AGENDA
May 17, 2021
Virtual Meeting

Virginia Department of
Health Professions

MEETING OF THE VIRGINIA BOARD OF DENTISTRY
REGULATORY-LEGISLATIVE COMMITTEE MEETING

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- **PUBLIC COMMENT:** Comments will be received during the public comment period at the beginning of the meeting from those persons who have submitted an email to sandra.reen@dhp.virginia.gov **no later than 1:00 PM on Friday, May 14, 2021** indicating that they wish to offer comment. Comment may be offered by these individuals when their names are announced by the Chair. Comments must be restricted to 3-5 minutes each.
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Virginia Department of Health Professions

VIRTUAL MEETING

VIRGINIA BOARD OF DENTISTRY
REGULATORY-LEGISLATIVE COMMITTEE MEETING
AGENDA
MONDAY, MAY 17, 2021

TIME		PAGE
1:30 p.m.	**Call to Order – Dr. Sandra J. Catchings, Vice-President, Chair**	
	Roll Call of Participants – Sandra K. Reen, Executive Director	
	Public Comment – Dr. Catchings	
	Approval of Minutes	
	• April 23, 2021	1-11
	• Virginia Commonwealth University Reference Documents:	
	○ Specifications for a Digital Design Lab Technician	12-14
	○ Digital Scan Qualities	15-17
	• Digital Scan Flowchart	18
	• Proposed Regulations	19-25
	• Proposed Work Order Requirements	26-27
	• Teledentistry Legislation	28-30
	• Sleep Apnea	31-42
	Next Meeting	
	Adjourn	

VIRGINIA BOARD OF DENTISTRY
REGULATORY-LEGISLATIVE COMMITTEE MEETING MINUTES
April 23, 2021

TIME AND PLACE: The virtual meeting of the Regulatory-Legislative Committee was called to order at 1:00 p.m., on April 23, 2021.

CALL TO ORDER: Dr. Catchings called the meeting to order.

Consistent with Amendment 28 to HB29 (the Budget Bill for 2018-2020) and the applicable provisions of § 2.2-3708.2 in the Freedom of Information Act, the Committee is convening today's meeting virtually to consider such regulatory and business matters as are presented on the agenda necessary for the Committee to discharge its lawful purposes, duties, and responsibilities.

Dr. Catchings provided the Board members, staff, and the public with contact information should the electronic meeting be interrupted.

COMMITTEE MEMBERS PRESENT VIRTUALLY:
Sandra J. Catchings, D.D.S., Chair
Patricia B. Bonwell, R.D.H., PhD
Sultan Chaudhry, D.D.S.
J. Michael Martinez de Andino, J.D.

OTHER PARTICIPATING BOARD MEMBERS PRESENT VIRTUALLY:
Margaret F. Lemaster, R.D.H.

STAFF PRESENT VIRTUALLY:
Sandra K. Reen, Executive Director, Board of Dentistry
Donna M. Lee, Discipline Case Manager, Board of Dentistry
Barbara Allison-Bryan, M.D., Chief Deputy Director, Department of Health Professions
Elaine Yeatts, Senior Policy Analyst, Department of Health Professions
Rebecca Schultz, Policy Specialist, Department of Health Professions

COUNSEL PRESENT VIRTUALLY:
James E. Rutkowski, Assistant Attorney General

ESTABLISHMENT OF A QUORUM: A roll call of the Board members and staff was completed. With all members of the Committee present, a quorum was established.

PUBLIC COMMENT: Dr. Catchings explained the parameters for public comment and opened the public comment period. Dr. Catchings also stated that written comment was received from Alexander T. Vaughan, D.D.S., which was sent by email to Committee members and will be posted with the draft minutes.

Alexander T. Vaughan, D.D.S., Dental Director, Virginia Total Sleep – Dr. Vaughan provided an overview regarding the two main modalities of sleep testing; a polysomnogram and the home sleep apnea test. He reiterated that the American Academy of Dental Sleep Medicine position

paper states that ordering a home sleep apnea test is within the scope of dentistry and that only a sleep physician can render the diagnosis. Dr. Vaughan stated that he could not find a published opinion of the Board regarding whether home sleep apnea testing is within the scope of dentistry and suggested that an advisory panel be formed so that information could be provided from both sides to address the regulatory issue.

Gianna Nawrocki, American Association of Orthodontists (AAO) – Ms. Nawrocki provided comment on the proposed regulations for the digital scan technicians. She stated that in letter "A" of the draft regulations, AAO and VAO are listed as one of the sponsors that have an approved program available for digital scan technicians. Ms. Nawrocki informed the Committee that at this time and in the foreseeable future, the AAO and VAO do not have the intent nor resources to create a program, and including it in the regulations would be misleading to individuals in Virginia that want to become a digital scan technician. She requested that the regulation be revised.

Ms. Nawrocki further specified that In Section "C" of the draft regulations where it lists the requirements, the AAO would like to propose a requirement that the "supervising dentist shall be available to inspect and verify the appliance or aligner prior to the beginning of treatment." She indicated this is to make sure that the aligner fits perfectly and the scan was taken correctly and the dentist is responsible for the beginning of that treatment.

APPROVAL OF MINUTES:

Dr. Catchings asked if there were any edits or corrections to the October 23, 2020 minutes. Dr. Bonwell moved to approve the minutes as presented. Following a second, a roll call vote was taken. The motion passed.

COMMITTEE DISCUSSION/ACTION:

Regulatory Actions Chart. Ms. Yeatts stated that there were no changes to the chart distributed to the Committee. The following proposed regulations are currently at the Governor's Office:

- amendment to restriction on advertising dental specialties;
- waiver for e-prescribing; and
- technical correction to fees.

Protocols for remote supervision of VDH and DBHDS dental hygienists will be final on April 26, 2021 and will be effective May 25, 2021.

The administration of sedation and anesthesia regulations went into effect on March 17, 2021.

The education and training for dental assistants II regulations went into effect on March 31, 2021.

The training and supervision of digital scan technicians and the training in infection control are NOIRAs and the comment period ended on March 31, 2021.

Consideration of Revisions to Guidance Documents.

- **Guidance Document 60-5:** Auditing Continuing Education – Ms. Yeatts reviewed the proposed changes with the Committee. The Committee amended the guidance document to add that acknowledgement of completion of the continuing education audit should be sent to licensees.
- **Guidance Document 60-10:** Failure to Comply with Advertising Guidelines – Ms. Yeatts reviewed the proposed changes with the Committee.
- **Guidance Document 60-18:** Approved Template for Dental Appliance Work Order Forms - Ms. Reen explained the proposed changes to the Committee.
- **Guidance Document 60-19:** Approved Template for Dental Appliance Subcontractor – Ms. Reen reviewed proposed changes with the Committee.
- **Guidance Document 60-22:** Failure to comply with Insurance and Billing Practices – Ms. Yeatts reviewed the proposed changes with the Committee.

Dr. Chaudhry moved that the Committee recommend to the Board adoption of revised Guidance Document 60-5 as amended; Guidance Document 60-10; Guidance Document 60-18; Guidance Document 60-19; and Guidance Document 60-22. Following a second, a roll call vote was taken. The motion passed.

TRAINING IN INFECTION CONTROL – DENTAL ASSISTANTS:

Ms. Yeatts informed the Committee that there were comments submitted from different organizations, some in favor of the training in infection control for dental assistants and some in opposition to the training. Ms. Yeatts reviewed and discussed the proposed language options for the regulations with the Committee.

Dr. Bonwell moved that the Committee recommend to the Board the adoption of the following language, with the understanding that staff will do some wordsmithing: The supervising dentist shall be responsible for assuring that dental assistants have annual training in infection control standards required by OSHA and as recommended by the CDC. Newly hired DA I shall receive training within 60 days of hire. Documentation records should show date of hire and date of completion of initial and annual training for all assistants and be maintained for three years. Following a second, a roll call vote was taken. The motion passed.

TRAINING AND SUPERVISION OF DIGITAL SCAN TECHNICIANS:

Ms. Yeatts explained to the Committee that Legislation does not authorize the Board to license digital scan technicians, but the Board is required to approve a training program for them. After discussion, Ms. Reen suggested that each Committee member send her an email regarding their concerns or questions pertaining to digital scan technician regulations, and that another meeting be scheduled to discuss the Committee's concerns.

Dr. Catchings moved that each Committee member send an email to Ms. Reen by May 1, 2021, outlining their concerns or questions regarding the regulations for digital scan technicians, and then another meeting will be scheduled to discuss the information received by Ms. Reen. Following a second, a roll call vote was taken. The motion passed.

PULP CAPPING BY DENTAL ASSISTANTS II:

Ms. Yeatts provided information about the laws in other states regarding pulp capping, however, there was no regulatory action required by the Committee. The Committee discussed removing pulp capping as a procedure Dental Assistants II can do in the future. Ms. Reen stated to the Committee that there is direct and indirect pulp capping; and in discussions with teaching programs, it is the indirect pulp capping that is being taught where there is no exposure. Ms. Yeatts explained that pulp capping is allowed according to the current regulations and is not a procedure that can be taken away. Mr. Rutkowski concurred with Ms. Yeatts and stated there is no legal mechanism to remove the certificate once it is obtained by a Dental Assistant II.

Dr. Chaudhry moved that the Committee recommend to the Board that it initiate rulemaking by publishing a NOIRA to remove pulp capping from the scope of practice for Dental Assistants II. Following a second, a roll call vote was taken. The motion passed.

SLEEP STUDY PROTOCOLS:

Ms. Reen requested that the Committee provide direction on what it wants to do about sleep study protocols. She explained the fundamental question is what role dentists have in diagnosing patients, whether it is a sleep study done through a polysomnographer or a home sleep study, is it within the scope of practice of dentistry as defined in the statute. The practice of polysomnography is under the direction of a medical physician and dentists can refer for sleep study. There is no provision currently in place that says dentists can do limited home study and then make a dental diagnosis based on that. The issue is: Is sleep apnea a dental condition? Staff can research the topic and bring information back to the Committee and discuss at the upcoming meeting.

The Committee directed Board staff to conduct research on home sleep studies, how they are conducted, what the regulations are in other states; and once all the information is compiled, convene a meeting with the Committee.

ADJOURNMENT:

With all business concluded, the Committee adjourned at 3:27 p.m.

_____
Sandra J. Catchings, D.D.S., Chair

_____
Sandra K. Reen, Executive Director

_____
Date

_____
Date

Commonwealth of Virginia

Lee, Donna <donna.lee@dhp.virginia.gov>

FW: Public Comment for RLC

2 messages

Sandra Reen <Sandra.Reen@dhp.virginia.gov>
To: Donna Lee <donna.lee@dhp.virginia.gov>

Thu, Apr 22, 2021 at 12:21 PM

From: Alex Vaughan <drvaughan@vatotalsleep.com>
Sent: Thursday, April 22, 2021 11:46 AM
To: Sandra Reen <sandra.reen@dhp.virginia.gov>
Subject: Public Comment for RLC

Good Morning,

I would appreciate the opportunity to address the RLC at their upcoming meeting on Friday, April 23, 2021.

I have attached written comments to this e-mail as well as a copy of my prior comments related to Home Sleep Apnea Testing that I submitted to the entire Board at the last Business Meeting for reference.

Thank you very much,

Alex

Alexander T. Vaughan, DDS, MS

Diplomate, American Board of Orofacial Pain

Dental Director | Virginia Total Sleep | Orofacial Pain

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VS VIRGINIA TOTAL SLEEP

April 22, 2021

Dr. Sandra Catchings
Chair, Regulatory Legislative Committee
Virginia Board of Dentistry
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Dr. Catchings and Members of the Committee,

I write to you on behalf of myself and my patients in response to the request by the American Academy of Sleep Medicine regarding home sleep testing. I believe I may offer some clarifications as the specialty of orofacial pain typically encompasses dental sleep medicine as well.

I have included with this letter a copy of my past comments at the March 19, 2021 Board Business Meeting for reference and today I wish to provider further clarification based on the discussion had during that Business Meeting.

Sleep Testing Modalities

There are generally two main modalities of "sleep testing". The most well known modality is an attended polysomnogram (PSG). As the name implies, this testing is comprised of recording multiple variables during sleep to provide a comprehensive analysis of a patient's functions during sleep. A PSG is typically completed in a sleep lab where a patient is monitored throughout the test by a Licensed Polysomnographic Technologist. The technologist's function is to apply the various electrodes and apparatus necessary for the PSG, analyze and score the study, and intervene during the study as necessary for the safety of the patient or for accuracy of the test (e.g. replace a sensor the fell off during the study).

A PSG is used to diagnose a large variety of sleep disorders including insomnia, sleep-related breathing disorders, movement disorders, disorders of excessive somnolence, and parasomnias.

A PSG will typically utilize the following "channels" for monitoring and scoring: electroencephalography, electrooculography, chin and leg electromyography, airflow, thoracoabdominal bands, snoring sensor, body position, electrocardiography, and oxygen saturation.

The second, and now much more common, modality of "sleep testing" is the home sleep apnea test (HSAT). While there are multiple defined "types" of HSATs, the general idea is that an HSAT is designed to simply evaluate a patient's breathing and effect of breathing during sleep to allow for the positive diagnosis of sleep apnea.

An HSAT is designed and approved by the FDA for at home use in which the patient is the "technologist". The patient applies the sensors and apparatus necessary for the HSAT and there is no live monitoring of the data. The other name of this test is an unattended polysomnogram.

An HSAT will typically utilize the following "channels" for monitoring and scoring: airflow, thoracoabdominal bands, body position, and oxygen saturation.

Scope of Medicine vs Dentistry

During the Business Meeting there was a comment made that Polysomnographic Technologists are regulated by the Board of Medicine. I wish to quickly highlight that Chapter 29 of Title 54.1 of the Code of Virginia, "Medicine and Other Healing Arts", § 54.1-2901 states:

A. The provisions of this chapter shall not prevent or prohibit:
    5. Any dentist, pharmacist or optometrist from rendering care or services within the scope of his usual professional activities

A plain text reading is clear that while the Board of Medicine may regulate Polysomnographic Technologists, that the existence of such license and regulation has no bearing on the practice of dentistry.

As the committee is aware, dentistry is defined in Chapter 27 of Title 54.1 of the Code of Virginia as:

> "'Dentistry' means the evaluation, diagnosis, prevention, and treatment, through surgical, nonsurgical, or related procedures, of diseases, disorders, and conditions of the oral cavity and the maxillofacial, adjacent, and associated structures and their impact on the human body."

Obstructive sleep apnea is typically managed through one of 4 main modalities. Positive airway pressure devices (CPAP, APAP, BiPAP), oral appliance therapy (mandibular advancement device, tongue retainer device), maxillomandibular advancement surgery (MMA), and/or hypoglossal nerve stimulation (HNS). Of those modalities, 3 clearly target intra-oral structures (oral appliance therapy, MMA, and HNS) with the remaining modality, PAP devices, targeting the oropharynx.

These modalities target the oral cavity as well as adjacent and associated structures specifically because the etiology of obstructive sleep apnea is so often related to these structures and their associated collapse during sleep.

There is clearly no question that the treatment of obstructive sleep apnea falls within the scope of dentistry. As dentistry is currently defined, our license includes not only the treatment by the evaluation of these conditions as well.

Ordering vs Diagnosing

At the heart of this discussion is an important distinction between ordering vs interpreting/diagnosing. Specifically, the American Academy of Dental Sleep Medicine (AADSM) position paper states that ordering an HSAT is within the scope of dentistry and that only a sleep physician can render the diagnosis.

The American Academy of Sleep Medicine's (AASM) letter improperly implied that the AADSM was advocating that both ordering and interpreting were within the scope of dentistry. At this time, there was no such recommendation from the AADSM to include diagnosing sleep apnea.

As the AASM and AADSM both highlight, obstructive sleep apnea is only one of many different sleep disorders and as such, a sleep physician in an important factor in accurate diagnosis. This is why the AADSM is not advocating that dentists provide the diagnosis of apnea.

Like other diagnostic testing such as radiology, pathology, and serology, home sleep testing is comprised of ordering, rendering, and interpreting. These stages can be completed by the same provider or multiple providers. Within dentistry, for example, we often order, expose, and interpret our own radiographs; whereas in medicine, the ordering, rendering, and interpreting provider are often 3 separate providers.

The AADSM position is that the ordering and dispensing of home sleep apnea testing is within the scope of dentistry as evaluation of a patient's oral structures is clearly within the scope of dentistry.

As a home sleep apnea test is approved by the FDA for at-home use, many HSATs are dispensed through mail-order services. In these cases the study is ordered by a provider and the study is then sent to the patient directly with no contact with a provider.

Prior Board Determinations

During the Business Meeting, Dr. Zapatero noted that the AADSM website lists that Virginia does not allow dentists to order an HSAT. This is based on a quote attributed to the "Board of Dentistry" that states:

> The advice given to me by the Board's attorney, in response to previous inquiries from dentists about testing patients for sleep apnea, is that a Virginia dentist may refer a patient to a polysomnographic technologist for a sleep study but a Virginia dentist cannot conduct sleep studies. The technologist is required to report sleep study results to the supervising physician who could refer the patient to a dentist for dental treatment.

In my search of the Board of Dentistry's website as well as the minutes of past meetings of the Board, I was unable to find any determination of the boards position as it relates to this question.

If there was a past discussion of the board as it relates to this matter, it may be helpful to have that cited as currently there is no published opinion of the board and the AADSM may have been provided inaccurate information leading to the statement on their website.

However, this has clearly led to confusion and it may be prudent for the Board to provide an official opinion or request that the AADSM update their website by removing this reference.

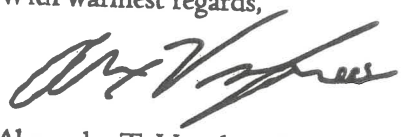
Requested Action

My hope is that this letter has provided some insight into the complexities of this issue. I am also hopeful that it has shown that these complexities involve multiple stakeholders. As indicated by the Public Participation Guidelines of the Board in 18VAC60-11-70, it would be my request that the Committee recommend the formation of a regulatory advisory panel (RAP) to provide the professional specialization needed to assist the agency in addressing this specific regulatory issue.

Alternatively, if the Committee feels it has been provided with enough background on this question, then I believe it is clear that the ordering of a home sleep apnea test is within the scope of dentistry. This would not include the diagnostic interpretation of such a study as that would be reserved for a sleep physician.

I thank the Committee for the time and careful consideration of this request. I also offer my support or help in any manor as one of the few orofacial pain specialists in Virginia and would be happy to provide further comment as requested. Should the Committee or Board determine that the formation of a RAP is appropriate, I also will happily serve if requested by the Board.

With warmest regards,



Alexander T. Vaughan, DDS, MS
Dental Director, Orofacial Pain
Virginia Total Sleep

Diplomate, American Board of Orofacial Pain
Fellow, American Academy of Orofacial Pain

VS VIRGINIA TOTAL SLEEP

March 18, 2021

Dr. Augustus Petticolas
President
Virginia Board of Dentistry
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Dr. Petticolas and Members of the Virginia Board of Dentistry,

As one of Virginia's orofacial pain specialists, I'd like to take a brief moment to respond to a letter sent by the American Academy of Sleep Medicine (AASM) to all state boards of dentistry. In their letter, the AASM highlights their concerns regarding the recently published position statement of the American Academy of Dental Sleep Medicine. In that position, the American Academy of Dental Sleep Medicine finds that ordering of home sleep tests is within the scope of dentistry. Importantly, this position statement does not state that interpretation of these tests is within the scope of dentistry.

According to a report commissioned by the American Academy of Sleep Medicine and published in 2016, an estimated 29.4 million adults in the United States at that time had sleep apnea and of those, 80% were undiagnosed. In 2019, studies estimated an increase to 54 million adults with sleep apnea. Assuming 80% remained undiagnosed, that may leave as many as 43 million undiagnosed.

Of concern to me, my patients, and my colleagues is that this straw man argument regarding interpreting sleep tests will continue to harm the 80% of patients with sleep apnea that remain undiagnosed due to reduced access to care currently available.

In their letter, our physician colleagues consistently refer to home sleep studies as "medical" testing, inferring that there is somehow a different patient between the two fields. We would never say a pediatrician examining a patient's mouth for tooth development or a physician managing oral candidiasis is providing "dental" treatment. After all, we should be allies fighting this fight together as we are both treating our patient's overall health.

To provide context, a home sleep test typically measures respiratory volume, respiratory effort, pulse rate, and blood oxygenation while a patient sleeps. If we consider these metrics as something only a physician is qualified to measure, would that not imply that dentists should no longer perform sedation? Afterall, the standards for sedation require monitoring of those exact same values.

Again, I wish to highlight where I feel our physician colleagues may have erred. The American Academy of Dental Sleep Medicine's position statement clearly states that ordering and administering testing is within the scope of dentistry but that "data from [Home Sleep Apnea Tests] should be interpreted by a licensed medical provider for initial diagnosis and verification of treatment efficacy."

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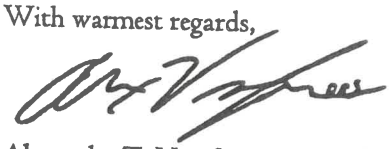
This is a similar situation to that of hypertension. Dentists have played an extremely key role in the early detection and treatment of hypertension through monitoring our patients with appropriate referral to physicians for interpretation of these test values. As we know, many of our healthy patients see their dentists more often than their physicians and we are a key component of the early detection of many diseases.

Fortunately, both medicine and dentistry practice self-governance. Just as it would be inappropriate for a dentist to attempt to restrict the practice of medicine, so too is it inappropriate for medical associations to attempt to restrict the practice of dentistry, chiropractic, pharmacy, or the practice of any of our other colleagues in the health professions.

I strongly urge the board to either consider the aforementioned letter as received with no action or, should there be a desire to take these concerns under further review, to appoint a Regulatory Advisory Panel composed of the various stakeholders and specialties to provide the professional specialization and expertise necessary to address this specific regulatory issue.

As one of the now 4 orofacial pain specialists that are licensed in Virginia, I am happy to provide any guidance, support, background, and help that the board deems necessary and appropriate as it relates to this matter or any other orofacial pain matter in the future. Thank you very much for your time and careful consideration of these issues.

With warmest regards,



Alexander T. Vaughan, DDS, MS
Dental Director, Orofacial Pain
Virginia Total Sleep

Diplomate, American Board of Orofacial Pain
Fellow, American Academy of Orofacial Pain

Specifications for a Digital Design Lab Technician

Position qualifications specified by: Marithe Baclagon, CDT, Te, M.Ed., Ceramist for the Digital Dentistry Department at VCU School of Dentistry

This is based on my thoughts of what would make a good digital designer/scanning technician. This is professional opinion and not to be held as 'the end all, be all' of what skills a technician should possess. It is solely up to the practitioner to decide who their confidence lies in with their dental lab work.

Over the last decade the position of a digital technician has diversified and expanded. The *National Board of Certification for Dental Laboratories* has recently identified the need for such a technician, but it is currently being examined before the launch of the practical examination. Certain credentials should be acquired with experience or education before considering the hire or confidence in one. In lieu of the NBC, we hope to have a credentialed certification exam for such a position in the near future, but for now these qualifications deem as appropriate for the basics:

Qualifications Digital Scanning Technician:
(*entails scanning impressions or scanning models on a digital model/impression scanner*)

- Understanding of Dental Anatomy, Tooth Numbers & various Tooth Numbering systems, Occlusion, etc.
- Attention to detail.
- At least 1-2 years of model/die analog experience. (pouring models, dies, pindexing, etc.).
- Experience or understanding of a good impression vs. bad impression.

Qualifications for a Digital Designer Technician:

(entails digital designing case work from iOS scan's or model/impression scans, qualifications will vary according to restorative work experience)

Crown & Bridge Design

(entails designing single or multi-unit abutment cases)

- Understanding of Dental Anatomy, Tooth Numbers & various Tooth Numbering systems, Occlusion, etc.
- Attention to detail.
- At least 1-2 years of model/die analog experience. (pouring models, dies, pindexing, etc.).
- Experience or understanding of a good impression vs. bad impression.
- Previous experience in a dental laboratory at least 1-2 years of experience with conventional applications with any C&B or Ceramics application (opaquing, metal finishing, waxing, etc).

Digital Dentures

(entails digital denture fabrication case work from iOS scan's or model/impression scans, qualifications will vary according to restorative denture experience. Selecting an individual with 2+ years experience of digital denture designing would have a higher degree of confidence.)

- Understanding of Dental Anatomy, Tooth Numbers & various Tooth Numbering systems, Occlusion, etc.
- Attention to detail.
- At least 1-2 years of model/die analog experience (pouring models, dies, pindexing, etc.).
- Experience or understanding of a good impression vs. bad impression.
- Previous experience in dentures at least 1-2 years conventionally (Pouring up models, Border Molding, Making Custom Trays, Bite Blocks, Relining, Setting up Teeth, Investing, or Pumicing & Finishing Dentures)

Implant Designers

(entails a digital technician who has been a part of a dental lab community for 3+ years solely with implants. Making sure the technician is very savvy in other aspects of dental lab technology with C&B or Metal Work previously.)

- Understanding of Dental Anatomy, Tooth Numbers & various Tooth Numbering systems, Occlusion, etc.
- Attention to detail.
- At least 1-2 years of model/die analog experience. (pouring models, dies, pindexing, etc.).
- Experience or understanding of a good impression vs. bad impression.
- At least 3 years of implant experience
- Knowledge of various Implant Systems.

Educational or Experience Requirements

- Graduated from an accredited dental laboratory technology program with a certification or AAS (Associate's in applied science).
- At least 1-2 years of hands-on experience in a dental laboratory or dental practice.
- If no accredited background of an accredited dental laboratory program, at least 2-4 years of dental experience (whether it be private practice, lab, or exposure to dental knowledge)

Digital Scan Qualities

Information provided by:
Marithe Baclagon
CDT, Te, M.Ed, Ceramist in the Digital Dentistry Department of VCU School of Dentistry

This reference sheet is not to be used as a final specification sheet for digital scans due to software, scanners, and computer technology varying amongst manufacturers.

This is a basic outline of what makes an *acceptable* iOS (intraoral scan) & what makes an *unacceptable* scan.

Acceptable Digital Scans

(*Based results from Planmeca Emerald & Romexis Software, as well as 3Shape TRIOS 3 & 4 scanner & 3Shape Dental Design Software*)

Key Points to do before scanning:

- **Making sure the area inside the mouth is dry & accessible** (**open the mouth as wide as possible with a good field of view, make sure to look at the computer screen for scanning, not the patient's mouth*)
- **Making sure the margin is in sight, cord is placed subgingival, & that there is a clear view of path of insertion without any obstructions in the way.**

What you should see on the screen after the iOS (intraoral scan) has been completed:

- **Clear path of insertion from adjacent teeth.**(Making sure the axial walls are parallel & will allow a smooth insertion of future restoration.)
- **Clear view of margin** (make sure to toggle the scan and make sure it is clear).
- **Making sure adjacent teeth have been captured in their entire form** (no holes should be showing through the adjacent teeth through the scan, 100% of preparation should be in the scan, 90% is acceptable for adjacent teeth.)

- **Make sure the occlusion/bite are correct.** (Please examine the scan on the screen, as well as what you see in your patient's mouth & ensure that this is what it is.)

- **In checking the occlusion & bite scan, please make sure there is enough reduction on the preparation to allow enough space for the material selected**. (A digital scan will allow the clear view of space and can be measured through a digital ruler. More clearance will allow for a better restoration, and provide more strength.)

- **Make sure there are no holes in the digital scan and also make sure there are no 'overlaps' in the scan data.** ('overlaps' of scan data are caused by holding the iOS over an area for a prolonged period of time. This causes 'static' and 'overlap' on the scan and can cause inaccurate data.)

- **For anterior cases, make sure to capture the full arch for maxillary & mandibular areas**. This is essential, especially for bigger anterior cases.

Unacceptable Digital Scans

- **Unclear path of insertion.** (The adjacent teeth have obstructed a smooth path of insertion. Can adjust prep or adjacent contacts as needed to allow for a better path).

- **Unclear margin.** (Parts of the margin are missing. The margin is too subgingival to allow for an all-ceramic restoration. On the screen, it will show holes in the scan data.Sometimes oversaturation of hem, saliva, or other liquids can cause distortion in the data. Be sure to check the area and make sure it is see-able).

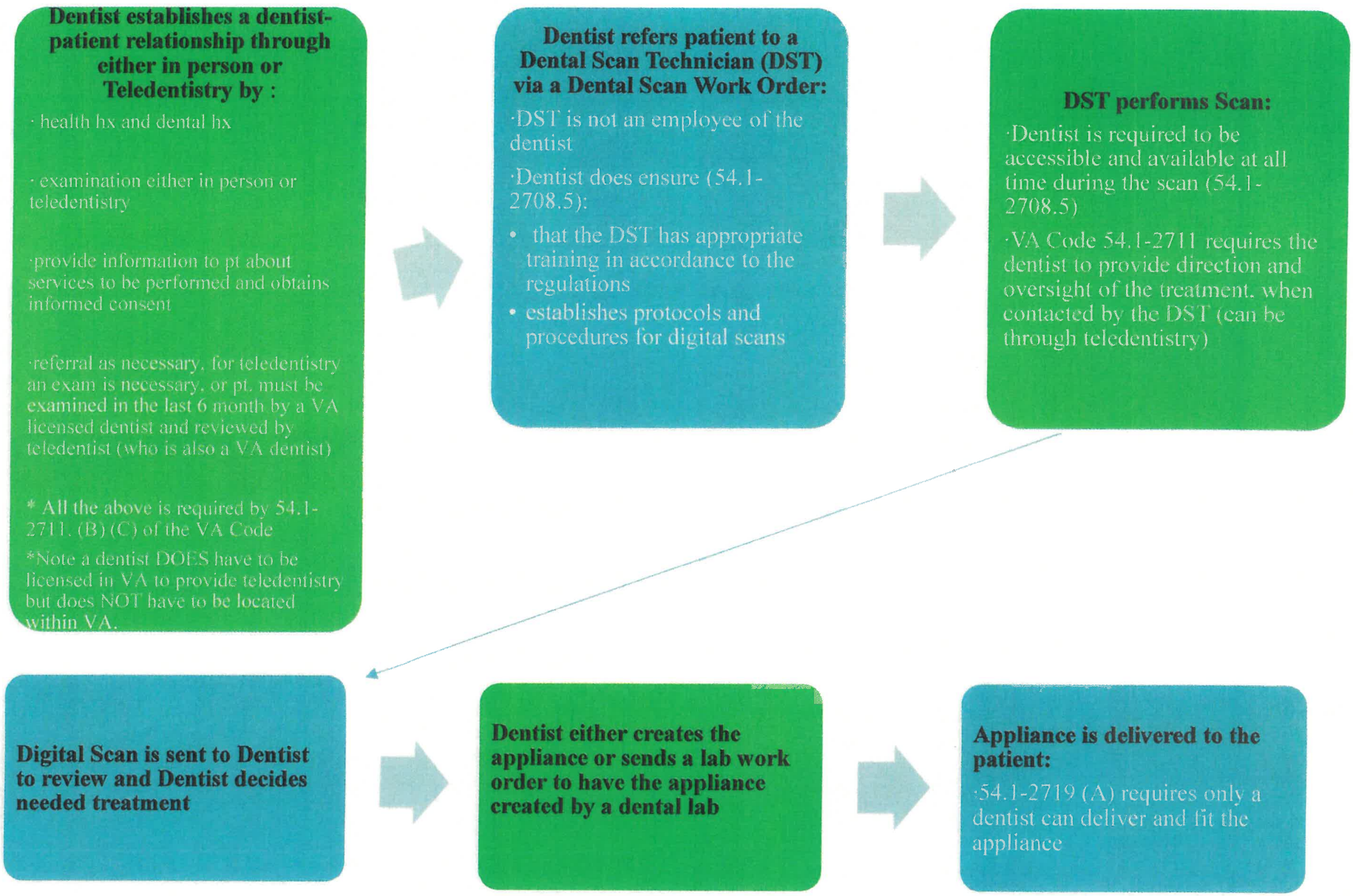
- **Not checking the occlusion or bite scan.** Without checking this, you can cause the lab to fabricate a restoration that is high in occlusion or lacking occlusion. Checking this portion of the digital scan is VITAL.

- **Scattered digital scan or uncompleted scan data.** Scanning insufficient amounts of data can cause a disruption in the fabrication of your restoration. Vital areas to capture are your occlusion, contact area, and

margin. You should make sure to get these all in 100% accuracy to establish the prescribed restoration.

- **Making fluid scan motions are best, staying in one area within the mouth and overscanning can cause discrepancies in the designing process.** This can cause over-bulking axial walls of the restoration, over-heightening occlusion, or over-extending the marginal areas. Be sure to practice your fluid motions. Scans shouldn't take more than 2000 images, but there are exceptions depending on the restoration & the scanner (Follow manufacturer guidelines.).

Digital Scan Flowchart



18VAC60-21-10. Definitions.

A. The following words and terms when used in this chapter shall have the meanings ascribed to them in § 54.1-2700 of the Code of Virginia:

"Appliance"

"Board"

"Dental hygiene"

"Dental hygienist"

"Dentist"

"Dentistry"

"Digital scan"

"Digital scan technician"

"Digital work order"

"License"

"Maxillofacial"

"Oral and maxillofacial surgeon"

"Teledentistry"

B. The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"AAOMS" means the American Association of Oral and Maxillofacial Surgeons.

"ADA" means the American Dental Association.

"Advertising" means a representation or other notice given to the public or members thereof, directly or indirectly, by a dentist on behalf of himself, his facility, his partner or associate, or any dentist affiliated with the dentist or his facility by any means or method for the purpose of inducing purchase, sale, or use of dental methods, services, treatments, operations, procedures, or products, or to promote continued or increased use of such dental methods, treatments, operations, procedures, or products.

"CODA" means the Commission on Dental Accreditation of the American Dental Association.

"Code" means the Code of Virginia.

"Dental assistant I" means any unlicensed person under the direction of a dentist or a dental hygienist who renders assistance for services provided to the patient as authorized under this chapter but shall not include an individual serving in purely an administrative, secretarial, or clerical capacity.

"Dental assistant II" means a person under the direction and direct supervision of a dentist who is registered by the board to perform reversible, intraoral procedures as specified in 18VAC60-21-150 and 18VAC60-21-160.

"Mobile dental facility" means a self-contained unit in which dentistry is practiced that is not confined to a single building and can be transported from one location to another.

"Nonsurgical laser" means a laser that is not capable of cutting or removing hard tissue, soft tissue, or tooth structure.

"Portable dental operation" means a nonfacility in which dental equipment used in the practice of dentistry is transported to and utilized on a temporary basis at an out-of-office location, including patients' homes, schools, nursing homes, or other institutions.

"Radiographs" means intraoral and extraoral radiographic images of hard and soft tissues used for purposes of diagnosis.

C. The following words and terms relating to supervision as used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Direct supervision" means that the dentist examines the patient and records diagnostic findings prior to delegating restorative or prosthetic treatment and related services to a dental assistant II for completion the same day or at a later date. The dentist prepares the tooth or teeth to be

restored and remains immediately available in the office to the dental assistant II for guidance or assistance during the delivery of treatment and related services. The dentist examines the patient to evaluate the treatment and services before the patient is dismissed.

"Direction" means the level of supervision (i.e., immediate, direct, indirect, or general) that a dentist is required to exercise with a dental hygienist, a dental assistant I, a dental assistant II, , or a certified registered nurse anesthetist or the level of supervision that a dental hygienist is required to exercise with a dental assistant to direct and oversee the delivery of treatment and related services. For a digital scan technician, "direction" means the written or electronic instructions provided by a dentist to a digital scan technician in the form of a work order for a digital scan of a patient and the dentist's specified availability to consult with a digital scan technician while the scan is taken.

"General supervision" means that a dentist completes a periodic comprehensive examination of the patient and issues a written order for hygiene treatment that states the specific services to be provided by a dental hygienist during one or more subsequent appointments when the dentist may or may not be present. Issuance of the order authorizes the dental hygienist to supervise a dental assistant performing duties delegable to dental assistants I.

"Immediate supervision" means the dentist is in the operatory to supervise the administration of sedation or provision of treatment.

"Indirect supervision" means the dentist examines the patient at some point during the appointment and is continuously present in the office to advise and assist a dental hygienist , a dental assistant, or a certified registered nurse anesthetist who is (i) delivering hygiene treatment, (ii) preparing the patient for examination or treatment by the dentist, (iii) preparing the patient for dismissal following treatment, or (iv) administering topical local anesthetic, sedation, or anesthesia as authorized by law or regulation.

"Remote supervision" means that a supervising dentist is accessible and available for communication and consultation with a dental hygienist during the delivery of dental hygiene services, but such dentist may not have conducted an initial examination of the patients who are to be seen and treated by the dental hygienist and may not be present with the dental hygienist when dental hygiene services are being provided. For the purpose of practice by a public health dental hygienist, "remote supervision" means that a public health dentist has regular, periodic communications with a public health dental hygienist regarding patient treatment, but such dentist may not have conducted an initial examination of the patients who are to be seen and treated by the dental hygienist and may not be present with the dental hygienist when dental

hygiene services are being provided. For the purpose of supervision of a digital scan technician, remote supervision means that a supervising dentist is accessible and available for communication and consultation in the practice of teledentistry.

D. The following words and terms relating to sedation or anesthesia as used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Analgesia" means the diminution or elimination of pain.

"Continual" or "continually" means repeated regularly and frequently in a steady succession.

"Continuous" or "continuously" means prolonged without any interruption at any time.

"Deep sedation" means a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. Reflex withdrawal from a painful stimulus is not considered a purposeful response. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

"General anesthesia" means a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilator function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

"Inhalation" means a technique of administration in which a gaseous or volatile agent, including nitrous oxide, is introduced into the pulmonary tree and whose primary effect is due to absorption through the pulmonary bed.

"Inhalation analgesia" means the inhalation of nitrous oxide and oxygen to produce a state of reduced sensation of pain with minimal alteration of consciousness.

"Local anesthesia" means the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.

"Minimal sedation" means a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, and ventilator and cardiovascular functions are unaffected. Minimal sedation includes

the diminution or elimination of anxiety through the use of pharmacological agents in a dosage that does not cause depression of consciousness and includes "inhalation analgesia" when used in combination with any such sedating agent administered prior to or during a procedure.

"Moderate sedation" means a drug-induced depression of consciousness, during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Reflex withdrawal from a painful stimulus is not considered a purposeful response. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

"Monitoring" means to observe, interpret, assess, and record appropriate physiologic functions of the body during sedative procedures and general anesthesia appropriate to the level of sedation as provided in Part VII (18VAC60-21-260 et seq.) of this chapter.

"Parenteral" means a technique of administration in which the drug bypasses the gastrointestinal tract (i.e., intramuscular, intravenous, intranasal, submucosal, subcutaneous, or intraocular).

"Provide" means, in the context of regulations for moderate sedation or deep sedation/general anesthesia, to supply, give, or issue sedating medications. A dentist who does not hold the applicable permit cannot be the provider of moderate sedation or deep sedation/general anesthesia.

"Titration" means the incremental increase in drug dosage to a level that provides the optimal therapeutic effect of sedation.

"Topical oral anesthetic" means any drug, available in creams, ointments, aerosols, sprays, lotions, or jellies, that can be used orally for the purpose of rendering the oral cavity insensitive to pain without affecting consciousness.

18VAC60-21-165. Delegation to digital scan technicians for use in teledentistry.

A. A dentist who delegates the taking of a digital scan by a digital scan technician shall ensure that the technician has a certificate of completion from a training program approved by the board that includes:

1. Training in prepping the patient, taking and evaluating the quality of a digital scan, safety protocols, and dental terminology given by a sponsor approved for continuing education as set forth in subsection C of 18VAC60-21-250; and

2. In-office training by the manufacturer on the proper operation of the digital scanner that includes orientation to the process and protocols for taking and evaluating digital scans for fabrication of a restoration or an appliance.

B. The dentist who directs a digital scan technician to take digital scans shall establish:

1. Written or electronic protocols for the practice of teledentistry in compliance with subsections B and C of § 54.1-2711 of the Code of Virginia;

2. Written or electronic protocols and procedures for the performance of digital scans by digital scan technicians in compliance with subsection B of §54.1-2708.5 of the Code of Virginia; and

3. A written or electronic work order for a digital scan that includes required components of a dental work order.

C. The dentist who directs a digital scan technician to take digital scans shall be:

1. Licensed by the board to practice dentistry in the Commonwealth;

2. Accessible and available for communication and consultation with the digital scan technician at all times during the patient interaction; and

3. Ultimately responsible for communicating with the patient or his representative the specific treatment the patient will receive, which aspects of treatment will be delegated to qualified personnel, and the direction required for such treatment, in accordance with the Regulations Governing the Practice of Dentistry and the Code of Virginia and for documenting such communication in the patient record.

D. The directing dentist shall make available to the board any requested:

1. Protocols and procedures as specified in subsection B of this section;

2. Evidence that the digital scan technician has complied with the training requirements of subsection A of this section; and

3. Written or electronic work orders used in reliance on digital scans.

Guidance document: 60-

Approved:

VIRGINIA BOARD OF DENTISTRY
APPROVED TEMPLATE FOR
SCANS AND LABORATORY WORK ORDER FORMS

This form is provided by the Board to guide dentists on meeting the legal requirements for written or digital scans and laboratory work order forms as addressed in §54.1-2719 of the Code of Virginia. Dentists have the option of using this form or another form to meet the requirements of the law. Regardless of the form and the format the dentist chooses to use, the information requested below must be included as part of the patient's treatment records and maintained as required by 18VAC60-21-90 of the Regulations Governing the Practice of Dentistry.

PATIENT NAME, INITIALS and an ID#: _____

Scan Technician Name: _____

Company Name: _____

_____

Physical Address: _____

_____

E-mail Address: _____

Phone Number: _____

RETURN BY: _____

INSTRUCTIONS (include diagrams if needed):

_____

_____

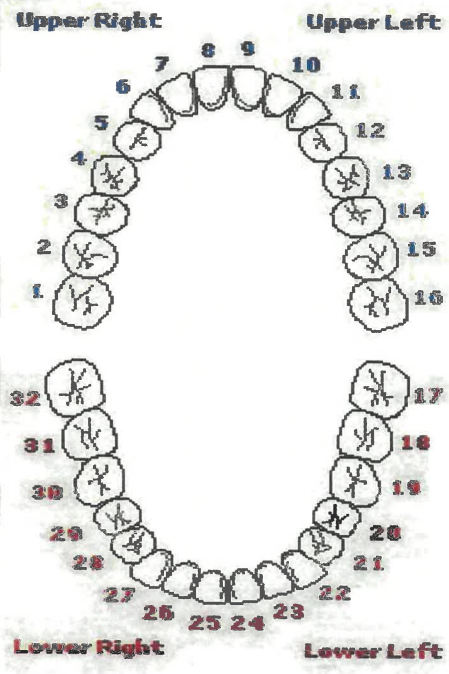
_____

_____

_____

_____

_____



DENTIST'S AVAILABILITY/TIMES SCAN BE TAKEN:

Date/Time: _____ Date/Time: _____

Date/Time: _____ Date/Time: _____

Date/Time: _____ Date/Time: _____

Date/Time: _____ Date/Time: _____

Date/Time: _____ Date/Time: _____

INSTRUCTIONS FOR RETURNING THE DIGITAL SCAN:

- Provide the name and physical address of the location where the scan was taken.
- Provide a copy of the information the lab received from a manufacturer.

INSTRUCTIONS FOR RETURNING THE RESTORATION:

- Provide the sanitized restoration in a sealed container.
- Provide the name and physical address of the location where the restoration was fabricated.
- Provide a copy of the information the lab received from a manufacturer on the composition of the casting and ceramic materials used in fabrication, such as an Identalloy sticker

INSTRUCTIONS REGARDING SUBCONTRACTING THIS ORDER

_____ I do not authorize subcontracting this order or any part of this order. Return the order to me if you are unable to complete this order.
_____ Contact me before subcontracting any work for this order.
_____ I authorize subcontracting to a domestic lab.
_____ I authorize subcontracting to an overseas/international lab.
_____ I authorize subcontracting to either a domestic or overseas lab.

NOTICE OF ACTIONS YOU ARE REQUIRED BY LAW TO TAKE WHEN SUBCONTRACTING THIS ORDER OR PORTIONS OF THIS ORDER - §54.1-2719.C of the Code of Virginia

- You must send me, the ordering dentist, a written disclosure of subcontracting this order with the subwork order you issued to the subcontractor.
- The written disclosure must include:
  - The name and address of the person, firm or corporation and subcontractor;
  - A number identifying the subwork order with the original order;
  - The date any subwork order was written;
  - A description of the work to be done and the work to be done by the subcontractor, including diagrams and digital files, if necessary;
  - Specification of the type and quality of material to be used; and
  - The signature of the person issuing the disclosure and subwork order.

Dentist's Signature: _____ Date: _____

Dentist's Name Printed: _____ Dental License # _____

Dentist's Address: _____ Telephone: _____

Dentist's Email Address: _____

CHAPTER 37

An Act to amend and reenact §§ 54.1-2700, 54.1-2711, and 54.1-2719 of the Code of Virginia and to amend the Code of Virginia by adding in Article 2 of Chapter 27 of Title 54.1 a section numbered 54.1-2708.5, relating to teledentistry.

[H 165]

Approved March 2, 2020

Be it enacted by the General Assembly of Virginia:

1. That §§ 54.1-2700, 54.1-2711, and 54.1-2719 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Article 2 of Chapter 27 of Title 54.1 a section numbered 54.1-2708.5 as follows:

§ 54.1-2700. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Appliance" means a permanent or removable device used in a plan of dental care, including crowns, fillings, bridges, braces, dentures, orthodontic aligners, and sleep apnea devices.

"Board" means the Board of Dentistry.

"Dental hygiene" means duties related to patient assessment and the rendering of educational, preventive, and therapeutic dental services specified in regulations of the Board and not otherwise restricted to the practice of dentistry.

"Dental hygienist" means a person who is licensed by the Board to practice dental hygiene.

"Dentist" means a person who has been awarded a degree in and is licensed *by the Board* to practice dentistry.

"Dentistry" means the evaluation, diagnosis, prevention, and treatment, through surgical, nonsurgical, or related procedures, of diseases, disorders, and conditions of the oral cavity and the maxillofacial, adjacent, and associated structures and their impact on the human body.

"Digital scan" means digital technology that creates a computer-generated replica of the hard and soft tissues of the oral cavity using enhanced digital photography.

"Digital scan technician" means a person who has completed a training program approved by the Board to take digital scans of intraoral and extraoral hard and soft tissues for use in teledentistry.

"Digital work order" means the digital equivalent of a written dental laboratory work order used in the construction or repair of an appliance.

"License" means the document issued to an applicant upon completion of requirements for admission to practice dentistry or dental hygiene in the Commonwealth or upon registration for renewal of license to continue the practice of dentistry or dental hygiene in the Commonwealth.

"License to practice dentistry" means any license to practice dentistry issued by the Board.

"Maxillofacial" means pertaining to the jaws and face, particularly with reference to specialized surgery of this region.

"Oral and maxillofacial surgeon" means a person who has successfully completed an oral and maxillofacial residency program, approved by the Commission on Dental Accreditation of the American Dental Association, and who holds a valid license from the Board.

"Store-and-forward technologies" means the technologies that allow for the electronic transmission of dental and health information, including images, photographs, documents, and health histories, through a secure communication system.

"Teledentistry" means the delivery of dentistry between a patient and a dentist who holds a license to practice dentistry issued by the Board through the use of telehealth systems and electronic technologies or media, including interactive, two-way audio or video.

§ 54.1-2708.5. Digital scans for use in the practice of dentistry; practice of digital scan technicians.

A. No person other than a dentist, dental hygienist, dental assistant I, dental assistant II, digital scan technician, or other person under the direction of a dentist shall obtain dental scans for use in the practice of dentistry.

B. A digital scan technician who obtains dental scans for use in the practice of teledentistry shall work under the direction of a dentist who is (i) licensed by the Board to practice dentistry in the Commonwealth, (ii) accessible and available for communication and consultation with the digital scan technician at all times during the patient interaction, and (iii) responsible for ensuring that the digital scan technician has a program of training approved by the Board for such purpose. All protocols and procedures for the performance of digital scans by digital scan technicians and evidence that a digital scan technician has complied with the training requirements of the Board shall be made available to the Board upon request.

§ 54.1-2711. Practice of dentistry.

A. Any person shall be deemed to be practicing dentistry who (i) uses the words dentist, or dental surgeon, the letters D.D.S., D.M.D., or any letters or title in connection with his name, which in any way represents him as engaged in the practice of dentistry; (ii) holds himself out, advertises, or permits to be advertised that he can or will perform dental operations of any kind; (iii) diagnoses, treats, or professes to diagnose or treat any of the diseases or lesions of the oral cavity, its contents, or contiguous structures~~,~~; or (iv) extracts teeth, corrects malpositions of the teeth or jaws, takes *or causes to be taken digital scans or* impressions for the fabrication of appliances or dental prosthesis, supplies or repairs artificial teeth as substitutes for natural teeth, or places in the mouth and adjusts such substitutes. *Taking impressions for mouth guards that may be self-fabricated or obtained over-the-counter does not constitute the practice of dentistry.*

B. No person shall practice dentistry unless a bona fide dentist-patient relationship is established in person or through teledentistry. A bona fide dentist-patient relationship shall exist if the dentist has (i) obtained or caused to be obtained a health and dental history of the patient; (ii) performed or caused to be performed an appropriate examination of the patient, either physically, through use of instrumentation and diagnostic equipment through which digital scans, photographs, images, and dental records are able to be transmitted electronically, or through use of face-to-face interactive two-way real-time communications services or store-and-forward technologies; (iii) provided information to the patient about the services to be performed; and (iv) initiated additional diagnostic tests or referrals as needed. In cases in which a dentist is providing teledentistry, the examination required by clause (ii) shall not be required if the patient has been examined in person by a dentist licensed by the Board within the six months prior to the initiation of teledentistry and the patient's dental records of such examination have been reviewed by the dentist providing teledentistry.

C. No person shall deliver dental services through teledentistry unless he holds a license to practice dentistry in the Commonwealth issued by the Board and has established written or electronic protocols for the practice of teledentistry that include (i) methods to ensure that patients are fully informed about services provided through the use of teledentistry, including obtaining informed consent; (ii) safeguards to ensure compliance with all state and federal laws and regulations related to the privacy of health information; (iii) documentation of all dental services provided to a patient through teledentistry, including the full name, address, telephone number, and Virginia license number of the dentist providing such dental services; (iv) procedures for providing in-person services or for the referral of patients requiring dental services that cannot be provided by teledentistry to another dentist licensed to practice dentistry in the Commonwealth who actually practices dentistry in an area of the Commonwealth the patient can readily access; (v) provisions for the use of appropriate encryption when transmitting patient health information via teledentistry; and (vi) any other provisions required by the Board. A dentist who delivers dental services using teledentistry shall, upon request of the patient, provide health records to the patient or a dentist of record in a timely manner in accordance with § 32.1-127.1:03 and any other applicable federal or state laws or regulations. All patients receiving dental services through teledentistry shall have the right to speak or communicate with the dentist providing such services upon request.

D. Dental services delivered through use of teledentistry shall (i) be consistent with the standard of care as set forth in § 8.01-581.20, including when the standard of care requires the use of diagnostic testing or performance of a physical examination, and (ii) comply with the requirements of this chapter and the regulations of the Board.

E. In cases in which teledentistry is provided to a patient who has a dentist of record but has not had a dental wellness examination in the six months prior to the initiation of teledentistry, the dentist providing teledentistry shall recommend that the patient schedule a dental wellness examination. If a patient to whom teledentistry is provided does not have a dentist of record, the dentist shall provide or cause to be provided to the patient options for referrals for obtaining a dental wellness examination.

F. No dentist shall be supervised within the scope of the practice of dentistry by any person who is not a licensed dentist.

§ 54.1-2719. Persons engaged in construction and repair of appliances.

A. Licensed dentists may employ or engage the services of any person, firm, or corporation to construct or repair *an appliance*, extraorally, ~~prosthetic dentures, bridges, or other replacements for a part of a tooth, a tooth, or teeth~~ *in accordance with a written or digital work order. Any appliance constructed or repaired by a person, firm, or corporation pursuant to this section shall be evaluated and reviewed by the licensed dentist who submitted the written or digital work order, or a licensed dentist in the same dental practice.* A person, firm, or corporation so employed or engaged shall not be considered to be practicing dentistry. No such person, firm, or corporation shall perform any direct dental service for a patient, but they may assist a dentist in the selection of shades for the matching of prosthetic devices when the dentist sends the patient to them with a written *or digital* work order.

B. Any licensed dentist who employs the services of any person, firm, or corporation not working in a dental office under ~~his~~ *the dentist's* direct supervision to construct or repair~~,~~ *an appliance* extraorally~~,~~ ~~prosthetic dentures, bridges, replacements, or orthodontic appliances for a part of a tooth, a tooth, or teeth,~~ shall furnish such person, firm, or corporation with a written *or digital* work order on forms

prescribed by the Board, which shall, at minimum, contain: (i) the name and address of the person, firm, or corporation; (ii) the patient's name or initials or an identification number; (iii) the date the work order was written; (iv) a description of the work to be done, including diagrams, if necessary; (v) specification of the type and quality of materials to be used; and (vi) the signature and address of the dentist.

The person, firm, or corporation shall retain the original *written* work order *or an electronic copy of a digital work order*, and the dentist shall retain a duplicate *of the written work order or an electronic copy of a digital work order*, for three years.

C. If the person, firm, or corporation ~~receiving~~ *receives* a written *or digital* work order from a licensed dentist ~~engages a subcontractor to perform services relative to the work order~~, a written *disclosure and* subwork order shall be furnished *to the dentist* on forms prescribed by the Board, which shall, at minimum, contain: (i) the name and address of the *person, firm, or corporation and* subcontractor; (ii) a number identifying the subwork order with the original work order; (iii) the date ~~the~~ *any* subwork order was written; (iv) a description of the work to be done *and the work to be done* by the subcontractor, including diagrams *or digital files*, if necessary; (v) a specification of the type and quality of materials to be used; and (vi) the signature of the person issuing the *disclosure and* subwork order.

The subcontractor shall retain the subwork order, and the issuer shall retain a duplicate *of the subwork order, which shall be* attached to the work order received from the licensed dentist, for three years.

D. No person, firm, or corporation engaged in the construction or repair of appliances shall refuse to allow the Board or its agents to inspect the files of work orders or subwork orders during ordinary business hours.

~~The provisions of this section shall not apply to a work order for the construction, reproduction, or repair, extraorally, of prosthetic dentures, bridges, or other replacements for a part of a tooth, a tooth, or teeth, done by a person, firm or corporation pursuant to a written work order received from a licensed dentist who is residing and practicing in another state.~~

SLEEP APNEA HOME SLEEP STUDIES

During the Board's March 19, 2021 meeting, discussion of the comments received from **AASM** and **AADSM** regarding ordering home sleep tests was referred to the Regulatory-Legislative Committee for discussion.

AASM's written comments are attached.

Dr. Erika Mason addressed her concerns about the letter from the American Academy of Sleep Medicine (AASM) which asks the Board to change or incorporate some rules to not allow dentists to use a home sleep test for the treatment of patients with obstructive sleep apnea. She said the AASM had misrepresented the article the American Academy of Dental Sleep Medicine (AADSM) provided. Dr. Mason said that dentists do not want to use the home sleep test for diagnostic purposes, but as something that would benefit the patient to make sure they receive proper treatment and is good for their health. Dr. Mason encouraged having further discussion about this issue before making any determinations about changing laws or regulations.

Dr. Alexander Vaughan stated that the AASM letter was sent to all state Boards. The AADSM found that only ordering the home sleep test was within the scope of dentistry. The AASM is focused on testing and the interpretation of that test; however, the AADSM is focused on ordering the administration of testing, which is within the scope of the practice of dentistry. Dr. Vaughan encouraged the Board to either take no action with respect to the letter received from AASM or consider appointing a regulatory advisory panel composed of the stakeholders and specialties so that information could be provided from both sides to address the regulatory issue. Dr. Vaughan offered to assist the Board in discussion of this subject.

Sandra Reen

From: denbd@dhp.virginia.gov
Sent: Friday, March 5, 2021 5:08 PM
To: Sandra Reen; jamie.sacksteder@dhp.virginia.gov
Subject: FW: Dental Scope of Practice & Sleep Apnea Concerns
Attachments: Dental Scope of Practice Final Joint Letter.pdf

From: Kannan Ramar, MD <kramar@aasm.org>
Sent: Friday, March 5, 2021 4:22 PM
To: denbd@dhp.virginia.gov
Cc: Eric Albrecht <ealbrecht@aasm.org>
Subject: Dental Scope of Practice & Sleep Apnea Concerns

Sandra Reen,

Attached for your review is a letter requiring your immediate attention. The American Academy of Sleep Medicine, American Thoracic Society, American Academy of Neurology, and American Academy of Otolaryngology – Head and Neck Surgery would like to express our concerns regarding a recently published position statement issued by the American Academy of Dental Sleep Medicine on the use of home sleep apnea tests (HSATs) by dentists. Please see the attached letter outlining our concerns; we urge you to adopt language clarifying the scope of practice for dentists in your state in relation to the use of HSAT.

Contact Eric Albrecht, AASM Advocacy Program Manager, at ealbrecht@aasm.org with any questions regarding this.

Kannan Ramar, MD
AASM President

AASM American Academy of SLEEP MEDICINE
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March 5, 2021

Dear Dental Board:

On behalf of the undersigned organizations, we are writing to express our concerns regarding a recently published position issued by the American Academy of Dental Sleep Medicine (AADSM). This statement encourages the use of home sleep apnea tests by dentists for the diagnosis of obstructive sleep apnea (OSA). We argue that ordering, administering, and interpreting home sleep apnea tests is outside the scope of practice for dentists, and herein are requesting that your board protect both patients and dentists in your state by adopting a policy to clarify this fact.

The AADSM position states that it is within the scope of practice for dentists to identify patients who are at risk for OSA and then order or administer diagnostic home sleep apnea tests. Furthermore, since most state dental boards have no policy addressing this issue, the AADSM position indicates that this "silence" gives dentists tacit permission to provide this medical service, which is a dangerous interpretation. This position statement is in direct conflict with that of the American Academy of Sleep Medicine (AASM) and a policy of the American Medical Association (AMA), both of which emphasize that a home sleep apnea test is a medical assessment that must be ordered by a medical provider and, moreover, must be reviewed and interpreted by a physician who is either board-certified in sleep medicine or overseen by a board-certified sleep medicine physician. The AADSM position also is not supported by the policy statement of the American Dental Association (ADA) or by a white paper from the American Association of Orthodontists (AAO).

An evidence-based AASM clinical practice guideline indicates that the decision to order a home sleep apnea test should be made by a medical provider only after reviewing the patient's medical history and conducting a face-to-face examination. The medical evaluation should include a thorough sleep history and a physical examination of the respiratory, cardiovascular, and neurologic systems. The sleep history is important because many patients have more than one sleep disorder or present with atypical sleep apnea symptoms. The medical provider also should identify chronic diseases and conditions that are associated with increased risk for OSA, such as obesity, hypertension, stroke, and congestive heart failure. An evaluation by a medical provider also is necessary to rule out conditions that place the patient at increased risk of central sleep apnea and other forms of non-obstructive sleep-disordered breathing, which typical home sleep apnea tests are insufficient to detect. While dentists can use questionnaires and examine the oral structures to screen patients for symptoms of OSA, they are untrained in conducting the comprehensive medical evaluation needed to assess OSA risk.

Based on this medical evaluation, the medical provider can determine if diagnostic testing is indicated to confirm a clinical suspicion of OSA. The selection of the appropriate diagnostic test — either in-lab polysomnography or a home sleep apnea test — is critical. Because a home sleep apnea test is less sensitive than polysomnography, it is more likely to produce false negative results when ordered inappropriately. The resulting misdiagnosis can lead to significant harm for the patient. Because dentists lack the required medical education and training needed to order, administer, and interpret diagnostic tests for OSA, implementing the AADSM position could jeopardize the quality of patient care.

In addition, the AADSM position does not align with the current national and local coverage determination policies of the Centers for Medicare & Medicaid Services (CMS) and the policies of private insurers for reimbursement of home sleep apnea tests and oral appliances for OSA.

These medical insurance policies also require a comprehensive clinical evaluation by a medical provider to determine that the test or treatment is reasonable and necessary. Patients will have to pay full price for the uncovered services provided by a dentist, dramatically increasing their out-of-pocket costs.

It is for the aforementioned reasons that our organizations urge your board to adopt a policy clarifying that ordering and administering a home sleep apnea test is outside the scope of practice for dentists in your state. We encourage you to use as a model the policy adopted by the Georgia Board of Dentistry, "Prescribing and Fabrication of Sleep Apnea Appliances":

> *Depending upon the diagnosis of the type and severity, one possible treatment option for obstructive apnea is the use of oral appliances. The design, fitting and use of oral appliances and the maintenance of oral health related to the appliance falls within the scope of practice of dentistry. The continuing evaluation of a person's sleep apnea, the effect of the oral appliance on the apnea, and the need for, and type of, alternative treatment do not fall within the scope of dentistry. Therefore, the prescribing of sleep apnea appliance does not fall within the scope of the practice of dentistry. It is the position of the Board that a dentist may not order a sleep study. Home sleep studies should only be ordered and interpreted by a licensed physician. Therefore, only under the orders of a physician should a dentist fabricate a sleep apnea appliance for the designated patient and conduct only those tasks permitted under O.C.G.A. Title 43, Chapter 11. (adopted 04/01/16)*

We thank you for your consideration of our concerns. For any additional information or to discuss this issue, please contact AASM Executive Director Steve Van Hout at (630) 737-9700.

Sincerely,

Kannan Ramar, MD, FAASM
American Academy of Sleep Medicine
President

James C. Stevens, MD, FAAN
American Academy of Neurology
President

Carol R. Bradford, MD, MS
American Academy of Otolaryngology-Head and Neck Surgery
President

Juan C. Celedón, MD, DrPH, ATSF
American Thoracic Society
President

VIRGINIA TOTAL SLEEP

April 22, 2021

Dr. Sandra Catchings
Chair, Regulatory Legislative Committee
Virginia Board of Dentistry
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Dr. Catchings and Members of the Committee,

I write to you on behalf of myself and my patients in response to the request by the American Academy of Sleep Medicine regarding home sleep testing. I believe I may offer some clarifications as the specialty of orofacial pain typically encompasses dental sleep medicine as well.

I have included with this letter a copy of my past comments at the March 19, 2021 Board Business Meeting for reference and today I wish to provider further clarification based on the discussion had during that Business Meeting.

Sleep Testing Modalities

There are generally two main modalities of "sleep testing". The most well known modality is an attended polysomnogram (PSG). As the name implies, this testing is comprised of recording multiple variables during sleep to provide a comprehensive analysis of a patient's functions during sleep. A PSG is typically completed in a sleep lab where a patient is monitored throughout the test by a Licensed Polysomnographic Technologist. The technologist's function is to apply the various electrodes and apparatus necessary for the PSG, analyze and score the study, and intervene during the study as necessary for the safety of the patient or for accuracy of the test (e.g. replace a sensor the fell off during the study).

A PSG is used to diagnose a large variety of sleep disorders including insomnia, sleep-related breathing disorders, movement disorders, disorders of excessive somnolence, and parasomnias.

A PSG will typically utilize the following "channels" for monitoring and scoring: electroencephalography, electrooculography, chin and leg electromyography, airflow, thoracoabdominal bands, snoring sensor, body position, electrocardiography, and oxygen saturation.

The second, and now much more common, modality of "sleep testing" is the home sleep apnea test (HSAT). While there are multiple defined "types" of HSATs, the general idea is that an HSAT is designed to simply evaluate a patient's breathing and effect of breathing during sleep to allow for the positive diagnosis of sleep apnea.

An HSAT is designed and approved by the FDA for at home use in which the patient is the "technologist". The patient applies the sensors and apparatus necessary for the HSAT and there is no live monitoring of the data. The other name of this test is an unattended polysomnogram.

An HSAT will typically utilize the following "channels" for monitoring and scoring: airflow, thoracoabdominal bands, body position, and oxygen saturation.

Scope of Medicine vs Dentistry

During the Business Meeting there was a comment made that Polysomnographic Technologists are regulated by the Board of Medicine. I wish to quickly highlight that Chapter 29 of Title 54.1 of the Code of Virginia, "Medicine and Other Healing Arts", § 54.1-2901 states:

A. The provisions of this chapter shall not prevent or prohibit:
    5. Any dentist, pharmacist or optometrist from rendering care or services within the scope of his usual professional activities

A plain text reading is clear that while the Board of Medicine may regulate Polysomnographic Technologists, that the existence of such license and regulation has no bearing on the practice of dentistry.

As the committee is aware, dentistry is defined in Chapter 27 of Title 54.1 of the Code of Virginia as:

> "'Dentistry' means the evaluation, diagnosis, prevention, and treatment, through surgical, nonsurgical, or related procedures, of diseases, disorders, and conditions of the oral cavity and the maxillofacial, adjacent, and associated structures and their impact on the human body."

Obstructive sleep apnea is typically managed through one of 4 main modalities. Positive airway pressure devices (CPAP, APAP, BiPAP), oral appliance therapy (mandibular advancement device, tongue retainer device), maxillomandibular advancement surgery (MMA), and/or hypoglossal nerve stimulation (HNS). Of those modalities, 3 clearly target intra-oral structures (oral appliance therapy, MMA, and HNS) with the remaining modality, PAP devices, targeting the oropharynx.

These modalities target the oral cavity as well as adjacent and associated structures specifically because the etiology of obstructive sleep apnea is so often related to these structures and their associated collapse during sleep.

There is clearly no question that the treatment of obstructive sleep apnea falls within the scope of dentistry. As dentistry is currently defined, our license includes not only the treatment by the evaluation of these conditions as well.

Ordering vs Diagnosing

At the heart of this discussion is an important distinction between ordering vs interpreting/diagnosing. Specifically, the American Academy of Dental Sleep Medicine (AADSM) position paper states that ordering an HSAT is within the scope of dentistry and that only a sleep physician can render the diagnosis.

The American Academy of Sleep Medicine's (AASM) letter improperly implied that the AADSM was advocating that both ordering and interpreting were within the scope of dentistry. At this time, there was no such recommendation from the AADSM to include diagnosing sleep apnea.

As the AASM and AADSM both highlight, obstructive sleep apnea is only one of many different sleep disorders and as such, a sleep physician in an important factor in accurate diagnosis. This is why the AADSM is not advocating that dentists provide the diagnosis of apnea.

Like other diagnostic testing such as radiology, pathology, and serology, home sleep testing is comprised of ordering, rendering, and interpreting. These stages can be completed by the same provider or multiple providers. Within dentistry, for example, we often order, expose, and interpret our own radiographs; whereas in medicine, the ordering, rendering, and interpreting provider are often 3 separate providers.

The AADSM position is that the ordering and dispensing of home sleep apnea testing is within the scope of dentistry as evaluation of a patient's oral structures is clearly within the scope of dentistry.

As a home sleep apnea test is approved by the FDA for at-home use, many HSATs are dispensed through mail-order services. In these cases the study is ordered by a provider and the study is then sent to the patient directly with no contact with a provider.

Prior Board Determinations

During the Business Meeting, Dr. Zapatero noted that the AADSM website lists that Virginia does not allow dentists to order an HSAT. This is based on a quote attributed to the "Board of Dentistry" that states:

> The advice given to me by the Board's attorney, in response to previous inquiries from dentists about testing patients for sleep apnea, is that a Virginia dentist may refer a patient to a polysomnographic technologist for a sleep study but a Virginia dentist cannot conduct sleep studies. The technologist is required to report sleep study results to the supervising physician who could refer the patient to a dentist for dental treatment.

In my search of the Board of Dentistry's website as well as the minutes of past meetings of the Board, I was unable to find any determination of the boards position as it relates to this question.

If there was a past discussion of the board as it relates to this matter, it may be helpful to have that cited as currently there is no published opinion of the board and the AADSM may have been provided inaccurate information leading to the statement on their website.

However, this has clearly led to confusion and it may be prudent for the Board to provide an official opinion or request that the AADSM update their website by removing this reference.

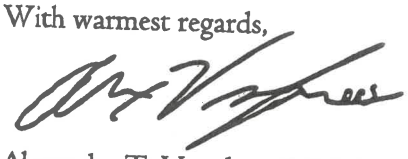
Requested Action

My hope is that this letter has provided some insight into the complexities of this issue. I am also hopeful that it has shown that these complexities involve multiple stakeholders. As indicated by the Public Participation Guidelines of the Board in 18VAC60-11-70, it would be my request that the Committee recommend the formation of a regulatory advisory panel (RAP) to provide the professional specialization needed to assist the agency in addressing this specific regulatory issue.

Alternatively, if the Committee feels it has been provided with enough background on this question, then I believe it is clear that the ordering of a home sleep apnea test is within the scope of dentistry. This would not include the diagnostic interpretation of such a study as that would be reserved for a sleep physician.

I thank the Committee for the time and careful consideration of this request. I also offer my support or help in any manor as one of the few orofacial pain specialists in Virginia and would be happy to provide further comment as requested. Should the Committee or Board determine that the formation of a RAP is appropriate, I also will happily serve if requested by the Board.

With warmest regards,



Alexander T. Vaughan, DDS, MS
Dental Director, Orofacial Pain
Virginia Total Sleep

Diplomate, American Board of Orofacial Pain
Fellow, American Academy of Orofacial Pain

VS VIRGINIA TOTAL SLEEP

March 18, 2021

Dr. Augustus Petticolas
President
Virginia Board of Dentistry
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Dr. Petticolas and Members of the Virginia Board of Dentistry,

As one of Virginia's orofacial pain specialists, I'd like to take a brief moment to respond to a letter sent by the American Academy of Sleep Medicine (AASM) to all state boards of dentistry. In their letter, the AASM highlights their concerns regarding the recently published position statement of the American Academy of Dental Sleep Medicine. In that position, the American Academy of Dental Sleep Medicine finds that ordering of home sleep tests is within the scope of dentistry. Importantly, this position statement does not state that interpretation of these tests is within the scope of dentistry.

According to a report commissioned by the American Academy of Sleep Medicine and published in 2016, an estimated 29.4 million adults in the United States at that time had sleep apnea and of those, 80% were undiagnosed. In 2019, studies estimated an increase to 54 million adults with sleep apnea. Assuming 80% remained undiagnosed, that may leave as many as 43 million undiagnosed.

Of concern to me, my patients, and my colleagues is that this straw man argument regarding interpreting sleep tests will continue to harm the 80% of patients with sleep apnea that remain undiagnosed due to reduced access to care currently available.

In their letter, our physician colleagues consistently refer to home sleep studies as "medical" testing, inferring that there is somehow a different patient between the two fields. We would never say a pediatrician examining a patient's mouth for tooth development or a physician managing oral candidiasis is providing "dental" treatment. After all, we should be allies fighting this fight together as we are both treating our patient's overall health.

To provide context, a home sleep test typically measures respiratory volume, respiratory effort, pulse rate, and blood oxygenation while a patient sleeps. If we consider these metrics as something only a physician is qualified to measure, would that not imply that dentists should no longer perform sedation? Afterall, the standards for sedation require monitoring of those exact same values.

Again, I wish to highlight where I feel our physician colleagues may have erred. The American Academy of Dental Sleep Medicine's position statement clearly states that ordering and administering testing is within the scope of dentistry but that "data from [Home Sleep Apnea Tests] should be interpreted by a licensed medical provider for initial diagnosis and verification of treatment efficacy."

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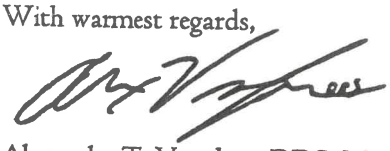
This is a similar situation to that of hypertension. Dentists have played an extremely key role in the early detection and treatment of hypertension through monitoring our patients with appropriate referral to physicians for interpretation of these test values. As we know, many of our healthy patients see their dentists more often than their physicians and we are a key component of the early detection of many diseases.

Fortunately, both medicine and dentistry practice self-governance. Just as it would be inappropriate for a dentist to attempt to restrict the practice of medicine, so too is it inappropriate for medical associations to attempt to restrict the practice of dentistry, chiropractic, pharmacy, or the practice of any of our other colleagues in the health professions.

I strongly urge the board to either consider the aforementioned letter as received with no action or, should there be a desire to take these concerns under further review, to appoint a Regulatory Advisory Panel composed of the various stakeholders and specialties to provide the professional specialization and expertise necessary to address this specific regulatory issue.

As one of the now 4 orofacial pain specialists that are licensed in Virginia, I am happy to provide any guidance, support, background, and help that the board deems necessary and appropriate as it relates to this matter or any other orofacial pain matter in the future. Thank you very much for your time and careful consideration of these issues.

With warmest regards,



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