

CHAPTER 35
BOARD OF MEDICAL EXAMINERS

Authority

N.J.S.A. 24:6I-1 et seq. (P.L. 2009, c. 307); 26:6A-1 et seq., specifically 26:6A-4; 45:1-15.1; 45:9-2; and 45:9-37.115.

Source and Effective Date

R.2011 d.155, effective May 3, 2011.
See: 42 N.J.R. 1310(a), 43 N.J.R. 1359(b).

Chapter Expiration Date

Chapter 35, Board of Medical Examiners, expires on May 3, 2018.

Chapter Historical Note

Chapter 35, Board of Medical Examiners, was adopted and became effective prior to September 1, 1969.

Chapter 35, Board of Medical Examiners, was repealed and Chapter 35, Board of Medical Examiners, was adopted as new rules by R.1983 d.314, effective August 1, 1983. See: 15 N.J.R. 503(a), 15 N.J.R. 1255(a).

Subchapter 7, Chiropractic Practice, was adopted as R.1984 d.533, effective November 19, 1984. See: 16 N.J.R. 686(a), 16 N.J.R. 3208(a).

Pursuant to Executive Order No. 66(1978), Chapter 35, Board of Medical Examiners, was readopted as R.1989 d.532, effective September 21, 1989. See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).

Subchapter 6A, Declarations of Death upon the Basis of Neurological Criteria, was adopted as R.1992 d.309, effective August 3, 1992. See: 23 N.J.R. 3635(a), 24 N.J.R. 2731(c).

Subchapter 2A, Limited Licenses: Certified Nurse Midwifery, was adopted as R.1992 d.332, effective September 8, 1992. See: 23 N.J.R. 3632(a), 24 N.J.R. 3094(a).

Subchapter 9, Acupuncture, was adopted as R.1993 d.299, effective June 21, 1993. See: 24 N.J.R. 4013(a), 25 N.J.R. 2689(c).

Subchapter 10, Athletic Trainers, was adopted as R.1993 d.546, effective November 1, 1993. See: 25 N.J.R. 265(a), 25 N.J.R. 4935(a), 26 N.J.R. 483(a).

Pursuant to Executive Order No. 66(1978), Chapter 35, Board of Medical Examiners, was readopted as R.1994 d.522, effective September 19, 1994, and Subchapter 7, Chiropractic Practice, was repealed by R.1994 d.522, effective October 17, 1994. See: 26 N.J.R. 2526(a), 26 N.J.R. 4195(a).

Subchapter 2B, Limited Licenses: Physician Assistants, was adopted as R.1994 d.538, effective November 7, 1994. See: 25 N.J.R. 5099(b), 26 N.J.R. 4411(b).

Subchapter 11, Alternate Resolution Program, was adopted as R.1995 d.339, effective June 19, 1995. See: 27 N.J.R. 1363(a), 27 N.J.R. 2412(a).

Subchapter 7, Prescription, Administration and Dispensing of Drugs, was adopted as R.1997 d.475, effective November 3, 1997. See: 29 N.J.R. 842(a), 29 N.J.R. 4706(a).

Subchapter 4A, Surgery, Special Procedures, and Anesthesia Services Performed in an Office Setting, was adopted as R.1998 d.294, effective June 15, 1998. See: 29 N.J.R. 2238(a), 30 N.J.R. 2236(b).

Petition for Rulemaking. See: 30 N.J.R. 740(c), 1642(a).

Pursuant to Executive Order No. 66(1978), Chapter 35, Board of Medical Examiners, was readopted as R.1999 d.356, effective September 20, 1999. See: 31 N.J.R. 1742(a), 31 N.J.R. 3117(a).

Subchapter 12, Electrologists Advisory Committee; Licensure of Electrologists and Electrology Instructors; Electrology Standards of Practice, was adopted as R.2004 d.279, effective July 19, 2004. See: 35 N.J.R. 3263(a), 36 N.J.R. 3401(a).

Subchapter 13, Perfusionists, Advisory Committee, was adopted as R.2005 d.88, effective March 7, 2005. See: 36 N.J.R. 1721(a), 37 N.J.R. 782(a).

Chapter 35, Board of Medical Examiners, was readopted as R.2005 d.120, effective March 17, 2005. See: 36 N.J.R. 4633(a), 37 N.J.R. 1203(a).

Subchapter 6A, Declarations of Death Upon the Basis of Neurological Criteria, was repealed and Subchapter 6A, Declarations of Death Upon the Basis of Neurological Criteria, was adopted as new rules by R.2007 d.120, effective May 7, 2007. See: 38 N.J.R. 2021(a), 39 N.J.R. 1751(a).

Subchapter 1, Medical Schools, Colleges, Externships, Clerkships and Post-Graduate Work, was renamed Medical Schools, Colleges, Externships and Clerkships; and Subchapter 3, Licensing Examinations and Endorsements, Limited Exemptions from Licensure Requirements, was renamed Licensing Examinations and Endorsements, Limited Exemptions from Licensure Requirements; Post-Graduate Training by R.2008 d.100, effective April 21, 2008. See: 39 N.J.R. 3876(a), 40 N.J.R. 2115(a).

Pursuant to Executive Order No. 1(2010), the chapter expiration date was extended from March 17, 2010 until the completion of the review of administrative regulations and rules by the Red Tape Review Group, and until such time as the extended regulation or rule was readopted pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. See: 42 N.J.R. 1310(a).

Chapter 35, Board of Medical Examiners, was readopted as R.2011 d.155, effective May 3, 2011. As a part of R.2011 d.155, Subchapter 1A, Standards for New Jersey Clinical Training Programs Sponsored by Medical Schools Not Eligible for Evaluation and Not Approved by the L.C.M.E., the A.O.A. or Other Agency Recognized by the New Jersey State Board of Medical Examiners, was repealed; and Subchapter 4A, Surgery, Special Procedures, and Anesthesia Services Performed in an Office Setting, was renamed Surgery, Special Procedures and Anesthesia Services Performed in an Office Setting, effective June 6, 2011. See: Source and Effective Date. See, also, section annotations.

Subchapter 7A, Compassionate Use Medical Marijuana, was adopted as new rules by R.2011 d.292, effective December 5, 2011. See: 42 N.J.R. 2728(a), 43 N.J.R. 3191(b).

Subchapter 14, Genetic Counseling Advisory Committee, was adopted as new rules by R.2013 d.136, effective December 2, 2013 (operative March 2, 2014). See: 44 N.J.R. 2447(a), 45 N.J.R. 734(a), 45 N.J.R. 2478(c).

Law Review and Journal Commentaries

How New Jersey Regulates Doctors. Theodosia Tamborlano, 132 N.J.L.J. No. 15, S24 (1992).

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(r) A permit holder may engage in the practice of medicine or podiatry provided that such practice shall be within the context of an accredited graduate medical education program conducted at a hospital licensed by the Department of Health and Senior Services (DHSS). A permit holder may engage in practice outside the context of a graduate medical education program for additional remuneration only if that practice is approved, in writing, by the residency program director of the graduate medical education program in which the permit holder is participating and the practice is supervised by a plenary licensee who shall:

1. Either remain on the premises of the health care facility or be available through electronic communication if that practice is at or through a health care facility licensed by the DHSS; or
2. Remain on the premises if that practice is outside of a health care facility licensed by the DHSS.

(s) The residency program director shall:

1. Require each permit holder to complete and submit a verification of supervision/employment form prior to approving practice outside of the approved graduate medical education program. A verification of supervision/employment form is required for each place of employment a permit holder practices outside the context of a graduate residency training program. The form shall include, but not be limited to, the following information:

- i. Name of the permit holder;
- ii. Field of practice;
- iii. New Jersey physician license number of the supervising physician;
- iv. Type of facility;
- v. Telephone number; and
- vi. Street address of the facility; and

2. Retain the verification of supervision/employment forms for seven years, which may be subject to review by the Board.

(t) The supervising physician shall:

1. Complete an affidavit accepting responsibility for reading and implementing the Board's statutes, N.J.S.A. 45:9-1 et seq., and rules, N.J.A.C. 13:35, that pertain to employment of permit holders outside the context of their approved graduate medical education programs; and

2. Provide evidence to the program director that arrangements have been made for professional liability coverage of the permit holder that is consistent with the rules of the Board, specifically N.J.A.C. 13:35-6.18.

(u) Prescriptions and orders may be issued by permit holders in the inpatient setting without countersignature. All prescriptions issued by permit holders in the outpatient setting, which are to be filled in a pharmacy outside a licensed

health care facility shall be signed by a licensed physician or licensed podiatric physician, as appropriate.

(v) The Board may refuse to issue a permit to a permit applicant if he or she has not certified that the prerequisites set forth in (c) above have been satisfied, if the supporting documentation set forth in (f) above has not been produced or if the Board is in possession of any information contradicting the representations made in the permit application form or supporting documentation. The Board shall give the Director and the applicant notice of its refusal, allowing the submission of documentary evidence in rebuttal. Upon a showing of good cause the applicant will be granted an appearance before a committee of the Board.

(w) In addition to any practice declared to be a basis for sanction, pursuant to P.L. 1978, c.73 (N.J.S.A. 45:1-14 et seq.), the practices listed below, upon proof, shall also provide basis for the termination or suspension of a permit. Upon receipt of the notice of proposed termination or suspension the permit holder may request a hearing which shall be conducted pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.

1. Termination or withdrawal from a graduate medical education program.
2. Failure to advise the Board of a termination or withdrawal from a graduate medical education program.
3. Engaging in any act or practice beyond the scope of those authorized pursuant to (r) above.

(x) A permit shall be valid for the duration of the graduate medical education program in which the permit holder is participating. If the permit holder seeks to change programs, he or she must submit a transfer application form. All transfer applications must be accompanied by a certification from the Director of the graduate medical education program in which the applicant has been or is currently participating, attesting to successful performance in the program.

(y) Each hospital offering a program(s) in medicine shall designate one physician who would qualify as a Director to fulfill the responsibilities set forth in this rule. Each hospital offering a podiatry program shall designate one podiatric physician who would qualify as a Director of a podiatry program to fulfill the responsibilities set forth in this rule. The Director may delegate to individual program directors these responsibilities, so long as the Director retains ultimate responsibility for the conduct of the program, except that the Director may not delegate the authority to issue temporary authorizations. In addition to the responsibilities placed upon any Director by this rule, he or she shall:

1. Implement procedures to assure that all prescriptions and orders issued by residents are countersigned or signed in accordance with the requirements of this rule.
2. Provide broad oversight of the activities of all program participants.

3. Report to the Board any conduct by a resident which, if proven, would represent cause for the withdrawal of registration or the suspension of a permit.

4. Report to the Board if any resident is granted a leave of absence for any reason, relating to a medical or psychiatric illness or to medical competency or conduct, which would represent cause for the withdrawal of the authority to practice, providing an explanation. This duty to report shall not apply if the resident is known to the Board's Impairment Review Committee through participation in the Alternative Resolution Program.

(z) The authorization granted to an unlicensed person to participate in the first year of a graduate medical education program shall not be construed to imply that that person will be deemed eligible for the issuance of a permit or a license. The issuance of a permit similarly should not be construed to imply that the permit holder will be deemed eligible for licensure.

New Rule, R.1988 d.203, effective May 2, 1988.

See: 19 N.J.R. 2243(a), 20 N.J.R. 986(a).

Amended by R.1994 d.522, effective October 17, 1994.

See: 26 N.J.R. 2526(a), 26 N.J.R. 4195(a).

Amended by R.1999 d.356, effective October 18, 1999.

See: 31 N.J.R. 1742(a), 31 N.J.R. 3117(a).

In (a), inserted a reference to words in the introductory paragraph, and inserted a reference to medicine in "Resident"; rewrote (c); in (d), rewrote the last sentence; in (l), substituted a reference to the Director for a reference to the Board in the introductory paragraph; and in (m)3, added "and the jurisdiction in which the didactic training was conducted" at the end.

Amended by R.2004 d.398, effective October 18, 2004.

See: 36 N.J.R. 2582(a), 36 N.J.R. 4827(a).

In (c)1ii, inserted "and that the didactic training was completed in the jurisdiction where the school is authorized to confer a medical degree" at the end of the first sentence and deleted the same at the end of the second sentence.

Amended by R.2008 d.100, effective April 21, 2008.

See: 39 N.J.R. 3876(a), 40 N.J.R. 2115(a).

Rewrote the introductory paragraph of (r); added (r)1 and (r)2; added new (s) and (t); recodified the last two sentences of the introductory paragraph of (r) as new (u) and deleted former (u); in (u), inserted a comma following the second occurrence of "setting"; recodified former (s) and (t) as (v) and (w); deleted former (y); and recodified former (v) through (x) as (x) through (z).

Amended by R.2011 d.155, effective June 6, 2011.

See: 42 N.J.R. 1310(a), 43 N.J.R. 1359(b).

In (c)1ii, inserted the second and third occurrences of "either" and inserted "published by the World Health Organization or the International Medical Education Directory (IMED) published by the Educational Commission for Foreign Medical Graduates (ECFMG)," and "published by the World Health Organization or the International Medical Education Directory (IMED) published by the Educational Commission for Foreign Medical Graduates (ECFMG)"; in (c)1v, substituted the first occurrence of "that" for "which"; and "ACGME" for "LCME"; in (d), substituted the fifth occurrence of "that" for the second occurrence of "which"; inserted a comma following the first occurrence of "list" and inserted "attended or"; and in (k) and (y)4, inserted the last sentence.

SUBCHAPTER 1A. (RESERVED)

SUBCHAPTER 2. LIMITED LICENSES: PODIATRY, DIAGNOSTIC TESTING CENTERS AND MISCELLANEOUS

13:35-2.1 Approved colleges of podiatry

An applicant for podiatric licensure shall have graduated from a college or colleges of podiatry approved during the entire course of the applicant's training by the American Podiatric Association and approved by the Board.

Amended by R.1989 d.532, effective October 16, 1989.

See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).

Deleted N.J.S.A. reference.

13:35-2.2 Podiatry internship or postgraduate work

The applicant for licensure shall have successfully completed an internship or postgraduate program fully approved by the American Podiatric Medical Association in a duly licensed clinic, hospital or institution acceptable to the Board, which shall take into account the standards adopted by the Advisory Graduate Medical Education Council (AGMEC).

Amended by R.1989 d.532, effective October 16, 1989.

See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).

Old text deleted, replaced with new text.

13:35-2.3 Military service in lieu of internship in podiatry

The Board may grant a license to practice podiatry to any person who shall furnish proof, satisfactory to the Board, that such person has fulfilled all of the formal requirements established by the Podiatric Practice Act, N.J.S.A. 45:5-1 et seq., and has served at least two years in active military service in the United States Army, Air Force, Navy, Marine Corps, Coast Guard or the United States Public Health Service as a commissioned officer and podiatrist in a medical facility which the Board determines constitutes the postgraduate training program required by law; provided, however, that such military service actively occurred subsequent to graduation from an approved school of podiatry.

Amended by R.1989 d.532, effective October 16, 1989.

See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).

Reference to Podiatric Practice Act.

13:35-2.4 (Reserved)

Amended by R.1985 d.102, effective March 4, 1985.

See: 16 N.J.R. 3177(a), 17 N.J.R. 605(a).

(k) substantially amended.

Amended by R.1985 d.631, effective December 16, 1985.

See: 17 N.J.R. 2231(b), 17 N.J.R. 2991(b).

Deleted "effective date of this rule" and substituted "March 4, 1985"; deleted "August 1, 1987" and substituted "March 31, 1988."

Amended by R.1989 d.532, effective October 16, 1989.

See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).

At (k), reference made to March 18, 1988 as date prior to which students are recognized.

Repealed by R.1994 d.522, effective October 17, 1994.

See: 26 N.J.R. 2526(a), 26 N.J.R. 4195(a).

Section was "Requirements for approval of college of chiropractic."

Case Notes

Emphasis on common subjects in medical and chiropractic education noted; medical doctor competent as expert in chiropractic diagnosis and use of x-rays in each area which the disciplines share in common in terms of education, training and licensure (citing former N.J.A.C. 13:35-10.0 and 13:35-10.9). *Rosenberg by Rosenberg v. Cahill*, 99 N.J. 318, 492 A.2d 371 (1985).

13:35-2.5 (Reserved)

Repealed by R.2001 d.43, effective February 20, 2001.
See: 32 N.J.R. 19(a), 33 N.J.R. 670(a).

Section was "Medical standards governing screening and diagnostic medical testing offices"

13:35-2.6 Medical standards governing screening and diagnostic medical testing offices; determinations with respect to the validity of certain diagnostic tests

(a) As used in this section, the following terms shall have the following meanings, unless the context clearly indicates otherwise.

"Board" means the New Jersey State Board of Medical Examiners.

"Clinically supported" means that a practitioner, prior to selecting, performing or ordering the administration of a diagnostic test, has:

1. Personally performed a physical examination, making an assessment of any current and/or historical subjective complaints, observations, objective findings, neurological indications;
2. Considered any and all previously performed test relating the patient's medical condition and the results; and
3. Documented in the patient record positive and negative findings, observations and medical indications to justify the test.

"Diagnostic office" means a practice location, whether stationary or mobile, not licensed by the State Department of Health and Senior Services, which provides equipment and staff necessary for the offering or performance of diagnostic tests and related services to any branch of the medical profession or to the public.

"Diagnostic test" means a medical service utilizing biomechanical, neurological, neurodiagnostic, radiological, vascular or any means, other than bioanalysis, intended to assist in establishing a medical diagnosis, for the purpose of recommending a course of treatment for the tested patient to be implemented by the treating practitioner or by the consultant.

"Emergency care" means all medically necessary treatment of a traumatic injury or a medical condition manifesting itself by acute symptoms of sufficient severity such that absence of immediate attention could reasonably be expected to result in: death; serious impairment of bodily func-

tions; or serious dysfunction of a bodily organ or part. "Emergency care" includes all medically necessary care immediately following a traumatic injury including, but not limited to, immediate pre-hospitalization care, transportation to a hospital or trauma center, emergency department care, surgery, critical and acute care and extends during the period of initial hospitalization until the patient is discharged from acute care by the attending physician.

"Normal" or "normally" means the usual, routine, customary or common experience and conclusion, which may in unusual circumstances differ from the actual judgment or course of treatment. The unusual circumstances shall be based on clinically supported findings of a practitioner. The use of these terms is intended to indicate some flexibility and avoid rigidity in the application of these rules and to recognize the good faith educated judgment of a practitioner.

"Physician" means a medical or osteopathic physician holding a plenary license issued by the New Jersey State Board of Medical Examiners.

"Practitioner" means a physician, podiatric physician, physician assistant or certified nurse midwife licensed by or registered with the New Jersey State Board of Medical Examiners.

"Screening office" means a practice location, whether stationary or mobile, not licensed by the State Department of Health and Senior Services, which provides equipment and staff necessary for the offering or performance of screening tests and related services to any branch of the medical profession or to the public, either upon referral or by walk-in.

"Screening test" means a medical service utilizing biomechanical, neurological, neurodiagnostic, radiological, vascular or any means, other than bioanalysis, performed in the absence of apparent immediate need for medical treatment for the purpose of providing medically useful information in circumstances where the anticipated benefits of the testing for an appropriate category of individual care are reasonably believed to outweigh the assessed risks, resulting in a health care evaluation, analysis or assessment; but does not include screenings such as, but not limited to, hypertension or glaucoma screenings, offered at no cost to examinees by community-sponsored public health services, hospitals or nonprofit professional or civic organizations, providing some means is established to give follow-up advice and referrals.

(b) A practitioner who identifies a need for a patient to undergo a diagnostic test:

1. Is authorized, if consistent with the practitioner's scope of practice, to perform the diagnostic test, for which a specific CPT code is assigned and for which a fee shall be charged, upon the attainment of education and supervised training in the pertinent test;

2. May directly request a specific diagnostic test, for which a specific CPT code is assigned and for which a fee shall be charged, when clinically supported, provided that referring practitioner:

- i. Is capable of recognizing scientifically supportable and practical indications for the test;
- ii. Has knowledge in the proper administration of the test;
- iii. Possesses skill at proper interpretation of the test; and
- iv. Has obtained training in how to integrate the test results into management of the patient's condition; or

3. May refer the patient to a practitioner who is deemed to meet the criteria identified at (b)2i through iv above.

(c) A practitioner qualified pursuant to (b) above to perform a diagnostic test may charge the patient or bill a third party payor for that test, except that:

1. No practitioner shall bill for any diagnostic tests which fail to yield data of sufficient clinical value in the development, evaluation or implementation of a plan of treatment, including the following:

- i. Spinal diagnostic ultrasonography/ultrasound imaging of the spine;
- ii. Iridology;
- iii. Reflexology;
- iv. Surrogate arm mentoring;
- v. Brain mapping, when not done in conjunction with appropriate neurodiagnostic testing;
- vi. Surface EMG;
- vii. Mandibular tracking and stimulation;
- viii. Videofluoroscopy; and
- ix. Computer supported range of motion tests.

2. The practitioner may bill for any of the following diagnostic tests which can yield data of sufficient clinical value in the development evaluation or implementation of a plan of treatment, when clinically supported, subject to the limitations relating to timing, frequency and manner as follows:

- i. Thermography when used to evaluate pain associated with reflex sympathetic dystrophy ("RSD"), in a controlled setting by a physician experienced in such use and properly trained.

ii. Needle electromyography (needle EMG) when used in the evaluation and diagnosis of neuropathies and radicular syndrome where clinically supported findings reveal a loss of sensation, numbness or tingling. A needle EMG is not indicated in the evaluation of TMJD and is contraindicated in the presence of infection on the skin or cellulitis. This test should not normally be performed within 14 days of a traumatic injury and should not be repeated where initial results are negative. Only one followup exam is normally appropriate.

iii. Somasensory evoked potential (SSEP), visual evoked potential (VEP), brain audio evoked potential (BAEP), or brain evoked potential (BEP), nerve conduction velocity (NCV) and H-reflex Study when used to evaluate neuropathies and/or signs of atrophy, but not within 21 days following the traumatic injury.

iv. Electroencephalogram (EEG) when used to evaluate head injuries, where there are clinically supported findings of an altered level of sensorium and/or a suspicion of seizure disorder. This test, if indicated by clinically supported findings, can be administered immediately following a traumatic injury. Repeat testing is not normally conducted more than four times per year.

v. Magnetic resonance imaging (MRI) when used in accordance with the guidelines contained in the American College of Radiology, Appropriateness Criteria to evaluate injuries in numerous parts of the body, particularly the assessment of nerve root compression and/or motor loss. MRI is not normally performed within five days of a traumatic injury. However, clinically supported indications of neurological gross motor deficits, incontinence or acute nerve root compression with neurologic symptoms may justify MRI testing during the acute phase immediately post injury.

vi. Computer assisted tomographic studies (CT or CAT scan) when used to evaluate injuries in numerous aspects of the body. With the exception of suspected brain injuries, CAT scan is not normally administered immediately post injury, but may become appropriate within five days of the trauma. Repeat CAT scans should not be undertaken unless there is clinically supported indications of an adverse change in the patient's condition.

vii. Sonograms/ultrasound when used in the acute phase to evaluate the abdomen and pelvis for intra-abdominal bleeding. These tests are not normally used to assess joints (knee and elbow) because other tests are more appropriate. Where MRI is performed, sonograms/ultrasound are not necessary. These tests should not be used to evaluate TMJD. However, echocardiogram is appropriate in the evaluation of possible cardiac injuries when clinically supported.

shall be determined by the practitioner pursuant to (q)1 above;

7. Not provide the lessor with a “certificate of medical necessity” or any document which implies authority to issue a bill for services to anyone other than the leasing practitioner;

8. Not allow the lessor entity or its technician prior or subsequent access to any portion of a patient or examinee record regarding treatment or billing or financial information;

9. Not allow the technician to conduct a clinical interview of the patient or to make any decisions regarding which tests are to be performed or their sequence or the method of performance of the test;

10. Not be a party to a contract, whether written or verbal, with the lessor of the equipment, its technicians or any other agent, whereby the lessor or agent would recommend or provide a consultant practitioner to read or overread and interpret the test data;

11. (Reserved);

12. Be fully responsible for the reasonableness of the fee charged.

(f) Consistent with N.J.A.C. 13:35-6.17(c), a consulting practitioner shall not request or receive, offer or pay, directly or indirectly, any form of remuneration from the practitioner/professional office for accepting a referral of a patient.

1. A referring practitioner shall not request or receive, offer or pay, directly or indirectly, any form of remuneration from the consulting practitioner for providing a referral.

2. A practitioner shall not request or receive any form of remuneration from the company providing testing equipment or technicians to that practitioner or to his or her office, whether in the form of a shared fee, or for “rent” (whether on premises or off-premises) or for “administrative services” or under any other description.

3. A referring or consulting practitioner shall not be deemed an independent contractor to anyone associated with the testing of a specific patient; thus, the bill, if any, for any component of the testing shall be submitted solely in the name of the referring or consulting practitioner, as applicable.

(s) A practitioner who transmits diagnostic test data/records, other than bioanalytical specimens to a clinical laboratory under the jurisdiction of the Department of Health and Senior Services pursuant to N.J.S.A. 45:9-42.27 et seq., for interpretation by a consultant who is not a licensee of the Board shall assure that advance written consent for such interpretation service by such consultant has been obtained from the patient/third party payor. Utilization of the provisions in this subsection shall be consistent with the re-

quirements of (n) above. This subsection is intended to be available for special, occasional or emergent consultations only. A consultant or consultant entity rendering medical services interpreting diagnostic test data/records, whether in or out of this State, by means of any media, for 10 or more patients under treatment in New Jersey on an annual basis is deemed to be rendering medical services in this State and requires licensure by the Board. However, the exchange of information, which may include patient specific information, between a licensee and a physician licensed in another state, a possession of the United States or the District of Columbia shall not be deemed to be rendering medical services.

New Rule, R.1999 d.70, effective March 1, 1999.

See: 30 N.J.R. 3751(a), 31 N.J.R. 659(a).

Amended by R.2001 d.43, effective February 20, 2001.

See: 32 N.J.R. 19(a), 33 N.J.R. 670(a).

In (a), added “Diagnostic office”, “Screening office”, and “Screening test”; added (d) through (s).

Administrative correction.

See: 33 N.J.R. 1203(a).

Amended by R.2005 d.120, effective April 18, 2005.

See: 36 N.J.R. 4633(a), 37 N.J.R. 1203(a).

Rewrote the section.

Amended by R.2011 d.155, effective June 6, 2011.

See: 42 N.J.R. 1310(a), 43 N.J.R. 1359(b).

In (j)4, inserted “or other proof of delivery,”.

13:35-2.7 (Reserved)

Amended by R.1989 d.532, effective October 16, 1989.

See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).

Deleted qualification of 2 years Obstetrical clinical experience.

Repealed by R.1992 d.332, effective September 8, 1992.

See: 23 N.J.R. 3682(a), 24 N.J.R. 3094(a).

Section was “Qualifications”.

13:35-2.8 (Reserved)

Repealed by R.1992 d.332, effective September 8, 1992.

See: 23 N.J.R. 3682(a), 24 N.J.R. 3094(a).

Section was “Minimum conditions of practice”.

13:35-2.9 (Reserved)

Repealed by R.1992 d.332, effective September 8, 1992.

See: 23 N.J.R. 3682(a), 24 N.J.R. 3094(a).

Section was “Minimum standards for C.N.M. and lay midwife practice during prenatal stages”.

13:35-2.10 (Reserved)

Repealed by R.1992 d.332, effective September 8, 1992.

See: 23 N.J.R. 3682(a), 24 N.J.R. 3094(a).

Section was “Management by a physician C.N.M. team for high-risk patients”.

13:35-2.11 (Reserved)

Repealed by R.1992 d.332, effective September 8, 1992.

See: 23 N.J.R. 3682(a), 24 N.J.R. 3094(a).

Section was “Intrapartum management”.

13:35-2.12 (Reserved)

Repealed by R.1992 d.332, effective September 8, 1992.

See: 23 N.J.R. 3682(a), 24 N.J.R. 3094(a).

Section was “Postpartum and other care”.

13:35-2.13 Limited privileges and conditions of practice permitted for a graduate physician pending licensure

(a) Persons who are graduates of medical schools recognized by the Board may commence a period of supervised post-graduate training in a licensed hospital with an Accreditation Council on Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) approved residency training program in this State immediately upon graduation. A training period commencing prior to the start of a formal ACGME or AOA approved post-graduate year term shall not exceed six months and shall be documented in the hospital record.

(b) Persons who are graduates of foreign medical schools recognized by the Board but who are not yet deemed eligible for licensure in this State because of the requirements of N.J.S.A. 45:9-8 and N.J.A.C. 13:35-3.11 may sit for the USMLE Step 3 upon completion of one year of approved post-graduate training and satisfaction of all other requirements of N.J.S.A. 45:9-1 et seq. and N.J.A.C. 13:35-3.1.

R.1984 d.138, effective April 16, 1984.
See: 16 N.J.R. 216(a), 16 N.J.R. 920(a).
Amended by R.1994 d.522, effective October 17, 1994.
See: 26 N.J.R. 2526(a), 26 N.J.R. 4195(a).

13:35-2.14 (Reserved)

R.1984 d.245, effective June 18, 1984.
See: 16 N.J.R. 685(a), 16 N.J.R. 1612(a).
Repealed by R.1992 d.332, effective September 8, 1992.
See: 23 N.J.R. 3682(a), 24 N.J.R. 3094(a).

Old section "Reserved" recodified to 13:35-2A.10. Section was "Limited privileges and conditions of practice permitted for a graduate nurse midwife pending results of certifying examination and licensure".

SUBCHAPTER 2A. LIMITED LICENSES: MIDWIFERY

13:35-2A.1 Purpose and scope

(a) The rules in this subchapter are intended to protect the health and safety of the public through licensure of midwives, pursuant to N.J.S.A. 45:10-1 et seq.

(b) This subchapter prescribes standards for midwifery licensure and for the renewal, suspension or revocation of that licensure.

Repeal and New Rule, R.2003 d.210, effective May 19, 2003.
See: 34 N.J.R. 3433(a), 35 N.J.R. 2227(a).
Section was "Certified Nurse Midwife practice".
Amended by R.2005 d.120, effective April 18, 2005.
See: 36 N.J.R. 4633(a), 37 N.J.R. 1203(a).

13:35-2A.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Affiliated physician" means a person who holds a plenary license to practice medicine and surgery in New Jersey, issued by the Board, who adheres to clinical guidelines with a licensed midwife.

"Board" means the New Jersey State Board of Medical Examiners.

"Certified midwife (CM)" means a person who is not a registered nurse and who holds certification from the American College of Nurse Midwives Certification Council (ACC) or its successors.

"Certified nurse midwife (CNM)" means a person who is a registered nurse and who holds certification from the American College of Nurse Midwives (ACNM) or the ACC or their successors.

"Certified professional midwife (CPM)" means a person who holds certification from the North American Registry of Midwives (NARM) or its successor.

"Clinical guidelines" means a document, which sets forth patterns of care and which provides for consultation, collaboration, management and referral as indicated by the health status of a woman receiving care from a licensee.

"Committee" means the Midwife Liaison Committee of the New Jersey State Board of Medical Examiners.

"Licensee" means any person who holds a license from the Board to practice as a midwife.

"Midwife" means a person licensed by the Board as a certified midwife (CM), certified nurse midwife (CNM) or certified professional midwife (CPM).

Repeal and New Rule, R.2003 d.210, effective May 19, 2003.

See: 34 N.J.R. 3433(a), 35 N.J.R. 2227(a).

Section was "Qualifications".

Amended by R.2005 d.120, effective April 18, 2005.

See: 36 N.J.R. 4633(a), 37 N.J.R. 1203(a).

Added "Midwife".

Amended by R.2010 d.110, effective June 21, 2010.

See: 41 N.J.R. 2203(a), 42 N.J.R. 1213(b).

In definition "Clinical guidelines", substituted "document" for "written agreement, signed by both the licensee and the affiliated physician".

13:35-2A.3 Midwifery Liaison Committee

(a) The Midwifery Liaison Committee shall consist of eight members who shall serve as consultants to the Board and who shall be appointed by the Board. The Committee shall include at least one certified nurse midwife, at least one certified professional midwife, at least one certified midwife, and two other midwives, all of whom shall hold licensure from the Board. The Committee shall also include one certified nurse midwife who is a member of the Board and two physicians, one of whom shall be a member of the Board of Medical Examiners and one of whom shall be Board-certified by either the American Board of Obstetrics and Gynecology, the American Osteopathic Board of Obstetrics

Director or his or her designee who shall possess appropriate experience with D & E procedures at least as advanced as those for which the applicant physician seeks approval. The applicant shall be evaluated during that number of procedures which shall be adequate to achieve a sufficient professional skill, and the evaluation procedure shall be documented in the personnel file maintained for that physician. The Medical Director shall agree to review the charts of all patients who suffer complications and in addition shall review charts at random, and shall calculate the complication rate of each physician.

5. The physician shall perform the procedure only on a patient who has been examined and found to be within the eligibility criteria established for advanced D & E procedures in the LACF setting.

6. The procedure shall be performed in an LACF providing adequate staff support and resources for the operative procedure as well as interim follow-up and post-operative care, and where a physician is available and readily accessible 24 hours/day to respond to any postoperative problem.

7. The physician shall cooperate with the Medical Director to maintain contemporaneous and cumulative statistical records demonstrating the utilization and safety record of each stage procedure and of each surgeon. Said records shall be available for inspection by the Board and copies shall be submitted to the Board semi-annually. These records shall include the following information and data shall be maintained in records compiled monthly, but individual patients comprising the lists shall be identified only by date and by initials and/or case number:

- i. Number of patients who received termination procedures;
- ii. Number of patients who received laminaria or osmotic cervical dilators who failed to return for completion of the procedure;
- iii. Number of patients who reported for postoperative visits;
- iv. Number of patients who needed repeat procedures;
- v. Number of patients who received transfusions;
- vi. Number of patients suspected of perforation;
- vii. Number of patients who developed pelvic inflammatory disease within two weeks;
- viii. Number of patients who were admitted to a hospital within two weeks of the procedure;
- ix. Number of patients who died within 30 days.

Subparagraphs ii. through ix. above shall be summarized by number and percentage of monthly total for post-18 week procedures. The Board shall inspect such

reports monthly for the first five months and at such further monthly intervals as it deems necessary.

(g) After 20 weeks: A physician may request from the Board permission to perform D & E procedures in an LACF after 20 weeks LMP. Such request shall be accompanied by proof, to the satisfaction of the Board, of superior training and experience as well as proof of support staff and facilities adequate to accommodate the increased risk to the patient of such procedure.

(h) The physician shall make suitable arrangements to insure that all tissues removed shall be properly disposed of by submission to a qualified physician for pathologic analysis or by incineration or by delivery to a person/entity licensed to make biologic and/or tissue disposals in accordance with law, including rules of the Department of Health and Senior Services applicable to an LACF.

As amended, R.1984 d.470, effective October 15, 1984.

See: 16 N.J.R. 2064(a), 16 N.J.R. 2823(a).

Section substantially amended.

Amended by R.1985 d.530, effective October 21, 1985.

See: 17 N.J.R. 1865(a), 17 N.J.R. 2562(b).

(e) recodified to (f) and new (e) added.

New Rule, R.1986 d.25, effective February 3, 1986.

See: 17 N.J.R. 2738(a), 18 N.J.R. 286(a).

Old rule repealed and new rule added.

Amended by R.1986 d.217, effective June 16, 1986.

See: 18 N.J.R. 614(a), 18 N.J.R. 1306(b).

Substantially amended.

Amended by R.1989 d.532, effective October 16, 1989.

See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).

Deleted references to specific statutes and rules.

Amended by R.2011 d.155, effective June 6, 2011.

See: 42 N.J.R. 1310(a), 43 N.J.R. 1359(b).

Inserted "and Senior Services" throughout; in (a), deleted a comma following "performed"; in (b), inserted the last sentence; in (e), inserted a comma following the second occurrence of "LACF", and deleted a comma following "biennially"; and in (f)3, substituted "that" for "which".

Case Notes

Preliminary injunction granted against regulation forbidding outpatient facility abortions after 18 weeks gestation or 20 weeks after last menstrual period; history of regulation; finding that plaintiffs likely to succeed in regulatory challenge due to regulation's possible result of causing women to forego their abortion rights if procedure medically acceptable on an outpatient basis is restricted to hospitals only (citing former regulation and previous codification as N.J.A.C. 13:35-7.2). *Pilgrim Medical Group v. New Jersey State Bd. of Medical Examiners*, 613 F.Supp. 837 (D.N.J.1985).

Former termination of pregnancy rule N.J.A.C. 13:35-7.2 upheld as properly adopted and reasonably related to maternal health; State has a compelling interest in maternal health after the first trimester of pregnancy so as to validate rules that foster that health. *Livingston v. New Jersey State Bd. of Medical Examiners*, 168 N.J.Super. 259, 402 A.2d 967 (App.Div.1979) certification denied 81 N.J. 406, 408 A.2d 800 (1979).

Physician's conduct in performing second trimester abortions was found not to constitute gross negligence, malpractice and incompetence; however, charges that physician's advertisements for safe, painless abortions were misleading were upheld. In the Matter of Steven Chase Brigham, 96 N.J.A.R.2d (BDS) 35.

SUBCHAPTER 4A. SURGERY, SPECIAL PROCEDURES
AND ANESTHESIA SERVICES PERFORMED IN
AN OFFICE SETTING

13:35-4A.1 Purpose

These rules are designed to promote the health, safety and welfare of the members of the general public who undergo surgery (other than minor surgery), special procedures and receive anesthesia services in an office setting.

13:35-4A.2 Scope

(a) This subchapter establishes policies and procedures and staffing and equipment requirements for practitioners and physicians who perform surgery (other than minor surgery), special procedures and administer anesthesia services in an office setting.

(b) For purposes of this subchapter, the standards set forth at N.J.A.C. 13:35-4A.6 do not apply to those performing non-invasive special procedures, such as non-invasive radiologic procedures. However, the standards set forth at N.J.A.C. 13:35-4A.7, including the privileging standards set forth at (a) above, do apply to the anesthesia services provided in connection with all special procedures, whether invasive or non-invasive.

Amended by R.2002 d.404, effective December 16, 2002.

See: 33 N.J.R. 3870(a), 34 N.J.R. 4449(a).

Rewrote the section.

Case Notes

Regulation promulgated by Board of Medical Examiners regarding the administration of anesthesia in physicians' offices during non-minor surgeries and procedures, which regulation required nurse anesthetists to be supervised by an anesthesiologist, was not arbitrary, capricious, or unreasonable given that anesthesiologists receive more training than nurse anesthetists, even though there was no medical research comparing mortality rates between anesthesiologists and nurses in administering anesthesia in an office setting. *New Jersey State Ass'n of Nurse Anesthetists, Inc. v. New Jersey State Bd. of Medical Examiners*. 859 A.2d 1239.

13:35-4A.3 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

“Advanced cardiac life support trained” means that a licensee has successfully completed an advanced cardiac life support course offered by a recognized accrediting organization appropriate to the licensee’s field of practice. For example, for those licensees treating adult patients, training in advanced cardiac life support (ACLS) is appropriate; for those treating children, training in pediatric advanced life support (PALS) or advanced pediatric life support (APLS) is appropriate.

“Anesthesia services” means administration of any anesthetic agent with the purpose of creating conscious sedation, regional anesthesia or general anesthesia. For the purposes of

this subchapter, the administration of topical or local anesthesia, minor conduction blocks, pain management or pain medication shall not be deemed to be anesthesia services.

“Anesthesiologist” means a physician who has successfully completed a residency program in anesthesiology approved by the Accreditation Council of Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA), or who currently is a diplomate of either the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology, or who was made a Fellow of the American College of Anesthesiology before 1982.

“Anesthetic agent” means any drug or combination of drugs administered with the purpose of creating conscious sedation, regional anesthesia or general anesthesia.

“Anesthetizing location” means any location in an office where anesthetic agents are administered to a patient.

“Board” means the New Jersey State Board of Medical Examiners.

“Certified registered nurse anesthetist” (CRNA) means a registered professional nurse who is licensed in this State and who holds current certification under a program governed or approved by the American Association of Nurse Anesthetists (AANA), and who meets the conditions for practice as a nurse anesthetist as set forth at N.J.A.C. 13:37-13.1.

“Complications” means an untoward event occurring at any time within 48 hours of any surgery, special procedure or the administration of anesthesia services which was performed in an office setting including, but not limited to, any of the following events: paralysis, nerve injury, malignant hyperthermia, seizures, myocardial infarction, renal failure, significant cardiac events, respiratory arrest, aspiration of gastric contents, cerebral vascular accident, transfusion reaction, pneumothorax, allergic reaction to anesthesia, wound infections requiring intravenous antibiotic treatment or hospitalization, unintended return to an operating room or hospitalization, death or temporary or permanent loss of function not considered to be a likely or usual outcome of the procedure.

“Conscious sedation” means the administration of a drug or drugs in order to induce that state of consciousness in a patient which allows the patient to tolerate unpleasant medical procedures without losing defensive reflexes, adequate cardio-respiratory function and the ability to respond purposefully to verbal command or to tactile stimulation if verbal response is not possible as, for example, in the case of a small child or deaf person. For the purposes of this subchapter, conscious sedation does not include an oral dose of pain medication or minimal pre-procedure tranquilization such as the administration of a pre-procedure oral dose of a benzodiazepine designed to calm the patient. Within the context of this subchapter, “conscious sedation” shall be

or other setting, including the review and monitoring of treatment and therapy plans;

6. Facilitating the referral of patients to, and promoting their awareness of, health care facilities and other appropriate agencies and resources in the community;

7. Collecting fluids for diagnostic purposes, including, but not limited to, blood, urine, sputum and exudates;

8. Placing and utilizing access catheters and tubes for diagnostic, therapeutic or interventional purposes, including, but not limited to, intravenous, arterial, nasogastric and urinary;

9. Performing minor surgical procedures such as simple excisions, incision and drainage, debridement and packing of wounds;

10. Applying and removing medical and surgical appliances and devices such as splints, casts, immobilizers, traction, monitors and medication delivery systems;

11. Management of emergency and life threatening conditions;

12. Performing low-risk obstetrical deliveries in a licensed hospital with the supervising physician or physician designee on premises and available to respond immediately; and

13. Subject to review by the Board, such other written procedures established by the employer, provided the procedures are within the training and experience of both the supervising physician and the physician assistant.

(b) A licensee who has complied with the provisions of N.J.A.C. 13:35-2B.3 may perform the following procedures, provided the procedures are within the training and experience of both the supervising physician and the physician assistant, only when the supervising physician directs the licensee to perform the procedures or orders or prescribes the procedures, or the procedures are specified in a written protocol approved by the Board.

1. Performing non-invasive laboratory procedures and related studies or assisting licensed personnel in the performance of invasive laboratory procedures and related studies;

2. Giving injections, administering medications and ordering diagnostic studies;

3. Suturing and caring for facial wounds, traumatic wounds requiring suturing in layers and infected wounds;

4. Ordering and prescribing medications and writing orders to implement therapeutic plans identified pursuant to (a)4 above;

5. In the operating room, assisting a supervising surgeon as a first assistant or as a second assistant when deemed necessary by the supervising surgeon and when a

qualified assistant physician is not required by N.J.A.C. 13:35-4.1;

6. Performing other procedures for diagnostic, therapeutic or interventional purposes such as, but not limited to, introduction of contrast material for radiologic studies, use of endoscopic instruments and aspiration of fluid from joints and body cavities, collection of cerebrospinal fluid, biopsy of tissues, placement of central venous catheters or chest tubes, and endotracheal intubation.

i. The supervising physician or physician designee shall be available on premises for those procedures requiring intravenous or intra-arterial injection of contrast material, endoscopic biopsy of tissue, and elective endotracheal intubation.

ii. The supervising physician shall maintain documentation, or ensure that documentation is maintained, evidencing that the physician assistant has the training, experience and proficiency to perform such procedures; and

7. Subject to review and approval by the Board, such other written procedures established by the employer, provided the procedures are within the training and experience of both the supervising physician and the physician assistant.

Amended by R.1996 d.126, effective March 4, 1996.

See: 27 N.J.R. 1956(a), 28 N.J.R. 1390(a).

In (a) added low-risk obstetrical deliveries and in (b) added other procedures for diagnostic, therapeutic or interventional purposes.

Amended by R.1999 d.356, effective October 18, 1999.

See: 31 N.J.R. 1742(a), 31 N.J.R. 3117(a).

In (b)4, deleted "In an inpatient setting," at the beginning.

Amended by R.2005 d.120, effective April 18, 2005.

See: 36 N.J.R. 4633(a), 37 N.J.R. 1203(a).

In (a), substituted "medication delivery systems" for "infusion pumps" in 10.

Amended by R.2011 d.155, effective June 6, 2011.

See: 42 N.J.R. 1310(a), 43 N.J.R. 1359(b).

In (b)4, deleted "medications" following "Ordering", substituted "medications" for "other than controlled dangerous substances" and substituted a semicolon for a period at the end.

13:35-2B.5 Eligibility for licensure

(a) An applicant for licensure shall submit to the Board, with the completed application form and the required fee, evidence that the applicant:

1. Is at least 18 years of age;

2. Is of good moral character, evidence of which shall require the applicant for licensure to respond to such inquiry as the Board deems appropriate regarding past and present fitness to practice, and issues pertinent thereto;

3. Has successfully completed an education program for physician assistants which is approved by the Accreditation Review Commission on Education for the Physician Assistant, Inc. (ARC-PA), or its successor; and

4. Has passed the examination administered by the National Commission on Certification of Physician Assistants (NCCPA), or its successor, except as set forth in (b) below.

(b) An applicant who submits satisfactory proof that he or she holds a current license, certification or registration to practice as a physician assistant in a state which has standards substantially equivalent to those of this State shall be deemed to satisfy the examination requirement set forth in (a)4 above.

Amended by R.2005 d.120, effective April 18, 2005.

See: 36 N.J.R. 4633(a), 37 N.J.R. 1203(a).

In (a), rewrote 3 and inserted “, or its succession” following “Physician Assistants (NCCPA)” in 4.

13:35-2B.6 Refusal to issue, suspension or revocation of license

(a) The Board may refuse to issue or may suspend or revoke any license issued by the Board for any of the reasons set forth in N.J.S.A. 45:1-21.

(b) Prior to any license suspension or revocation, the licensee shall be afforded the opportunity for a hearing pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and 52:14F-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

13:35-2B.7 License renewal, continuing education requirement

(a) The Board shall not issue a biennial license renewal unless the applicant submits, with the renewal application, proof that he or she completed courses of continuing professional education of the types and number of credits specified in N.J.A.C. 13:35-2B.8.

(b) Falsification of any information submitted with the renewal application may result in an appearance before the Board or a duly appointed Committee thereof and, after due notice to the licensee and the opportunity for a hearing pursuant to the Administrative Procedure Act and the Uniform Administrative Procedure Rules, penalties and/or suspension or revocation of the license.

(c) The Board will, from time to time, conduct inquiries among licensees on a random basis to determine compliance with continuing education requirements.

13:35-2B.8 Credit-hour requirements

(a) Each applicant for a biennial license renewal shall be required to complete, during the preceding biennial period, a minimum of 50 continuing education credit hours in category I courses approved by the American Medical Association, the American Academy of Physician Assistants, the American Academy of Family Physicians, the American Osteopathic Association or the Accreditation Council on Continuing Medical Education. The Board reserves the right to review

and approve continuing education courses offered by entities other than those set forth above.

(b) Fifteen credits may be carried over into a succeeding biennial period only if earned during the last six months of the preceding biennial period.

Amended by R.2005 d.120, effective April 18, 2005.

See: 36 N.J.R. 4633(a), 37 N.J.R. 1203(a).

In (a), substituted “50” for “40” following “a minimum of”.

13:35-2B.9 Waiver of continuing education requirement

(a) The Board may, in its discretion, temporarily waive continuing education requirements on an individual basis for a period of time designated by the Committee for reasons of hardship, such as illness or disability, or other good cause.

(b) Any licensee seeking a waiver of the continuing education requirements must apply to the Board in writing and set forth with specificity the reasons for requesting the waiver. The licensee shall also provide the Board with such additional information as it may reasonably request in support of the application.

Amended by R.2005 d.120, effective April 18, 2005.

See: 36 N.J.R. 4633(a), 37 N.J.R. 1203(a).

In (a), inserted “a period of time designated by the Committee for” preceding “reasons of hardship”.

13:35-2B.10 Supervision

(a) A physician assistant shall engage in practice only under the direct supervision of a physician.

(b) The physician assistant shall not render care unless the following conditions are met:

1. In an inpatient setting, the supervising physician or physician-designee is continuously or intermittently present on-site with constant availability through electronic communications for consultation or recall;

2. In an outpatient setting, the supervising physician or physician-designee is constantly available through electronic communications for consultation or recall;

3. The supervising physician regularly reviews the practice of the physician assistant;

4. The supervising physician or physician designee personally reviews all charts and patient records and countersigns all medical orders as follows:

i. In an inpatient setting, within 24 hours of the physician assistant’s entry of the order in the patient record; and

ii. In an outpatient setting, within a maximum of seven days of the physician assistant’s entry of the order in the patient record, except that in the case of any medical order prescribing or administering medication, a physician shall review and countersign the order within 48 hours of its entry by the physician assistant; and

duplication of the materials, or the fee charged to the licensee for duplication, plus an administrative fee of the lesser of \$10.00 or 10 percent of the cost of reproduction to compensate for office personnel time spent retrieving or reproducing the materials and overhead costs.

5. Licensees shall not charge a patient for a copy of the patient's record when:

i. The licensee has affirmatively terminated a patient from practice in accordance with the requirements of N.J.A.C. 13:35-6.22; or

ii. The licensee leaves a practice that he or she was formerly a member of, or associated with, and the patient requests that his or her medical care continue to be provided by that licensee.

6. If the patient or a subsequent treating health care professional is unable to read the treatment record, either because it is illegible or prepared in a language other than English, the licensee shall provide a transcription at no cost to the patient.

7. The licensee shall not refuse to provide a professional treatment record on the grounds that the patient owes the licensee an unpaid balance if the record is needed by another health care professional for the purpose of rendering care.

(d) Licensees shall maintain the confidentiality of professional treatment records, except that:

1. The licensee shall release patient records as directed by a subpoena issued by the Board of Medical Examiners or the Office of the Attorney General, or by a demand for statement in writing under oath, pursuant to N.J.S.A. 45:1-18. Such records shall be originals, unless otherwise specified, and shall be unedited, with full patient names. To the extent that the record is illegible, the licensee, upon request, shall provide a typed transcription of the record. If the record is in a language other than English, the licensee shall also provide a translation. All x-ray films and reports maintained by the licensee, including those prepared by other health care professionals, shall also be provided.

2. The licensee shall release information as required by law or regulation, such as the reporting of communicable diseases or gunshot wounds or suspected child abuse, etc., or when the patient's treatment is the subject of peer review.

3. The licensee, in the exercise of professional judgment and in the best interests of the patient (even absent the patient's request), may release pertinent information about the patient's treatment to another licensed health care professional who is providing or has been asked to provide treatment to the patient, or whose expertise may assist the licensee in his or her rendition of professional services.

4. The licensee, in the exercise of professional judgment, who has had a good faith belief that the patient

because of a mental or physical condition may pose an imminent danger to himself or herself or to others, may release pertinent information to a law enforcement agency or other health care professional in order to minimize the threat of danger. Nothing in this paragraph, however, shall be construed to authorize the release of the content of a record containing identifying information about a person who has AIDS or an HIV infection, without patient consent, for any purpose other than those authorized by N.J.S.A. 26:5C-8. If a licensee, without the consent of the patient, seeks to release information contained in an AIDS/HIV record to a law enforcement agency or other health care professional in order to minimize the threat of danger to others, an application to the court shall be made pursuant to N.J.S.A. 26:5C-5 et seq.

(e) Where the patient has requested the release of a professional treatment record or a portion thereof to a specified individual or entity, in order to protect the confidentiality of the records, the licensee shall:

1. Secure and maintain a current written authorization, bearing the signature of the patient or an authorized representative;

2. Assure that the scope of the release is consistent with the request; and

3. Forward the records to the attention of the specific individual identified or mark the material "Confidential."

(f) Where a third party or entity has requested examination, or an evaluation of an examinee, the licensee rendering those services shall prepare appropriate records and maintain their confidentiality, except to the extent provided by this section. The licensee's report to the third party relating to the examinee shall be made part of the record. The licensee shall:

1. Assure that the scope of the report is consistent with the request, to avoid the unnecessary disclosure of diagnoses or personal information which is not pertinent;

2. Forward the report to the individual entity making the request, in accordance with the terms of the examinee's authorization; if no specific individual is identified, the report should be marked "Confidential"; and

3. Not provide the examinee with the report of an examination requested by a third party or entity unless the third party or entity consents to its release, except that should the examination disclose abnormalities or conditions not known to the examinee, the licensee shall advise the examinee to consult another health care professional for treatment.

(g) (Reserved)

(h) If a licensee ceases to engage in practice or it is anticipated that he or she will remain out of practice for more than three months, the licensee or designee shall:

1. Establish a procedure by which patients can obtain a copy of the treatment records or acquiesce in the transfer of those records to another licensee or health care professional who is assuming responsibilities of the practice. However, a licensee shall not charge a patient, pursuant to (c)4 above, for a copy of the records, when the records will be used for purposes of continuing treatment or care.

2. Publish a notice of the cessation and the established procedure for the retrieval of records, and the location at which the records will be permanently maintained, in a newspaper of general circulation in the geographic location of the licensee's practice, at least once each month for the first three months after the cessation. Such notice shall be submitted to the Board after the first publication; and

3. Make reasonable efforts to directly notify any patient treated during the six months preceding the cessation, providing information concerning the established procedure for retrieval of records.

Repeal and New Rule, R.1990 d.176, effective March 19, 1990.

See: 21 N.J.R. 3253(a), 22 N.J.R. 978(a).

Amended by R.1992 d.429, effective October 19, 1992.

See: 24 N.J.R. 50(a), 24 N.J.R. 3729(d).

Revised (b).

Amended by R.1994 d.119, effective April 4, 1994.

See: 25 N.J.R. 4862(a), 26 N.J.R. 1522(a).

Amended by R.1998 d.184, effective April 6, 1998.

See: 29 N.J.R. 840(b), 30 N.J.R. 1295(a).

In (a), added exception at the end of the sentence; in (c)3, substituted "patient's mental or physical condition will be adversely affected upon being made aware" for "patient may be harmed by release"; in (c)3iii, added "through an employee thereof; or" at the end of the sentence and added a new iv; in (d)4, added the last two sentences; in (h)1, inserted "a copy of the" preceding "treatment records" and added the last sentence.

Petition for Rulemaking.

See: 36 N.J.R. 4333(a).

Amended by R.2005 d.120, effective April 18, 2005.

See: 36 N.J.R. 4633(a), 37 N.J.R. 1203(a).

Rewrote (c).

Amended by R.2011 d.155, effective June 6, 2011.

See: 42 N.J.R. 1310(a), 43 N.J.R. 1359(b).

Rewrote (b)3viii; in the introductory paragraph of (c), inserted "including records from other licensees or other health care providers that are part of a patient's record," and in (h)2, inserted "and the location at which the records will be permanently maintained," and "Such notice shall be submitted to the Board after the first publication".

Case Notes

Any error in trial court's failure to charge jury concerning duty specialist physician had to communicate his findings of stress test he performed on patient to patient's primary care physician, was harmless in medical malpractice action brought by executrix of patient's estate against specialist after patient died within two weeks after having undergone stress test; no dispute existed that specialist advised patient of his preliminary findings, told him that they were essentially normal, and sent a written report to primary physician, but alleged negligence at issue went to specialist's evaluation of patient's condition. *Sinclair v. Roth*, 356 N.J. Super. 4, 811 A.2d 460 (App. Div. 2002).

Physician's disclosure of patient's medical records to patient's husband's attorney in response to subpoena that did not include patient's authorization to disclose, or a notice of physician's deposition, and which patient and her attorney were not copied on, supported a cause of action against physician, in lawsuit against physician alleging breach of confidentiality, violation of physician-patient privilege, medical malpractice, intentional infliction of emotional distress, and negligent in-

fiction of emotional distress. *Crescenzo v. Crane*, 350 N.J. Super. 531, 796 A.2d 283 (App. Div. 2002).

To the extent that a contract purports to insulate the examining physician from liability for breaching the duty to communicate abnormalities found in a pre-employment exam, it violates public policy of New Jersey in addition to common law notions. *Reed v. Bojarski*, 166 N.J. 89, 764 A.2d 433 (2001).

Board of Medical Examiners neither abused its statutory authority nor mistakenly exercised its discretion when it refused to expunge or otherwise modify consent order disciplining a doctor for failing to keep adequate patient medical records; consent order was legally entered into with doctor's consent, and the Board had authority to file order and fine doctor accordingly. *In re D'Aconti*, 316 N.J. Super. 1, 719 A.2d 652 (N.J. Super. A.D. 1998).

Verification may be required before personal injury protection benefits are paid. *State Farm Mut. Auto. Ins. Co. v. Dalton*, 234 N.J. Super. 128, 560 A.2d 683 (A.D.1989) certification denied 117 N.J. 664, 569 A.2d 1356, certiorari denied 110 S.Ct. 1131, 493 U.S. 1078, 107 L.Ed.2d 1037.

Reprimand by Board for failure to prepare patient record noted; transcript of Board proceeding not records within the meaning of the Right to Know Law, but are public records under common law; injury action's plaintiff's right to examine and inspect records superior to Board's interest in confidentiality (citing former N.J.A.C. 13:13-6.12). *Beck v. Bluestein*, 194 N.J. Super. 247, 476 A.2d 842 (App. Div. 1984).

Physician who was both a board-certified anesthesiologist and a pain management specialist but who was acting only as a pain management specialist in three surgical cases under review was not responsible for errors made by a different physician who was the anesthesiologist for all three cases, which errors were the basis on which the State Board of Medical Examiners formally reprimanded the anesthesiologist, because the anesthesiologist, not the pain management specialist, was responsible for monitoring each patient's blood pressure and determining whether to go forward with a scheduled surgery. Though the records maintained by the physician may have been sloppy, there was no evidence submitted by the Board establishing a relevant standard of care nor that the physician had violated the record-keeping requirements in N.J.A.C. 13:35-6.5. *In re Stillman*, OAL Dkt. No. BDS 10543-10, 2013 N.J. AGEN LEXIS 24, Initial Decision (January 10, 2013).

Physician who committed gross negligence by removing the middle and lower lobes of the wrong lung from a patient and by failing to obtain a second CT scan before commencing surgery also was found by the Board of Medical Examiners to have attempted to conceal the error by altering the medical records (adopting in part and modifying in part 2008 N.J. AGEN LEXIS 280). *In re Perera*, OAL Dkt. No. BDS 11295-05, Final Decision (June 5, 2008).

Physician licensee, a compulsive gambler, was guilty of professional misconduct by soliciting money loans from a patient on two occasions in violation of Medical Board orders and by failing to prepare and maintain truthful patient records. Physician's license was suspended for 24 months and physician was ordered to reimburse the improper loans, cease gambling, participate in the Gamblers Anonymous program, perform community service, and pay attorney fees and costs. *In re Suspension or Revocation of License of Singh*, OAL Dkt. No. BDS 1638-05N, 2006 N.J. AGEN LEXIS 426, Initial Decision (June 30, 2006).

Since there was no justification for a limb length discrepancy examination in the record where a victim patient was being examined without a chaperone for a toe injury, and the surrounding circumstances showed that it was only a pretext to get the patient to disrobe, the physician's conduct constituted sexual misconduct and sexual harassment, and therefore was in violation of N.J.S.A. 45:1-21(h). *In re Suspension or Revocation of License of Hakimi*, OAL Dkt. No. BDS 11873-04, 2006 N.J. AGEN LEXIS 148, Initial Decision (February 24, 2006).

Use of improper procedures at abortion clinics and failure to supervise staff support suspension of doctors operating facility. In the Matter of Miro and Steck, 97 N.J.A.R.2d (BDS) 1.

Revocation of license; psychiatrist who engaged in sexual contact with patients. In the Matter of the Suspension or Revocation of the License of Schermer, 94 N.J.A.R.2d (BDS) 33.

Performing numerous cardiac procedures without sufficient medical justification, failing to maintain accurate patient records, along with other acts of negligence, malpractice and incompetence, warranted license revocation; penalty and costs also assessed. In Matter of Suspension or Revocation of License of Rodriguera, 93 N.J.A.R.2d (BDS) 33.

Surgeon's license revoked; unauthorized prescriptions for controlled dangerous substances, failure to maintain medical records, and prescrib-

potential risks and complications should be discussed with the physician rendering this procedure”.

2. Where an advertiser directly or indirectly provides compensation to a testimonial giver, the fact of such compensation shall be conspicuously disclosed in a legible and readable manner in any advertisement in the following language: “COMPENSATION HAS BEEN PROVIDED FOR THIS TESTIMONIAL.”

3. A physician who advertises through the use of testimonials shall maintain documentation relating to such testimonials for a period of three years from the date of the last use of the testimonial. Such documentation shall include, but not be limited to, the name, address and telephone number of the individual in the advertisement, the type and amount or value of compensation and a signed, notarized statement and release verifying the truthfulness of the information contained in the testimonial and indicating that person’s willingness to have his or her testimonial used in the advertisement obtained prior to the time the testimonial is advertised.

4. Any guarantee of results from any procedure is prohibited.

(o) Nothing contained in this section shall be construed to prohibit the licensing board from adopting additional rules concerning advertising by Board licensees. To the extent that any conflict or inconsistency may arise between the provisions of this section and any subsequently adopted rule dealing more specifically with the same subject matter as set forth, such subsequent adopted rule shall control.

R.1984 d.139, effective April 16, 1984.

See: 16 N.J.R. 32(a), 16 N.J.R. 921(a).

A rule entitled “Advertising and Solicitation” formerly at this cite was repealed and replaced.

Amended, R.1984 d.372, effective August 20, 1984.

See: 16 N.J.R. 1026(b), 16 N.J.R. 2286(a).

Subsection (m) new.

Amended by R.1986 d.467, effective December 1, 1986.

See: 18 N.J.R. 1788(d), 18 N.J.R. 2390(a).

Text added to (h) and (l).

Amended by R.1989 d.325, effective June 19, 1989.

See: 21 N.J.R. 696(a), 21 N.J.R. 1710(b).

In (a): deleted “Definitions” and added new 7 regarding graphic representation. Revised language throughout to modify an existing prohibition on use of testimonials, discounts and offering of free services.

Added new (c)11 and 12, deleting old (c)11.

Added new (g)1-8 and new (m) and (n), recodifying old “n” as new “o”.

Amended by R.1994 d.329, effective July 5, 1994.

See: 26 N.J.R. 1219(b), 26 N.J.R. 2795(c).

Amended by R.1994 d.522, effective October 17, 1994.

See: 26 N.J.R. 2526(a), 26 N.J.R. 4195(a).

Amended by R.1999 d.356, effective October 18, 1999.

See: 31 N.J.R. 1742(a), 31 N.J.R. 3117(a).

In (a)5, added a reference to the Internet.

Amended by R.2005 d.120, effective April 18, 2005.

See: 36 N.J.R. 4633(a), 37 N.J.R. 1203(a).

Rewrote (m).

Petition for Rulemaking.

See: 42 N.J.R. 859(b), 1255(d), 2150(c).

Amended by R.2011 d.155, effective June 6, 2011.

See: 42 N.J.R. 1310(a), 43 N.J.R. 1359(b).

In (h) and (l), inserted “and Senior Services”.

Case Notes

Abstention; action by podiatrist association challenging constitutionality of regulation restricting medical professionals’ advertising of board certification. *American Institute of Foot Medicine v. New Jersey State Bd. of Medical Examiners*, D.N.J.1992, 807 F.Supp. 1170.

Former N.J.A.C. 13:35-4.1 and 13:35-6.13 requiring degree designations on licenses and regulating advertising, respectively, held invalid as outside Board’s authority under the Medical Practices Act. *Eatough v. Bd. of Medical Examiners*, 191 N.J.Super. 166, 465 A.2d 934 (App.Div.1983).

13:35-6.11 Excessive fees

(a) The Board of Medical Examiners shall review information and complaints concerning allegations of excessive fees charged by licensees of the Board and may establish Excessive Fee Review Committees to perform various aspects of the review function. This regulation is not intended to impinge upon the strong public policy in favor of a competitive, free enterprise economy embodied in the antitrust laws of the United States and of this State. Excessive Fee Review Committees shall consider comparable fees charged by licensees not under inquiry only to the minimum extent necessary to render a determination as to whether a fee is excessive.

(b) A licensee of the Board of Medical Examiners shall not charge an excessive fee for services. A fee is excessive when, after a review of the facts, a licensee of ordinary prudence would be left with a definite and firm conviction that the fee is so high as to be manifestly unconscionable or overreaching under the circumstances.

(c) Factors which may be considered in determining whether a fee is excessive include, but are not limited to, the following:

1. The time and effort required;
2. The novelty and difficulty of the procedure or treatment;
3. The skill required to perform the procedure or treatment properly;
4. Any requirements or conditions imposed by the patient or by the circumstances;
5. The nature and length of the professional relationship with the patient;
6. The experience, reputation and ability of the licensee performing the services;
7. The nature and circumstances under which services are provided. Unless services are provided during an emergency or other circumstances where opportunity, custom and practice will preclude discussion prior to the rendition of such services, the licensee shall, in advance of providing services, specify or discuss and agree with the patient, the fee or basis for determination of the fee to be charged.

(d) Charging an excessive fee in violation of (b) above shall constitute professional misconduct subjecting the licensee to disciplinary action by the Board of Medical Examiners.

Amended by R.1989 d.532, effective October 16, 1989.
See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).
(c)4 deleted, 5-8 recodified to 4-7.

Case Notes

Physician found guilty by New York Board of Regents properly had New Jersey medical license revoked. In the Matter of the Suspension or Revocation of the License of Del Gizzo, 94 N.J.A.R.2d (BDS) 1.

13:35-6.12 (Reserved)

Amended by R.1989 d.532, effective October 16, 1989.
See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).
Superfluous language deleted from (f).
Repealed by R.1994 d.522, effective October 17, 1994.
See: 26 N.J.R. 2526(a), 26 N.J.R. 4195(a).
Section was "Excessive fee review committees".

13:35-6.13 Fee schedule

(a) The following fees shall be charged by the Board of Medical Examiners:

1. Medicine and Surgery (M.D. or D.O. license)

i.	Initial application fee	\$325.00
ii.	Initial license fee	
	(1) If paid during the first year of a biennial renewal period	580.00
	(2) If paid during the second year of a biennial renewal period	290.00
iii.	N.J.S.A. 45:9-21(n)—exemption	225.00
iv.	N.J.S.A. 45:9-21(b)—temporary license	50.00
v.	Endorsement	225.00
vi.	Biennial license	580.00
vii.	Biennial license for licensee over 65 without health care facility or HMO affiliation	125.00
viii.	Permit	50.00

2. Podiatry (license)

i.	Application fee	\$125.00
ii.	Examination	\$150.00
iii.	Initial license fee	
	(1) If paid during the first year of a biennial renewal period	580.00
	(2) If paid during the second year of a biennial renewal period	290.00
iv.	Endorsement	150.00
v.	Biennial license	580.00
vi.	Biennial license for licensee over 65 without health care facility or HMO affiliation	85.00
vii.	Permit	50.00

3. Bioanalytical laboratory directorship, plenary or specialty license

i.	Application fee	125.00
ii.	Examination	350.00

iii.	Exemption	150.00
iv.	Initial license fee	
	(1) If paid during the first year of a biennial renewal period	390.00
	(2) If paid during the second year of a biennial renewal period	195.00
v.	Biennial license	390.00

4. Midwifery (license)

i.	Application fee	125.00
ii.	Examination	50.00
iii.	Endorsement	50.00
iv.	Initial license fee	
	(1) If paid during the first year of a biennial renewal period	270.00
	(2) If paid during the second year of a biennial renewal period	135.00
v.	Biennial license	270.00
vi.	Biennial prescriptive authorization (Certified Nurse Midwife)	50.00

5. Physician assistant (license)

i.	Application fee	125.00
ii.	Temporary license fee	50.00
iii.	Initial license fee	
	(1) If paid during the first year of a biennial renewal period	220.00
	(2) If paid during the second year of a biennial renewal period	110.00
iv.	License renewal fee, biennial	220.00
v.	Late renewal fee	100.00
vi.	Reinstatement fee	175.00
vii.	Duplicate license fee	40.00
viii.	Duplicate wall certificate	50.00

6. General

i.	Recording of name change and issuance of replacement license	50.00
ii.	Replacement of lost engrossed copy/certified true copy/biennial registration certificate	50.00
iii.	Preparation of certification papers for applicants to other states	50.00
iv.	Late renewal fee	100.00
v.	Reinstatement fee	175.00
vi.	Inactive license fee	(to be determined by Director by regulation)

New Rule, R.1983 d.510, effective November 7, 1983.
See: 15 N.J.R. 784(a), 15 N.J.R. 1865(e).
Deleted old fee schedule and added new fee schedule.
Amended by R.1985 d.223, effective May 6, 1985.
See: 17 N.J.R. 562(a), 17 N.J.R. 1132(a).
Substantially amended.
Amended by R.1987 d.201, effective May 4, 1987.
See: 19 N.J.R. 353(a), 19 N.J.R. 772(a).
Both components raised from \$300.00 to \$425.00; Component I raised from \$200.00 to \$250.00 and Component II raised from \$225.00 to \$300.00.
Amended by R.1987 d.371, effective September 8, 1987.
See: 19 N.J.R. 1054(a), 19 N.J.R. 1648(a).
Increased the biennial registration fee.
Amended by R.1989 d.532, effective October 16, 1989.
See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).
Biennial registration fee decreased from \$120 to \$60 and endorsement fee set at \$60.

Amended by R.1990 d.525, effective November 5, 1990.
See: 22 N.J.R. 1988(a), 22 N.J.R. 3384(a).

Medicine and surgery examination fees increased.
Amended by R.1991 d.286, effective June 3, 1991.

See: 23 N.J.R. 833(a), 23 N.J.R. 1815(a).

Added (a)1viii and (a)2v.

Deleted (a)2 [Chiropractic (license)]; redesignated existing (a)3 through 11 as (a)2 through 10.

Changed fees in (a)1 through 8.

Amended by R.1993 d.91, effective February 16, 1993.

See: 24 N.J.R. 4011(a), 25 N.J.R. 708(a).

Revised (a)1 through 4.

Amended by R.1993 d.92, effective February 16, 1993.

See: 24 N.J.R. 4334(a), 25 N.J.R. 709(a).

Added new (a)10; redesignated old (a)10 to (a)11.

Amended by R.1993 d.260, effective June 7, 1993.

See: 25 N.J.R. 1058(a), 25 N.J.R. 2487(a).

Amended by R.1993 d.299, effective June 21, 1993.

See: 24 N.J.R. 4013(a), 25 N.J.R. 2689(c).

Amended by R.1994 d.170, effective April 4, 1994.

See: 25 N.J.R. 4583(a), 26 N.J.R. 1520(a).

Administrative Correction.

See: 26 N.J.R. 2589(b).

Amended by R.1994 d.522, effective October 17, 1994.

See: 26 N.J.R. 2526(a), 26 N.J.R. 4195(a).

Amended by R.1995 d.330, effective June 19, 1995.

See: 27 N.J.R. 640(a) (see also, 27 N.J.R. 1746(a)), 27 N.J.R. 2410(a).

Increased some of the fees.

Amended by R.1995 d.423, effective August 7, 1995.

See: 27 N.J.R. 1526(a), 27 N.J.R. 2959(a).

Added Physician Assistant temporary license fee at (a)8.ii.

Administrative correction.

See: 33 N.J.R. 1411(a).

Amended by R.2005 d.120, effective April 18, 2005.

See: 36 N.J.R. 4633(a), 37 N.J.R. 1203(a).

Rewrote the section.

Amended by R.2005 d.175, effective June 6, 2005.

See: 37 N.J.R. 206(a), 37 N.J.R. 1203(a), 37 N.J.R. 2041(b).

In (a), increased the fees in lii(1), lii(2), lvi, 2iii(1), 2iii(2), 2v, 3iv(1), 3iv(2), 3v, 5iv(1), 5iv(2) and 5v.

Administrative correction.

See: 37 N.J.R. 2553(a).

Amended by R.2005 d.378, effective November 7, 2005.

See: 37 N.J.R. 1918(a), 37 N.J.R. 4281(a).

Increased fees in (a).

Case Notes

Degree designation on license. *Eatough v. Albano*, 673 F.2d 671 (1982) certiorari denied 102 S.Ct. 2931, 457 U.S. 1119, 73 L.Ed.2d 1331, see: dissenting opinion.

Preliminary injunction against rule. *Davis v. Board of Medical Examiners*, 497 F. Supp. 525 (1980).

13:35-6.14 Delegation of physical modalities to a licensed health care provider or an unlicensed physician aide

(a) "Physician," for the purpose of this section, shall mean a doctor of medicine (M.D.), a doctor of osteopathic medicine (D.O.) or a doctor of podiatric medicine (D.P.M.).

1. "Licensed health care provider," for the purpose of this section, shall mean an individual holding a current, valid license in this State as a physical therapist, registered nurse, licensed practical nurse, physician assistant, chiropractor or athletic trainer. "Licensed health care provider" also includes, for purpose of this section, an individual who holds a current, valid license as an occupational therapist,

except that nothing shall authorize the delegation of a physical modality, which pursuant to N.J.A.C. 13:44K-5.4 is deemed to be an advanced physical agent modality without the occupational therapist having complied with N.J.A.C. 13:44K-5.4(e).

(b) A physician may direct his or her unlicensed employee to administer to the doctor's patients certain physical modalities in the limited circumstances set forth in this section, without being in violation of the pertinent professional practice act implemented by the Board, to the extent such conduct is permissible under any other pertinent law or rule administered by the Board or any other State agency.

(c) A physician may direct a licensed health care provider with training and experience to administer to the physician's patients physical modalities including ultraviolet (B and C bands) and electromagnetic rays including, but not limited to, deep heating agents, microwave diathermy, shotwave diathermy, ultrasound, and those modalities listed in (d) below. The physician shall retain responsibility for examining the patient, determining the appropriate modalities, assessing training and experience, as well as providing the appropriate level of supervision consistent with practice standards, applicable to the specific licensed health care provider.

(d) A physician may direct an unlicensed aide to administer the following physical modalities: hot packs, cold packs, paraffin baths, contrast baths, and whirlpool baths. The aide shall not be permitted to perform any rehabilitative exercise programs. No other modalities including T.E.N.S. or traction shall be performed by the unlicensed physician's aide.

(e) A physician may direct the administration of an appropriate physical modality by an unlicensed assistant only where the following conditions are satisfied:

1. The doctor shall examine the patient to ascertain the nature of the trauma or disease; to determine whether the application of a physical modality will encourage the alleviation of pain and promotion of healing; to assess the risks of the modality for a given patient and the diagnosed injury or disease and to decide that the anticipated benefits are likely to outweigh those risks.

2. The doctor shall determine all the components of the precise treatment to be given at the present therapy session, including the type of modality to be used, extent of area to which it shall be applied, the length of treatment, and any other factors peculiar to the risks of that modality such as strict avoidance of certain parts of the body. This information shall be written on the patient's chart and made available at all times to the assistant carrying out the instructions. The doctor shall assure that the aide administering the treatment is identified in the patient chart on each such occasion.

3. The doctor shall ascertain a satisfactory level of education, competence and comprehension of the particular

assistant, who shall be at least 18 years of age, to whom instruction has been given by the doctor as to modalities used in that office. The doctor shall prepare and maintain a written document certifying as to the instructions given to each assistant, and both doctor and assistant shall sign it.

4. The doctor shall see the patient prior to any subsequent scheduled application of the modality to ascertain that continued treatment is appropriate and that no contraindications to treatment have become apparent.

5. The doctor shall remain on the premises at all times that treatment orders are being carried out by the assistant and shall be within reasonable proximity to the treatment room and available in the event of emergency.

(f) A physician shall have due regard for the specialized training and experience of registered physical therapists, and of physiatrists and orthopedists. Injuries or diseases requiring prolonged treatment, if not administered personally by the doctor, shall normally be referred to a licensed physical therapist, to a physiatrist, orthopedist or other appropriate health care provider.

(g) A bill rendered for the limited consultation set forth in (d)4 above shall not exceed a sum which reasonably reflects the actual level of service, supervision and responsibility personally rendered by the doctor, and consistent with the factors listed in the rule prohibiting excessive fees, N.J.A.C. 13:35-6.11(b) and (c).

(h) On a health insurance claim form pertaining to such service and requiring certification by the doctor, the doctor shall specify the modality applied and shall not generically identify physical therapy.

New Rule, R.1985 d.159, effective April 1, 1985.

See: 16 N.J.R. 2065(a), 17 N.J.R. 836(a).

Amended by R.1989 d.532, effective October 16, 1989.

See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).

Requirements added that aides be identified on the patient Chart and that the aides be at least 18 years of age.

Amended by R.1994 d.522, effective October 17, 1994.

See: 26 N.J.R. 2526(a), 26 N.J.R. 4195(a).

Amended by R.2011 d.155, effective June 6, 2011.

See: 42 N.J.R. 1310(a), 43 N.J.R. 1359(b).

In (a)1, inserted the second sentence.

Case Notes

Rule was not ultra vires as to the Board of Medical Examiners on theory that authority rested solely with the Board of Physical Therapists. Matter of Promulgation of N.J.A.C. 13:35-6.14, 205 N.J.Super. 492, 501 A.2d 547 (App.Div.1985).

13:35-6.15 Continuing medical education

(a) The following words and terms, when used in this section, shall have the following meanings, unless the context clearly indicates otherwise:

“Category I” and “Category II” mean the categories of medical education courses recognized by the American Medical Association as credited toward the Physician Recognition

Award, and those categories of medical education courses recognized by the American Osteopathic Association or the American Podiatric Medical Association.

“Licensee” means a physician or podiatrist licensed and subject to regulation by the Board of Medical Examiners (the “Board”).

(b) Except as provided in (c) below, a licensee applying for a biennial license renewal shall complete 100 continuing medical education credits in Category I or Category II courses, of which at least 40 of such credits shall be in Category I. Commencing with the biennial renewal period beginning on July 1, 2013, two of the 40 credits in Category I courses shall, pursuant to P.L. 2011, c. 145 (N.J.S.A. 45:9-7.7), be in programs or topics related to end-of-life care.

(c) An applicant for initial licensure who has completed an accredited graduate medical education program within 12 months prior to licensure shall be exempt from the continuing medical education requirements of this section for the initial biennial period of licensure. Notwithstanding such exemption from the continuing medical education requirements, the applicant, once licensed by the Board, shall complete, within 24 months of becoming licensed, an orientation course which is presented or approved by the Board.

(d) A licensee shall certify on the application for biennial licensure renewal that he or she has completed the required number of continuing medical education credits. The Board may conduct random audits to determine licensee compliance with the continuing medical education requirements of this section.

(e) A licensee who completes credits in excess of the 100 continuing medical education credits required pursuant to this section may apply no more than 25 of the excess credits to the continuing medical education requirements for the following biennial period only.

(f) Licensees holding an inactive or retired license shall be exempt from continuing medical education requirements, except that any licensee holding an inactive or retired license, or whose license is suspended or revoked, who applies to resume practice shall provide proof of having attained 50 credits of continuing medical education for each year out of practice in New Jersey. At least 50 credits shall have been obtained in the year preceding the application to resume practice. At the time of application to resume practice, the licensee shall provide proof of the completed continuing medical education during the period while out of practice in New Jersey. The Board may accept such continuing medical education credits or require additional credits as a condition to return to practice.

(g) The Board may delineate specific topics of medical education which the Board deems necessary to address a particular issue or problem. Notification of the specific topic(s) shall be through the Board newsletter, the Division of

fessional service corporation or a general business corporation (see N.J.A.C. 13:35-6.16(f)) shall notify the Board of such interest no later than February 18, 1993. Notice is not required for a practice conducted under the practitioner's own name.

(k) This rule shall be operative April 15, 1992.

New Rule, R.1992 d.75, effective February 18, 1992 (operative April 15, 1992, except as noted).

See: 23 N.J.R. 161(a), 23 N.J.R. 1063(a), 24 N.J.R. 626(a).

Public Notice: Stay of operative date of (e) until July 15, 1992.

See: 24 N.J.R. 1905(a).

Public Notice: Stay of operative date of portion of (a)2 until August 12, 1992.

See: 24 N.J.R. 2460(a).

Public Notice: Delayed operative date of (e) until August 15, 1992.

See: 24 N.J.R. 3443(b).

Administrative Correction to (a)5.

See: 24 N.J.R. 4409(a).

Amended by R.1995 d.8, effective January 3, 1995.

See: 25 N.J.R. 5441(a), 27 N.J.R. 120(a).

Amended by R.2011 d.155, effective June 6, 2011.

See: 42 N.J.R. 1310(a), 43 N.J.R. 1359(b).

In (a)2iii and (h)5, inserted "and Senior Services"; in (a)2iii, deleted a comma following "uncompensated care"; in (a)2vi and (c)1ii, substituted "Accreditation" for the first occurrence of "American"; in (a)2vi, substituted "third-party" for "third party"; in the introductory paragraph of (c)1, deleted a comma following "patient use"; and rewrote (e).

Law Review and Journal Commentaries

Examiners' Board Hits Physician Referrals. 133 N.J.L.J. No. 4, 11 (1993).

Rules Changes Target Medical Group Practices. Theodosia A. Tamborlana, 136 N.J.L.J. No. 11, 10 (1994).

13:35-6.18 Medical malpractice coverage; letter of credit

(a) The following words and terms, when used in this section, shall have the following meanings, unless the context clearly indicates otherwise.

"Authorized" means recognized by a governmental agency to offer medical malpractice insurance products.

"Covered" means ongoing maintenance of insurance in the sum of \$1 million per occurrence and \$3 million dollars per policy year, with extended reporting endorsement coverage for claims made ("tail coverage") issued by a carrier or other entity authorized to write medical malpractice policies.

"Letter of credit" means a non-assignable, non-transferable, unexpired, continuous irrevocable obligation, liability bond or other instrument issued by a bank or saving association authorized to do business in this State, payable to the physician or podiatrist as the beneficiary within 30 days after a demand for payment and the presentation of a final judgment or settlement in a medical malpractice action.

"Maintaining a professional practice with responsibility for patient care" means the furnishing of professional services to patients in New Jersey, including, but not limited to, the testing for, or diagnosis of, or the offering or furnishing of

treatment, preventative medical care or consultation relating to human disease or dysfunction or physical condition, including the prescribing, administering or dispensing of products, devices or drugs at a place, such as an office (even if located in a home), hospital or clinic, or through a business entity, such as a laboratory or mobile van service.

"Not available" means that a physician or podiatrist is unable to purchase medical malpractice insurance coverage from a carrier authorized to write medical malpractice insurance, including through programs relating to risk retention groups deemed eligible by the Department of Banking and Insurance, surplus lines registered with the Department of Banking and Insurance, self-insurance trusts or captive insurance companies approved by the New Jersey Health Care Facilities Financing Authority in the Department of Health and Senior Services. "Not available" for purposes of this section does not mean "not affordable."

(b) All physicians and podiatrists licensed to practice in this State who maintain a professional practice and have responsibility for patient care shall be covered by medical malpractice insurance or, if medical malpractice insurance is not available, shall secure and maintain a letter of credit at least in the sum of \$500,000 or more.

(c) For purposes of this section, physicians or podiatrists when practicing as employees of the Federal, State or county government or physicians practicing pursuant to an exemption from the prohibitions of the Medical Practice Act set forth at N.J.S.A. 45:9-21 will not be deemed to be maintaining a professional practice.

(d) Physicians and podiatrists who are not covered by medical malpractice insurance shall present to the Board a true copy of the letter of credit required pursuant to (b) above and shall notify the Board, within seven days, whenever:

1. A demand for payment on the letter has been made;
2. The continuing viability of the letter has been affected, for whatever reason; or
3. There has been a change in status affecting whether the physician or podiatrist is or continues to be exempt from the requirement.

(e) Violations of (b) and (d) above shall be deemed professional misconduct within the meaning of N.J.S.A. 45:1-21(e).

New Rule, R.1993 d.604, effective December 6, 1993.

See: 24 N.J.R. 4012(a), 25 N.J.R. 5487(a).

Repealed by R.1997 d.475, effective November 3, 1997.

See: 29 N.J.R. 842(a), 29 N.J.R. 4706(a).

Section was "Prescribing, dispensing or administering anabolic steroids".

New Rule, R.1999 d.117, effective April 5, 1999.

See: 30 N.J.R. 4318(a), 31 N.J.R. 881(a).

Petition for Rulemaking.

See: 35 N.J.R. 3418(a), 3967(c).

Petition for Rulemaking.

See: 36 N.J.R. 588(a).

Public Notice: Conference for Solicitation of Informal Public Input on Medical Malpractice Coverage Requirements.

See: 36 N.J.R. 1134(a).

Petition for Rulemaking.

See: 36 N.J.R. 4180(a).

Amended by R.2005 d.120, effective April 18, 2005.

See: 36 N.J.R. 4633(a), 37 N.J.R. 1203(a).

In (a), added "Authorized, inserted "or other entity" following "issued by a carrier" in "Covered", inserted ", liability bond or other instrument" following "irrevocable obligation" in "Letter of credit", and rewrote "Not available".

Case Notes

That a workers' compensation insurer's doctor, an independent contractor who only performed independent medical examinations, did not have malpractice insurance did not make the insurer vicariously liable for the doctor's alleged malpractice in diagnosing a claimant. At the time of the diagnosis, N.J.A.C. 13:35-6.18 had not yet been adopted, so carrying malpractice insurance was not yet a clear legal condition of the doctor's existing license; therefore, the incompetent-contractor exception to non-liability did not apply. *Basil v. Wolf*, 193 N.J. 38, 935 A.2d 1154, 2007 N.J. LEXIS 1419 (2007).

N.J.S.A. 45:9-19.17(a) requires a physician maintaining a "professional medical practice," which was later defined by N.J.A.C. 13:35-6.18, to obtain a minimum amount of medical malpractice insurance as a condition for licensure; after the effective date of N.J.A.C. 13:35-6.18, a workers' compensation insurer that engages an independent medical evaluation contract physician must ensure that the physician has the requisite malpractice insurance. *Basil v. Wolf*, 193 N.J. 38, 935 A.2d 1154, 2007 N.J. LEXIS 1419 (2007).

13:35-6.19 Duty to report changes in status

(a) The following words and terms, when used in this section, shall have the following meanings unless the context clearly indicates otherwise.

"Ability to practice" means and is construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Affiliation" means a professional relationship, including an employment relationship, a position as an independent contractor or the grant of privileges by a health care facility or health maintenance organization in this State or any other jurisdiction.

"Alternative Resolution Program" refers to the program established pursuant to N.J.A.C. 13:35-11 by which licensees suffering from medical conditions or chemical dependency may confidentially enter into a rehabilitation and monitoring program, under the sponsorship of an approved professional

assistance program, subject to the periodic submission of coded status reports and continuing confidential review by the Board's Impairment Review Committee. To be deemed a participant in the Alternative Resolution Program, the licensee must be accepted by the Impairment Review Committee and assigned a code number.

"Biennial renewal form" means the form provided to a licensee by the Board, which must be completed in order to renew and keep current a license to practice in this State.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Conviction" means a judgment of conviction entered following plea agreement or trial on an arrest, indictment, accusation or bill of particulars in a state or Federal criminal proceeding, or the resolution of such charges, whether by a plea of no contest or nolo contendere or by pre-trial diversion program.

"Directly associated" means a professional relationship including an employment relationship, partnership arrangement or a shareholder status in a professional service corporation or general business corporation. "Directly associated" does not include any relationship established pursuant to preferred provider agreements, IPA's or other provider panels.

"Disciplinary order" means a disposition suspending or revoking licensure privileges or imposing civil penalties or ordering the restoration of money or ordering corrective action or medical or other professional treatment or monitoring, or censuring or reprimanding a licensee.

"Financial interest" means a monetary interest of any amount held by a practitioner personally or through immediate family, as defined at N.J.S.A. 45:9-22.4 et seq.

"Health care facility" means a facility or institution, whether public or private, engaged in providing medical services, including diagnosis or treatment of human disease, pain, injury, deformity or physical condition, including, but not limited to, a general hospital, special hospital, mental hospital, health maintenance organizations, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing home, nursing home, intermediate care facility, tuberculosis hospital, chronic disease hospital, maternity hospital, outpatient clinic, dispensary, home health care agency, boarding home for the sheltered care of adult persons, and bio-analytical laboratory or central services facilities serving one or more such institutions but excluding institutions that provide healing solely by prayer.

"Health care service entity" means a business entity which provides on an inpatient or outpatient basis: testing for a diagnosis or treatment of human disease or dysfunction; or dispensing of drugs or medical devices for the treatment of

5. Treatments and drugs prescribed or provided, as in (a) above;
6. Any agreements with the patient; and
7. Periodic reviews conducted.

Amended by R.2003 d.263, effective July 7, 2003.

See: 34 N.J.R. 3441(a), 35 N.J.R. 2935(a).

Rewrote (c).

Amended by R.2011 d.155, effective June 6, 2011.

See: 42 N.J.R. 1310(a), 43 N.J.R. 1359(b).

In (c)1, deleted "and" from the end; in (c)2, substituted "; and" for a period at the end; and added (c)3.

Case Notes

Five-year revocation of a physician's license was appropriate where the physician fraudulently prescribed Percocet and deliberately falsified medical records to justify the issuance of those prescriptions. Two undercover officers testified that the physician prescribed the medication over a period of time without conducting a thorough physical examination and medical history and in spite of their statements that they were in no pain whatsoever. In re Costino License Revocation, OAL Dkt. No. BDS 736-08, 2009 N.J. AGEN LEXIS 276, Initial Decision (May 14, 2009), adopted (N.J. State Bd. of Medical Examiners June 8, 2009); aff'd per curiam, A-2348-09T2, 2010 N.J. Super. Unpub. LEXIS 2455 (App. Div. December 21, 2009).

13:35-7.7 Prohibitions on prescribing, administering or dispensing of controlled substances for detoxification; limited exceptions

(a) A practitioner shall not issue a prescription for a narcotic drug or for a depressant drug listed in any schedule which drug is intended for the purpose of "detoxification" or "maintenance treatment."

(b) Unless registered with the Division of Consumer Affairs to conduct a narcotic treatment program pursuant to N.J.S.A. 24:21-10 and N.J.A.C. 13:45H-11.2, a practitioner shall not dispense or administer a narcotic drug or a depressant drug listed in any schedule which drug is intended for the purpose of "detoxification" or "maintenance treatment," except:

1. To relieve acute withdrawal symptoms, provided that:
 - i. Such treatment shall not exceed 72 hours;
 - ii. No more than one day's supply of the drug is provided to the patient at a time; and
 - iii. Arrangements are made for referring the patient to an addiction specialist or a drug treatment program for treatment; or
2. As an adjunct to other medical or surgical treatment for conditions other than addiction in a licensed health care facility.

Amended by R.2000 d.400, effective October 2, 2000.

See: 31 N.J.R. 2454(a), 32 N.J.R. 3576(a).

In (a), and (b), inserted references to depressant drugs.

Administrative change.

See: 43 N.J.R. 1204(b).

13:35-7.8 Prohibitions and limitations in the prescribing, administering or dispensing of amphetamines and sympathomimetic amines

(a) A practitioner shall not prescribe, order, dispense, administer, sell or transfer any amphetamine or sympathomimetic amine designated as a Schedule II controlled substance for use in weight management, dieting or any other anorectic purpose, or for the treatment of fatigue.

(b) A practitioner may prescribe, dispense or administer amphetamine or sympathomimetic amine drugs or compounds designated as Schedule II controlled substances, only as follows:

1. For the treatment of the following conditions:
 - i. Narcolepsy established by recognized diagnostic criteria;
 - ii. Idiopathic Central Nervous System Hypersomnia established by recognized diagnostic criteria;
 - iii. Attention Deficit Disorder established by recognized diagnostic criteria;
 - iv. Drug-induced brain dysfunction;
 - v. Epilepsy;
 - vi. Depression shown to be refractory to other therapeutic modalities; and
 - vii. Senile apathetic behavior;
2. For immediate use in a hospital for acute conditions such as depression associated with illness or surgery;
3. For the differential diagnostic psychiatric evaluation of depression; or
4. For the clinical investigation of the effects of such drugs or compounds in which case, in addition to other requirements of applicable law, prior application therefor shall have been made to the Board and approval granted before any such investigation is begun.

(c) A practitioner who prescribes, dispenses or administers amphetamines or sympathomimetic amines shall prepare and maintain patient medical records which accurately reflect the utilization of any drug subject to this section, the specific diagnosis, the information upon which the diagnosis is based, including testing and consultations, and the treatment objectives for which the drug is being prescribed.

(d) The following list, although not exhaustive or exclusive, includes many of the generic and brand-name Schedule II drugs which are subject to this section:

Adderall
Amphetamine
Desoxyn
Dexedrine
Dextroamphetamine

Methamphetamine
Methylphenidate
Ritalin

13:35-7.9 Prohibitions and special limitations on prescribing, administering, or dispensing anabolic steroids and human growth hormone or its similar analogs

(a) A practitioner shall not prescribe, order, dispense, administer, sell, or transfer any anabolic steroid or human growth hormone or its similar analogs, unless there is a bona fide relationship with the patient, a medical history has been obtained, and a full physical examination has been performed, establishing a valid medical indication and necessity as provided in (b), (c), or (d) below.

(b) Valid medical indication and necessity for human growth hormone or its similar analogs is established when there is:

1. A documented diagnosis of hormonal deficiency causing short stature in children;
2. A record of long-term treatment of growth failure due to lack of endogenous GH secretion;
3. A record of long-term treatment of short stature associated with Turner's syndrome;
4. A documented diagnosis of adult short bowel syndrome;
5. A documented diagnosis of adult deficiency due to pituitary tumors or their treatment or muscle wasting disease associated with HIV/AIDS; or
6. A documented diagnosis of any other medical condition specifically recognized by the U.S. Secretary of Health and Human Services as appropriate for treatment with human growth hormone or its similar analogs.

(c) Valid medical indication and necessity for use of anabolic steroids may be established when there is:

1. A documented diagnosis of the condition specified in this paragraph in an adult male patient, associated with a deficiency or absence of endogenous testosterone:
 - i. Primary hypogonadism (congenital or acquired); or
 - ii. Hypogonadotropic hypogonadism (congenital or acquired);
2. A record of treatment of delayed puberty in males;
3. A documented need in a female patient for palliative treatment of breast cancer; or
4. A documented diagnosis of a valid medical indication specific to an identified anabolic steroid for the following conditions:

- i. AIDS wasting syndrome;
- ii. Anemia accompanying renal failure;
- iii. Bone marrow failure anemia;
- iv. Refractory red cell production anemia;
- v. Constitutional delay in growth (androgenic anabolic steroids);
- vi. Growth failure in children with growth hormone deficiency (treatment adjunct);
- vii. Endometriosis, fibrocystic breast disease, or hereditary angioedema;
- viii. Microphallus (androgenic anabolic steroids);
- ix. Severe burn injury;
- x. Weight loss from cancer chemotherapy; or
- xi. Wasting due to prolonged corticosteroid use.

(d) Valid medical indication and necessity for human growth hormone or its similar analogs and anabolic steroids also may be established for use in treatment of conditions other than those identified at (b) and (c) above, only if the practitioner:

1. Obtains and maintains documentation of the receipt of informed consent after the provision of information concerning the risks and benefits of short- and long-term treatment and its less-intrusive alternatives, the consequences of the cessation of treatment, and the financial costs associated with treatment;
2. Obtains and maintains documentation of the appropriate clinical data and laboratory tests undertaken prior to the start of treatment that support the medical indication and necessity; and
3. Provides and maintains documentation of proper follow up at appropriate intervals during the course of treatment and adheres to monitoring protocols consistent with professional standards.

(e) A practitioner shall not prescribe, order, dispense, administer, sell, or transfer any anabolic steroid or human growth hormone, or its similar analogs, to any person for the purpose of hormonal manipulation intended to increase muscle mass, strength, stamina, or weight, except as permitted under (b) and (c) above. Body building, muscle enhancement, or increasing muscle bulk or strength through the use of anabolic steroid or human growth hormone by a person in good health for the intended purpose of improving performance in any form of exercise, sport, or game is not a valid medical indication or necessity.

(f) The following list, although not exhaustive or exclusive, includes many of the generic and brand-name anabolic steroids and human growth hormones or its similar analogs subject to this section:

Bolenone
 Chlorotestosterone(4-chlortestosterone)
 Chorionic gonadotropin
 Closebol
 Dehydrochlormethyltestosterone
 Dihydrotestosterone(4-dihydrotestosterone)
 Ethylestrenol
 Fluoxymesterone
 Mesterolone
 Methandienone
 Methandriol
 Methandrostenolone
 Methenolone
 Methyltestosterone
 Mibolone
 Nandrolone
 Norethandrolone
 Oxandrolone
 Oxymesterone
 Oxymetholone
 Somatrem
 Somatropin
 Stanolone
 Stanozolol
 Testolactone
 Testosterone
 Trebolone

Repeal and New Rule, R.2013 d.037, effective February 19, 2013.

See: 44 N.J.R. 2353(a), 45 N.J.R. 334(a).

Section was "Prohibitions and special limitations on prescribing, administering or dispensing anabolic steroids".

13:35-7.10 Enforcement

(a) A violation of N.J.A.C. 13:35-7.1 through 7.9 may be deemed to constitute one or more of the following:

1. Distribution or dispensing of a controlled substance in an indiscriminate manner, or not in good faith, or without good cause, as prohibited by N.J.S.A. 45:1-21(e);
2. Gross or repeated malpractice, neglect, or incompetence in the practice of medicine, as prohibited by N.J.S.A. 45:1-21(c) and (d);
3. Professional misconduct, as prohibited by N.J.S.A. 45:1-21(e);

4. A failure to comply with the provisions of an Act or regulation administered by the Board, as prohibited by N.J.S.A. 45:1-21(h); and

5. Unprofessional conduct, which would present an imminent danger to an individual patient or to the public health, safety or welfare, within the meaning of N.J.S.A. 45:1-37(a).

(b) A practitioner who is in possession of information that reasonably indicates that another practitioner has prescribed, dispensed or administered any drug or drugs in a manner that jeopardizes the public health, safety or welfare or for purposes deemed to be unlawful pursuant to this subchapter shall report such information to the Board pursuant to N.J.S.A. 45:1-37.

Amended by R.2011 d.155, effective June 6, 2011.

See: 42 N.J.R. 1310(a), 43 N.J.R. 1359(b).

In (a)1, (a)5 and (b); updated the N.J.S.A. reference; and in (b), substituted the first and third occurrences of "that" for "which".

SUBCHAPTER 7A. COMPASSIONATE USE MEDICAL MARIJUANA

13:35-7A.1 Purpose and scope

(a) The rules in this subchapter implement certain provisions of the New Jersey Compassionate Use Medical Marijuana Act, P.L. 2009, c. 307.

(b) The rules in this subchapter shall apply to physicians who provide certifications and written instructions for patients seeking marijuana for medical use pursuant to rules adopted by the Board and by the Department of Health and Senior Services.

13:35-7A.2 Definitions

The following words and terms when used in this subchapter shall have the following meanings, unless the context indicates otherwise.

"Bona fide physician-patient relationship" means a relationship in which the physician has ongoing responsibility for

the assessment, care and treatment of a patient's debilitating medical condition, consistent with the requirements of N.J.A.C. 13:35-7A.5. For purposes of this definition, "on-going responsibility" means:

1. The physician-patient relationship has existed for at least one year;
2. The physician has seen and/or assessed the patient for the debilitating medical condition on at least four visits; or
3. The physician assumes responsibility for providing management and care of the patient's debilitating medical condition after conducting a comprehensive medical history and physical examination, including a personal review of the patient's medical record maintained by other treating physicians reflecting the patient's reaction and response to conventional medical therapies.

"Certification" means a statement signed by a physician with whom a patient has a bona fide physician-patient relationship, which attests to the physician's authorization for the patient to be registered to use marijuana.

"Debilitating medical condition" means:

1. One of the following conditions, if resistant to, or if the patient is intolerant to, conventional medical therapy: seizure disorder, including epilepsy; intractable skeletal muscular spasticity; or glaucoma;
2. One of the following conditions, if severe or chronic pain, severe nausea or vomiting, cachexia or wasting syndrome results from the condition or its treatment: positive status for human immunodeficiency virus, acquired immune deficiency syndrome or cancer;
3. Amyotrophic lateral sclerosis, multiple sclerosis, terminal cancer, muscular dystrophy or inflammatory bowel disease, including Crohn's disease;
4. Terminal illness, if the physician has determined a prognosis of less than 12 months of life; or
5. Any other medical condition or its treatment that is approved by the Department of Health and Senior Services by rule.

"Medical use of marijuana" means the acquisition, possession, transport or use of marijuana or paraphernalia by a qualified patient registered with the Department of Health and Senior Services under P.L. 2009, c. 307.

13:35-7A.3 Requirement for physician participation

(a) A physician shall provide a certification and written instructions for a patient for the medical use of marijuana only if:

1. The physician holds an active New Jersey license in good standing issued by the Board and possesses an active controlled dangerous substances registration issued by the Division of Consumer Affairs that is not subject to limitation; and
2. The physician has a bona fide physician-patient relationship with the patient.

13:35-7A.4 Certification requirements

(a) Prior to issuing a certification for the medical use of marijuana, the physician shall have conducted a comprehensive medical history and physical examination of the patient to determine whether the patient suffers from a debilitating medical condition that qualifies the patient to receive marijuana pursuant to N.J.S.A. 24:6I-3.

(b) The certification shall be signed and dated by the physician and shall attest to the physician's authorization for the patient to be registered with the Department of Health and Senior Services for the medical use of marijuana. If authorized by the Department of Health and Senior Services, the certification shall be electronically transmitted to the Department of Health and Senior Services. The certification shall include the following information:

1. Physician name, address and telephone number;
2. Physician license number and CDS registration number;
3. Patient name, address, telephone number and date of birth;
4. If applicable, caregiver name, address, telephone number and date of birth;
5. Diagnosis of debilitating medical condition; and
6. Any other information required by the Department of Health and Senior Services by rule.

(c) Prior to issuing a certification for the medical use of marijuana for a minor patient, a physician shall:

1. Obtain written confirmation from a physician trained in the care of pediatric patients and from a psychiatrist, establishing that, in their respective professional opinions, following review of the minor patient's medical record or examination of the minor patient, the minor patient is likely to receive therapeutic or palliative benefits from the medical use of marijuana to treat or alleviate symptoms associated with his or her debilitating medical condition. If the certifying physician is trained in the care of pediatric patients, he or she shall only be required to obtain written confirmation from a psychiatrist; and

2. Explain the potential risks and benefits of the medical use of marijuana to the minor patient and to a parent, guardian or person having legal custody of the minor patient. Such explanation shall be documented in the minor patient's medical record.

13:35-7A.5 Written instruction requirements; reassessment; records

(a) A physician may provide written instructions for the medical use of marijuana for a qualified patient registered with the Department of Health and Senior Services, provided the requirements in this section are satisfied. If authorized by the Department of Health and Senior Services, the physician may provide the written instruction by electronic or other means directly to an alternative treatment center on behalf of a registered qualifying patient.

(b) The physician's written instructions shall include the following information:

1. Physician name, address and telephone number;
2. Physician license number and CDS registration number;
3. Patient name, address, telephone number, date of birth and registry identification number;
4. If applicable, caregiver name, address, telephone number, date of birth and registry identification number;
5. Name of the permitted alternative treatment center;
6. Quantity of marijuana to be dispensed; and
7. Any other information required by the Department of Health and Senior Services by rule.

(c) A physician authorizing the medical use of marijuana shall review, at a minimum of every three months, the course of treatment for the patient's debilitating medical condition, and the patient's progress toward treatment objectives as a result of the use of medical marijuana, including whether the patient is achieving the therapeutic results intended, has developed significant untoward side effects, or is experiencing any physical or psychological problems associated with marijuana use. If the physician determines that the patient is achieving treatment objectives, and is not experiencing untoward side effects or physical or psychological problems associated with marijuana use, the physician may continue the patient's treatment with medical marijuana without alteration.

(d) If treatment objectives for the patient's debilitating medical condition are not being met as a result of the use of medical marijuana, or the patient is experiencing untoward side effects or physical or psychological problems associated with marijuana use, the physician shall:

1. Modify the dosage of medical marijuana or mode of delivery authorized, provided the authorized amount does not exceed two ounces in a 30-day period consistent with (g) below, undertake a trial of other drugs or treatment modalities, or discontinue the use of medical marijuana; and

2. Consider referring the patient for independent evaluation or treatment in order to achieve treatment objectives.

(e) The physician shall remain alert to the possibility that marijuana may be misused or diverted. A physician issuing written instructions for a patient with a history of substance abuse shall exercise extra care by way of monitoring, documentation and possible consultation with addiction medicine specialists, and should consider the use of an agreement between the physician and the patient concerning the medical use of marijuana and consequences for misuse.

(f) The physician shall keep accurate and complete records that include:

1. The medical history and physical examination of the patient;
2. The diagnosis of the debilitating medical condition, including the patient's symptoms and their severity and the patient's reaction and response to conventional medical therapies, which qualify the patient for the medical use of marijuana;
3. Other evaluations and consultations;
4. Treatment plan objectives;
5. Evidence of informed consent. In obtaining informed consent, the physician shall advise the patient about the lack of scientific consensus for the medical use of marijuana, its sedative properties and the risks for addiction;
6. Treatments and other drugs prescribed or provided;
7. Any agreements with the patient; and
8. Periodic reviews conducted.

(g) A physician shall not issue written instructions authorizing a patient to receive more than two ounces of marijuana in a 30-day period.

(h) A physician may issue multiple written instructions at one time authorizing the patient to receive a total of up to a 90-day supply of marijuana, provided that the following conditions are met:

1. Each separate set of instructions is issued for the treatment of the patient's documented debilitating medical condition;

2. Each separate set of instructions indicates the earliest date on which the alternative treatment center may dispense the marijuana, except for the first dispensation if it is to be filled immediately; and

3. The physician has determined that providing the patient with multiple instructions in this manner does not create an undue risk of diversion or abuse.

(i) The physician shall keep a copy of the patient's, or if applicable, the caregiver's registry identification card, in the patient's medical record.

(j) If the physician determines that the patient's underlying debilitating medical condition no longer exists or that the patient's continued use of marijuana is no longer appropriate, the physician shall notify the Department of Health and Senior Services of his or her findings.

13:35-7A.6 Duty to report information to the Division

(a) A physician shall comply with all requests for information from the Division of Consumer Affairs concerning the issuance of certifications and written instructions for the medical use of marijuana as provided in N.J.A.C. 13:45A-33.

(b) Failure on the part of a physician to comply with the requirements of N.J.A.C. 13:45A-33 may subject the physician to disciplinary action pursuant to N.J.S.A. 45:1-21 et seq.

SUBCHAPTER 8. HEARING AID DISPENSERS

13:35-8.1 Purpose

The rules in this subchapter are established pursuant to N.J.S.A. 45:9A-7 and govern the licensing and the practice of hearing aid dispensing in the State of New Jersey.

13:35-8.2 Definitions

The following words and terms when used in this subchapter shall have the following meaning unless the context clearly indicates otherwise.

"Act" means the New Jersey Hearing Aid Dispensers Act, N.J.S.A. 45:9A-1 et seq. as amended and/or supplemented.

"Advertisement" means any attempt, directly or indirectly, by publication, display, dissemination or circulation, in print or electronic media, which induces or attempts to induce any person to purchase or enter into an agreement to purchase a hearing aid, services and/or merchandise from a licensee.

"Board" means the State Board of Medical Examiners.

"Committee" means the Hearing Aid Dispensers Examining Committee.

"Hearing aid" means a hearing aid as defined by N.J.S.A. 45:9A-2(c) and includes the earmold system.