CHAPTER 35

BOARD OF MEDICAL EXAMINERS

Authority

N.J.S.A. 45:9–2.

Source and Effective Date

R.1999 d.356, effective September 20, 1999.
See: 31 N.J.R. 1742(a), 31 N.J.R. 3117(a).

Executive Order No. 66(1978) Expiration Date

Chapter 35, Board of Medical Examiners, expires on September 20, 2004.

Chapter Historical Note

Chapter 35, Board of Medical Examiners, was filed 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Chapter 35, Board of Medical Examiners, was repealed and Chapter 35, Board of Medical Examiners, was adopted as new rules by R.1983 d.314, effective August 1, 1983.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 Subchapter 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Examiners, was readopted as R.1994 d.522, effective September 19, 1994, and Subchapter 7, Chiropractic Practice, was repealed by R.1994 d.522, effective October 17, 1994.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: Source and Effective Date. See, also, section annotations.

Law Review and Journal Commentaries

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

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SUBCHAPTER 1. MEDICAL SCHOOLS, COLLEGES, EXTERNSHIPS, CLERKSHIPS AND POST–GRADUATE WORK

13:35–1.1 Observership program

(a) "Observer" shall mean an undergraduate medical student of an allopathic or osteopathic school accredited either by the Liaison Committee on Medical Education or the American Osteopathic Association or a foreign medical school listed in the World Health Organization Directory and whose graduates are accepted by the New Jersey Board of Medical Examiners as eligible to sit for the licensure examination. Observerships are limited to the student's vacation period in an extra-curricular professional experience as delineated in this section.

(b) An observership program shall be limited to:

1. Observation of operative procedures;

2. The taking of histories;

3. The performance of physical examinations;

4. The performance of non-invasive procedures under the direct supervision of and in the immediate presence of the supervising licensed physician; and

5. The participation in patient rounds and other organized patient care activities of the supervising physician.

(c) At no time shall the observer be delegated any responsibility for the care of the patient, the patient's diagnosis or any aspect of the patient's treatment, including the prescription of medication for the patient. An observer shall make no entries on the patient's permanent record.

(d) The observer shall at all times of patient contact wear an identifying badge inscribed "Medical Student."

(e) Prior to commencing participation in an observership program, the student shall have obtained written permission

from the Chief of Staff and the Administration of the participating hospital and shall retain such letter.

(f) Under no circumstances shall the performance of any of the duties listed in (b) above by an observer, while engaged in such a program, be construed as the practice of medicine.

(g) The time spent in an observership program shall not be considered as part of or credited toward fulfillment of any statutory academic or clinical requirements for licensure.

Amended by R.1999 d.356, effective October 18, 1999.
See: 31 N.J.R. 1742(a), 31 N.J.R. 3117(a).
Substituted references to observers for references to externs and substituted references to observerships for references to externships throughout; in (a), substituted "delineated in this section" for "hereafter delineated" at the end; and in (f), substituted "duties listed in (b) above" for "above duties" following "any of the".

13:35–1.2 Fifth Pathway

(a) The Board shall accept application for licensure from an applicant who does not meet the usual statutory prerequisites for educational background, in the following circumstances to be known as the Fifth Pathway:

1. The applicant has completed the entirety of the academic curriculum in residence at a medical school in a foreign country located outside of the United States, Puerto Rico or Canada or in a school-authorized clinical training program;

2. The medical school was approved throughout the applicant's period of education by the government of the country of domicile to confer the degree of Doctor of Medicine and Surgery or its equivalent, and was listed in the World Health Organization Directory;

3. The applicant has satisfactorily completed all the requirements for a matriculated student of that foreign medical school to receive a diploma, except for internship and/or social service;

4. The applicant has achieved a passing score on a screening examination acceptable to the Educational Commission on Foreign Medical Graduates (ECFMG) even though not eligible for ECFMG certification; and

5. The applicant has had his or her academic record reviewed and approved by a medical school approved by the Liaison Committee on Medical Education, which school has accepted the applicant in a one-academic-year program of supervised clinical training under its direction, and the applicant has satisfactorily completed that program as evidenced by receipt of a certificate issued by the sponsoring medical school.

(b) The applicant meeting the requirements in (a) shall thereafter be deemed by the Board to be eligible to enter a graduate training program approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA). Upon satisfactory completion of the three years of post-graduate training required by N.J.A.C. 13:35–3.11, the applicant may apply for licensure in this State.

Amended by R.1989 d.532, effective October 16, 1989.
See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).
Rule deleted and replaced with new text.

13:35–1.3 Postgraduate training

Postgraduate training shall be taken under the auspices of a hospital or hospitals accredited for such training by the Accreditation Council for Graduate Medical Education (ACGME) or by the American Osteopathic Association (AOA) or by the American Podiatric Medical Association (APMA), as applicable to the profession. The program shall further be 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).
Rule deleted and replaced with new text.

Case Notes

Reasonable regulation of advertising. Att'y Gen. Form Op. No. 20 (1977).

13:35–1.4 Military service in lieu of M.D. or D.O. internship or postgraduate training

The Board may grant a license to practice medicine and surgery to any person who shall furnish proof, satisfactory to the Board, that such person has fulfilled all of the formal requirements established by law, and who has served at least two years in active military service in the United States Army, Air Force, Navy, Marine Corps, Coast Guard or the U.S. Public Health Service as a commissioned officer and physician and surgeon in a medical facility which the Board determines constitutes the substantial equivalent of the approved internship or residency training program required by law; provided, however, that such military service actively occurred subsequent to graduation from an approved medical school.

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 N.J.S.A. deleted and replaced with word "law".

13:35–1.5 Registration and permit requirements for graduate medical education programs in medicine or podiatry

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

"Applicant" means a graduate of a medical or podiatric school, unlicensed in this State, seeking authorization to engage in the practice of medicine or podiatry as a resident in a graduate medical education program. A registration applicant is seeking authorization to participate in the first year of a graduate medical education program. A permit applicant is seeking authorization to participate in his or her second year (or beyond) of a graduate medical education program.

1. The physician is certified or eligible for certification by the American Board of Obstetrics-Gynecology or the American Osteopathic Board of Obstetrics-Gynecology, and the physician satisfactorily completes at least 15 hours of Continuing Medical Education each year in obstetrics-gynecology.

2. The physician has admitting and surgical privileges at a nearby licensed hospital which has an operating room, blood bank, and an intensive care unit. The hospital shall be accessible within 20 minutes driving time during the usual hours of operation of the clinic.

3. The procedure shall be done in a location which is designated by the Department of Health as a licensed ambulatory care facility (LACF) authorized to perform surgical procedures as in subsection (e) above. The LACF shall be licensed by the Department of Health as an ambulatory care facility authorized to perform surgical procedures. The facility shall be in current and good standing at all times when surgical procedures are performed there. The LACF shall have a written agreement with an ambulance service assuring immediate transportation of a patient at all times when a patient has been admitted for surgery and until the patient has been discharged from the recovery room.

4. The procedure shall be done in an LACF which shall have a Medical Director and a Credentials Committee which have duly evaluated the training, experience and skill of the physician at continuous and successive levels of complexity of the D & E procedure in pregnancies advancing in stages from 18 weeks LMP through 19 weeks LMP through 20 weeks LMP, and the physician has been granted successive practice privileges consistent with management of the increased risk to the health and safety of the patient at that stage documented in the personnel file maintained for that physician. (Where the applicant physician is also the Medical Director, the physician shall submit a certificate from the Administrator or Chief of Department of a hospital or the Medical Director of an LACF where the applicant has been evaluated and credentialed in a comparable manner.) The physician new to the LACF shall have his or her operating technique evaluated initially and at least yearly by the Medical 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 postoperative 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 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.

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

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.

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 (ALPS) 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 American 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, unintended hospitalization for more than 24 hours or death.

"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 synonymous with the term "sedation/analgesia" as used by the American Society of Anesthesiologists.

"Credentialed" means that a practitioner or physician has been granted, and continues to maintain, the privilege by a hospital licensed in the jurisdiction in which it is located to provide specified services, such as surgery or the administration or supervision of the administration of one or more types of anesthetic agents or procedures.

"General anesthesia" means the administration of a drug or drugs which cause loss of consciousness as the result of which the patient is unable to make meaningful responses but may still display reflex withdrawal from a painful stimulus.

"Health care personnel" means any office staff member who is licensed by a professional or health care occupational licensing board such as a professional registered nurse, licensed practical nurse or physician assistant.

"Hospital" means a hospital licensed by the state in which it is situated.

"Local anesthesia" means an agent which produces a transient and reversible loss of sensation in a circumscribed portion of the body.

"Minor conduction block" means the injection of local anesthesia to stop or prevent a painful sensation in a circumscribed area of the body (that is, local infiltration or local nerve block), or the block of a nerve by direct pressure and refrigeration. Minor conduction blocks include, but are not limited to, retobulbar blocks, peribulbar blocks, pudendal blocks and ankle blocks.

"Minor surgery" means surgery which can safely and comfortably be performed on a patient who has received local or topical anesthesia, without more than minimal preoperative medication or minimal intra-operative tranquilization and where the likelihood of complications requiring hospitalization is remote. For example, minor surgery includes the excision of moles, warts, cysts, lipomas, the repair of simple lacerations or surgery limited to the skin and subcutaneous tissue, the incision and drainage of abscesses, certain simple ophthalmologic surgical procedures, such as treatment of chalazions and non-invasive laser procedures performed with topical anesthesia, limited endoscopies such as proctoscopies, skin biopsies, arthrocenteses, thoracenteses and paracenteses. Minor surgery shall not include any procedure identified as "major surgery" within the meaning of N.J.A.C. 13:35–4.1.

"Monitoring" means continuous visual observation of a patient and continuous observation of the patient using instruments to measure, display and record the values of certain physiologic variables such as pulse, oxygen saturation, blood pressure and respiration.

"Office" means a location at which medical, surgical or podiatric services are rendered and which contains only one operating room and which is not subject to the jurisdiction and licensure requirements of the New Jersey State Department of Health and Senior Services.

"Operating room" means that location in the office dedicated to the performance of surgery or special procedures.

"Pain management" means the administration to a patient, by any route, of pharmacologic agents or drugs which are not intended to result in a loss of consciousness, awareness or defensive reflexes, but which are intended to alleviate pain. It includes the use or application of other modalities and medical devices such as, but not limited to, heat or cold, massage, transepidermal nerve stimulation (TENS), and neurolytic techniques such as radiofrequency coagulation and cryotherapy.

"Pain medication" means, for the purpose of this subchapter, the administration to a patient, by any route, of pharmacologic agents or drugs which are not intended to result in a loss of consciousness, awareness or defensive reflexes, but which are intended to alleviate pain occurring in the absence of an invasive, operative or manipulative procedure.

"Physical status classification" means a description of a patient used in determining if an office surgery or procedure is appropriate. The American Society of Anesthesiologists enumerates classifications: I—Normal healthy patient; II—A patient with mild systemic disease; III—A patient with severe systemic disease limiting activity but not incapacitating; IV—A patient with incapacitating systemic disease that is a constant threat to life; and V—Moribund patients not expected to live 24 hours with or without operation.

"Physician" means an individual holding an M.D. or D.O. degree licensed pursuant to N.J.S.A. 45:9–1 et seq.

"Podiatrist" means an individual holding a D.P.M. degree licensed pursuant to N.J.S.A. 45:5–1 et seq.

"Practitioner" means a physician or a podiatrist.

"Recovery area" means a room or limited access area of an office dedicated to providing medical services to patients recovering from surgery or anesthesia.

"Regional anesthesia" means the administration of anesthetic agents to a patient to interrupt nerve impulses without loss of consciousness and includes epidural, caudal, spinal and brachial anesthesia.

"Special procedure" means patient care which requires entering the body with instruments in a potentially painful manner, or which requires the patient to be immobile, for a diagnostic or therapeutic procedure requiring anesthesia services; for example, diagnostic or therapeutic endoscopy; invasive radiologic procedures; pediatric magnetic resonance imaging; manipulation under anesthesia (MUA) or endoscopic examination with the use of general anesthetic.

"Supervision" means responsibility by a credentialed physician who is immediately available to oversee the administration and monitoring of anesthesia by health care personnel authorized by this rule to render anesthesia services in an office.

"Surgery" means a manual or operative procedure, including the use of lasers, performed upon the body for the purpose of preserving health, diagnosing or treating disease, repairing injury, correcting deformity or defects, prolonging life or relieving suffering. Surgery includes, but is not limited to: incision or curettage of tissue or an organ; suture or other repair of tissue or an organ; a closed or open reduction of a fracture or extraction of tissue from the uterus.

"Topical anesthesia" means an anesthetic agent applied directly or by spray to the skin or mucous membranes, intended to produce a transient and reversible loss of sensation to a circumscribed area.

13:35–4A.4 Policies and procedures requirements

(a) Practitioners who perform surgery (other than minor surgery) or special procedures and physicians who administer or supervise the administration or monitoring of anesthesia services in an office shall establish written policies and procedures concerning the following:

1. The specific surgical or special procedures which may be performed in the office;

2. The specific anesthesia services which may be performed in the office;

3. The responsibilities of the health care personnel providing services to patients in the office;

4. The infection control practices to be followed, including lawful disposal of hazardous waste;

5. The procedures to be followed in the event that a patient experiences a complication;

6. The procedures to be followed if the patient requires transport for emergency services, including the identity and telephone numbers of the ambulance service if one is to be utilized and the hospital to which the patient is to be transported, and the functions to be undertaken by health care personnel until a transfer of the patient is completed;

7. The procedures to be followed in the event that a surgery or special procedure needs to be terminated because of an equipment malfunction or other complication;

8. The procedures to be followed while a patient is recovering in the office;

9. The objective criteria for discharging patients; and

10. The procedures to be followed to review records, and to ensure follow-up on complications and outcomes.

(b) The written policies and procedures shall also contain the identity of the specific practitioners within the office who are responsible for ensuring that:

1. All healthcare personnel providing services to patients possess the qualifications required by this subchapter and are currently licensed, registered or certified, as applicable;

2. All equipment and instruments utilized in the performance of surgery are maintained in proper working order and in accordance with such sterilization techniques as are required for safe medical practice;

3. All equipment and safety systems utilized in the administration and monitoring of anesthesia as required by N.J.A.C. 13:35–4A.14 are maintained in proper working order;

4. All emergency equipment and supplies as required by N.J.A.C. 13:35–4A.13 are available and are not outdated; and

5. All medical records are audited on at least an annual basis to assess quality of care and complications.

(c) The written policies and procedures are to be reviewed annually and revised as needed with the person conducting the review or making the revision recording the date thereof.

(d) Written policies and procedures shall be presented to the Board upon request.

13:35–4A.5 Duty to report incidents related to surgery, special procedures or anesthesia in an office

Any incident related to surgery, special procedures or the administration of anesthesia within the office which results in a patient death, transport of the patient to the hospital for observation or treatment for a period in excess of 24 hours, or a complication or untoward event as defined in N.J.A.C. 13:35–4A.3, shall be reported to the Executive Director of the Board within seven days, in writing and on such forms as shall be required by the Board. Such reports shall be investigated by the Board and will be deemed confidential pursuant to N.J.S.A. 45:9–19.3.

13:35–4A.6 Standards for practitioners performing surgery and special procedures in an office; credentials necessary; pre-procedure counseling; patient records; recovery and discharge

(a) A practitioner who performs surgery (other than minor surgery) or special procedures in an office requiring the administration of anesthesia services shall be credentialed to perform that surgery or special procedure by a hospital. If a practitioner is not credentialed but wishes to perform surgery or special procedures in an office, the practitioner shall apply to the Board pursuant to N.J.A.C. 13:35–4A.12 to seek Board-approved credentialing.

(b) Before a credentialed practitioner may perform surgery (other than minor surgery), or special procedures, the practitioner shall have:

1. A written transfer agreement with a licensed hospital which can be reached within 20 minutes during all hours in which surgery or special procedures are performed in the office, if the hospital where the practitioner is credentialed is not reachable within 20 minutes or if the practitioner is credentialed by the Board; and

2. A written policy for handling emergency transport to a hospital at which the practitioner is credentialed through 9–1–1 call or a written transfer agreement with a licensed ambulance service which assures immediate transport of patients experiencing complications to the hospital at which the practitioner has established a transfer agreement. The written transfer agreement shall be posted in the office and all health care personnel in the office shall specifically be informed of the procedure to be followed.

(c) A practitioner who performs surgery (other than minor surgery) or special procedures in an office requiring the administration of anesthesia services shall provide pre-procedure counseling and preparation as follows:

1. The practitioner shall appropriately assess, or review a referring physician's assessment of, the physical condition of the patient on whom surgery or a special procedure is to be performed. The practitioner shall refer a patient who, by reason of pre-existing medical or other conditions, is at undue risk for complications (for example, morbidly obese patients; patients with severe cardiac, pulmonary, airway or neurological problems; substance abusers) to an appropriate specialist for a pre-procedure consultation, or to another treatment setting or other appropriate facility for performance of the surgery or special procedure. Only patients with a physical status classification of I or II are appropriate candidates for an office surgical or special procedure for which general or regional anesthesia are to be used. Patients with a physical status classification of III are appropriate candidates for conscious sedation;

2. A history and physical examination shall be performed within the 14 days preceding the proposed surgery either by the practitioner performing the surgery or procedure (as appropriate to that practitioner's scope of practice) or by another physician or physician assistant under the supervision of a physician. Necessary laboratory tests, as guided by the patient's underlying medical condition, shall be conducted within seven days preceding the proposed surgery;

3. The risks and benefits of the surgery or special procedure and alternative methods or treatments shall be fully explained by the practitioner or other health care personnel, and written informed consent for the specific surgery or special procedure contemplated shall be obtained from the patient, guardian or authorized representative;

4. An appropriate fasting protocol shall be explained and provided to the patient;

5. If the history and physical are not done on the same day as the procedure, an interim assessment shall be performed by the practitioner or a physician assistant under the supervision of a physician immediately prior to the procedure, which assessment shall be documented and dated; and

6. Prior to surgery, the practitioner shall ensure that the patient removes all cosmetics, jewelry, contact lenses, dental appliances and prosthetic devices which might reasonably jeopardize patient safety.

(d) A practitioner who performs surgery (other than minor surgery) or special procedures in an office requiring the administration of anesthesia services shall ensure the following during recovery and prior to discharge:

1. Immediately after the surgery or special procedure, the patient shall be evaluated by either the practitioner who performed the surgery or the physician or CRNA who administered the anesthesia;

2. At least one practitioner shall remain on the premises until the patient is discharged from the recovery area;

3. The patient shall be provided with written and verbal instructions for follow-up care and with advice concerning possible complications; and

4. The patient shall be discharged into the company of a responsible individual.

(e) Practitioners who perform surgery (other than minor surgery) or special procedures in an office shall prepare a patient record which shall include the following:

1. A pre-procedure medical history and physical, appropriate to the practitioner's scope of practice, including such data as allergies, physical and mental impairments, vital signs, drug use, mobility limitations and, as applicable, electrocardiogram results, radiologic findings, laboratory values and the identity of the examining practitioner;

2. Documentation reflecting that informed consent has been obtained;

3. A description of the surgery or special procedure performed, including pre-operative diagnosis, techniques used, names and titles of medical personnel participating, complete findings, post-operative diagnosis, and any unusual occurrence, complications or untoward events. Where similar procedures are performed at the office routinely, partially pre-printed forms may be utilized as a guide, provided that original data and conclusions applicable to the specific patient are contemporaneously entered to create a complete report;

4. A post-procedure note, entered prior to discharge from the office, which shall include at least such post-procedure data as the patient's general condition, vital signs, any treatments ordered, and all drugs prescribed, administered or dispensed including dosages, quantities and strengths;

5. The identity of healthcare personnel providing services, as evidenced by a legible signature following that staff member's notation in the patient's record; and

6. The plan for follow-up care and documentation of results of follow-up efforts.

Public Notice: Suspension of enforcement.
See: 30 N.J.R. 4485(b).

13:35–4A.7 Standards for physicians administering or supervising the administration of anesthesia services in an office; pre-anesthesia counseling; patient monitoring; recovery; patient record; discharge of patient

(a) A physician who administers or supervises the administration and monitoring of anesthesia services in an office shall be credentialed by a hospital to provide the particular anesthesia service. If a physician is not credentialed but wishes to administer or supervise the administration of anesthesia services, the physician shall apply to the Board pursuant to N.J.A.C. 13:35–4A.12 to seek Board-approved credentialing.

(b) A physician who administers or supervises the administration or monitoring of anesthesia services in an office shall provide pre-anesthesia counseling and preparation as follows:

1. Any patient to whom anesthesia services are to be provided shall be appropriately screened by the individual administering anesthesia services. Patients who, by reason of pre-existing medical or other conditions, are at undue risk for complications (for example, morbidly obese patients; patients with severe cardiac, pulmonary, airway or neurological problems; substance abusers) shall be referred to an appropriate specialist for a pre-procedure consultation or to another treatment setting or other appropriate facility. Only patients with a physical status classification of I or II are appropriate candidates for an office surgical or special procedure for which general or regional anesthesia are to be used. Patients with a physical classification of III are appropriate candidates for conscious sedation;

2. A medical history shall be conducted including a review of abnormalities in any organ system; previous adverse experience with anesthesia services; any history of stridor, snoring or sleep apnea, or of advanced rheumatoid arthritis or spinal disorder; current medications being taken; drug allergies; or any history of substance abuse;

3. The risks and benefits of anesthesia and alternative methods or treatments shall be fully explained by the physician or certified registered nurse anesthetist (CRNA), and written informed consent for the anesthesia services contemplated shall be obtained from the patient, guardian or authorized representative;

4. An appropriate fasting protocol shall be explained and timely provided to the patient, guardian or authorized representative;

5. Pre-procedure laboratory test results shall be reviewed and recorded;

6. A focused physical examination shall be conducted, including auscultation of the heart and lungs, and an evaluation of the airway, particularly an assessment of anatomical abnormalities (that is, jaw, mouth, head and neck) which may increase the likelihood of an airway obstruction;

7. A plan of anesthesia shall be developed by the physician administering anesthesia services or personally reviewed by the supervising physician if the plan has been developed by other authorized personnel;

8. A patient shall be counseled prior to the procedure that the procedure will be canceled if the patient plans to drive home after the procedure and has not made arrangements to be accompanied home by an individual who accepts responsibility for the patient; and

9. Prior to the administration of anesthesia services, the physician shall ensure that the patient removes all cosmetics, jewelry, contact lenses, dental appliances and prosthetic devices which might reasonably jeopardize patient safety.

(c) A physician who administers or supervises the administration or monitoring of any anesthesia services (general anesthesia, regional anesthesia or conscious sedation) in an office shall ensure that monitoring is provided as follows when clinically feasible for the patient:

1. Direct observation of the patient and, to the extent practicable, observation of the patient's responses to verbal commands;

2. Pulse oximetry shall be performed continuously. Any alternative method of measuring oxygen saturation may be substituted for pulse oximetry if the method has been demonstrated to have at least equivalent clinical effectiveness;

3. An electrocardiogram monitor shall be used continuously on the patient;

4. The patient's blood pressure, pulse rate, and respirations shall be measured at least every five minutes; and

5. The body temperature of a pediatric patient shall be measured continuously.

(d) In addition to the monitoring requirements in (c) above, a physician who administers or supervises the administration or monitoring of general anesthesia services in an office shall ensure that additional monitoring is provided as follows:

1. End-tidal carbon dioxide monitoring shall be performed on the patient continuously during endotracheal anesthesia;

2. An in-circuit oxygen analyzer shall be used to monitor the oxygen concentration within the breathing circuit, displaying the oxygen percent of the total inspiratory mixture;

3. A respirometer (volumeter) shall be used to measure exhaled tidal volume whenever the breathing circuit of a patient allows;

4. The body temperature of each patient shall be measured continuously; and

5. An esophageal or precordial stethoscope shall be available and utilized on the patient when indicated.

(e) Physicians who administer or supervise the administration or monitoring of anesthesia services in an office shall establish within that office a recovery area and ensure that recovery services are provided as follows:

1. Immediately after the surgery or special procedure, the practitioner who performed the surgery or the individual who administered the anesthesia shall evaluate the patient;

2. The individual responsible for the administration or monitoring of anesthesia shall accompany the patient into the recovery area;

3. Healthcare personnel who were present with the patient at the anesthetizing location shall remain with the patient in the recovery area at least until the patient's vital signs, including blood pressure, pulse, and respiration are recorded;

4. An oral report on the patient's condition shall be given to any healthcare personnel in the recovery area not present in the anesthetizing location;

5. Whenever a patient is present in the recovery area, the recovery area shall be staffed by at least one registered professional nurse or physician assistant who is trained and experienced in advanced cardiac life support and post anesthesia care. This includes recognizing the actions and interactions of anesthetic techniques, managing of airway and ventilatory function and managing patients during altered states of consciousness, as well as cardiopulmonary resuscitation, monitoring of cardiac function, recognition of arrhythmias, and the recognition and treatment of life-threatening emergencies. For every additional two patients present in the recovery area, there shall be one additional professional registered nurse or physician assistant present, having the requisite training;

6. In addition to the healthcare personnel specified in (e)5 above, at least one other additional healthcare personnel shall remain on site in a position to render immediate assistance whenever a patient is in the recovery room; and

7. From the time of entry into the recovery area until discharge, the condition of the patient shall be regularly evaluated and the patient's vital signs checked at least every five minutes. If the patient's vital signs remain unchanged, documentation can be reflected with a straight line on the chart; any changes shall be specifically noted. Electrocardiographic monitoring and pulse oximetry monitoring shall be continued in the recovery area for each patient who has received anesthesia services.

(f) A physician who administers or supervises the administration of anesthesia may allow a dischargeable patient to remain in the office overnight for a period not to exceed 23 hours in a special overstay area, if the patient may benefit from additional nursing care because of symptoms such as nausea. The special overstay area shall be staffed by at least one registered professional nurse or physical assistant for each two patients staying overnight. The patient's vital signs shall be taken and recorded at least every four hours. A physician shall be able to reach the office within 20 minutes at all times that a patient is remaining overnight in the office. Appropriate sleeping accommodations, as well as food, shall be provided for the patient.

(g) Physicians who administer or supervise the administration of anesthesia services in an office shall ensure the following prior to discharge:

1. That at least one practitioner shall remain on the premises until the patient is discharged to home or transferred to the special overnight stay area;

2. That the patient shall be given written and verbal instructions for follow-up care and advice concerning complications;

3. That before the patient leaves the office or is transferred to the special overnight stay area, the physician shall evaluate the patient and shall review and sign the post-anesthesia record; and

4. That the patient shall be discharged only into the company of a responsible individual.

(h) Physicians who administer or supervise the administration or monitoring of anesthesia services in an office shall ensure that a patient record is prepared which contains the following:

1. A pre-anesthesia note, including pre-anesthesia vital signs (blood pressure, temperature, respiration rate and pulse), and a plan of anesthesia;

2. Signed informed consent from the patient, guardian or authorized representative;

3. An intra-procedure record which includes anesthetic agents and techniques used, any changes since the inception of anesthesia in vital signs, oxygen saturation, electrocardiogram interpretation, temperature and end-tidal carbon dioxide measurements when required, as well as the volume and type of fluids administered;

4. A post-anesthesia note entered prior to the patient's discharge from the office which shall include at least such post-procedure data as the patient's vital signs and general condition, respiration, consciousness, circulation, special problems or precautions and a summary of fluids received during surgery or any complication or untoward event which occurred;

5. The identity of each healthcare personnel providing services, as evidenced by the staff member's legible signature on each entry made by that staff member in the patient record; and

6. The plan for follow-up care.

Public Notice: Suspension of enforcement.
See: 30 N.J.R. 4485(b).

13:35–4A.8 Performance of general anesthesia; authorized personnel

(a) General anesthesia shall be administered and monitored in an office only by the following individuals:

1. A physician credentialed by a hospital or the Board pursuant to N.J.A.C. 13:35–4A.12 to provide general anesthesia services and who, during every consecutive three-year period beginning July 1, 1998, completes at least 60 Category I hours of continuing education courses in anesthesia, as approved by the Accreditation Council for Continuing Medical Education or the American Osteopathic Association; or

2. A certified registered nurse anesthetist (CRNA), under the supervision of a physician eligible under (a)1 above.

(b) The administration and monitoring of general anesthesia shall be provided by an individual who meets the requirements of (a) above and who is at all times present in the anesthetizing location and who is not the practitioner performing the surgery or special procedure.

(c) When the administration and monitoring of general anesthesia is being performed by a CRNA, the supervising physician shall be physically present and available to immediately diagnose and treat the patient in an emergency without concurrent responsibilities to administer anesthesia or perform surgery, other than minor surgery.

(d) An advanced cardiac life support-trained physician, registered professional nurse or physician assistant shall remain with the patient at all times that the patient is receiving or recovering from general anesthesia.

Public Notice: Suspension of enforcement.
See: 30 N.J.R. 4485(b).

13:35–4A.9 Administration of regional anesthesia; authorized personnel

(a) Regional anesthesia shall be administered and monitored in an office only by the following individuals:

1. A physician credentialed by a hospital or the Board pursuant to N.J.A.C. 13:35–4A.12 to provide regional anesthesia and who, during every consecutive three-year period beginning July 1, 1998, completes at least eight Category I hours of continuing education courses in anesthesia exclusively or, in anesthesia as it relates to a specific field of practice, as approved by the Accreditation Council of Continuing Medical Education or the American Osteopathic Association; or

2. A certified registered nurse anesthetist (CRNA), under the supervision of a physician eligible under (a)1 above.

(b) The administration and monitoring of regional anesthesia shall be provided by an individual who meets the requirements of (a) above and who is at all times present in the anesthetizing location and who is not the practitioner performing the surgery or the special procedure.

(c) When the administration and monitoring of regional anesthesia is being performed by a CRNA, the supervising physician shall be physically present and available to immediately diagnose and treat the patient in an emergency, without concurrent responsibilities to administer anesthesia or perform surgery, other than minor surgery.

(d) An advanced cardiac life support trained physician, registered professional nurse or physician assistant shall be present at all times when a patient is receiving or recovering from regional anesthesia.

Public Notice: Suspension of enforcement.
See: 30 N.J.R. 4485(b).

13:35–4A.10 Administration of conscious sedation; authorized personnel

(a) Conscious sedation shall be administered in an office only by the following individuals:

1. A physician credentialed by a hospital or the Board pursuant to N.J.A.C. 13:35–4A.12 to provide conscious sedation and who, during every consecutive three-year period beginning July 1, 1998, completes at least eight hours of continuing education courses in any anesthesia services, including conscious sedation exclusively, or in anesthesia as it relates to the physician's field of practice, as approved by the Accreditation Council on Continuing Medical Education or the American Osteopathic Association;

2. A certified registered nurse anesthetist (CRNA), under the supervision of a physician eligible under (a)1 above; or

3. A registered professional nurse or physician assistant, who is trained and has experience in the use of anesthetic agents, at the specific direction of a physician eligible under (a)1 above, but only for the purpose of administering through an established intravenous line, a specifically prescribed supplemental dose of conscious sedation which was selected and initially administered by the physician who remains continuously present in the procedure room.

(b) A patient under conscious sedation shall be monitored in an office by a physician, CRNA, or a registered professional nurse or physician assistant who has training and experience in the use of monitoring devices, under the supervision of a physician eligible under (a)1 above, to administer conscious sedation.

(c) The monitoring of a patient under conscious sedation shall be provided by an individual who meets the requirements of (b) above and who is at all times present and who is not the practitioner who is performing the surgery or special procedure.

(d) When the administration and monitoring of conscious sedation is being performed by a CRNA, or when the monitoring is being performed by a registered professional nurse or physician assistant, the supervising physician shall be physically present, but may be concurrently responsible for patient care.

(e) An advanced cardiac life support-trained physician, registered nurse or physician assistant shall be present at all times when a patient is receiving or recovering from the administration of conscious sedation.

Public Notice: Suspension of enforcement.
See: 30 N.J.R. 4485(b).

13:35–4A.11 Administration of minor conduction blocks; authorized personnel

(a) Minor conduction blocks shall be administered in an office for surgery (other than minor surgery) or special procedures only by the following individuals:

1. A practitioner;

2. A certified registered nurse anesthetist (CRNA); or

3. A certified nurse midwife, a nurse practitioner, clinical nurse specialist or physician assistant who has training and experience in the administration of minor conduction blocks.

(b) A practitioner shall be physically present on the premises and shall supervise the administration of minor conduction blocks.

13:35–4A.12 Alternative credentialing procedure (Reserved)

13:35–4A.13 Requirements for anesthetizing locations; emergency equipment and supplies

(a) An office in which any anesthesia services are to be provided shall be equipped with the appropriate medical equipment, supplies and pharmacological agents which are required or might be needed in order to provide anesthetic and recovery services, as well as to treat any likely complication which might arise as a result of these services, in such manner that complies with the accepted standards of care as set forth in the "Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists" of the American Society of Anesthesiology (520 Northwest Highway, Park Ridge, IL 60068–2573), appearing in Anesthesiology, Vol. 84, No. 2, February 1996, incorporated herein by reference, as amended and supplemented.

(b) An office in which general anesthesia is to be provided shall be equipped with the following additional emergency equipment:

1. Special equipment to manage a difficult airway;

2. Drugs and equipment to treat malignant hyperthermia, shock and anaphylactic reactions;

3. A precordial stethoscope or esophageal stethoscope; and

4. A peripheral nerve stimulator.

(c) In an office in which anesthesia services are to be provided to infants and children, the required emergency equipment shall be appropriately sized for a pediatric population.

13:35–4A.14 Requirements for anesthetizing locations; safety systems, monitoring devices

(a) An office in which anesthesia services are to be provided shall be equipped with the following safety systems and monitoring devices:

1. A pulse oximeter with appropriate alarms (or an equivalent method of measuring oxygen saturation);

2. A continuous electrocardiograph with paper recorder;

3. Devices for measuring blood pressure, heart rate and respiratory rate;

4. A defibrillator; and

5. An accepted method of identifying and preventing the interchangeability of gases, whenever gases are used.

(b) Any anesthesia machine or built-in anesthesia system utilized in the administration of general anesthesia in an office shall be equipped with the following:

1. An end-tidal carbon dioxide monitor (capnograph);

2. An in-circuit oxygen analyzer designed to monitor the oxygen concentration within the breathing circuit by displaying the oxygen percent of the total inspiratory mixture;

3. A respirometer (volumeter) measuring exhaled tidal volume;

4. Oxygen failure-protection devices ("fail-safe" system) which have the capacity to announce a reduction in oxygen pressure and, at lower levels of oxygen pressure, to discontinue other gases when the pressure of the supply of oxygen is reduced;

5. A vaporizer exclusion ("interlock") system, which ensures that only one vaporizer, and therefore only a single anesthetic agent, can be actuated on any anesthesia machine at one time;

6. Pressure-compensated anesthesia vaporizers, designed to administer a constant non-pulsatile output, which shall not be placed in the circuit downstream of the oxygen flush valve;

7. Flow meters and controllers, which can accurately gauge concentration of oxygen relative to the anesthetic agent being administered and prevent oxygen mixtures of less than 21 percent from being administered;

8. Alarm systems for high (disconnect), low (subatmospheric), and minimum ventilatory pressures in the breathing circuit for each patient under general anesthesia; and

9. A gas evacuation system.

(c) Anesthesia equipment used in the administration of anesthesia services for the performance of MRI shall be made of nonferrous materials to ensure the quality of the diagnostic studies. Monitoring techniques shall take into consideration the unique characteristics of the magnetic field.

(d) In an office in which anesthesia services are to be provided to infants and children, the required monitoring devices shall be appropriately sized for a pediatric population.

13:35–4A.15 Equipment requirements for recovery areas

(a) In any office in which anesthesia services are to be provided, a recovery area adjacent to, or within the operating room, shall be established. Access to the recovery area shall be limited to staff and family or significant others, as appropriate. The recovery area shall be equipped with at least the following:

1. A pulse oximeter with appropriate alarms (or an equivalent method of measuring oxygen saturation);

2. A continuous electrocardiogram monitor with paper recorder;

3. A defibrillator;

4. Drugs adequate for cardiopulmonary resuscitation;

5. Emergency equipment for intubation and extubation; and

6. Basic airway management equipment as follows:

i. A source of compressed oxygen (tank with regulator or pipeline supply with flowmeter);

ii. A source of suction, suction catheters, Yankauer-type suction;

iii. Face masks (in appropriate sizes for the patient population);

iv. A self-inflating breathing bag-valve set, oral and nasal airways and lubricant; and

v. A method by which oxygen can be administered (for example, masks, nasal cannulas).

13:35–4A.16 Maintenance requirements

(a) All equipment as required by N.J.A.C. 13:35–4A.13 through 4A.15 is subject to inspection and maintenance as follows:

1. A record shall be maintained of all service and maintenance including that performed on all anesthesia machines, ventilators and vaporizers. The record shall include machine identification; the name of the servicing agent; the problem, if any; the work performed and the date of the work. Maintenance shall conform with maintenance requirements established by the machine manufacturer. Credentials of each servicing agent shall be approved by the machine manufacturer or shall be reasonably determined by the permit holder to be equivalent to the credentials of the manufacturer's servicing agents.

2. All anesthesia equipment shall be inspected fully at the beginning of each day of use by a physician, or a certified registered nurse anesthetist (CRNA), under the supervision of a physician, credentialed to utilize that equipment. A record of each such inspection, including the date of the inspection and the identity of the individual conducting the inspection, shall be maintained for each machine. The inspection shall conform with a checklist that is supplied by the manufacturer of the machine, or issued by the Federal Food and Drug Administration or, alternatively, reasonably developed by the physician and set forth in an appropriate written protocol.

3. Before each use, the physician or the CRNA who is to administer the anesthesia shall inspect all anesthesia equipment. Inspections shall be documented on the anesthesia record.

(b) A physician shall not permit anyone to tamper with a safety system or any monitoring device or disconnect an alarm system.

13:35–4A.17 Compliance timetables

(a) (Reserved)

(b) A practitioner or physician who offers anesthesia services in an office setting shall purchase and install the equipment and safety systems, as required pursuant to this rule , no later than December 15, 1998. Alternatively, a practitioner or physician shall have written proof that by October 15, 1998, an order for such equipment has been transmitted to and received by a manufacturer or legitimate vendor of the equipment. Such proof shall include an anticipated date of delivery. All such equipment shall be properly installed in a timely fashion after delivery and shall be used in conformance with this section, no later than December 15, 1998.

(c) All other requirements of this subchapter shall be effective June 15, 1998.

13:35–4A.18 Enforcement

(a) Any violation of N.J.A.C. 13:35–4A.3 through 4A.17 shall be deemed to be professional misconduct within the meaning of N.J.S.A. 45:1–21(e) and may further constitute violation of other law or rule, as applicable to the circumstances.

SUBCHAPTER 5. EYE EXAMINATIONS; EYEGLASSES

Subchapter Historical Note

Petition for Rulemaking. See: 30 N.J.R. 3340(b), 30 N.J.R. 3867(a), 31 N.J.R. 905(a), 31 N.J.R. 2276(a), 32 N.J.R. 609(a), 32 N.J.R. 1260(a).

13:35–5.1 Minimum eye examination; contact lenses

(a) Physicians licensed to practice medicine and surgery, when performing an eye examination for the purpose of prescribing corrective lenses, shall fully and adequately disclose to the patient the limited purpose of the eye examination. The physician shall perform, and keep a complete record of, physical examination of the patient which shall include:

1. A complete history of visual aberrations;

2. A determination of visual acuity in each eye separately;

3. A cover test, distance and near, and a determination of muscle balance or imbalance;

4. An ophthalmoscopic examination and a determination of any abnormalities of lids, cornea, pupils, lens, vitreous and fundus. A record entry of "negative" or "clear" should be made if no pathology is found.

(b) Upon observing positive findings of ocular disease or abnormality, the physician shall disclose his findings to the patient and suggest an appropriate course of action.

(c) An ophthalmologist shall release a copy of a patient's contact lens prescription directly to a patient or to a licensed ophthalmologist, a licensed optometrist, or a New Jersey licensed ophthalmic dispenser upon either the oral or written request of a patient or a professional acting on a patient's behalf, provided that the prescription is not more than two years old.

Amended by R.1999 d.356, effective October 18, 1999.
See: 31 N.J.R. 1742(a), 31 N.J.R. 3117(a).
Rewrote (c).

13:35–5.2 Minimum standards and tolerances of optical lenses

(a) Every pair of lenses, spectacles, eyeglasses or appurtenances thereto, prepared for or dispensed to the intended wearers from written prescriptions of physicians duly licensed to practice their profession, or duplication, replacements, reproductions or repetitions, must conform to the following minimum standards and tolerances:

PHYSICAL QUALITY AND APPEARANCE

1. Surface imperfections

TOLERANCE: No pits, scratches (other than hairline), grayness or watermarks shall be acceptable.

2. Glass defects

TOLERANCE: No bubbles, striae and inclusions shall be acceptable.

3. Localized power errors

TOLERANCE: Waves found by visual inspection shall be passable if no deterioration in image quality is found when the localized area is examined with a standard lens measuring instrument.

4. Refractive powers

TOLERANCE: 0.0. to 6.00, + or −0.12.

6.25 to 12.00, 2 per cent of power.

Above 12.00, + or −0.25.

Maximum cylinder power variation + or −0.12.

5. Refractive power addition

TOLERANCE: + or −0.12.0.

6. Cylinder Axis

TOLERANCE: 0.12 to 0.37 + or −3 degrees.

0.50 to 1.00, + or −2 degrees.

1.12 on up, + or −1 degree.

7. Prism power and location of specified optical center

TOLERANCE: Vertical + or −0.25 prism for each lens or a total of 0.50 prism imbalance. Horizontal + or −0.25 prism for each lens or a total of 0.50 prism imbalance.

8. Segment size

TOLERANCE: + or −0.5 mm. Pair must be symmetrical upon visual inspection.

9. Segment location

TOLERANCE: As specified within + or −0.5 mm.

10. Lens size:

i. Rimless

TOLERANCE: + or −0.5 mm;

ii. Bevel, for plastic frames

TOLERANCE: + or −0.5 mm;

iii. Bevel, for metal frames

TOLERANCE: To fit standard specified frame. Lens shape must match. Edges must be smooth and straight and sharp edge must be removed.

11. Heat-treated and chemically-treated industrial safety eyewear

TOLERANCE: Tolerance for power, size and the like shall be as above, except that minimum thickness edge or center shall meet the requirements of American Standard Z80.1–1972 and subsequent revisions.

12. Heat-treated and chemically-treated dress eyewear

TOLERANCE: Tolerance for power, size and the like shall be as above, except that minimum thickness edge or center shall meet the requirements of American Standard Z80.1–1972 and subsequent revisions.

(b) Provided, however, that nothing herein shall be construed to prohibit deviations beyond those established by this rule, provided that good medical cause exists therefor.

SUBCHAPTER 6. GENERAL RULES OF PRACTICE

13:35–6.1 Practice identification

(a) A physician with a plenary license to practice medicine and surgery in the State of New Jersey shall make representation for professional purposes (office identification, stationery, professional cards, signature on insurance claim forms, education, etc.) in a manner clearly indicating such plenary licensure and/or practice specialty; for example: Dr. John Doe, physician and surgeon; or Dr. Jane Smith, physician; or Dr. John Doe, surgeon; or Dr. Jane Smith, licensed to practice medicine and surgery; or Dr. Jane Doe, physician, practice limited to (name of specialty); or similar accurate descriptive terms. In addition to or as an alternative to these titles, a licensee may use the standard and accepted abbreviation of professional degree conferred by the medical school; that is, John Smith, M.D.; Jane Smith, D.O., as the case may be.

(b) An applicant or current licensee who is a graduate of both an A.M.A.-accredited allopathic professional school and an A.O.A.-accredited osteopathic professional school may elect to use either M.D. or D.O. as the primary abbreviation following the name and shall notify the Board of such election.

(c) A licensee with a limited license issued by the Board shall identify himself or herself for professional purposes in a manner clearly indicating the licensed profession by name or by using the recognized and accepted abbreviation of the degree actually conferred by the professional college; for example: Jane Smith, Podiatrist or Jane Smith, D.P.M.; John Doe, Bioanalytical Laboratory Director or John Doe, B.L.D. or John Doe, Specialty Bioanalytical Laboratory Director in Chemistry, etc.; Jane Smith, Certified Nurse Midwife or C.N.M.

(d) The use of any letters in immediate conjunction with the name of a licensee shall be deemed a representation of earned academic professional degree. Any such degree shall have been conferred by an educational institution authorized by the appropriate higher education authorities in its state of domicile to do so. The licensee may also list abbreviations of membership in non-profit incorporated professional societies.

(e) All representations by licensees of degree abbreviations or of professional society affiliations shall comply with this rule, and any use of an academic degree or professional or membership abbreviation not in accordance with these standards shall be deemed a misrepresentation and professional misconduct.

(f) All professional representations, including, but not limited to, letterhead stationery, business cards and claim forms, shall identify the street address(es) of the licensee's professional practice location(s). A post office box, whether for general mailing or for billing purposes, may be listed on the professional representation as a preferred mailing address but the professional representation shall also include the licensee's professional practice location(s).

New Rule, R.1985 d.103, effective March 4, 1985.
See: 16 N.J.R. 3178(a), 17 N.J.R. 606(a).
This adoption repealed former rule "Degree designation".
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.154, effective May 17, 1999.
See: 30 N.J.R. 4317(a), 31 N.J.R. 1360(b).
Added (f).

13:35–6.2 Pronouncement of death

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