2016 legislative update https://www.oregon.gov/DHS/ABOUTDHS/DHSBUDGET/20152017%20Budget/realD-OEMS-Legis-presentation.pdf
- Oregon Regional Health Equity Coalitions Evaluation Report, 2016 http://www.oregon.gov/oha/oei/reports/RHEC%20Evaluation%202016.pdf
- The Transformation Center posts CCO Transformation Plans and reports for both 2013-2015, and 2015-2017. http://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/Oregon-CCO-Transformation-Plans.aspx

Finance

CCO annual audited financial statements and internal financial statements are available: https://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/Oregon-CCO-Financial-Information.aspx

Appendix: Additional Transformation Reporting

Patient-Centered Primary Care Homes

- The Senate Bill 231 (2015) Primary Care Spending in Oregon first legislative report was published in February 2016. http://www.oregon.gov/oha/pcpch/Documents/SB231_Primary-Care-Spending-in-Oregon-Report-to-the-Legislature.pdf
- Additional reports including the PCPCH Program Annual Report, and evaluation results are available. http://www.oregon.gov/oha/pcpch/Pages/reports-and-evaluations.aspx
- Oregon standards for certified community behavioral health clinics (CCBHCs), as directed by Senate Bill 832. https://www.oregon.gov/oha/bhp/CCBHC%20Documents/Oregon-Standards-for-CCBHCs.pdf

Evaluations

Evaluation reports include:

- Midpoint Evaluation of Oregon's Medicaid Section 1115 Demonstration, 2015. https://www.oregon.gov/oha/OHPB/Documents/Final%20Report%20for%20the%20Midpoint%20Evaluation%20%204-30-2015.pdf
- Patient-Centered Primary Care Home (PCPCH) utilization and expenditure evaluation, 2014 http://www.oregon.gov/oha/pcpch/Documents/2014%20PCPCH%20Cost%20and%20Efficiency%20Evaluation.pdf
- Hospital Transformation Performance Program (HTPP) evaluation, 2016. Report available upon request.
- State Health Access Reform Evaluation (SHARE) of CCO organizational structures and governance, 2015 http://www.shadac.org/publications/oregons-coordinated-care-organizations-governance-impacts
- State Health Access Reform Evaluation (SHARE) of CCO impact on access, quality, patient engagement, health behaviors, and health outcomes, 2015. Report available upon request.

Local Government

- Senate Bill 436 report on community health improvement plan (CHIP) development, 2014 http://www.oregon.gov/oha/Transformation-Center/Resources/SB436_FINAL_report-0107152.pdf
- OHA's Public Health Division publishes State Health Improvement Plan indicators by CCO https://public.health.oregon.gov/About/Pages/HealthStatusIndicators.aspx

Eligibility and Enrollment

- OHA's processing and customer service performance charts are presented monthly. http://www.oregon.gov/oha/healthplan/pages/ohp-Update.aspx
- DCBS posts quarterly enrollment reports http://www.oregon.gov/DCBS/insurance/insurers/other/Pages/quarterly-enrollment-reports.aspx

THE WALL STREET JOURNAL.

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http://www.wsj.com/articles/the-pill-makers-next-door-how-americas-opioid-crisis-is-spreading-1475693346

U.S.

The Pill Makers Next Door: How America's Opioid Crisis Is Spreading

Ingredients for the deadly synthetic narcotic fentanyl are so easy to obtain that mom-and-pop drug labs are cropping up around the country, Breaking Bad-style

A California couple operated an illegal pill-making lab from their third-floor apartment in this San Francisco building, according to the Drug Enforcement Administration. *PHOTO: LAURA MORTON FOR THE WALL STREET JOURNAL*

By JON KAMP and ARIAN CAMPO-FLORES

Oct. 5, 2016 2:49 p.m. ET

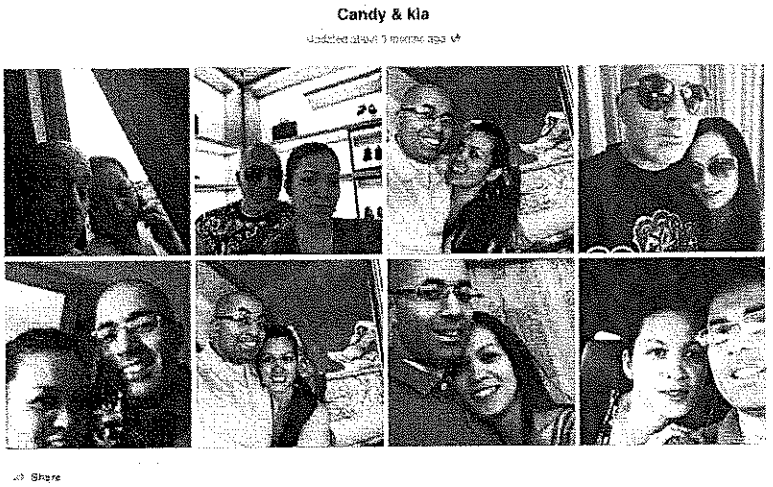
SAN FRANCISCO—The married couple living in the third-floor, ocean-view apartment were friendly and ambitious. She explored the city, posting selfies on Facebook. He started a small music label at home.

"They were nice people," said Ann McGlenon, their former landlady. "She's very sweet. He's a go-getter."

Authorities say Candelaria Vazquez and Kia Zolfaghari had darker aspirations. Working from unit 6, the pair built a small enterprise making counterfeit prescription pills, the Drug Enforcement Administration says. They designed pills to resemble legitimate oxycodone tablets, with an important, and potentially dangerous, twist, according to the DEA: Instead of oxycodone, they used the deadly synthetic opioid fentanyl as a main ingredient.

Mr. Zolfaghari worked a pill-press machine in their two-bedroom, 1,100 square-foot apartment, the DEA said, where they also kept an action figure of Walter White, the protagonist of the series "Breaking Bad," in which a high-school chemistry teacher cooks up batches of methamphetamine.

According to a DEA affidavit, the couple sold the pills to buyers around the U.S., including in Washington state and North Carolina. A federal grand jury in San Francisco indicted them on June 21 on charges including conspiracy to manufacture and distribute fentanyl. Both pleaded not guilty.



A screenshot of Facebook photos showing Candelaria Vazquez and her husband, Kia Zolfaghari.

Small-scale drug labs are cropping up around the country, as budding home-brew traffickers discover how easy it is to manufacture pills using synthetic opioids to meet a skyrocketing demand. Law enforcement says the phenomenon threatens to atomize the illicit narcotics trade, adding a troubling new dimension for authorities already strained trying to halt larger-scale drug gangs.

Abuse of opioids, including prescription drugs, heroin and synthetic narcotics like fentanyl, has reached crisis proportions. The Centers for Disease Control and Prevention said more than 28,000 people died from opioid-related overdoses in 2014, the last year of nationwide data, more than double the total from a decade earlier.

More-recent figures from individual states compiled by The Wall Street Journal suggest the crisis is getting worse, supercharged by fentanyl, a synthetic drug up to 50 times as powerful as heroin. Ten states—Maine, New Hampshire, Vermont, Rhode Island, Connecticut, Pennsylvania, Maryland, North Carolina, Kentucky and Ohio—saw 12,244 fatal drug overdoses of all kinds in 2015, up 21% from 2014, while fentanyl-related deaths across those states soared 128% to 3,883.

Authorities are investigating roughly a dozen suspected fentanyl pill-making operations in states including California, Tennessee and Utah, according to the DEA and local investigators.

These manufacturers aren't the usual drug kingpins, and some, such as Mr. Zolfaghari and Ms. Vazquez, have no known cartel ties. Instead, they have all the necessary supplies. Though illegal, anyone can order online ingredients needed to set up shop at home, including mixing agents and pill-pressing equipment.

One kilogram of fentanyl, which runs about $3,500 from a Chinese manufacturer, can yield as many as one million pills, according to the DEA. At a street price of $10 a tablet, that can generate $10 million in sales. And barriers to entry are low. A pill press used to mold powder into a tablet runs roughly $1,000, and a die set to stamp it with markings that mimic prescription medication costs about $130, the DEA says.

"What is scary is that it's the tip of the iceberg," says Casey Rettig, a special agent in the DEA's San Francisco division, referring to the freewheeling nature of some small-scale pill-making operations. "It begs the question for us: Are sellers just going to press anything" into pills?

The arrival of small-scale fentanyl pill makers represents a new phase in the illicit drug trade. A decade ago, fentanyl surfaced as a street drug in the U.S., mixed into the heroin supply. At the time, federal authorities traced it to a lab in Toluca, Mexico, that obtained fentanyl ingredients from suppliers in China, according to the DEA. After Mexican authorities shut the Toluca lab down in 2006, the problem largely petered out.

Around 2013, roughly when authorities were cracking down on pain clinics that sold vast quantities of prescription opioids, bootleg fentanyl started making a comeback on the streets. Some U.S. buyers today are ordering fentanyl online directly from Chinese labs. Catering to the same demand pain clinics once served, new drugmakers are turning fentanyl powder into tablets that often are externally identical to legitimate prescription drugs.

In June, law enforcement in Utah arrested a man who allegedly bought a fentanyl variant online and pressed it into fake oxycodone pills in a motel room in the Salt Lake City suburb of Sandy. In January, authorities arrested a union tradesman accused of making thousands of imitation oxycodone tablets with the fentanyl variant acetyl fentanyl in his Queens, N.Y., home.

Because of a lack of quality control—the pill makers sometimes use kitchen blenders to mix ingredients—the amount of fentanyl in tablets can vary by a factor of 10 or more, according to a lab analysis cited by the DEA. Unsuspecting buyers could end up ingesting something much more powerful than what they were expecting.

Replicas of generic hydrocodone painkiller tablets that actually contained fentanyl caused more than 50 overdoses, including at least 13 deaths, in the Sacramento, Calif., area in March and April. "These people are going down hard, they're going down extremely fast," said Timothy Albertson, a toxicologist and internist at UC Davis Medical Center in Sacramento, which received 18 pill victims in eight days, including one who died.

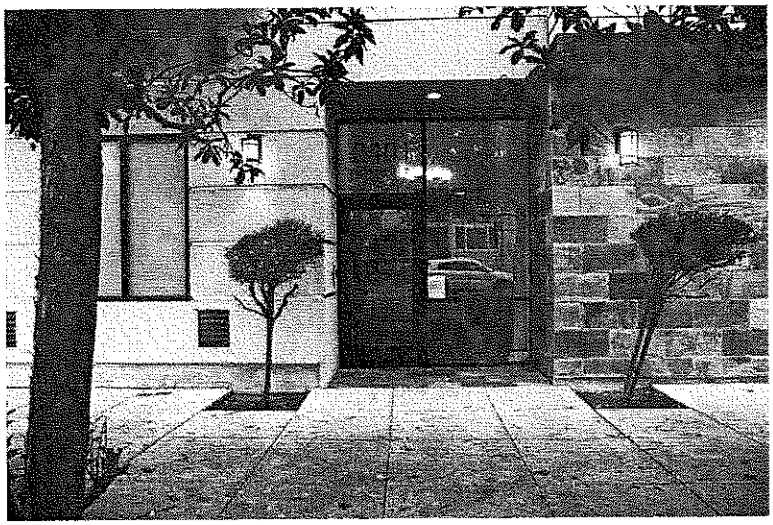
The pills were stamped with "M367," which made them look like real generic pain tablets sold by Mallinckrodt PLC that are supposed to contain hydrocodone bitartrate and acetaminophen. A company spokeswoman said the company has been working with the DEA concerning the Sacramento probe.

In Tennessee, authorities linked three deaths earlier this year to fentanyl-laced tablets that were made to resemble a brand-name painkiller. Investigators believe multiple pill-making operations function in the state, said Tennessee Bureau of Investigation spokesman Josh DeVine.

At least nine people in Pinellas County, Fla., died between January and March from tablets mimicking an antianxiety medication that instead contained synthetic opioids, said Sheriff Bob Gualtieri. "For all I know, it was some guy in a garage here" making them, he said.

Ms. Vazquez and Mr. Zolfaghari, the San Francisco couple, who are both 40, are unlikely candidates to run a drug lab.

Ms. Vazquez, who goes by "Candy," studied health information technology at Western Career College in the nearby city of Emeryville nearly a decade ago, according to her Facebook page. Of Filipino heritage, she worked several years ago in a job taking care of elderly people, according to her friend Mae Romano-Dunning.



The entrance to the building where a San Francisco couple allegedly operated an illegal pill lab using the synthetic opioid fentanyl as a main ingredient. *PHOTO: LAURA MORTON FOR THE WALL STREET JOURNAL*

Mr. Zolfaghari is from Fremont, Calif., and played football in high school and community college, according to his father, Behrooz Zolfaghari, who came to the U.S. from Iran nearly 50 years ago. The younger Mr. Zolfaghari started his own independent hip-hop music label focused on up-and-coming rappers. The label no longer has an operating website.

By about 2010, Mr. Zolfaghari had rented a small house in Richmond, Calif., telling his landlord, Robert Riggs, he worked at a local Honda dealership. "As far as I know he was a nice guy," Mr. Riggs said.

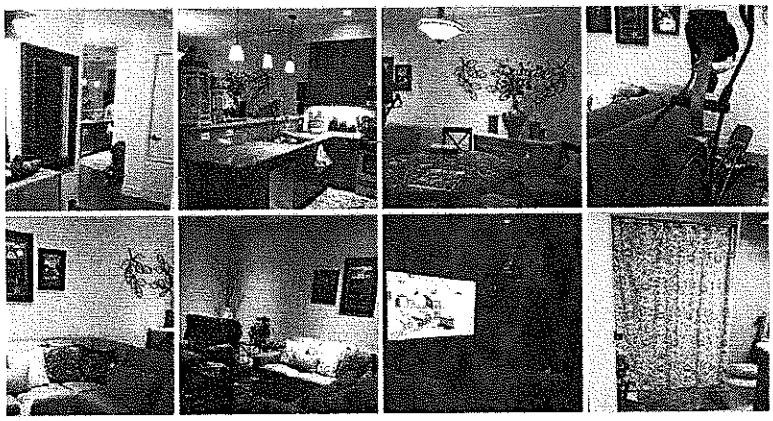
Mr. Zolfaghari and Ms. Vazquez traveled to Reno, Las Vegas and Beverly Hills together, posting photos of their trips on Ms. Vazquez's Facebook page. They married in 2013, according to her attorney.

Mr. Zolfaghari was struggling with an addiction to opioids sparked by old football injuries, his father said, which led his son to fentanyl.

In March 2014, likely while living in Richmond, Mr. Zolfaghari started buying pill-making supplies, including cutting and binding agents, to process fentanyl, according to email records reviewed by the DEA.

The agency's Ms. Rettig declined to address where he allegedly acquired the equipment. She said it is common for manufacturers to order supplies online from China or sometimes through the "darknet"—a restricted part of the internet accessible only with special software. Though it is illegal to import pill presses without notifying the DEA, the agency said Chinese suppliers sometimes ship them in pieces to evade detection.

HOME SWEET HOME



A screenshot of Ms. Vazquez's Facebook page shows the interior of the apartment allegedly used to manufacture illegal pills.

In early 2015, Ms. Vazquez and Mr. Zolfaghari relocated to a modern apartment in San Francisco's tranquil Sunset District. They told their new landlady they wanted to improve their credit so they could buy a place of their own.

Mr. Zolfaghari talked about his passion for music. He had high hopes for an album by their friend King Harris, a rapper from Oxnard, Calif., and in September 2015, he filed paperwork with the California Secretary of State for a new venture called Planet Zero Records LLC.

The husband and wife set up their fentanyl pill-making operation after moving in, the DEA says. The tablets Mr. Zolfaghari made were circular, white and stamped "ETH" and "446," markings seen on some oxycodone pills, according to a DEA affidavit.

Pill-making typically involves mixing fentanyl with a cutting agent such as mannitol, a sugary substance, to dilute its strength, according to Karl Nichols, a special agent in the DEA's San Francisco division. The manufacturer adds a binding agent to hold the ingredients together and pours the mixture into a funnel on the pill press. A small amount drops into a die set, and with the swing of a handle, the pill press stamps the mixture into a tablet.

During a six-month span, Mr. Zolfaghari sold more than 1,500 fentanyl-laced pills to a confidential source working with the DEA, in deals brokered by their friend, the rapper Mr. Harris, according to the DEA affidavit. The grand jury also indicted Mr. Harris, who has pleaded not guilty.

Ms. Vazquez didn't return calls seeking comment, and her lawyer, Mark Goldrosen, said he was still reviewing the case. Mr. Harris declined to discuss the case, citing his attorney's advice. Mr. Zolfaghari's attorney, Harris Taback, declined to address the charges against his client, who, he recently said, was in court-ordered drug treatment.

On one recorded call, the DEA says, Mr. Harris told the source that Mr. Zolfaghari promised "that he can press 100 out fast as f—."

Authorities say Mr. Zolfaghari also sold pills on the darknet, including one package sent to Charlotte, N.C. He conducted numerous transactions using bitcoin and appeared to have cashed out over $230,000 in the digital currency, according to a DEA seizure-warrant application. Ms. Vazquez's role centered on receiving drug proceeds, buying supplies and mailing pill shipments, authorities say.

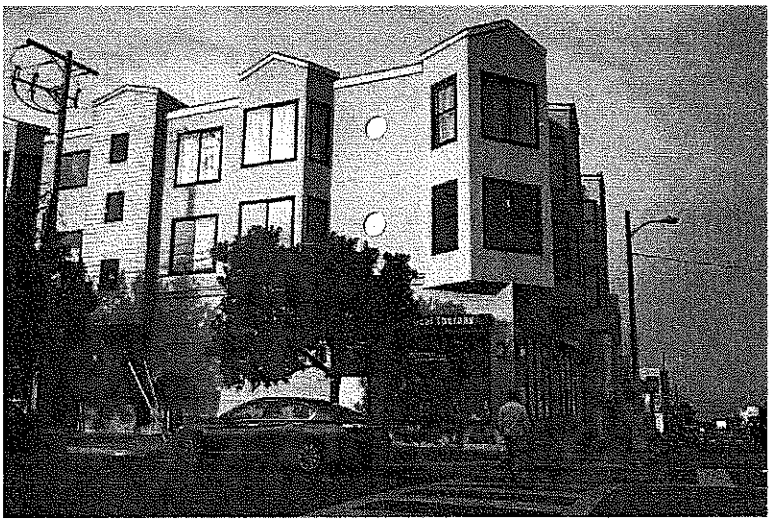
California's largest tax-collection agency doesn't show any reported employer wages for Mr. Zolfaghari for the years 2012 through 2015, according to the seizure-warrant application. But the couple were good tenants who paid their $3,000 monthly rent on time with cashier's checks, according to their landlady. They once triggered a noise complaint, which they quickly addressed by moving a TV and disconnecting a subwoofer speaker, their landlady said.

In May, Mr. Zolfaghari and Ms. Vazquez celebrated their third wedding anniversary at a Morton's steakhouse, where a custom-printed menu congratulated them. Mr. Zolfaghari bought his wife flowers and a Louis Vuitton purse. Ms. Vazquez posted pictures on her Facebook page as she went to the hair salon and prepared for their date. "Have fun beautiful couple," one friend wrote.

That same month, Mr. Zolfaghari's Planet Zero Records label released "Nightmare on Wolff Street," an album by Mr. Harris. "We believe we'll be up for a Grammy," Mr. Zolfaghari told Ms. McGlenon, his landlady. He sent her a link to listen to the album, whose second track is called "Dope House."

In a June buy, Mr. Harris ordered 500 pills at a price of $6,000 for a DEA informant, the agency said. After the informant deposited the money in a bank account in Ms. Vazquez's name, the DEA said, Mr. Zolfaghari texted Mr. Harris, "Got it, had orders for 800 yesterday so I gotta get back to work right now."

The next day, Mr. Zolfaghari and Mr. Harris met outside the San Francisco apartment. Agents observed Mr. Zolfaghari exit the building wearing a dark beanie cap, sunglasses and a satchel. Mr. Harris opened his car trunk and Mr. Zolfaghari handed him a tan envelope that agents said they later found contained 500 fentanyl-laced tablets.



A view of the apartment building where Candelaria Vazquez and Kia Zolfaghari allegedly operated a pill-making lab. *PHOTO: LAURA MORTON FOR THE WALL STREET JOURNAL*

On June 10, authorities descended on their building, sealed off the street below and arrested the couple, as well as Mr. Harris. A clandestine-lab team from the DEA, outfitted with white hazardous-materials suits and oxygen tanks, entered their apartment.

Inside, investigators found the array of pill-making equipment, according to the seizure-warrant application.

A glass display case contained three luxury watches valued at $70,000. Ms. Vazquez's "shoe collection was stacked virtually from floor to ceiling," many with price tags of more than $1,000, the seizure-warrant application says. There was $44,000 in cash in a bedroom and a trove of expensive goods, including Hermès bracelets and Tom Ford handbags. And one Walter White doll.

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AGDtranscript
a quarterly newsletter for state dental boards

The AGDtranscript is a quarterly e-newsletter sent to each state dental board in an effort to facilitate greater awareness of dental trends and issues across the nation. Through this newsletter, AGD hopes to build a lasting relationship with state licensing agencies while communicating information of interest.

Sedation a Hot Topic in the States

The Texas State Board of Dental Examiners established a blue-ribbon panel to review de-identified data surrounding dental anesthesia-related deaths and adverse events over the past five years. Recommendations are due to the Texas Legislature by Jan. 11, 2017.

The Dental Board of California commissioned a study to investigate dental pediatric anesthesia cases. State Senator Jerry Hill requested that a subcommittee assess whether California's laws, regulations and policies are sufficient to guard against the unnecessary use of general anesthesia in the treatment of pediatric patients, and whether the laws assure patient safety. State actions on this study are anticipated. Numerous other states are assessing their sedation guidelines as well.

In July of this year, in support of patient safety and access, the AGD submitted written comments to the American Dental Association's (ADA) Council on Dental Education and Licensure (CDEL) with regard to CDEL's proposed changes to the ADA's *Guidelines for the Use of Sedation and General Anesthesia by Dentists* and *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students*. The AGD will engage in discussions about the proposed sedation guidelines of the ADA House of Delegates at the upcoming 2016 ADA annual meeting, Oct. 20–27 in Denver.

AGD believes that diluting in the patient experience requirements for parenteral moderate sedation by combining these requirements with enteral moderate sedation, as suggested in the new guidelines, would pose an unnecessary risk for patients undergoing moderate parenteral sedation in the future.

Opioid Activity at the Federal and State Levels

To help combat the opioid epidemic, on Aug. 31, the U.S. Department of Health and Human Services (HHS) awarded $53 million to 44 states, four tribes and the District of Columbia, to improve access to treatment for opioid use disorders, reduce opioid related deaths and strengthen drug misuse prevention efforts.

Also in August, U.S. Surgeon General Vivek H. Murthy, MD, MBA, sent a letter to 2.3 million American health professionals expressing his concern about the extent of the opioid epidemic and asking health professionals for a commitment to combating the epidemic.

Opioid prescriptions continue to be discussed at the state level as well. In July, 46 governors signed the National Governors Association Compact to Fight Opioid Addiction. The document states the governors' commitment to fighting the epidemic by, among other steps, requiring that all opioid prescribers receive education on pain management, opioid prescribing and addiction throughout their training and careers.

In Pennsylvania, the State Board of Dentistry voted to adopt opioid prescribing guideline recommendations on the use of opioids in dental practice. The guidelines were announced by Pennsylvania Gov. Tom Wolf on July 29 and were developed by a task force convened by the Department of Health and the Department of Drug and Alcohol Programs.

States such as Maine, Michigan, New Hampshire and Vermont, among others, continue to discuss opioid prescribing guidelines and prescription monitoring program requirements at their board meetings.

State Lobbying on Opioid Issues

In a joint collaboration, The Associated Press and the Center for Public Integrity investigated state lobbying activities on opioids. Manufacturers of opioids formed a coordinated lobby and spent more than $880 million on campaign contributions and lobbying activities from 2006 to 2015. While not vocal in legislative hearings, the opioid lobby met with state senators and representatives one-on-one. Known as the Pain Care Forum, the lobby worked under the radar with advocacy groups and a public relations firm. The drug makers and allied advocacy groups employed around 1,350 lobbyists to fight limits on prescribing and bills meant to reign in opioid abuse. In 2015, patients in the United States received 227 million opioid prescriptions.

FDA Issues New Labeling Requirements for Opioids and Benzodiazepines

On Aug. 31, the U.S. Food and Drug Administration (FDA) issued a safety communication about the combined use of opioid medications and benzodiazepines and other drugs that suppress the central nervous system. After a review of all available data, FDA issued its strongest warning — a boxed warning — on opioids and benzodiazepines to alert health professionals that these drugs work in a synergistic manner. Patients taking these drugs together have experienced serious side effects, including suppressed and slowed breathing, and deaths have been reported.

Opioids and benzodiazepines are both commonly prescribed drugs. In 2014, within the U.S., 81 million patients were dispensed an opioid, while 30 million patients were dispensed a benzodiazepine. As always, FDA encourages health

professionals and the public to file a MedWatch report if a patient experiences an adverse reaction. MedWatch is a voluntary reporting service for health professionals; it is mandatory for manufacturers of medical products.

NIH Clinical Trials Rule Is Finalized

On Sept. 21, HHS issued a final rule from the National Institutes of Health (NIH) on the requirements for submitting registration and summary results from a clinical trial. The rule builds on prior efforts and intends to enhance the design of clinical trials and prevent duplication of unsuccessful or unsafe trials, increase the efficiency of drug and device development processes, improve clinical research practice, and improve the evidence base that informs clinical care.

NIH also released a policy on the dissemination of NIH-funded clinical trial information. In *clinicaltrials.gov*, as of Sept. 22, there are 2,219 trials using the search term "dental," while there are 4,751 trials using the search term "oral care" in the NIH database.

FDA Announces Off-Label Communications Two-Day Meeting

FDA will hold an open public meeting Nov. 9–10 to obtain feedback on manufacturer communications of unapproved uses of approved or cleared medical/dental products. Decisions in three recent court cases have changed the landscape for findings in off-label issues. Truthful off-label promotional speech, FDA's pursuit of misbranding provisions (for statements that were truthful and not misleading), and speech that is solely truthful and not misleading cannot be the bases for a misbranding charge. FDA intends to draft a guidance document to provide a more consistent response to a variety of off-label product issues.

Silver diamine fluoride is one example of a dental product that is used off-label. While it is FDA-cleared as a Class II medical device to reduce sensitivity, it is often used to delay tooth decay. Medical professionals may use medical/dental products in the manner they deem appropriate for their patients.

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Make Doctor’s Licenses Like Driver’s Licenses? Medical Groups Say No

December 11, 2015

By Michael Ollove

Nursing graduates at the University of Texas. In half the states, one state license is all a nurse needs to practice in the others. Several medical professions are moving to license portability.

When it comes to licensing, the nursing profession works almost exactly the way it does with driving a car — at least in half the states. A nurse with a license from one of those 25 states can practice in any other state that has signed on to a reciprocal licensing compact.

Contrast that with doctors. A doctor licensed in one state who wants to practice in another still needs a license from the other state. That’s a costly and time-consuming process, especially in an era when many health plans and their employees operate across state lines and the use of telemedicine, in which patients and their providers interact from a distance, is growing.

But the state licensing situation for doctors and other health care professionals — psychologists, social workers, physical and occupational therapists, and mental health counselors — is starting to change.

Doctors, for instance, are creating their own multistate compact. It won’t go as far as the nurses’ agreement, which grants reciprocity to practice in each state that signs on. But it will provide an expedited application process to get licenses in other states.

Other health professions are moving in the same direction — a recognition that Americans are mobile and there's a need to increase patients' access to health care.

"There is just a greater recognition that this is the world we live in today and that the medical professions have to adapt to the way health care is delivered today," said Colmon Elridge, director of the National Center for Interstate Compacts of the Council of State Governments, a public policy organization that works with several of the medical professions on the design of their license portability plans.

The main obstacle to portability for all the professions is that they are regulated by the states, each of which is free to demand its own qualifications — and collect its own fees — for licensing. To achieve portability, states either have to standardize their licensing requirements or agree to live with the differences, so long as there are some baseline qualifications accepted by all.

Nurses' Compact

The system in place for nurses in 25 states is the model for professional licensing portability among health care professions because it grants reciprocity to practice in participating states without getting a license.

It grew out of a 1990s trend of nurses becoming heavily involved in answering health questions on telephone hotlines, with calls often originating from other states, said Jim Puente, director of the Nurse Licensure Compact with the National Council of State Boards of Nursing (NCSBN).

That raised questions about whether they were licensed to deal with out-of-state patients, and helped prompt the formation in 2000 of the Nurse Licensure Compact for registered nurses, licensed practical nurses and licensed vocational nurses.

Creating a multistate compact was easier for nurses than some other health professions, Puente said, because nurses take the same licensing exam in every state and states' licensing requirements are mostly uniform.

Under the compact, a nurse's license can only be suspended by the state in which the nurse resides. But compact states have a disciplinary mechanism that allows one state to conduct an investigation into the actions of a nonresident nurse operating in that state and take action, including barring that nurse from working in the state.

The NCSBN is about to launch a separate compact for advanced practice registered nurses, those with advanced degrees who often work in specialty areas of medicine or are allowed to see patients without a doctor's supervision.

The Federation of State Boards of Physical Therapy this year decided to pursue a model similar to what nurses have and plans to start introducing legislation in states next year. And because emergency service personnel often cross state lines in natural disasters, the National Association of State EMS Officials plans to start pushing bills next year to establish a reciprocity compact.

The American Occupational Therapy Association and the Association of Social Work Boards are just beginning to consider their own compacts, but they haven't settled on a model.

Doctors Are Reluctant

Doctors chose not to seek a reciprocity agreement among the states as the nurses have, although a version of one does exist: A doctor licensed in any state can practice in any facility operated by the U.S. Department of Veterans Affairs.

There are stumbling blocks to reciprocity between the states for doctors' licenses, including varying requirements and concerns that states won't be able to discipline doctors from other states or fully investigate doctors accused of violating their standards.

Instead, the doctors have created a compact that the Federation of State Medical Boards (FSMB) says will offer an expedited and cheaper process for getting a license to practice in member states. So far, 11 states have joined the compact, with nearly an equal number expected to join next year. Telemedicine advocates and doctors who use telemedicine say the doctors' portability model, which still requires full licensure in every state, will impede the spread of telemedicine, particularly in rural areas that have a shortage of doctors.

"If you still require a doctor to be licensed in every state, in practical terms, you're still putting brakes on the use of telemedicine," said Gary Capistrant, chief policy officer of the American Telemedicine Association.

But the federation of medical boards says a reciprocal licensing scheme would diminish the ability of states to regulate medical practices within their own borders.

Lisa Robin, chief advocacy officer for the FSMB, said in most cases, nurses operate under the supervision of doctors. By contrast, she said, doctors operate independently. "It is therefore critical that medical boards are aware of which physicians are practicing in their states, as well as have oversight over those providing care to patients in the state where the practice occurs," Robin said.

On the other hand, even the conservative compact adopted by the FSMB is opposed by the Association of American Physicians and Surgeons, a right-leaning advocacy group, which is concerned that any kind of license portability would make it easier for doctors who perform abortions to cross state lines.

Different Model for Psychologists

Other health professionals are seeking ways to trim what can be an arduous licensing process for people who want to practice across state lines.

Mental health counselors, for instance, have a system in 10 states plus the District of Columbia that allows a licensed counselor from one participating state, with five years of practical experience and no disciplinary actions, to apply for a license in another state without the need for further review of their educational background, supervised training and experience. Pharmacists operate a similar model.

Dr. Mark Cunningham, a clinical and forensic psychologist in Texas, may be the poster child for medical professionals’ call for portability.

At the peak of his practice in 2013, he had licenses to practice psychology in 22 states. Obtaining and maintaining all those licenses was neither easy nor cheap for Cunningham, a psychologist board-certified in both clinical and forensic practice who often travels to other states to provide expert testimony in legal matters.

The cost of acquiring and maintaining all those licenses was astronomical, Cunningham said. He said it cost him $400,000 over about ten years in licensing and renewal fees, continuing education courses, travel to states to sit for examinations, clerical and administrative time, and lost billable hours.

Cunningham, whose case is an extreme one because he’s an expert witness, has a little relief now.

Licensed psychologists with at least five years’ experience, and no disciplinary action against them, can receive a Certificate of Professional Qualification from the Association of State and Provincial Psychology Boards (ASPPB). In 33 states plus D.C. that serves as a baseline confirmation of a psychologist’s educational background, supervised training and passing grade on the national psychology exams and makes it faster and cheaper to navigate the licensing process in other states.

Many states now also offer out-of-state psychologists the option of obtaining a temporary license, enabling them to practice for five to 30 days a year.

And the ASPPB is working on another compact that would enable a licensed psychologist from one state to practice telemedicine in another state without the need for a license from that state. Stephen DeMers, ASPPB’s CEO, said he expected some legislatures to consider bills pertaining to that compact next year.

Interstate Medical Licensure Compact

Sign In

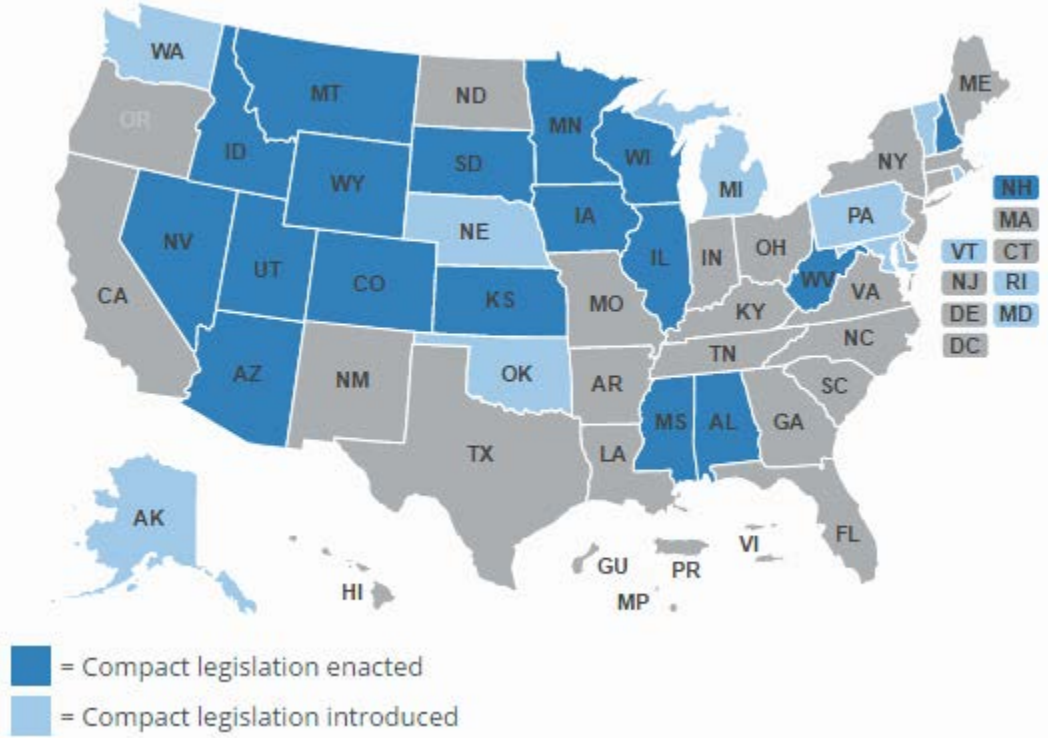
Home | About | Model Legislation | ToolKit | Endorsements | News | Contact

About the Compact

The Interstate Medical Licensure Compact offers a new, voluntary expedited pathway to licensure for qualified physicians who wish to practice in multiple states, increasing access to health care for patients in underserved or rural areas and allowing them to more easily connect with medical experts through the use of telemedicine technologies.

While making it easier for physicians to obtain licenses to practice in multiple states, the Compact strengthens public protection by enhancing the ability of states to share investigative and disciplinary information. The Compact is being implemented in a growing number of states, with others expected to adopt it soon.
To learn more, call (202) 463-4000.

Enactments: 17 Introductions: 9



Latest News

Comments on First Draft of Rule on Expedited Licensure Process

On July 19, 2016, the Interstate Medical Licensure Compact Commission's Bylaws and Rules Committee distributed to all commissioners the first draft of an administrative rule on the Compact's expedited licensure process. Commissioners were given a July 29, 2016, deadline to submit comments to the Bylaws and Rules Committee. Learn more.

How and when can I apply for an expedited license?

The Interstate Medical Licensure Compact is in the process of establishing its administrative process for expedited licensure. Expedited licensing is not yet available but will be soon. To request information from the Interstate Medical Licensure Compact Commission (IMLCC), or to make a comment to the IMLCC, please contact Ian Marquand, IMLCC Chairperson, at imarquand@mt.gov. Please consult the interactive map on this page to see the status of your state, and visit this site in the future to learn more.

ORAL HEALTH ACROSS THE LIFESPAN

Presenters: Tony Finch, MA, MPH Karen Hall, RDH, EPDH

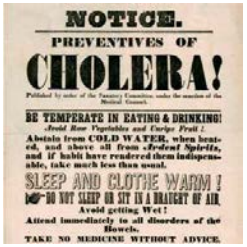
Oral Health – Why it Matters

- In 2000, the U.S. Surgeon General released *Oral Health in America: A Report of the Surgeon General*
  - Oral health = HEALTH. It is more than just healthy teeth
  - The mouth reflects general health and well-being
  - The mouth is the gateway to the rest of the body and oral disease is associated with other systemic health problems
  - Oral disease is prevalent across all ages and populations, but there are profound oral health disparities within the U.S. population especially among minorities, lower economic families and rural communities

"A silent epidemic of oral diseases is affecting our most vulnerable citizens—poor children, the elderly, and many members of racial and ethnic minority groups."

Epidemic - A Public Health Crisis

Consider epidemics in America that have created a public health crisis . . .



How do we respond to epidemics?

- *We take action at every level to eradicate terrible infectious diseases – it usually takes a while, but we stick with it until we **WIN!***

What about the epidemic of oral diseases?

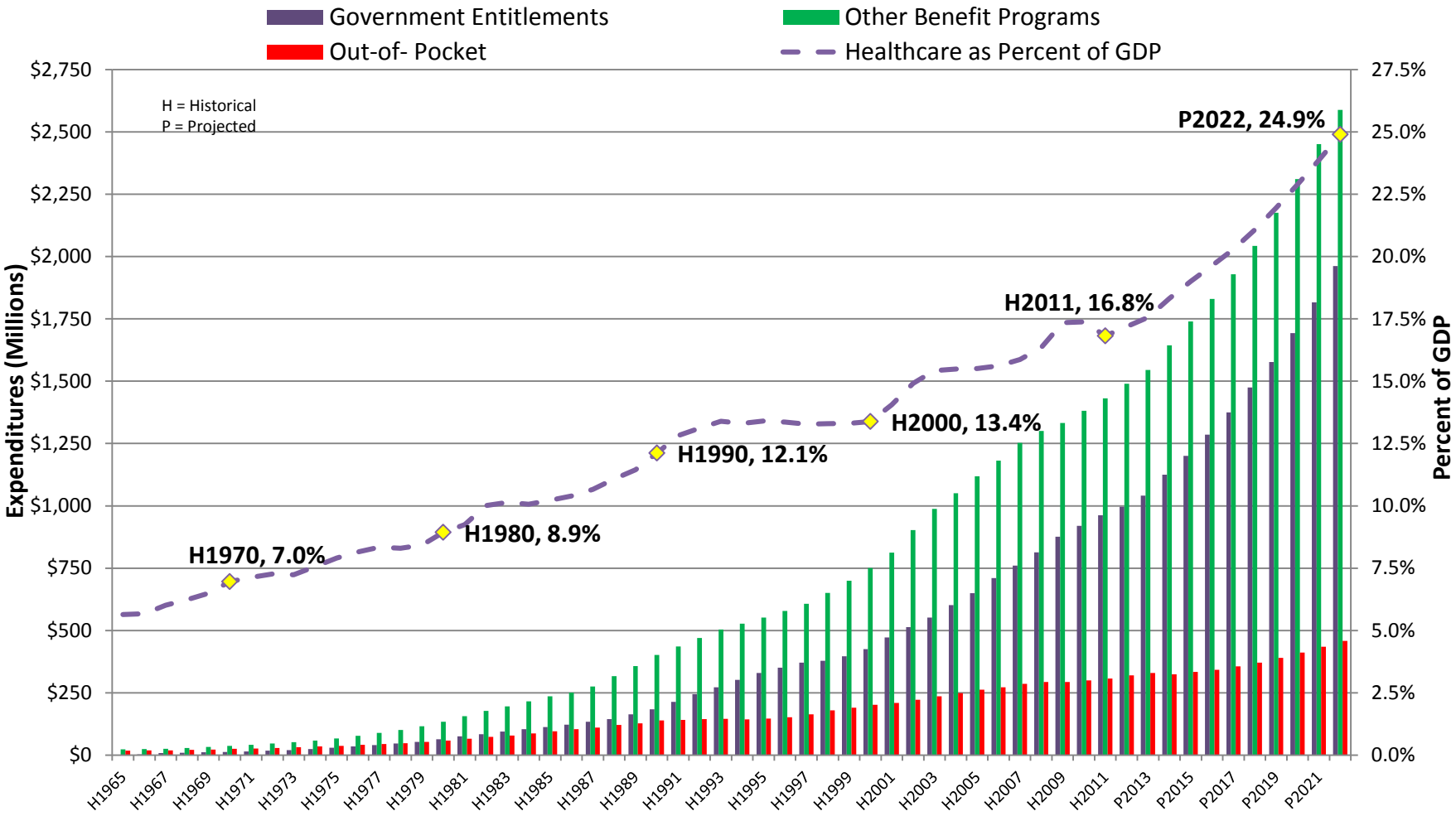
- *We have failed to treat it as an infectious, contagious disease that impacts systemic health*
- *We have accepted the presence of oral disease as a <u>natural way of life</u>*

Possibly the greatest public health crisis is when a prevalent, but preventable, disease is accepted as "NORMAL"

A Continuing Public Health Crisis

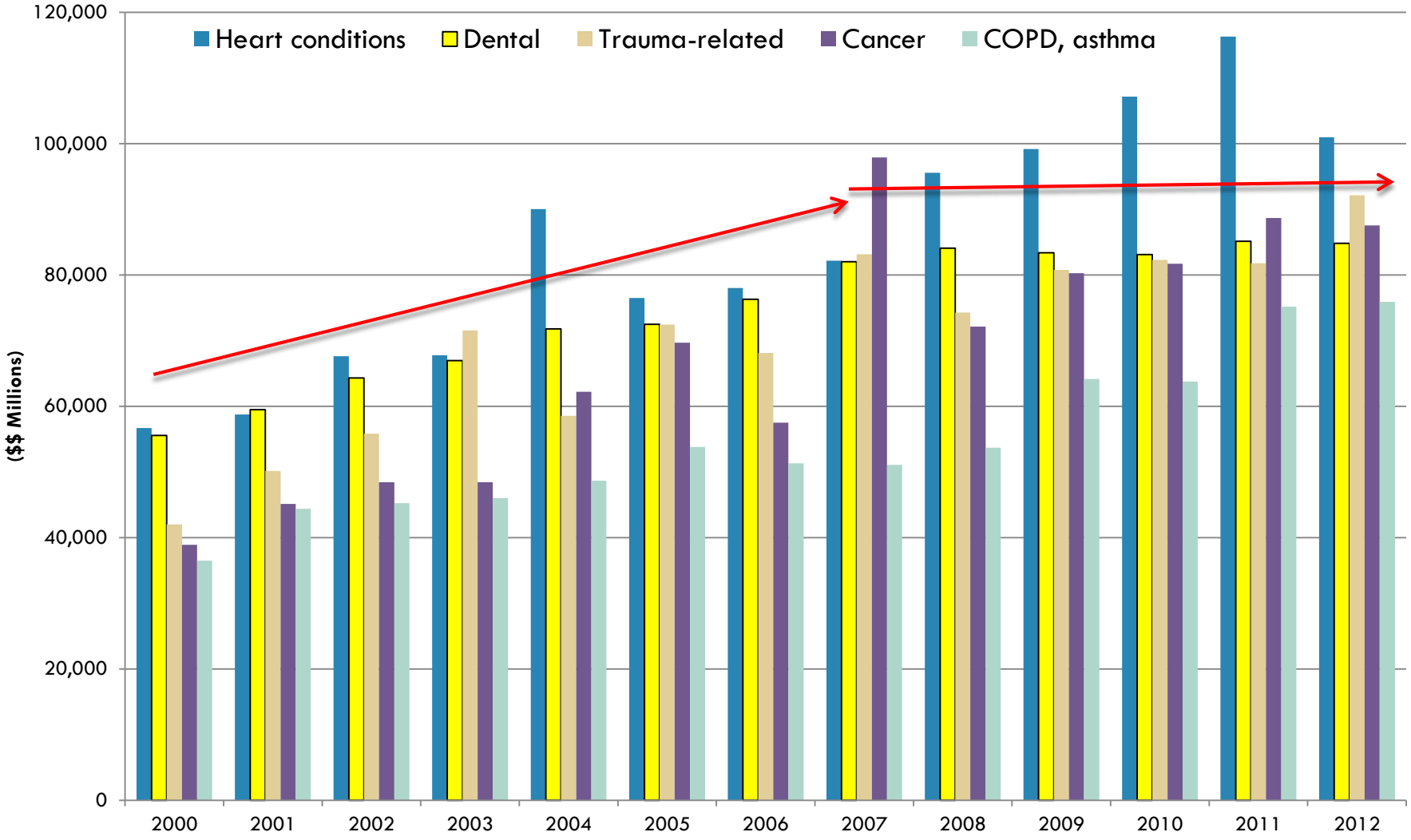
- Common risk factors for all dental diseases include:
  - Increased risk if we are at a lower income level or socioeconomic status, or if we are a minority community
  - Lack of water fluoridation as a healthy benefit for building natural barriers to disease
  - Genetics
  - Transmission of bacteria – parents to children, between siblings and friends
  - Poor diet – (American diet) including frequent exposure to carbohydrates (simple sugars) and lack of healthy foods
  - Poor oral hygiene in self-care
  - Smoking or other tobacco use

Health Care Cost Crisis

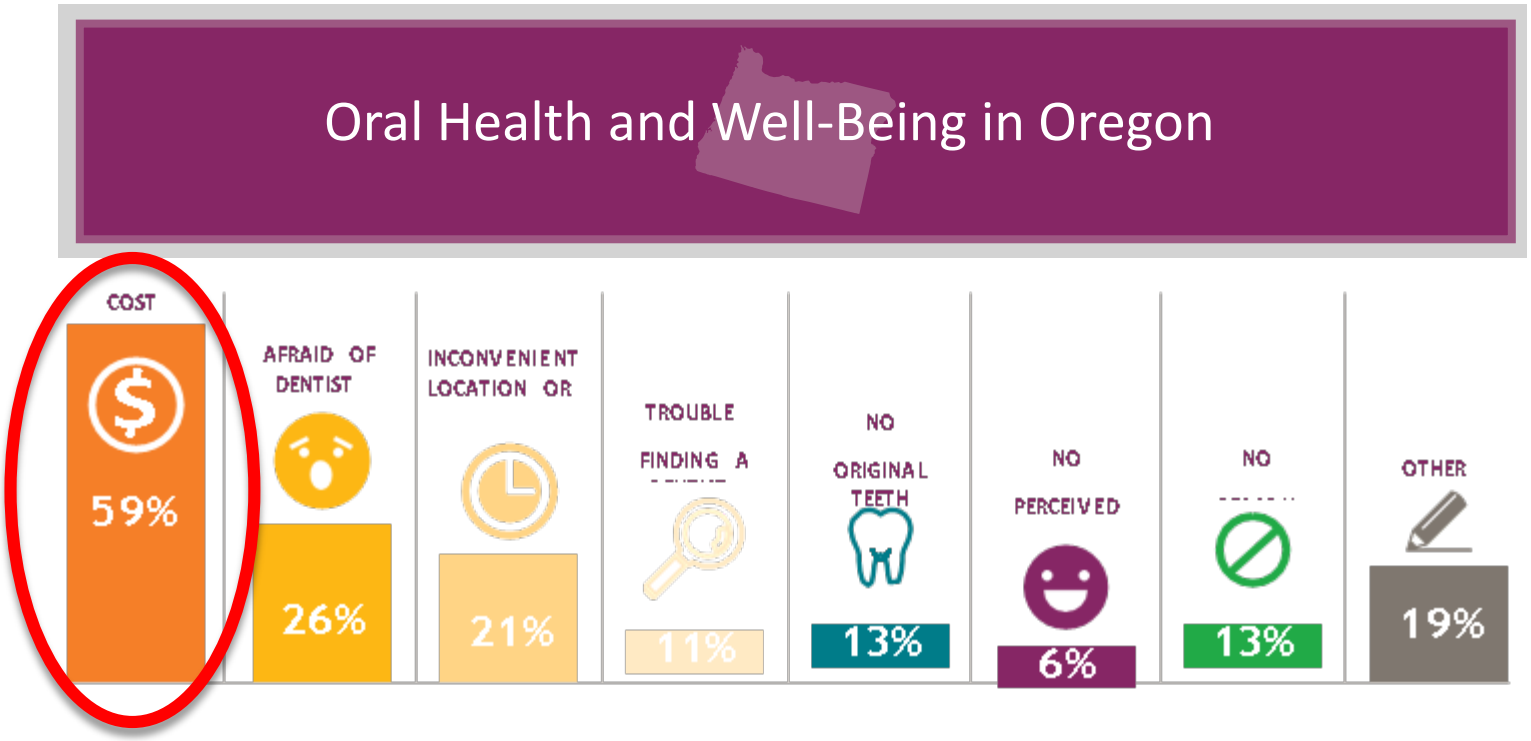


National Health Expenditure Survey Historical and Projection Data

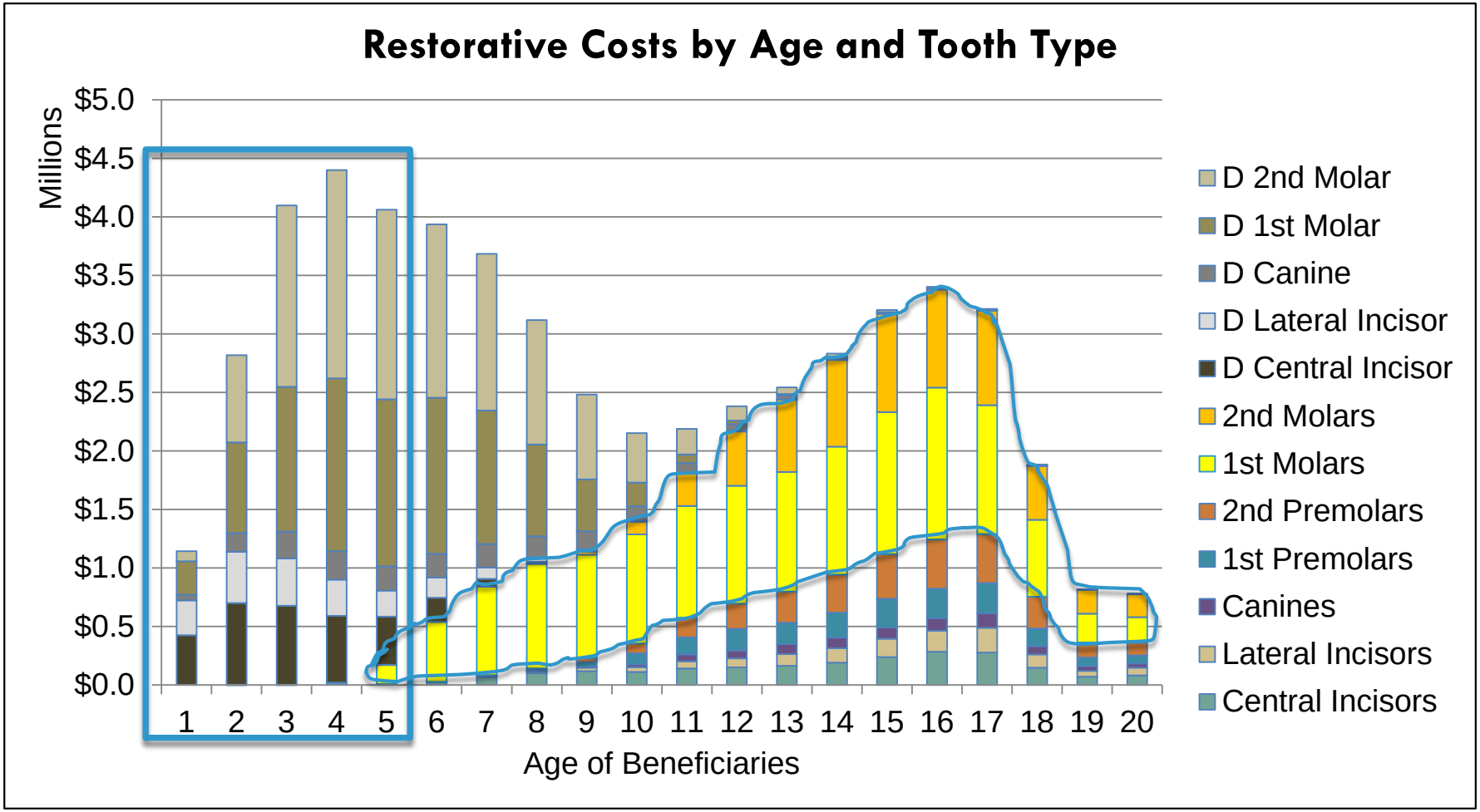
Heavy Hitters in Health Care Expenditures



How do costs impact care?



Restorative Costs - Typical Medicaid Program



Early Prevention = Lower Costs

"The age of a child at the first preventive dental visit has a significant effect on dentally related expenditures."

*Early Preventive Dental Visits: Effects on Subsequent Utilizations and Costs Savage MF, et al. Pediatrics October, 2004

Oral diseases for 0-5 age group

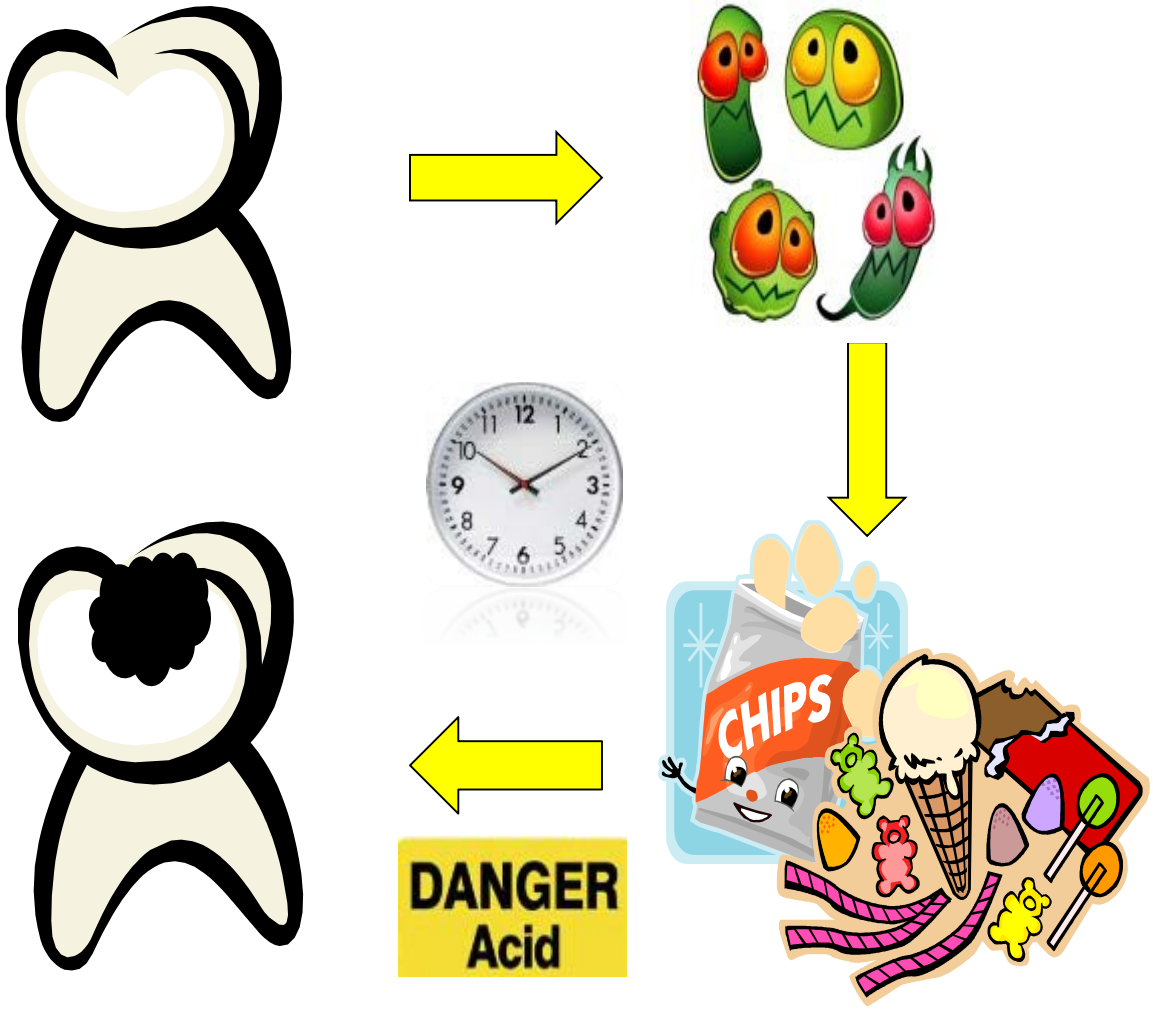
Early Childhood Caries (ECC) is a chronic, infectious dental disease affecting primary teeth of young children.

- Dental caries (tooth decay) is the single most common chronic disease in childhood.
  - Five times more common than asthma.
  - Affects 63% of Oregon's low-income children.

First clinical signs of caries

- White spots
- Acids have demineralized enamel
- First appear at gumline of upper front teeth
- High risk for developing cavities

Caries Process



Consequences of untreated ECC

Short Term:

- Pain and infection
- Impaired chewing & nutrition
- Disturbed sleep
- Trouble concentrating
- Diminished ability to learn
- Need for extractions
- Need for treatment under general anesthesia
- Low self-esteem

Long Term:

- Poor oral health and dental disease continue into adulthood
- Increased risk for caries in permanent dentition
- Growth delays, insufficient physical development.
- Impaired speech development

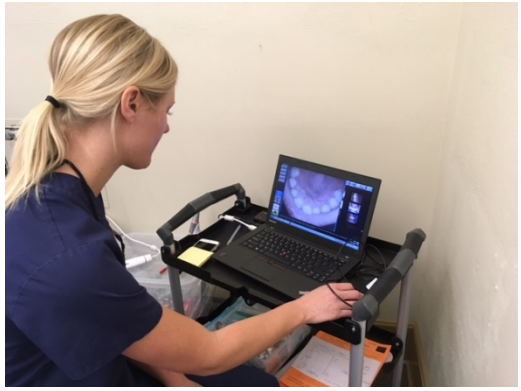
Key Messages - interventions

- Prevention works- fluoride (systemic and topical)
- Good oral health and nutrition prevents disease
- Fears may keep parent from seeking dental care for their child
- New methods of treating ECC may minimize traumatic experiences

What is Oregon doing about ECC?

- First Tooth - OrOHC's training for primary care pediatric and family practice providers
- Utilizing expanded practice dental hygienists (EPDHs)

- Head start, childcare centers
  - Assessments, fluoride varnish (FV), education, referrals and navigation
- WIC
  - Assessments, FV silver diamine fluoride, interim therapeutic restorations, education, referrals and navigation
- Co-location in medical offices



Good News – We can prevent . . .

- Pain and suffering among our children that translates into 3800 children a day in Oregon missing school with oral related pain
- Lost time and income for working parents, transportation costs and healthcare costs associated with treating a preventable disease
- Misconceptions about oral health with health literate messaging:
  - Oral health = good health
  - Oral disease is NOT normal, it's preventable

We've looked at children 5 and under . . .

– what changes when kids go off to school?

- The mouth changes – teeth are coming and going
- There's a new dynamic taking place in oral health issues and disease prevention

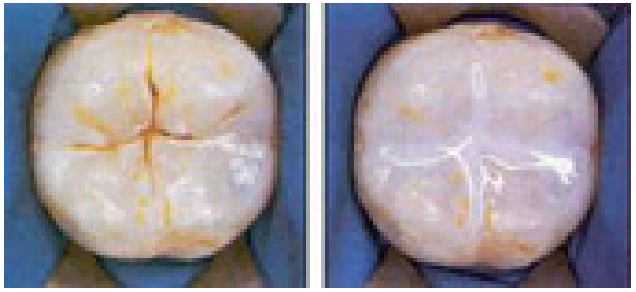
School-Aged / K-12 Students

- The last Smiles Survey in Oregon reported that 20% of Oregon children ages 6-9 had untreated tooth decay
  - 25% minority
  - 30% low income
- Students with poor oral health are:
  - 3X more likely to miss school
  - 4X more likely to have a low GPA
- Acute dental pain can result in:
  - Depression or anxiety
  - Difficulty concentrating
  - Impaired speech development
  - Nutritional deficiencies
  - Low self esteem

Oral Considerations in children 6-18

- Mixed dentition
- Caries and gum disease
- Trauma- sports-related
- Orthodontia- when and how
- Tobacco- smoking, chewing
- Permanent molars- needing sealants, eruption of third molars
- Dietary challenges
- Eating disorders
- Chronic diseases- obesity, diabetes, heart disease

Dental Sealants



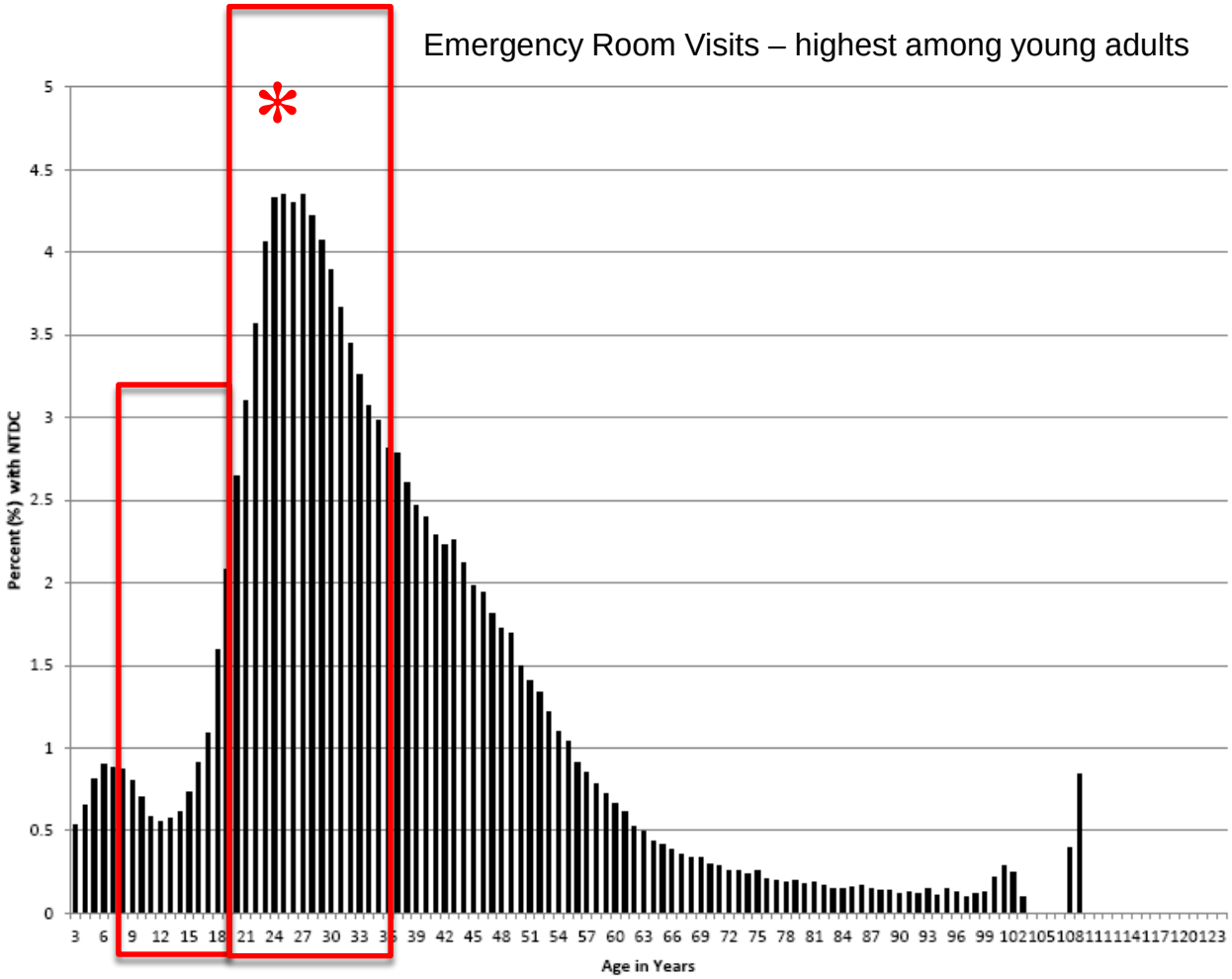
- Sealants prevent tooth decay and stop early cavities from progressing.
- Thin plastic coatings are applied to the grooves of the permanent molars.
- Sealants protect chewing surface by keeping germs and food particles out.
- Reduces decay in school children by 70-78%
- Sealant programs are offered to all Oregon elementary and middle schools where at least 40% of the students are eligible for the Free and Reduced Lunch Program
  - 88% of the eligible elementary schools were served
  - 47% of the eligible middle schools were served

What are we doing in Oregon to address school aged kids?

- Sealant program- state certification, but many areas served by local programs
- Metrics- driving prevention
  - Sealant metric
  - Foster children metric
- SBHC integration- 20% offer oral health services
- Boys and Girls Clubs
- ODS Children's program
- Assessments, sealants, and FV
- Mobile dentistry- MTI, ODS Tooth Taxi, SK

Adolescents and young adults

– a big gap in care when they aren't in school



Am J Public Health. 2015 May

Education high school drop out rates
- increased risk

- Oregon drop out rate
  - 2010-2013 highest rate in US among all states
  - 68% in 2010, 68.7% in 2013
  - US average is around 75%

- Risks increase, ED usage goes up, lack of routine care
  - Less education, greater unemployment, poorer health
  - Behavioral issues, tobacco & drug use
  - Lack of family and educator influences
  - Members are missing in systems of care

Adolescence and Young Adulthood

- Emerging oral health risk factors during adolescence:
  - Poor diet
  - Decreased oral hygiene - caries and gum disease
  - Eating disorders
  - Orthodontic appliances
  - Trauma - particularly sports injury
  - Tobacco use
  - Illicit drug use
  - Oral piercings
  - Third molars
  - HPV virus - oral cancer risk
  - Chronic diseases- obesity, heart disease, diabetes

What are we doing for adolescents?

- Not enough
- ED usage for oral/facial pain in Oregon is over $8.1 million – highest users are young adults
  - ED doesn't provide dental care – maybe antibiotics or pain meds
  - Access to a dentist by referral is sometimes challenging
- Increase efforts to reduce opioid use, more efforts in coordination and communication in healthcare systems
- Must focus on associated risk of extremely high drop out rates in Oregon high schools – we have to start early
- Expand focus beyond oral health for early childhood and transition to adult care and across the lifespan

Oral Health Across the Lifespan
– where do we start?

- Pregnancy – Healthy mouths are a must for pregnant mothers and the children they carry
- Data on care – barriers to care during
  - Access to care – most PG women in Oregon don't see a dentist during pregnancy, varies by region & the population demographic
  - Coverage vs. care utilization – studies shows numerous barriers to care even when a PG mom has coverage
- Old school – dentists consider PG patients high liability
  - Statement from ADA - It's safe for pregnant women to undergo dental treatment with local anesthetics, according to a study published in the August, 2015 issue of JADA

Pregnancy and oral health

Good oral health during pregnancy can improve the overall health of mother and baby.

50% of women do not receive dental care during their pregnancy.

Poor oral health during pregnancy has shown to increase risk of:

- Adverse birth outcomes
- Risk of infections which can harm mother and unborn child

Untreated maternal decay nearly doubles the odds of their children having severe decay

Common Oral Health Conditions During Pregnancy

Pregnancy gingivitis	Increase inflammatory response to dental plaque during pregnancy causes gingiva to swell and bleed more easily.	
Pyogenic granuloma (pregnancy tumors)	A lesion may result from heightened inflammatory response to oral pathogens.	
Tooth erosion	Erosion of tooth enamel may be more common because of increased exposure to gastric acid during pregnancy.	
Dental Caries	Pregnancy may result in dental caries due to the increased acidity in the mouth, greater intake of sugar, and decreased attention to prenatal oral health maintenance.	
Periodontitis	Untreated gingivitis can progress to periodontitis. The teeth may loosen, bone may be lost, and a bacteremia may result.	

Barriers to Dental Care During Pregnancy

Patient	Medical Provider	Dental Provider
• Unaware of oral-systemic health link • Misconceptions about oral health care: - Poor oral health is normal during pregnancy. - Dental treatment is unsafe. • Fear of the dentist • Financial concerns • Lack of dental coverage or awareness of coverage options	• Do not routinely refer patients for dental care • Unsure about safety of dental interventions during pregnancy • Limited understanding of the impact and safety of oral health care • Competing health demands during appointments	• Unsure how to manage the pregnant patient • Lack of practical training • Worry about injuring the woman or the fetus • Fear of malpractice repercussions.

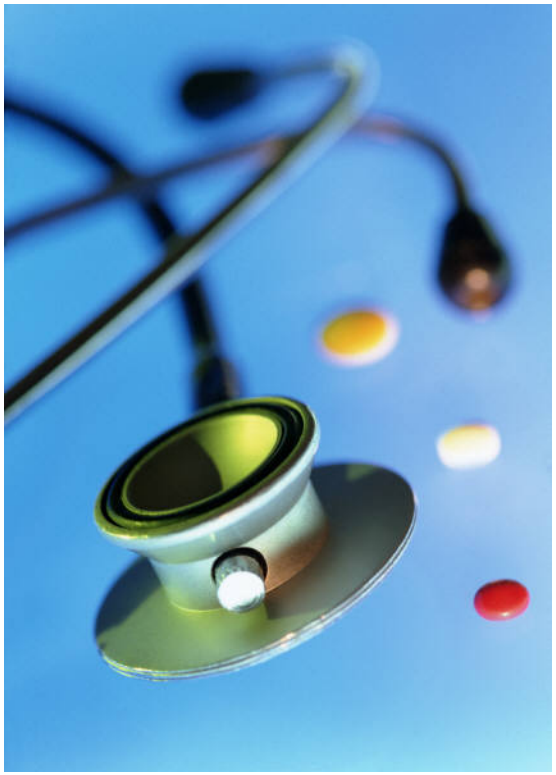
How is Oregon addressing oral health for pregnant women?

- OrOHC's Maternity Teeth for Two training for prenatal medical providers, WIC staff
- EPDH's in WIC-
  - 25/36 counties
  - Assessments, FV, referrals, navigation, education, ITR's and tobacco cessation services
- Co-location of EPDH's
- CCO's offering integrated referral services, navigation and incentives for keeping appointments

Adults and oral disease

- Gum disease is the leading cause of tooth loss in adults
  - 47.2% of adults over 30 years have some form of periodontal disease
- Gum disease is most easily treated in it's early stages
- When coinciding with systemic disease, gum disease worsens illness
- If 60% of people with diabetes better managed their oral health, savings could equal close to **$39 Billion** a year nationally
  - $245 Billion spent on diabetes alone in 2012 – 20% of healthcare costs
- In addition to health issues, social life, employment, self-esteem and general happiness are impacted by the conditions of ones mouth and teeth

Oral diseases/considerations for adults



- Periodontal disease
- Caries
- Oral cancer
- Chronic disease management
- Medications causing dry mouth
- Access- inadequate or lack of insurance despite expansion

Periodontal Disease- process and impact

- Moderate to severe chronic condition
- Oral microflora shifts to more pathogenic species
- Host immuno-inflammatory response to the persistent bacterial attack causes bone and tissue to break down.
- 50% increased risk of periodontal disease in smokers
- Frequent dental hygiene appointments help control periodontal disease, but structure loss is permanent

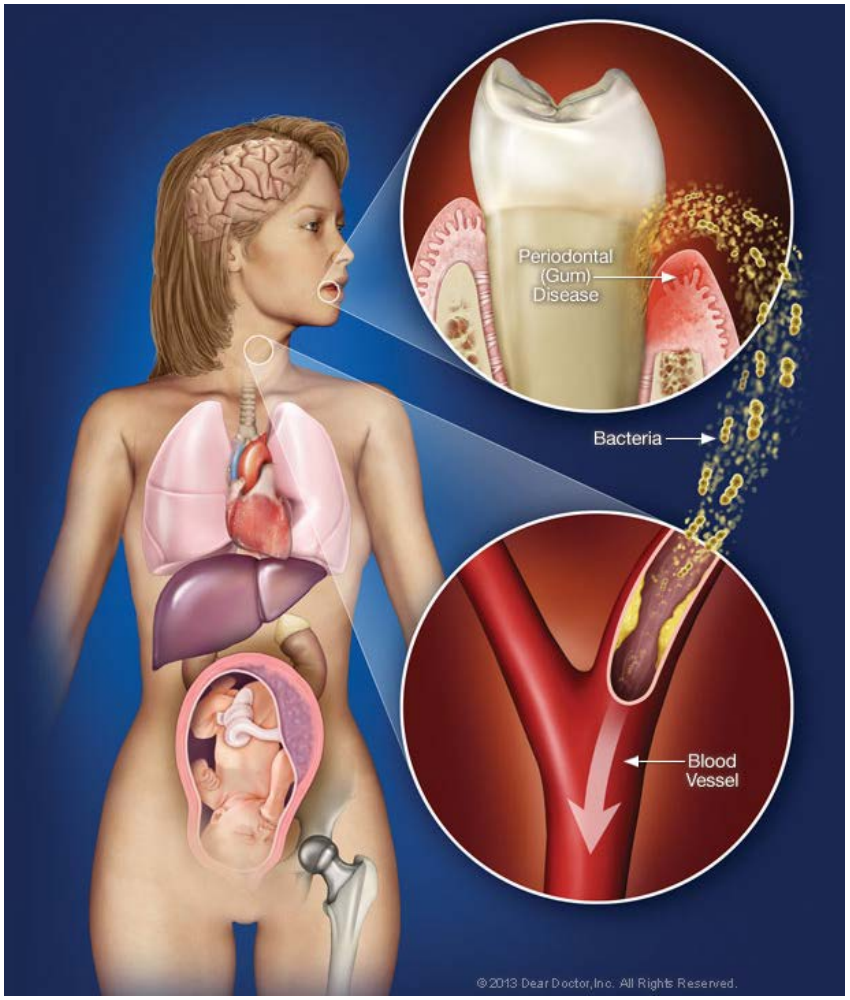
The Never Ending Cycle

Research concludes periodontal disease has an effect on controlling blood glucose levels and uncontrolled diabetes exacerbates periodontal disease.

BUT, controlling periodontal disease can improve diabetic health and controlling diabetes can improve periodontal health.

Inflammation and Chronic Disease

- Chronic inflammation of gum tissue can affect other parts of the body
- Periodontal disease is associated with serious health concerns, including:
  - Diabetes
  - Heart disease & stroke
  - Respiratory infections
  - Kidney infections
  - Osteoporosis
  - Alzheimer's disease and dementia



Addressing oral health needs of adults

- OrOHC's education for adult primary care providers

  A Healthy Mouth for a Healthy Body

- Reduce ED use - local oral health coalitions are working with ED

- Expansion of Medicaid to adult populations

What happens when teeth turn 65?

- No dental benefit with Medicare
- Senior population is rapidly growing – 10,000 a day turn 65
- In 2010, people 65 and older were 13% of population

  By 2030 65 and older will represent 20% of the population
- Barriers to care and good health
  - Lack of fluoridated water systems
  - Access to care
  - Transportation
  - Chronic disease complications
  - Good nutrition / diet
  - Self-care challenges
  - Caregiver oral health competency
  - Nobody seems to care . . . isolation

Older Adulthood Considerations

- Oral health can help to prevent and control chronic diseases in seniors.
- 1 in 9 Oregon seniors lost all their teeth due to tooth decay or gum disease in 2013.
- In 2012, 60% of older adults managed 2 or more chronic conditions, including:

- Heart Disease
- Cancer
- Chronic bronchitis or emphysema
- Stroke
- Diabetes mellitus
- Alzheimer's disease

Common oral health problems among the senior population

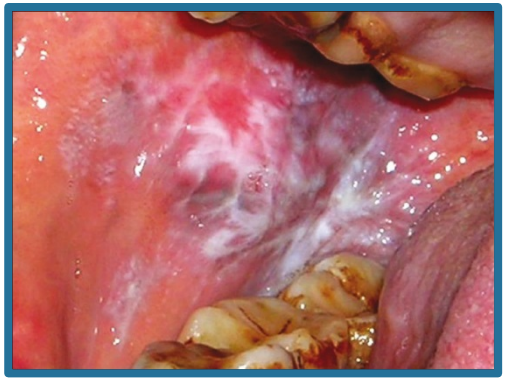
- Tooth loss
- Full or partial dentures – chewing ability or ill-fitting
- Decreased salivary flow- affects mastication and taste, increases disease risk
- Periodontal (Gum) disease
- Atrophy of oral mucosa and musculature
- Root caries (Root decay)– most common cause of tooth loss in seniors
- Poor oral hygiene – impaired manual dexterity
- Taste diminishing

Other common oral health problems with seniors

- Candidiasis (Thrush)

- Angular Cheilosis

- Oral cancer



Addressing seniors' needs

- Education for seniors and care providers
  - Oral Health for Seniors- OrOHC's training for care providers
  - Tooth Wisdom-OHA education for seniors
- Co-located EPDH's in adult facilities
- E.N.D.S.- exceptional needs dental services
- Dental Resource Guide For Seniors

Oral health spanning the lifespan

- Integration into patient-centered primary care - a systems approach
- Access for all ages across the lifespan
- Expanding the dental care team with a variety of approaches to care and prevention through new workforce models - in the office and in the community
- Moving upstream – prevention and education at every stage of life

A Systems Change Approach

- Oral health integration and coordination of care means we have to break down the silos of primary care and dental care across the entire lifespan
  - Education
  - Insurance / benefits
  - Practice / payment systems
  - IT – Electronic Medical Records
  - State and statewide delivery systems
- **Leadership** - Systems change framework has to start at the leadership level of every organization

OREGON ORAL HEALTH COALITION

Improving general health through oral health for all Oregonians

CODA
Commission on Dental Accreditation

CODA Communicator: Summer/Fall 2016

An Introduction from the Chair

Summer 2016 Commission Meeting Highlights

Major Actions of Interest

Adopted Policy Revisions

Actions of General Interest

Upcoming Hearings, Events and Meetings

Discipline-Specific Updates

Deadlines for Program Reports

An Introduction from the Chair

I am especially proud to announce that, at its Summer 2016 meeting, the Commission on Dental Accreditation (CODA) adopted a Strategic Plan for 2017-2021. During the past few months, the Commission and Staff engaged in concentrated development work that I know will strengthen CODA's position as "a globally recognized leader for accrediting educational programs in the dental professions."

I encourage you to review the new Mission, Vision and Value statements in the Accreditation Updates page on the CODA website.

In addition, the Commission not only took hundreds of accreditation actions but also directed staff to circulate many proposed revisions to Accreditation Standards for comment. This involved a tremendous amount of detailed review and editing by our Review Committees and the Commission, and will do much to align CODA's standards with current trends in education.

Review these standards, which are in circulation for a period of public comment, on CODA's Hearings on Standards/Comments Due webpage.

My term on the Commission will end at the close of the 2016 ADA House of Delegates. I thank the Commission for the privilege to serve as your CODA Chair. I also want to thank my fellow commissioners and CODA staff for their dedication to develop and implement standards that support the continuous improvement of dental education programs. It's been an honor to work with you.

Dr. Karen West
Chair, Commission on Dental Accreditation (2015–2016)

Summer 2016 Commission Meeting Highlights

This year's Summer 2016 Meeting was held on August 4 – 5, 2016. The Unofficial Report of Major Actions provides a summative review of the major activities during this meeting.

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Major Actions of Interest to All Accredited Programs

The Commission reviewed accreditation reports and took 325 accreditation actions on dental, advanced dental and allied dental education programs and recorded one (1) mail ballot on an advanced dental education program. Accreditation Status Actions can be found on the Commission's website.

Three (3) programs received a formal warning that accreditation will be withdrawn in February 2017 unless the requested information, demonstrating compliance with accreditation standards, is submitted prior to that time.

The Commission affirmed the reported voluntary discontinuance effective date or planned closure date of seven (7) education programs, at the request of their respective sponsoring institutions.

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Adopted Policy Revisions

The Commission adopted the following revised policies with immediate implementation:

- Due Process: Due Process Related to Review Committee Special Appearances; Due Process Related to Appeal of Accreditation Status Decisions; Due Process Related to Denial of Initial Accreditation; and Due Process Related to Withdrawal of Accreditation
- Function and Procedures of the Appeal Board
- Mechanisms for the Conduct of the Appeal Hearing
- International Predoctoral Policies and Procedures
- International Predoctoral Dental Education Site Visits
- Policy on Simultaneous Service
- Time Limitation for Review of Applications
- Criteria for Granting Accreditation
- Policies and Procedures for Accreditation of Programs in Areas of Advanced Education in General Dentistry
- Coordinated Site Visits
- Invoicing Process for Special Focused Site Visits
- Site Visitors: Allied Education in Dental Hygiene
- Site Visitors: Allied Education in Dental Assisting
- Site Visitors: Allied Education in Dental Therapy
- Rescheduling Dates of Site Visits

- Reporting Program Changes in Accredited Programs
- Policy on Non-Enrollment of First Year Students/Residents
- Policy on Enrollment Increases in Advanced Dental Specialty Programs
- Policy on Advertising
- Conflict of Interest

A red-lined version of the changes made to policy, as well as the current Evaluation Policies and Procedures manual, can be found online.

Additional Commission Actions of General Interest

CODA Quality Assurance and Strategic Planning

Prior to the Commission's summer meeting, the Commission conducted a one-half day strategic planning mega issue discussion. The Commission reviewed the report of the Standing Committee on Quality Assurance and Strategic Planning and took several actions, including:

- Adopting the proposed Mission, Vision, and Values statements, and the proposed 2017-2021 CODA Strategic Plan, effective January 1, 2017.
- Revising documents which contain the Mission, Vision, and Values statements, effective January 1, 2017.
- Directing submission of a resolution to the 2016 ADA House of Delegates to amend CODA's Rules to incorporate the new Mission statement, effective January 1, 2017.
- A PDF of the complete CODA Strategic Plan 2017-2021 is available on the Commission's Accreditation Updates page.

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UPCOMING COMMISSION HEARINGS, EVENTS AND MEETINGS

Proposed Standards Circulated for Public Comment are due December 1, 2016 and June 1, 2017. Read Hearings on Standards/Comments Due for the list of standards open for comments and their respective due dates.

2016 American Dental Association (ADA) Annual Meeting Hearing on Standards

The Commission will conduct a hearing on accreditation standards at the 2016 ADA Annual Meeting on Friday, October 21, 2016 in Denver, Colorado, from 10:00 a.m. to 11:00 a.m. in the Hyatt Regency Denver, Level 3, Centennial Ballroom F. Please verify the room location upon arrival.

Winter 2017 Commission on Dental Accreditation Meetings:

- Review Committee Meetings – January 9-13, 2017
- Commission Meeting – February 2, 2017 (Closed Session) and February 3, 2017 (Open Session)

For a more comprehensive list of all upcoming meeting dates, read Review Committee and CODA Meeting Dates 2016-2017.

DISCIPLINE-SPECIFIC UPDATES: SUMMER 2016 CODA MEETING

The Commission adopted revisions to the following accreditation standards:

- Accreditation Standards for Advanced Education in General Dentistry, Advanced Education in General Practice Residency, and Advanced General Dentistry Education Programs in Dental Anesthesiology, Standard 3-1 and Advanced Education in General Dentistry, and Advanced Education in General Practice Residency, Standard 3-2, with implementation July 1, 2017.
- Accreditation Standards for Advanced General Dentistry Education Programs in Orofacial Pain, with implementation July 1, 2017.
- Accreditation Standards for Dental Assisting Education Programs, Standards 2-9k, 4-10g, 4-10 intent statement, and 5-1, with immediate implementation.
- Accreditation Standards for Dental Hygiene Education Programs, Standards 2-15 and 4-4, with immediate implementation, and Standard 3-6 with implementation July 1, 2017.
- Accreditation Standards for Dental Laboratory Technology Education Programs, Standard 4-3j, and 4-3 intent statement, with immediate implementation.
- Accreditation Standards for Advanced Specialty Education Programs in Dental Public Health, Standard 2, with implementation January 1, 2017, and Standard 4-5 and 4-7, with immediate implementation.
- Accreditation Standards for Advanced Specialty Education Programs in Prosthodontics, Standard 6, with implementation January 1, 2017.

Deadlines for Program Reports

***Deadlines for many Program Change Reports are June 1 and December 1.** Please refer to the Program Changes and Other Report Guidelines page for details. The Commission expects programs to adhere to published deadlines. These deadlines allow sufficient time for the appropriate Review Committees and the Commission to review the report and determine whether the change could impact the program's potential ability to comply with the accreditation standards. You may also contact Commission staff with specific questions about reports and deadlines.

Anytime	Applications for programs pursuing CODA accreditation; The first opportunity for the Commission to consider the program, provided that the application is in order, could be approximately 12 to 18 months following the application submission date.
November 15, 2016	Deadline for Progress Reports related to Site Visits for Commission review in Winter 2017.
December 1, 2016	Deadline for Initial Response to Site Visit Report for Commission review in Winter 2017.
December 1, 2016	Deadline for Program Change Report Request for Authorized Enrollment Report Sites Where Educational Activity Occurs Report Teach-Out Report Other reports for Commission review in Winter 2017

NOTE: Program reports and documentation must not include Patient Protected Health Information (PHI) or Personally Identifiable Information (PII). A $1,000 penalty fee will be assessed if a program submits documentation that does not comply with the CODA policy on privacy and data security. A resubmission that continues to contain PHI or PII will be assessed an additional $1,000 fee. Review the Policy on Privacy and Data Security Summary for Institutions/Programs on CODA's website.

Programs are also reminded that they must comply with CODA's Electronic Submission Guidelines.

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Staff Contact Information

Commission staff are available to assist you.

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LICENSE RATIFICATION

16 . RATIFICATION OF LICENSES

As authorized by the Board, licenses to practice dentistry and dental hygiene were issued to applicants who fulfilled all routine licensure requirements. It is recommended the Board ratify issuance of the following licenses. Complete application files will be available for review during the Board meeting.

DENTAL HYGIENISTS

H7281	MARISSA BROOKE MC GINNIS, R.D.H.	8/16/2016
H7282	AMANDA M TZEO, R.D.H.	8/16/2016
H7283	MARLA ANN MICHALSEN, R.D.H.	8/16/2016
H7284	LISA ANN MILLER, R.D.H.	8/16/2016
H7285	LAUREN CHARLENE ONDREJCKA, R.D.H.	8/16/2016
H7286	COURTNEY MICHELLE RAE, R.D.H.	8/16/2016
H7287	TATYANA ALEKSANDROVA, R.D.H.	8/16/2016
H7288	KIMBERLY A BENJAMIN, R.D.H.	8/16/2016
H7289	EVELYN DEUTSCHER, R.D.H.	8/16/2016
H7290	TABITHA MIRANDA GRIEGO, R.D.H.	8/17/2016
H7291	KIMBERLEE D STEWART, R.D.H.	8/17/2016
H7292	CAMBRIA LEENTHA CURRAN, R.D.H.	8/17/2016
H7293	MARIA HAILEY MEJIA, R.D.H.	8/18/2016
H7294	SELENA PONCE, R.D.H.	8/18/2016
H7295	LACY AUTUMN RYSER, R.D.H.	8/18/2016
H7296	HEATHER M ATCHLEY-GREY, R.D.H.	8/18/2016
H7297	CHRISTY ANNA A REED, R.D.H.	8/22/2016
H7298	LYUDMILA VOROBETS, R.D.H.	9/1/2016
H7299	JASMIN DEOCA MITCHELL, R.D.H.	9/1/2016
H7300	SHENEICE L FRANCIS, R.D.H.	9/1/2016
H7301	CHRISTINE NAPINA ESPE, R.D.H.	9/1/2016
H7302	ALLYSEN ANN BUSH, R.D.H.	9/1/2016
H7303	COURTNEY TIMMS, R.D.H.	9/1/2016
H7304	TARA JACLYN BUDGEON, R.D.H.	9/1/2016
H7305	SARAH JUNE TWIFORD, R.D.H.	9/1/2016
H7306	DANIELLE MARIE WAGNER, R.D.H.	9/1/2016
H7307	IRYNA P REVUTSKA, R.D.H.	9/1/2016
H7308	PATRICIA RODRIGUEZ, R.D.H.	9/1/2016
H7309	STEPHANIE HUTCHINSON, R.D.H.	9/1/2016
H7310	KRISTINA PETERSEN, R.D.H.	9/1/2016
H7311	ANNA NGUYEN, R.D.H.	9/1/2016
H7312	JANA MARY C AYCO, R.D.H.	9/1/2016
H7313	MADELINE JEAN LARSON, R.D.H.	9/1/2016
H7314	ADRIENNE A THUSTON, R.D.H.	9/1/2016
H7315	TIMOTHY MATIA, R.D.H.	9/12/2016
H7316	BRITTNEY BAER, R.D.H.	9/12/2016
H7317	ERIN PATRICIA BULL, R.D.H.	9/12/2016
H7318	NICOLE WHITNEY LAMBERT, R.D.H.	9/12/2016
H7319	STEVI MARIE HAUGEBERG, R.D.H.	9/12/2016
H7320	ANNA SINCLAIR, R.D.H.	9/13/2016
H7321	NADIA VIADO, R.D.H.	9/13/2016
H7322	CAITLIN ANN-HANSON HERINIRINA, R.D.H.	9/13/2016
H7323	TAYLON H ROWLEY, R.D.H.	9/13/2016
H7324	SHELLY NICOLE GREGORY, R.D.H.	9/13/2016
H7325	MARIANNE ELIZABETH TARDY, R.D.H.	9/13/2016
H7326	LARENE K HAAS, R.D.H.	9/13/2016

H7327	JILLONA MARIE FRANGIPANI, R.D.H.	9/13/2016
H7328	NICHOLE LACIE MCGUIGAN, R.D.H.	9/30/2016
H7329	JOCELYN BROOKE ADAMS, R.D.H.	9/30/2016
H7330	MING RAN ZHANG, R.D.H.	9/30/2016
H7331	TESSIA MARLENA BARRERA, R.D.H.	9/30/2016
H7332	MAI DOAN, R.D.H.	9/30/2016
H7333	LAUREN E MCCALL, R.D.H.	9/30/2016
H7334	ALEXIS J HOGAN, R.D.H.	9/30/2016
H7335	JESSE TREANOR, R.D.H.	9/30/2016
H7336	JENNIFER MARIE BROWN, R.D.H.	9/30/2016
H7337	MARNA L DUNCAN, R.D.H.	10/3/2016
H7338	SIERRA WILSON, R.D.H.	10/10/2016
H7339	HOPE ALEXANDRIA DAWSON, R.D.H.	10/10/2016
H7340	COURTNEY TAYLOR HARRINGTON, R.D.H.	10/10/2016
H7341	OCTAVIA JULIET VARGAS, R.D.H.	10/10/2016
H7342	ANNIE NGUYEN, R.D.H.	10/10/2016

DENTISTS

D10534	ELIZABETH ANN MCELHINNEY, D.M.D.	8/16/2016
D10535	JIMMY QUIRINO LAPNAWAN, D.M.D.	8/16/2016
D10536	TODD STUART WEIL, D.M.D.	8/17/2016
D10537	NHU-NGUYEN NGUYEN, D.M.D.	8/17/2016
D10538	JOSEPH HOWARD KNIGHT, D.M.D.	8/17/2016
D10539	PETER VILLADIEGO, D.M.D.	9/1/2016
D10540	ANUPAMA KULKARNI ARANYA, D.D.S.	9/1/2016
D10541	MARK HABERMEYER, D.D.S.	9/1/2016
D10542	JONATHAN WILLIAM PLUID, D.M.D.	9/1/2016
D10543	JUN HYUG CHOI, D.D.S.	9/9/2016
D10544	CALEB STUEBING, D.D.S.	9/15/2016
D10545	NICHOLAS S SKOURTES, D.M.D.	9/23/2016
D10546	KYONG HWA MOON, D.M.D.	9/28/2016
D10547	JONATHAN H SHENG, D.D.S.	9/28/2016
D10548	KEVIN SWEENEY, D.D.S.	9/30/2016
D10549	BRADLEY WILLIAM TUCKER, D.D.S.	9/30/2016
D10550	KAYLA NICHOLE ELIOTT, D.M.D.	9/30/2016
D10551	NICHOLAS MARVIN ALEXANDER TAPP, D.D.S.	10/3/2016
D10552	LAWRENCE B CAPLIN, D.M.D.	10/3/2016
D10553	LEON VERNON JONES, D.D.S.	10/3/2016
D10554	KARIN DAVIS, D.M.D.	10/10/2016
D10555	KEVIN LAWRENCE TINGEY, D.D.S.	10/10/2016
D10556	PAUL O CHOI, D.M.D.	10/10/2016

LICENSE, PERMIT & CERTIFICATION

Nothing to report under this tab