

PUBLIC PACKET

**OREGON BOARD
OF
DENTISTRY**

**BOARD MEETING
FEBRUARY 27, 2026**





Oregon

Tina Kotek, Governor

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

NOTICE OF REGULAR MEETING

www.oregon.gov/dentistry

PLACE: BOARD OFFICE & VIRTUAL VIA ZOOM
DATE: February 27, 2026
TIME: 8:00 a.m. – 3:00 p.m.

Call to Order – Aarati Kalluri, D.D.S. – President

8:00 a.m.

OPEN SESSION (Zoom option available)

<https://us02web.zoom.us/j/82525047988?pwd=IsfaUf7ZGoqSWlpaT1OrYAcYGSvl7p.1>

Phone # 1-253 205 0468 Meeting ID: 825 2504 7988 Passcode: 589079

Confirm Quorum & Review Agenda

1. Approval of Minutes
 - December 12, 2025 Board Meeting Minutes

NEW BUSINESS

2. Association Reports
 - Oregon Dental Association
 - Oregon Dental Hygienists' Association
 - Oregon Dental Assistants Association
3. Committee and Liaison Reports
 - DAWSAC Meeting 12.9.2025 – Chair Dr. Clark
 - Meeting minutes
 - DAWSAC Meeting 2.17.2026 – Chair Dr. Clark
 - Draft meeting minutes
 - Oregon Dental Assistant Shortage Proposal
 - Committee & Liaison Assignments
4. Executive Director's Report
 - Board Member & Staff Updates
 - Required Workday Learning
 - OBD Budget Report
 - Customer Service Survey
 - FY 2025 Accounts Receivable Honor Roll
 - 2026 Dental License Renewal
 - Staff Speaking Engagements
 - 2026 Legislative Session
 - AADB Mid-Year Meeting
 - CRDTS Annual Meeting
5. Unfinished Business and Rules
 - Board of Dentistry Fingerprint Authority
6. Correspondence
 - ADEX Supports State Dental Boards
 - ADEX Report of Licensure Examinations

Notes:

(1) The meeting location is accessible to persons with disabilities. A request for an interpreter for the hearing impaired or for other accommodations for persons with disabilities should be made at least 48 hours before the meeting to Haley Robinson at (971) 673-3200.

(2) The Board may from time to time throughout the meeting enter into Executive Session to discuss matters on the agenda for any of the reasons specified in ORS 192.660.

Prior to entering into Executive Session, the Board President will announce the nature of and authority for holding the Executive Session. No final action will be taken in Executive Session.

- OHP Clinical Connections Series
- EBAS Request to Present at Board Meeting

7. Other

- OBD Recognition as 2025 Wellbeing First Champion – Lorna Breen Heroes’ Foundation
- OPMC Membership Recruitment Notice
- CSG License Compact
 - Draft Rules
 - February 19, 2026 Meeting
- Tribes – Open Comment Period
- Open Public Comment Period – Public comment is limited to matters on the public meeting agenda or otherwise relevant to matters that may come before the OBD. Comments will not be allowed that are longer than the time allotted by the President or are disruptive to the OBD’s conduct of its business.

8. Articles & Newsletters (No Action Necessary)

- Artificial Intelligence in Dentistry - A Descriptive Review
- ADA White Paper - Dentistry — Overview of Artificial and Augmented Intelligence Uses in Dentistry
- Health Policy Institute - ADA - Trends in Dentists’ Income, Revenue, and Hours Worked

Executive Session Legal Advice per ORS 192.660(2)(f).

Open public comment re: Executive Director Recruitment

- Open public comment period

Executive Recruitment Overview: John Paschal, DAS CHRO Executive Recruiter will join the meeting to offer general insights into executive recruitment processes, estimated timelines, and to answer any questions the Board may have.

Board discussion

EXECUTIVE SESSION

10:30 a.m.

The Board will meet in Executive Session pursuant to ORS 192.345(4); ORS 192.660(2)(f), ORS 192.660(2)(f)(h) and (l); ORS 676.165, ORS 676.175(1) and ORS 679.320 to review records exempt from public disclosure, to review confidential materials and investigatory information, consider legal advice in regards to the Executive Director recruitment process, and to consult with counsel. No final action will be taken in Executive Session.

9. Review New Cases Placed on Consent Agenda
10. Review New Case Summary Reports
11. Review Completed Investigative Reports
12. Previous Cases Requiring Further Board Consideration
13. Compliance and Monitoring Reports
14. Licensing and Examination Issues
15. Consult with Counsel

LUNCH

11:30 a.m.

OPEN SESSION

12:00 p.m.

(Zoom option available)

<https://us02web.zoom.us/j/82525047988?pwd=IsfaUf7ZGogSWIpaT1OrYAcYGSvl7p.1>

Phone # 1-253 205 0468 Meeting ID: 825 2504 7988 Passcode: 589079

Enforcement Actions (vote on cases reviewed in Executive Session)

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 (2) The Board may from time to time throughout the meeting enter into Executive Session to discuss matters on the agenda for any of the reasons specified in ORS 192.660. Prior to entering into Executive Session, the Board President will announce the nature of and authority for holding the Executive Session. No final action will be taken in Executive Session.

LICENSURE AND EXAMINATION

16. Ratification of Licenses Issued

17. License and Examination Issues

- Request for reinstatement of an expired license - Tyler Fix, DMD
- Request for reinstatement of an expired license - Dena M Schimel, RDH

20-Minute Break

18. Strategic Planning

1:00 p.m.

The next regular Board Meeting is scheduled for April 24, 2026.

ADJOURN

3:00 p.m.

Notes:

(1) A working lunch will be served for Board members at approximately 11:30 a.m.

(2) The meeting location is accessible to persons with disabilities. A request for an interpreter for the hearing impaired or for other accommodations for persons with disabilities should be made at least 48 hours before the meeting to Haley Robinson at (971) 673-3200.

(3) The Board may from time to time throughout the meeting enter into Executive Session to discuss matters on the agenda for any of the reasons specified in ORS 192.660.

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APPROVAL OF MINUTES

DRAFT
OREGON BOARD OF DENTISTRY
MINUTES
DECEMBER 12, 2025

MEMBERS PRESENT: Aarati Kalluri, D.D.S., President
Sheena Kalia, D.D.S., Vice President
Reza Sharifi, D.M.D.
Terrence Clark, D.M.D.
Michelle Aldrich, D.M.D.
Olesya Salathe, D.M.D.
Kristen Simmons, R.D.H., E.P.P.
Sharity Ludwig, R.D.H., E.P.P.
Ginny Jorgensen
Kieshawn Lewis

STAFF PRESENT: Haley Robinson, Interim Executive Director
Angela Smorra, D.M.D., Dental Director/ Chief Investigator
Winthrop “Bernie” Carter, D.D.S., Dental Investigator
Kathleen McNeal, Licensing Manager
Gabriel Kubik, Investigator
Dawn Dreasher, Office Specialist

ALSO PRESENT: Joanna Tucker-Davis, Sr. Assistant Attorney General

VISITORS ALSO PRESENT: Brett Hamilton, Director of Government and Regulatory Affairs (ODA); Lisa Rowley, Advocacy & Membership Director, Oregon Dental Hygienists’ Association (ODHA); Mary Harrison, Vice President, Oregon Dental Assistants Association (ODAA); Stephen Quimby, R.D.H., President-Elect of ODHA; Jen Coyne, CEO, The PEAK Fleet; Tyler Anderson, Assistant Attorney General;

VIA ZOOM*: Amberlena Fairlee, D.M.D., President, Oregon Dental Association (ODA); John Paschal, Executive Recruiter, DAS CHRO; Sherry Lauer, Client Agency HR Manager, DAS

*This list is not exhaustive, as it was not possible to verify all participants on the Zoom.

Call to Order: The meeting was called to order by the President at 8:02 a.m. President Kalluri then read the Mission Statement as follows:

The mission of the Oregon Board of Dentistry is to promote quality oral health care and protect all communities in the State of Oregon by equitably and ethically regulating dental professionals.

President Kalluri welcomed everyone to the meeting and had the Board Members, Joanna Tucker-Davis, and Haley Robinson introduce themselves.

NEW BUSINESS

Approval of October 24, 2025 Minutes

Dr. Aldrich asked whether the minutes should reflect the disruptions during the October Board meeting. Ms. Robinson offered that Board staff would review the Zoom records and document the Zoom disruptions from that meeting.

Dr. Kalluri moved and RS seconded that the Board approve the minutes from the October 24, 2025, Board Meeting as presented. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, GJ, and KL voting Aye.

ASSOCIATION REPORTS

Oregon Dental Association (ODA)

Dr. Amberena Fairlee, President of ODA, greeted everyone with a message of “Happy Holidays.” Dr. Fairlee thanked the Board for giving her the opportunity to provide the association report and shared that she is honored to serve as the President of the ODA. Dr. Fairlee expressed ODA’s gratitude to the Board for its dedication to the dental profession and stated that the Board’s commitment is deeply appreciated. Dr. Fairlee reflected on Stephen Prisby’s service and contributions to the Board and wished him the very best. Dr. Fairlee stated that the ODA is looking forward to working with Ms. Robinson as Interim Executive Director and continuing collaborative efforts with the Board.

Dr. Fairlee stated that she serves on the Dental Assistant Workforce Shortage Advisory Committee (DAWSAC) and that it has been an interesting and valuable experience. She stressed that workforce challenges remain a top priority and that she is looking forward to exploring innovative opportunities to address these issues together.

Dr. Fairlee reported that ODA held its Regional Event in Lincoln City and that it was a great success. Dr. Fairlee elaborated that members enjoyed learning and connecting in person and expressed appreciation to everyone who participated.

Dr. Fairlee announced that ODA will be hosting its Winter Webinar Series for members beginning in January. Dr. Fairlee added that the first topic will be Ensuring Effective Communication with Clients Who Are Hard of Hearing, which she described as a timely

and important subject for dental practices.

Dr. Fairlee shared that ODA has been awarded an ADA State Public Affairs (SPA) Program grant. Dr. Fairlee noted that this grant aligns perfectly with ODA's strategic plan focus of addressing workforce challenges. Dr. Fairlee explained that these resources will help ODA expand outreach, build coalitions, and strengthen communication efforts.

Dr. Fairlee said ODA looks forward to beginning discussions on the 2026-2029 Strategic Plan priorities. Dr. Fairlee presented a few suggestions ODA would like to offer for consideration:

- Workforce and access to care
- The changing landscape of dentistry, including technology such as AI and large practice organizations
- Clarification of current rules and regulations

Dr. Fairlee again thanked everyone for their time and continued commitment to advancing dentistry in Oregon, adding that she looked forward to working together as we move into the new year.

Oregon Dental Hygienists' Association (ODHA)

Lisa Rowley, Advocacy & Membership Director of ODHA, announced this year's **ODHA Annual Membership Meeting** has been postponed until January because December has become too busy for everyone. Ms. Rowley added that agenda items will include a message from ADHA President Lancette Van Guilder, a report from our ADHA District XI Director Laura Vanderwerf, 2025 ODHA accomplishments & annual reports, introduction of 2026 ODHA board members, and a preview of ODHA 2026 events.

Ms. Rowley reported that ODHA hosted a webinar for dental hygiene educators in Oregon to discuss the new clinical examination for dental hygiene. Ms. Rowley said twenty educators participated and were able to get their questions answered by the Joint Commission on National Dental Examinations (JCNDE), the same agency that develops and administers the National Board Dental Hygiene Exam (NBDHE). Ms. Rowley explained that JCNDE has launched a new clinical board examination for dental hygiene licensure. Ms. Rowley explained that the **Dental Hygiene Licensure Objective Structured Clinical Examination (DHLOSCE)** is a computer-based exam that uses three-dimensional models, clinical cases, and real-world scenarios to fairly and accurately evaluate if candidates have the level of clinical judgement and skills necessary to safely practice dental hygiene. Ms. Rowley added that this new clinical board examination will help states move away from requiring live patient or manikin-based clinical board examinations for dental hygiene licensure. Ms. Rowley stated that the Oregon Board of Dentistry currently accepts the Dental Licensure Objective Structured Clinical Examination (DLOSCE) for dental licensure and will accept the DHLOSCE for dental

hygiene licensure. Ms. Rowley said the DLOSCE and the DHLOSCE are both offered at Prometric Test Centers. Ms. Rowley noted that the JCNDE has approved a special offer for candidates who are currently enrolled in a dental hygiene program in Oregon. Ms. Rowley said that these candidates will be able to take the DHLOSCE once at no cost (a \$575 savings) in 2025 and 2026. Ms. Rowley added that if these candidates do attempt the DHLOSCE in 2025 or 2026, they will also receive a \$525 refund on their NBDHE fee. Ms. Rowley provided the following link for more information about the DHLOSCE: <https://jcnde.ada.org/dhlosce>.

Oregon Dental Assistants Association (ODAA)

Mary Harrison, Vice President (ODAA) offered Holiday greetings to everyone. Ms. Harrison stated that ODAA appreciates being part of the dental team and participating in the Oregon Board of Dentistry's (OBD) meetings and activities, explaining that DAWSAC is a great opportunity for dental assistants in the state to be heard. Ms. Harrison stated that ODAA appreciates the Board's movement on the activities and recommendations DAWSAC has presented to the Board.

Ms. Harrison reported that ODAA continues to work on workforce issues and has updated the ODAA website to include a New Job Placement area. Ms. Harrison encouraged everyone to visit the website to view updates of education courses, meetings, assistant recognition, and other important activities and information.

Ms. Harrison expressed her concern that ODAA's input be included in the Board's strategic planning, especially since dental assisting is a prominent priority on the agenda.

Ms. Harrison concluded with the hope that the holidays bring good times and many fun memories to all and their families.

COMMITTEE AND LIAISON REPORTS

Dental Assistant Workforce Shortage Advisory Committee (DAWSAC)

Dr. Kalluri reported that DAWSAC met on December 9, 2025, and that the draft meeting minutes will be available at the next Board meeting on February 27, 2026.

ADEX Council on Examinations

The Board discussed the appointment of a new Dental Member to the ADEX Council on Examination. Ms. Robinson said she would investigate whether Dr. Clark's appointment to CRDTS would automatically enroll him in the ADEX Council because of the recent merger. Dr. Salathe volunteered to be a Dental Member for the ADEX Council.

Healthy Smiles, Healthy Hearts Initiative

Dr. Salathe presented an overview of the Healthy Smiles, Healthy Hearts initiative. Dr. Salathe discussed the value of taking blood pressure readings during dental visits and

identified resources for dental professionals. Dr. Salathe shared a video of her patient describing his experience of having his blood pressure taken during his dental visit, which may have saved his life. The Board briefly discussed cooperation between dental and medical offices.

EXECUTIVE DIRECTOR'S REPORT

Staff Updates

Interim Director Robinson announced that the OBD will be closed for the holidays on Thursday, Dec. 25th and Thursday, Jan. 1st. Ms. Robinson stated that most OBD Staff will be taking time off throughout December, but that emails and calls will still be responded to promptly when the OBD is open during regular business hours.

Ms. Robinson reported that Dr. Carter gave a presentation to OHSU third- and fourth-year dental students on November 3rd. Dr. Carter shared an overview of his presentation and discussed the benefits of OBD staff presenting every other year at bridge meetings to reach all classes and more faculty.

Ms. Robinson shared that Kathleen McNeal celebrated her 4-year Work Anniversary on November 29th.

OBD Budget Status Report

Ms. Robinson presented the budget report for the 2025 – 2027 Biennium. Ms. Robinson highlighted that this report, which is from October 1, 2025, through November 16, 2025, shows revenue of \$103,560.10 and expenditures of \$172,940.01.

OHA Fee Increase

Ms. Robinson reported that the Oregon Health Authority submitted a fee increase request that, if approved by DAS, would go into effect January 1, 2026. Ms. Robinson explained that OHA is proposing a \$2 increase to the existing fees that the health licensing boards collect and transfer to OHA to support Health Workforce Reporting Program (HWRP) operations. Ms. Robinson said she would have more information to share with the Board at the February 27th meeting.

American Board of Dental Examiners (ADEX) Letter

Ms. Robinson directed the Board's attention to a recap of the ADEX annual meeting submitted to the OBD, which memorialized important work and actions from that October meeting.

Customer Service Survey

Ms. Robinson reported that, in customer service surveys received from July 1, 2025 – November 30, 2025, a majority rated their experience with us positively.

UNFINISHED BUSINESS AND RULES

Dr. Kalluri directed the Board's attention to the Secretary of State filing, wherein the Board amended 9 rules that went into effect on December 1, 2025. Ms. Robinson provided a brief overview of the rule changes.

Ms. Robinson informed the Board that rule changes related to the merger of CDCA-WREB-CITA into ADEX will be discussed at the next Licensing, Standards and Competency Committee meeting.

CORRESPONDENCE

- October 14, 2025 OHA letter to the OBD supporting expanding the scope of practice for dental hygienists and dental therapists to include administering vaccines, especially for HPV.

The Board briefly discussed the potential scope of practice change for dental hygienists and dental therapists.

- November 20, 2025 ODHA Letter Recognizing Stephen Prisby
- November 10, 2025 ODAA Letter Recognizing Stephen Prisby

Ms. Robinson recognized Stephen Prisby for his 13 years of service to the Board and wished him well as he leaves state service.

- ADA and ADEX Joint Statement

The Board briefly discussed the implications of standardized examinations and portability opportunities for licensees.

OTHER

Items were in the Board meeting packet for informational purposes.

- November 5, 2025, CODA Letter to OBD regarding State Board Participation on 2026 Accreditation Site Visits

Board members shared some of their experiences participating in site visits. Dr. Aldrich volunteered to participate in the Rogue Community College on April 15-16, 2026.

President Kalluri invited Stephen Quimby, President-Elect of ODHA, to introduce himself.

- November 21, 2025 OHA Memo regarding Immunization Counseling

2026 – 2029 Strategic Planning Update

Ms. Robinson reminded the Board that the OBD will undertake strategic planning in person in February 2026. Ms. Robinson presented a draft of possible strategic plan priorities and a draft survey for discussion.

Ms. Robinson introduced Jen Coyne, CEO of The PEAK Fleet, as the selected facilitator for the Board's strategic planning session. Ms. Coyne presented information about herself and her company, including her work with the OBD in 2021. Ms. Coyne offered an overview of the strategic planning process and led Board members and OBD staff in a rapport-building exercise.

Ms. Robinson announced that, at next Board meeting on February 27th, about an hour of time would be devoted to setting up for the strategic planning meeting the next day. The strategic planning meeting will be held in the Board conference room on Saturday, February 28th. Ms. Robinson thanked Board members for making arrangements to attend and participate in this important activity.

Ms. Robinson reviewed strategic priorities from the previous planning session and how the Board has addressed them. The Board discussed logistics of the planning session.

The Board reviewed and discussed changes to the draft survey. Ms. Robinson said she would incorporate members' ideas into the survey and reach out to the Oregon Government Ethics Commission (OGEC) for guidance about how to proceed.

- Other Public Comment (no comments)
- Tribes (no comments)

ARTICLES AND NEWS

- DANB Summit – AI & Dental Assisting

The Board discussed some of the benefits and drawbacks of using AI in the dental office. Dr. Smorra offered to include in the February board book a 2022 white paper from the ADA regarding AI.

- Dental Assisting Professional Model Overview

Ms. Jorgensen initiated a discussion about how existing Oregon dental assisting pathways might fit into the professional model. The Board discussed professional development of dental assistants and the workforce shortage. The Board discussed supporting legislation to expand the number of Board members to include representatives from the dental assisting and dental therapy professions. Ms. Robinson offered to reach out to the Governor's office for guidance about how the Board might proceed in expanding its membership.

- October 31, 2025, FDA Letter to Health Care Professionals regarding Fluoride

The Board discussed the FDA's recommendations and current practices.

EXECUTIVE SESSION: The Board entered into Executive Session pursuant to ORS 192.345(4); ORS 192.660(2)(f), ORS 192.660(2)(f)(h) and (l); ORS 676.165, ORS 676.175(1) and ORS 679.320 to review confidential investigations, consider exempt records and to consult with legal counsel.

OPEN SESSION: The Board returned to Open Session at 11:56 p.m. President Kalluri took roll call and announced the Board had a quorum.

EXECUTIVE RECRUITMENT OVERVIEW

John Paschal, DAS CHRO Executive Recruiter, presented general insights into executive recruitment processes, estimated timelines, and answered questions from Board Members regarding filling the Board's executive director position.

Board members reviewed Interim Executive Director Robinson's resume and discussed Ms. Robinson's qualifications.

Dr. Clark offered his support for Ms. Robinson. Dr. Kalluri offered her support for Ms. Robinson. Dr. Sharifi offered his support for Ms. Robinson.

Ms. Robinson gave remarks about her vision for the Board's future.

Ms. Jorgenson offered her support for Ms. Robinson, sharing Ms. Robinson's recent outreach to the dental assisting community. Ms. Simmons offered her support for Ms. Robinson. Dr. Aldrich offered her support for Ms. Robinson. Dr. Kalia offered her support for Ms. Robinson.

Dr. Kalluri moved and Dr. Kalia seconded that the Board directly appoint Haley Robinson as Executive Director. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, GJ, and KL voting Aye.

Dr. Sharifi moved and Dr. Kalluri seconded that the Board direct DAS to facilitate the direct appointment process and negotiation. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, GJ, and KL voting Aye.

EXECUTIVE SESSION: The Board entered into Executive Session pursuant to ORS 192.345(4); ORS 192.660(2)(f), ORS 192.660(2)(f)(h) and (l); ORS 676.165, ORS 676.175(1) and ORS 679.320 to review confidential investigations, consider exempt records and to consult with legal counsel.

OPEN SESSION: The Board returned to Open Session at 1:50 p.m. President Kalluri took roll call and announced the Board had a quorum.

***Note the Board Members' votes are identified by their initials.**

CONSENT AGENDA

2026-0056, 2026-0070, 2026-0091, 2026-0080, 2026-0087, 2026-0075, 2026-0073, 2026-0089, 2026-0071, 2026-0079, 2026-0090, 2026-0084, 2026-0081, 2026-0042

Dr. Kalia moved and Dr. Sharifi seconded that the Board close the matters with a finding of No Violation or No Further Action. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, GJ, and KL voting Aye.

COMPLETED CASES

2026-0059, 2026-0057, 2026-0082, 2026-0043, 2026-0001

Dr. Kalia moved and Dr. Sharifi seconded that the Board close the matters with a finding of No Violation or No Further Action. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, GJ, and KL voting Aye.

2026-0009

Dr. Sharifi moved and Dr. Kalluri seconded that the Board close the matter with a Letter of Concern. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, GJ, and KL voting Aye.

JOHN K. SULLIVAN, D.D.S.; 2025-0194 and 2026-0083

Mr. Lewis moved and Dr. Sharifi seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand, dental license revocation, and a \$9,000.00 civil penalty to be paid within 120 days of the effective date of the order.

PREVIOUS CASES REQUIRING BOARD ACTION

2025-0193

Dr. Aldrich moved and Dr. Kalia seconded that the Board deny the request under ORS 676.175. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, GJ, and KL voting Aye.

RATIFICATION OF LICENSES

Ms. Simmons moved and Dr. Kalia seconded that the Board ratify the licenses presented in Tab 16. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, GJ, and KL voting Aye.

LICENSE, PERMIT & CERTIFICATION

Ms. Ludwig moved and Dr. Sharifi seconded that the Board approve Interim Therapeutic Restorative (ITR) course for Capitol Dental Care. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, GJ, and KL voting Aye.

Ms. Jorgensen moved and Dr. Kalluri seconded that the Board approve the reinstatement of expired license for Colette Rose Graham, R.D.H. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, GJ, and KL voting Aye.

ADJOURNMENT

Dr. Kalluri announced that the next Board Meeting was scheduled for February 27, 2026, at 8:00 a.m.

The meeting was adjourned at 1:56 p.m.

Aarati Kalluri, D.D.S., President

ASSOCIATION REPORTS

**Oregon Board of Dentistry Meeting
February 27, 2026**

Oregon Dental Hygienists' Association

Sheba N. Jones, MSDH, RDH, CHSE, FADHA, is the new Dental Hygiene Program Director for **Concorde Career College** located in northeast Portland. Sheba is a dental hygiene educator, program leader & clinical dental hygienist with nearly 25 years of experience in dentistry. Sheba's career spans private practice, corporate dentistry, public health, research, & higher education, with a strong focus on developing clinically confident, workforce-ready graduates. An updated list of Oregon dental hygiene programs is included with this report.

ODHA is offering a **Winter-Spring Education Series** with four continuing education courses scheduled on Thursday evenings February through May 2026. Course topics are forensic dentistry, advocacy, nitrous oxide sedation and lasers. Some of these courses will be offered in-person at one of our dental hygiene schools, and all courses will be offered virtually via Zoom & on-demand as a video recording.

ADHA has published an online article authored by Lisa Rowley titled **Expanding Scope of Practice Without Legislation** <https://www.adha.org/hygienist-hub/expanding-scope-without-legislation/>. The article describes how dental hygiene scope of practice could be expanded by making administrative rule changes with a state board of dentistry, as we have done in Oregon.

Oregon Dental Hygiene Education Programs January 5, 2026

<p>Concorde Career College Dental Hygiene Program 1425 NE Irving Street Portland, OR 97232 www.concorde.edu/dental-programs/dental-hygiene Program Director: Sheba Jones shjones@concorde.edu Class size = 32</p>	<p>Oregon Institute of Technology Salem Campus Dental Hygiene Program 4000 Lancaster Dr. NE Building 8-101 Salem, OR 97305 www.oit.edu/academics/degrees/dental-hygiene Program Director: Paula Hendrix paula.hendrix@oit.edu Class size = 20</p>
<p>Lane Community College Dental Hygiene Program 4000 E. 30th Avenue Eugene, OR 97405 www.lanecc.edu/hp/dental/dental-hygiene Program Director: Michelle Cummins cumminism@lanecc.edu Class size = 20</p>	<p>Pacific University Dental Hygiene Program 222 SE 8th Avenue, Suite 271 Hillsboro, OR 97123 www.pacificu.edu/dentalhygiene Program Director: Amy Coplen amy.coplen@pacificu.edu Class size = 32</p>
<p>Mount Hood Community College Dental Hygiene Program 26000 SE Stark Street Gresham, OR 97030 https://www.mhcc.edu/DentalHygiene/ Program Director: Jennifer Aubry jennifer.aubry@mhcc.edu Class size = 18</p>	<p>Portland Community College Dental Hygiene Program 1810 SW 5th Avenue, 3rd Floor Portland, OR 97201 www.pcc.edu/programs/dental-hygiene/ Program Director: Kimberly Pennington kimberly.pennington@pcc.edu Class size = 20</p>
<p>Oregon Institute of Technology Klamath Falls Campus Dental Hygiene Program 3201 Campus Drive Klamath Falls, OR 97601 www.oit.edu/academics/degrees/dental-hygiene Program Director: Krista Beaty Krista.beaty@oit.edu Class size = 20</p>	<p>Rogue Community College Dental Hygiene Program 7731 Pacific Avenue White City, OR 97503 www.roguecc.edu Program Director: Carmen Mons cmons@roguecc.edu Class size = 20</p>

Greetings from the ODAA!

We wish you, your family and friends a happy, peaceful 2025 holiday season. There are many things to be thankful for and one of those is having the opportunity to be a professional dental assistant who contributes to high quality dental treatment and access to care for all.

It is with great pride that we live in a progressive state where the Oregon Board of Dentistry (OBD) listened to what dentists were requesting and followed up on approving a new rule allowing Expanded Function Dental Assistants (EFDA) to complete an approved Local Anesthetic Course and obtain a Local Anesthetic Functions Certificate (LAFC).

“It makes total sense that dental assistants get the training and pass the exam that allows them to provide local anesthetic injections for dental patients”, said Dr. Dean Gregson who employs Marilyn Wilson, one of the first Oregon LAFC recipients. Although it took over 4 years to gain the support from the dental community and passage of the rule by the OBD, there are now 106 Oregon LAFC’s. Marilyn does not provide injections for all the dental patients in Dr. Gregson’s practice but throughout the busy day when there are multiple patients needing anesthetic to have her be available, “reduces the feeling of being rushed and improves the flow of the day”. Dr Gregson also mentioned it is very beneficial to not have to ask his hygienists to leave their hygiene patient to provide anesthetic for a restorative patient. It lessens an unnecessary interruption to the hygiene appointment when a dental assistant is able to provide local anesthetic injections.

Of course, not all dentists want their dental assistants to provide local anesthetic. It is completely up to the dentist and assistant to make this decision. There are dental assistants who may not want to obtain the LAFC training and are perfectly happy engaging in and performing the duties they are currently responsible for. Marilyn happens to have 28 years of experience and 12 years of employment with Dr. Gregson. She was interested in growing her career and supporting the practice with an additional certificate. Dr. Gregson was supportive along with the dental hygienists in his practice and agrees that not all dental assistants, especially those that are newly graduated or have not had an opportunity for direct patient care experiences, would be appropriate candidates for obtaining the LAFC.

Another example of a LAFC holder is Charissa Griffith. She recently passed the course and exam and has 25 years of experience as a dental assistant. She has worked for the same dentist, Dr. Gregory Williams, for her entire career. Obtaining additional certificates is not new for Charissa. She currently holds the Certified Anesthesia Dental Assistant certificate, Anesthesia Dental Assistant and the Initiation of IV line and Phlebotomy Blood Draw certificate. Charissa has challenged herself by following the Oregon dental assistant career path that is available for all Oregon dental assistants. Adding the LAFC makes her an extremely valuable asset to Dr. Williams’ practice. Charissa currently provides local anesthetic for all scheduled patients. Dr. Williams said, “It makes the day flow much better” and the “whole team is much happier”.

Both Marilyn and Charissa took the 65 Hour, Local Anesthetic OBD approved course from Teacher Tina. (Tina Clarke, RDH, MEd) They agreed it was challenging yet doable with the excellent online

preparation and the additional clinical training where the class participants practice injections on each other. Passing the exam was hard but they both felt like they were extremely prepared to provide local anesthetic for dental patients with an excellent understanding of anesthesia and injection techniques.

I spoke to one other LAFC holder, Joanne, who confirmed she is using her local anesthetic injection skills every day in the practice where she is employed. It has been a huge benefit to her dental practice. Joanne is currently enrolled in an OBD approved Restorative Functions (RFC) Course and will have her certification in the next few months. Combining the RFC with the LAFC will not only enhance access to care for dental patients but is a career advancement that is allowing her to grow her dental assisting career to the highest level possible without changing her path to hygienist or dentist.

The following Local Anesthetic approved courses are available for EFDA's:

- [Portland Community College](#)
- [Pacific University](#)
- [Teacher Tina](#)

Because this is a relatively new certification for EFDA's the dental community is still learning about the benefits and how it may fit into a dental practice. Both Dr. Gregson and Dr. Williams have discovered their patients are happy with local anesthetic being injected by their dental assistants and therefore they feel they are the lucky ones to have two of the first Oregon LAFC holders. Their dental practices are now reaping the benefits of increasing a less stressful, positive environment where their dental teams are working together to provide the best possible care for their patients. Hopefully this will encourage other dentists to promote the LAFC for their EFDA's.

The [ODAA Website](#) is filled with all things Oregon.Dental.Assisting including job postings and CE course information. Please take a moment to visit and as always, we would love to hear your feedback and how we can help to support you and your dental assisting career.

My Best to you and your families for a very special New Year,

Ginny Jorgensen, ODAA Executive Director

COMMITTEE REPORTS

**OREGON BOARD OF DENTISTRY
DENTAL ASSISTANT WORKFORCE SHORTAGE ADVISORY COMMITTEE MEETING MINUTES
(DAWSAC)
December 9, 2025**

MEMBERS PRESENT: Terrence Clark, DMD, Co-Chair
Ginny Jorgensen, Co-Chair
Amberena Fairlee, DMD – ODA Rep.
Kari Hiatt – ODAA Rep.
Lynn Murray
Carmen Mons
Alexandria Case
Jessica Andrews
Amanda Nash
Cassie Gilbert
Alyssa Kobylinsky

STAFF PRESENT: Kathleen McNeal, Licensing Manager

VISITORS PRESENT:
VIA TELECONFERENCE* Mary Harrison, ODAA; Lisa Rowley, ODHA; Brett Hamilton; ODA

*This list is not exhaustive, as it was not possible to verify all participants at the teleconference.

Call to Order: The meeting was called to order by Chair Dr. Terrence Clark at 5:00 p.m. via Zoom.

Self-Introductions of Committee Members

Chair Clark welcomed everyone to the meeting and had the DAWSAC Members introduce themselves and share information about their current positions in the dental field.

Dr. Clark announced that the Committee had a quorum.

Public Meeting Notice

Dr. Clark announced that the Committee is subject to Public Meetings Law.

Approval of September 23, 2025 Minutes

Ms. Nash moved and Ms. Andrews seconded that the Committee approve the minutes from the September 23, 2025 DAWSAC Committee Meeting as amended. The motion passed with TC, GJ, AF, KH, LM, CM, AC, JA, CS, AK and AN voting Aye.

DAWSAC Packet Introduced

A copy of HB 3223 was attached for informational purposes.

OBD Letter to the Governor

Dr. Clark directed the Committee's attention to a copy of an OBD Letter to the Governor asking for Board discretion to hold DAWSAC Meetings as needed, not each quarter. The OBD had not heard back from the Governor's office regarding the status of the request.

Arizona Oral Preventive Assistants Article

December 9, 2025

DENTAL ASSISTANT WORKFORCE SHORTAGE ADVISORY COMMITTEE MEETING

Page 1 of 2

The Committee reviewed and discussed information from Arizona that created an “Oral Preventive Assistant” which allowed dental assistants to perform scaling. Dr. Fairlee reported that at the ODA House of Delegates meeting, over 85% of the dentists in attendance wanted a scaling assistant in Oregon. She also stated that the article was an opinion-piece without any data or statistics and that it was important to rely on scientific articles. Committee members discussed scaling and various issues such as proper wages, and education.

Dr. Fairlee moved and Ms. Kobylinsky seconded for the Board to reconsider allowing dental assistants to perform scaling. GJ, KH, LM, CM, AN, JA voted nay. AF, TC, AK, and AC voted aye. The motion died.

The committee discussed getting more information and presenting it to the Board regarding dental assistants performing scaling.

DAWSAC Requests to the Board as of December 2025

Committee members discussed the requests to the Board as provided in the document. The proposed rule changes allowing dental assistants to scale has been moved to the Rules Oversight committee by the Board for further discussion. This committee discussed gathering more information regarding the issue to provide to the Rules Oversight Committee.

The request for a dental assistant registry was discussed and more information would be provided at a later date.

The 2019 dental assistant questionnaire was discussed and Ms. Robinson will provide the survey questions to discuss at the next regularly scheduled meeting.

Open Comment

Ms. Harrison commended the progress in the field of dental assistant since the formation of DAWsAC.

Committee members discussed the workforce shortage issues and the next steps necessary to address these as a committee.

ADJOURNMENT

The meeting was adjourned at 6:30 p.m. Chair Clark stated that the next DAWsAC meeting will be scheduled at a later date.

DRAFT

**OREGON BOARD OF DENTISTRY
DENTAL ASSISTANT WORKFORCE SHORTAGE ADVISORY COMMITTEE (DAWSAC)
MEETING MINUTES
February 17, 2026**

MEMBERS PRESENT: Terrence Clark, DMD, Co-Chair
Ginny Jorgensen, Co-Chair
Amberena Fairlee, DMD – ODA Rep.
Laura Vanderwerf, RDH – ODHA Rep.
Kari Hiatt – ODAA Rep.
Jessica Andrews
Alyssa Kobylinsky

STAFF PRESENT: Haley Robinson, Interim Executive Director
Angela Smorra, DMD, Dental Director/Chief Investigator
Dawn Dreasher, Office Specialist

**VISITORS PRESENT
VIA TELECONFERENCE*:** Mary Harrison, ODAA; Brett Hamilton, ODA; Ahmed Farag, DDS,
OHA; Mary Ellen Murphy

*This list is not exhaustive, as it was not possible to verify all participants at the teleconference.

Call to Order: The meeting was called to order by Chair Dr. Terrence Clark at 5:01 p.m. via Zoom. Dr. Clark announced that the Committee had a quorum.

Self-Introductions of Committee Members

Chair Clark welcomed everyone to the meeting and had the DAWSAC Members introduce themselves and share information about their current positions in the dental field.

Public Meeting Notice

Dr. Clark announced that the Committee is subject to Public Meetings Law.

DAWSAC Packet Introduced

A copy of HB 3223 was attached for informational purposes.

Dr. Clark asked Ms. Robinson for an update on DAWSAC items brought to the Board at the October and December Board meetings. Ms. Robinson reported that various issues were referred to committees. Ms. Robinson noted that the scaling issue was moved to the Rules Oversight Committee, which would convene in the next couple of months and then report back to the Board.

Approval of December 9, 2025 Minutes

Ms. Jorgensen moved and Dr. Fairlee seconded that the Committee approve the minutes from the December 9, 2025, DAWSAC Committee Meeting as presented. The motion passed with TC, GJ, AF, LV, KH, JA, and AK voting Aye.

Oral Preventative Assistant (OPA)

The Committee discussed issues related to dental assistants performing scaling, including training and workforce shortages.

Dr. Fairlee stated that the ODA will be discussing the OPA model at the next ODA board meeting. Dr. Fairlee shared that delegates polled at the last House of Delegates meeting overwhelmingly support the OPA model in some form. Dr. Fairlee stated that the ODA strategic plan includes pursuing the issue through the Board or through legislation. Dr. Fairlee said she would share the ODA Board of Trustee's position statement on the OPA model when it is available.

Ms. Vanderwerf stated that the ODHA would strongly oppose any OPA legislation on the basis of patient safety.

The Committee reviewed and discussed the materials from the meeting packet, including the University of Washington EFDA Study and Missouri Oral Preventative Assistant EFDA Pilot Project, and related research from Kansas and Illinois.

Ms. Jorgensen initiated a discussion of other possible models of dental assistant development, including hygiene assistants.

Dr. Fairlee shared her thoughts about the benefits of OPAs working in public health and in rural areas. Dr. Fairlee pointed out that instituting formal training in scaling would enhance the safety of scaling by dental assistants that is already taking place in dental offices.

The Committee discussed the status of the workforce shortage and retention issues.

Dental Assistant Surveys

Ms. Robinson presented the proposed 2026 Draft Survey Questions for Future Survey. The Committee reviewed and discussed changes to the draft survey. The Committee decided the survey should be disseminated to all dental professionals.

Dental Assistant Wage Information

The Committee discussed adding questions regarding compensation to the draft survey.

Ms. Robinson offered to provide a revised survey incorporating the Committee's suggestions at the next DAWSAC meeting.

Open Comment

No comments presented.

ADJOURNMENT

The meeting was adjourned at 6:21 p.m. The next DAWSAC meeting will be scheduled at a later date.

Oregon Dental Assistant Shortage Proposal

In July 2024 the ADA developed the ALEC Dental Access Model, which includes Oral Preventive Assistants (Scaling Dental Assistants) as a solution to address dental assistant workforce shortages/challenges. This model continues to be recommended by the ADA and state dental associations experiencing dental assistant workforce issues.

At the 12/9/25 DAWSAC meeting, the members requested ODA provide information from states that have implemented the OPA. In the DAWSAC 2/17/26 packet ODA provided several reports and information from other states who have introduced the OPA.

Currently the Oregon Employment Department lists 35 job openings for dental hygienists & 43 job openings for dental assistants. This is good news that indicates the shortage is shrinking. It may have changed since ODA wrote a letter to OBD stating, "At a time when workforce shortages are severely limiting access to dental care across the state and disrupting daily practice operations, ..." This is an important reason to obtain current accurate information from Oregon dental practices regarding dental assistant employment opportunities and open positions.

Some in the dental community continue to face dental assistant challenges that are not just the hiring of qualified dental assistants but often the ability to retain dental assistants. Research shows dental assistants remain in their positions when they earn a living wage, are provided benefits, receive respect and feel appreciated as an important dental team member and have career growth opportunities.

Following the ADA scaling assistant model may not be the only way to address the shortage/challenges. Oregon has a unique career growth pathway for dental assistants from being trained on-the-job to graduating from a CODA program.

Using the Oregon dental assistant education, training and certification pathways to develop a dental hygiene assistant is already available without the need to for an OPA. This model has been used in different formats for several years and could be a huge benefit to the current shortage of both dental hygienists and dental assistants. <https://www.danb.org/news-blog/detail/certified-press/is-assisted-hygiene-right-for-you>

I would propose that DAWSAC approach the shortage by using what our state already has available that will support dental hygienists and dental practices that are currently experiencing a shortage which can limit access to patient care.

By offering an alternative career opportunity that is directed toward dental hygiene rather than a restorative pathway, a dental assistant who holds the following certificates could perform a number of skills that would support dental hygiene practices:

- RHS Certificate
- EFDA Certificate (coronal polish)
- Pit & Fissure Sealant Certificate
- Local Anesthetic Certificate

Assisted hygiene practices could support a 2-chair model by having the assistant perform the following:

- Seat patient/review health history

- Take and record vital signs
- Expose radiographs
- Provide local anesthetic
- Provide charting support
- Coronal polish
- Sealant placement
- Fluoride application
- OHI
- Dismiss and reschedule

A hygiene assistant could be seating the next patient in a 2-chair practice while the dental hygienist is scaling in the next operator.

The list of skills could be performed by a dental assistant with the above certificates without further time, money or training that it would require for scaling. Coding would not be an issue as a dental hygienist would be perform all the scaling.

There could be numerous ways to schedule a hygiene assistant that would benefit the dental practice.

I propose investigating this avenue to address the Oregon dental assistant shortage prior to investing the time and money into an OPA Certification Program that may or may not benefit Oregon dental practices or the patients they serve.

**Oregon Board of Dentistry Committee and Liaison Assignments
May 2025 - April 2026
STANDING COMMITTEES**

Dental Assistant Workforce Shortage Advisory Committee (DAWSAC)

Purpose: To review, discuss and make recommendations to the Board on addressing workforce shortages in accordance with HB 3223 (2023).

Committee:

Terrence Clark, D.M.D., Co-Chair	Lynn Murray
Ginny Jorgensen, Co-Chair	Alexandria Case
Amberena Fairlee, D.M.D., ODA Rep.	Jessica Andrews
Laura Vanderwerf R.D.H., ODHA Rep.	Amanda Nash
Kari Hiatt, ODAA Rep.	Carmen Mons
Kimberly Perlot R.D.H., D.T.- DT Rep.	Cassie Gilbert
Alyssa Kobylinsky	Megan Barron

Licensing, Standards and Competency

Purpose: To improve licensing programs and assure competency of licensees and applicants.

Committee:

Sheena Kansal, D.D.S., Chair
Michelle Aldrich, D.M.D.
Sharity Ludwig, R.D.H.
Kieshawn Lewis
Julie Spaniel, D.D.S., ODA Rep.
Heidi Klobes, R.D.H., ODHA Rep.
Jill Lomax, ODAA Rep.
Kristen Moses, R.D.H., DT, DT Rep.

Rules Oversight

Purpose: To review and refine OBD rules.

Committee:

Aarati Kalluri, D.D.S., Chair
Olesya Salathe, D.M.D.
Kristen Simmons, R.D.H.
Ginny Jorgensen
Phillip Marucha, D.M.D., ODA Rep.
Alicia Riedman, R.D.H., ODHA Rep.
Mary Harrison, ODAA Rep.
Raelene Cabrera, R.D.H., DT, DT Rep

Dental Therapy Rules Oversight

Purpose: To draft, refine and update dental therapy rules.

Committee:

Kristen Simmons, R.D.H. Chair
Terrence Clark, D.M.D.
Ginny Jorgensen
Sarah Kowalski, R.D.H., OHA Rep.
Brandon Schwindt, D.M.D., ODA Rep.

Amy Coplen, R.D.H., DT, ODHA Rep.
Alexandria Case, ODAA Rep.
Wilbur Ramirez-Rodriguez, R.D.H., DT, DT Rep.
Raelene Cabrera, DT, DT Rep.
Miranda Davis, D.D.S., DT Rep.

Communications

Purpose: To enhance communications to all constituencies.

Committee:

Michelle Aldrich, D.M.D., Chair
Sharity Ludwig, R.D.H.
Olesya Salathe, D.M.D.
Kieshawn Lewis
Alayna Schoblaske, D.M.D., ODA Rep.
Alicia Riedman, R.D.H., ODHA Rep.
Christina Becker, ODAA Rep.
Jason Mecum, DT, DT Rep.

Dental Hygiene

Purpose: To review issues related to Dental Hygiene.

Committee:

Sharity Ludwig, R.D.H., Chair
Kristen Simmons, R.D.H.
Michelle Aldrich, D.M.D.
David J. Dowsett, D.M.D., ODA Rep.
Daniel Martinenez Tovar, R.D.H., ODHA Rep.
Lynn Murray, ODAA Rep.
Mark Kobylinsky, R.D.H., DT, DT Rep.

Enforcement and Discipline

Purpose: To improve the discipline process.

Committee:

Terrence Clark, D.M.D., Chair
Kristen Simmons, R.D.H.
Kieshawn Lewis
Jason Bajuscak, D.M.D., ODA Rep.
Jill Mason R.D.H., ODHA Rep.
Mary Harrison, ODAA Rep.
Yadira Martinez, R.D.H., DT, DT Rep.

Anesthesia

Purpose: To review and make recommendations on the Board's rules regulating the administration of sedation in dental offices.

Committee:

Reza Sharifi, D.M.D., Chair
Sheena Kansal, D.D.S.
Julie Ann Smith, D.D.S., M.D.

Brandon Schwindt, D.M.D.
Mark Mutschler, D.D.S.
Normund Auzins, D.D.S
Ryan Allred, D.M.D.
Jay Wylam, D.M.D.
Michael Doherty, D.D.S.
Eric Downey, D.D.S
Jeffrey Kobernik, D.M.D.

LIAISONS

Stephen Prisby, Executive Director and current OBD Board Members choose assignments and interest in other entities as they arise.

American Assoc. of Dental Administrators (AADA)
American Assoc. of Dental Boards (AADB)
American Board of Dental Examiners (ADEX)
CDCA WREB CITA
CRDTS-SRTA

**INTERIM
EXECUTIVE
DIRECTOR'S
REPORT**

INTERIM EXECUTIVE DIRECTOR'S REPORT

February 27, 2026

Board Member & Staff Updates

Dr. Michelle Aldrich has informed the Board that she will not seek reappointment to the OBD at the conclusion of her current term, which ends on April 3, 2026. Dr. Aldrich joined the Board on April 3, 2022, and throughout her tenure has provided exemplary service and leadership. Her clinical experience, as well as her previous licensure as a Registered Dental Hygienist, has brought significant depth and perspective to Board discussions and decision-making.

Dr. Terrence Clark has also indicated that he will not seek an additional term on the OBD. He joined the Board on April 3, 2022, and his current term concludes on April 3, 2026. We are deeply grateful for Dr. Clark's service and steadfast support of the Board's mission. His experience in private practice and his thoughtful insight have been invaluable contributions to Board deliberations and decisions.

During their service, Dr. Aldrich and Dr. Clark each chaired and participated in multiple OBD committees. They generously dedicated their time and expertise to regular and special Board meetings, committee meetings, rulemaking hearings, and workgroups. Their professionalism, leadership, and commitment have made a lasting impact on the Board's work.

We look forward to welcoming two new Board members. In the interim, we appreciate that Dr. Aldrich and Dr. Clark have graciously agreed to continue serving until their successors are appointed, ensuring a smooth and seamless transition.

CODA – Site Accreditation Visits

State Board Representative: Michelle Aldrich, DMD
Rogue Community College
Grants Pass, OR
4/15/2026-4/16/2026
Program: Dental Hygiene

We also celebrated and recognized Dr. Bernie Carter for seven years of service with the OBD on February 1st.

OBD Budget Status Report

Attached is the latest budget report for the 2025 - 2027 Biennium. This report, which is from July 1, 2025 through, January, 2026 shows revenue of \$1,095,992.66 and expenditures of \$1,125,810.09. **Attachment #1**

Customer Service Survey

Attached are the legislatively mandated survey results from July 1, 2025 – February 17, 2026. The results of the survey show that the OBD continues to receive positive ratings from the majority of those that submit a survey. **Attachment #2**

FY 2025 Accounts Receivable Honor Roll

The OBD was recognized for financial controls, again and this aligns with one of the OBD's annual goals. We strive to submit timely and accurate A/R reports, and this honor roll recognition memorializes that we do it. **Attachment #3**

2026 Dental License Renewal

The 2026 dental license renewal began in late January and will conclude on March 31 for those Oregon dentists whose license expires in 2026.

Board and Staff Speaking Engagements

Kathleen McNeal gave a License Application virtual presentation to the graduating Dental Hygiene Students at OIT in Salem on Thursday, January 22, 2026.

2026 Legislative Session

The 2026 Legislative Session began on February 2, 2026. HB 4040 is attached for your attention and discussion. **Attachment #4**

American Association of Dental Boards Mid-Year Meeting

The AADB Mid-Year Meeting is scheduled for April 24 – 25, 2026 in Rosemont, Illinois. Any Board Members interested in attending should confirm with me so I can assist with logistics and approve travel authorization. **Attachment #5**

CRDTS Annual Meeting

The CRDTS Annual Meeting is scheduled for August 28 – 29, 2026 in Omaha, NE. Any Board Members interested in attending should confirm with me so I can assist with logistics and approve travel authorization. **Attachment #6**

Newsletter

We will produce a late summer newsletter with updates on new board members, strategic planning session updates, and other important news for our Licensees.



Oregon Board of Dentistry

Date run: 2/15/2026

For the Month of **JANUARY 2026** AY 2027 FY 2026

3400 BOARD OF DENTISTRY REVENUE

D10 Compt Srce Grp	D10 Compt Srce Grp Ttl	Current Month	Bien To Date	Financial Plan	Unobligated Balance
0205	OTHER BUSINESS LICENSES	129,280.00	965,372.00	4,174,320.00	3,208,948.00
0210	OTHER NONBUSINESS LICENSES AND FEES	0.00	7,400.00	14,000.00	6,600.00
0410	CHARGES FOR SERVICES	696.50	7,941.50	146,000.00	138,058.50
0505	FINES AND FORFEITS	1,966.66	82,319.86	240,000.00	157,680.14
0605	INTEREST AND INVESTMENTS	3,892.82	32,619.30	60,000.00	27,380.70
0975	OTHER REVENUE	40.00	340.00	9,000.00	8,660.00
Grand Total		135,875.98	1,095,992.66	4,643,320.00	3,547,327.34

3400 BOARD OF DENTISTRY TRANSFER OUT

D10 Compt Srce Grp	D10 Compt Srce Grp Ttl	Current Month	Bien To Date	Financial Plan	Unobligated Balance
2443	TRANSFER OUT TO OREGON HEALTH AUTHORITY	1,350.00	3,105.00	200,000.00	196,895.00
Grand Total		1,350.00	3,105.00	200,000.00	196,895.00

3400 BOARD OF DENTISTRY PERSONAL SERVICES

D10 Compt Srce Grp	D10 Compt Srce Grp Ttl	Current Month	Bien To Date	Financial Plan	Unobligated Balance
3110	CLASS/UNCLASS SALARY & PER DIEM	46,376.50	408,736.26	1,444,488.00	1,035,751.74
3115	BOARD MEMBER STIPENDS	0.00	12,104.00	0.00	(12,104.00)
3160	TEMPORARY APPOINTMENTS	0.00	0.00	4,778.00	4,778.00
3170	OVERTIME PAYMENTS	0.00	0.00	6,949.00	6,949.00
3190	ALL OTHER DIFFERENTIAL	3,637.69	11,838.55	43,252.00	31,413.45
3210	ERB ASSESSMENT	18.00	126.00	504.00	378.00
3220	PUBLIC EMPLOYES' RETIREMENT SYSTEM	11,173.80	90,039.60	296,742.00	206,702.40
3221	PENSION BOND CONTRIBUTION	2,000.59	18,098.49	67,187.00	49,088.51
3230	SOCIAL SECURITY TAX	3,770.07	32,343.59	113,690.00	81,346.41
3241	PAID FAMILY MEDICAL LEAVE INSURANCE	197.15	1,685.85	5,572.00	3,886.15
3250	WORKERS' COMPENSATION ASSESSMENT	8.04	67.46	294.00	226.54
3260	MASS TRANSIT	300.07	2,523.32	10,321.00	7,797.68
3270	FLEXIBLE BENEFITS	10,945.64	79,426.73	296,856.00	217,429.27
Grand Total		78,427.55	656,989.85	2,290,633.00	1,633,643.15

3400 BOARD OF DENTISTRY SERVICES AND SUPPLIES

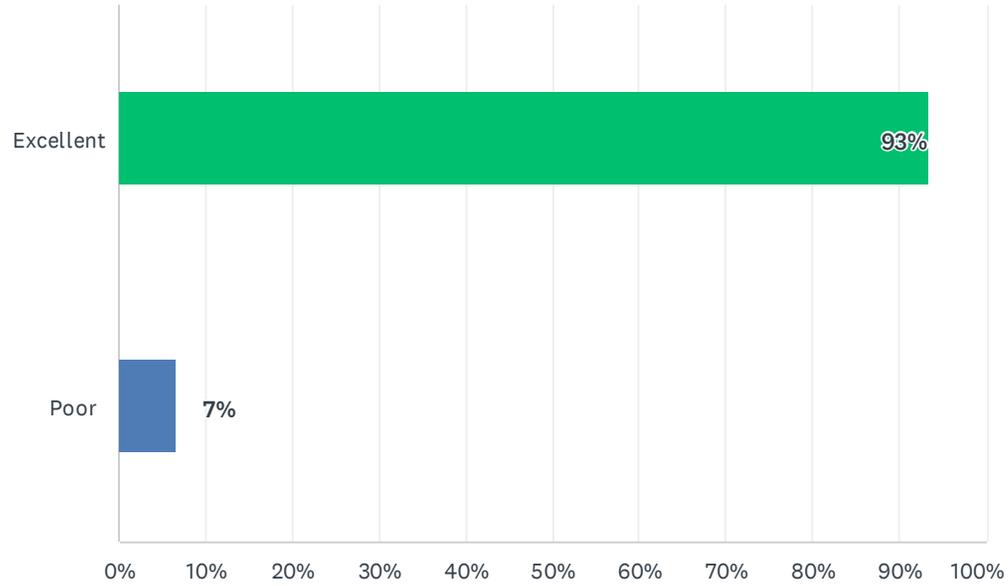
D10 Compt Srce Grp	D10 Compt Srce Grp Ttl	Current Month	Bien To Date	Financial Plan	Unobligated Balance
4100	INSTATE TRAVEL	0.00	2,506.06	57,512.00	55,005.94
4125	OUT-OF-STATE TRAVEL	0.00	0.00	8,564.00	8,564.00
4150	EMPLOYEE TRAINING	0.00	1,999.31	61,404.00	59,404.69
4175	OFFICE EXPENSES	933.03	15,359.10	103,313.00	87,953.90
4200	TELECOMM/TECH SVC AND SUPPLIES	588.51	5,198.03	28,227.00	23,028.97
4225	STATE GOVERNMENT SERVICE CHARGES	51.10	129,465.97	266,545.00	137,079.03
4250	DATA PROCESSING	4,331.36	45,712.57	170,267.00	124,554.43
4275	PUBLICITY & PUBLICATIONS	0.00	469.97	37,519.00	37,049.03
4300	PROFESSIONAL SERVICES	5,771.25	50,289.00	557,636.00	507,347.00
4315	IT PROFESSIONAL SERVICES	34.00	2,084.00	176,116.00	174,032.00
4325	ATTORNEY GENERAL LEGAL FEES	0.00	45,470.35	459,308.00	413,837.65

D10 Compt Srce Grp	D10 Compt Srce Grp Ttl	Current Month	Bien To Date	Financial Plan	Unobligated Balance
4375	EMPLOYEE RECRUITMENT AND DEVELOPMENT	0.00	0.00	798.00	798.00
4400	DUES AND SUBSCRIPTIONS	0.00	600.00	11,807.00	11,207.00
4425	LEASE PAYMENTS & TAXES	6,917.50	47,424.50	215,252.00	167,827.50
4475	FACILITIES MAINTENANCE	711.00	4,977.00	661.00	(4,316.00)
4575	AGENCY PROGRAM RELATED SVCS & SUPP	1,544.79	10,460.85	148,652.00	138,191.15
4650	OTHER SERVICES AND SUPPLIES	2,424.86	101,885.78	97,723.00	(4,162.78)
4700	EXPENDABLE PROPERTY \$250-\$10000	0.00	0.00	6,609.00	6,609.00
4715	IT EXPENDABLE PROPERTY	0.00	1,812.75	26,593.00	24,780.25
Grand Total		23,307.40	465,715.24	2,434,506.00	1,968,790.76

				Current Month	Bien_To_Date	Rpt Mm Bal Ytd Avg	
3400	BOARD OF DENTISTRY	Revenue	REVENUE	135,875.98	1,095,992.66	819,901.81	
		Revenue Total		135,875.98	1,095,992.66	819,901.81	
		Expenditures	PERSONAL SERVICES		78,427.55	656,989.85	421,088.97
			SERVICES AND SUPPLIES		23,307.40	465,715.24	414,317.32
			TRANSFER OUT		1,350.00	3,105.00	29,015.00
		Expenditures Total		103,084.95	1,125,810.09	864,421.29	

Q1 How would you rate the timeliness of services provided by the Oregon Board of Dentistry?

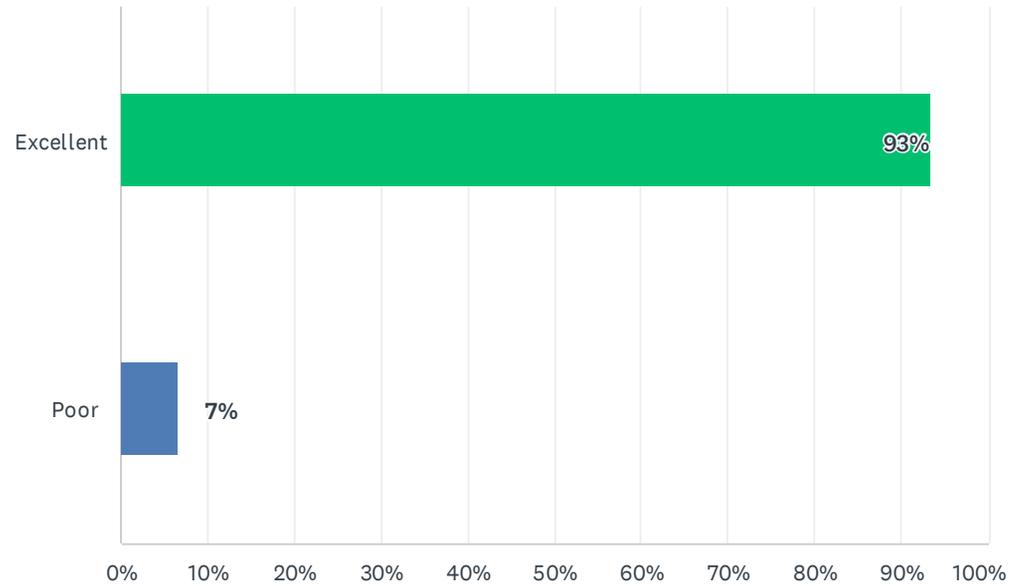
Answered: 15 Skipped: 0



ANSWER CHOICES	RESPONSES	
Excellent	93%	14
Poor	7%	1
TOTAL		15

Q2 How do you rate the ability of the Oregon Board of Dentistry to provide services correctly the first time?

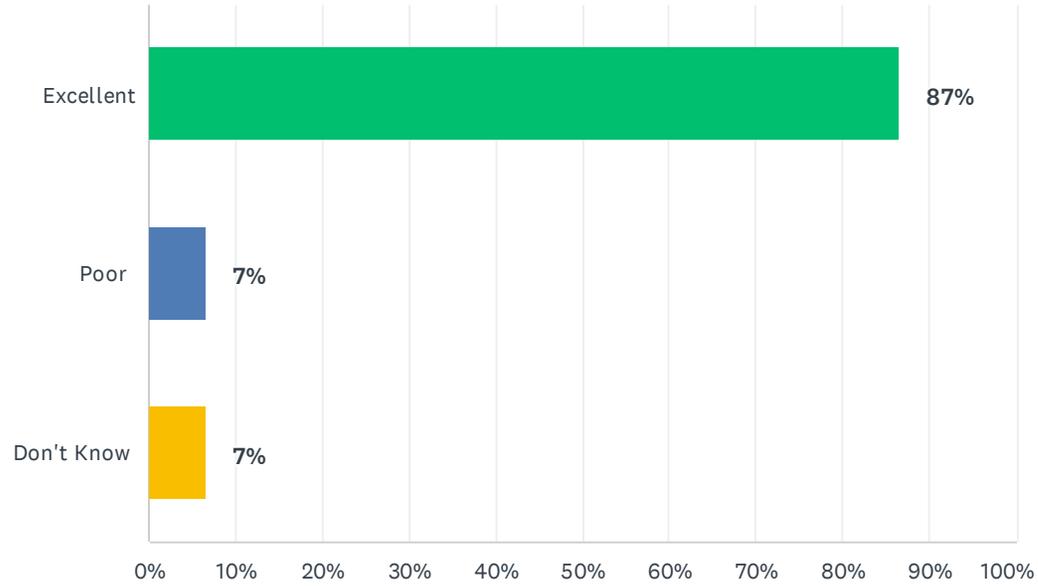
Answered: 15 Skipped: 0



ANSWER CHOICES	RESPONSES	
Excellent	93%	14
Poor	7%	1
TOTAL		15

Q3 How do you rate the helpfulness of the Oregon Board of Dentistry employees?

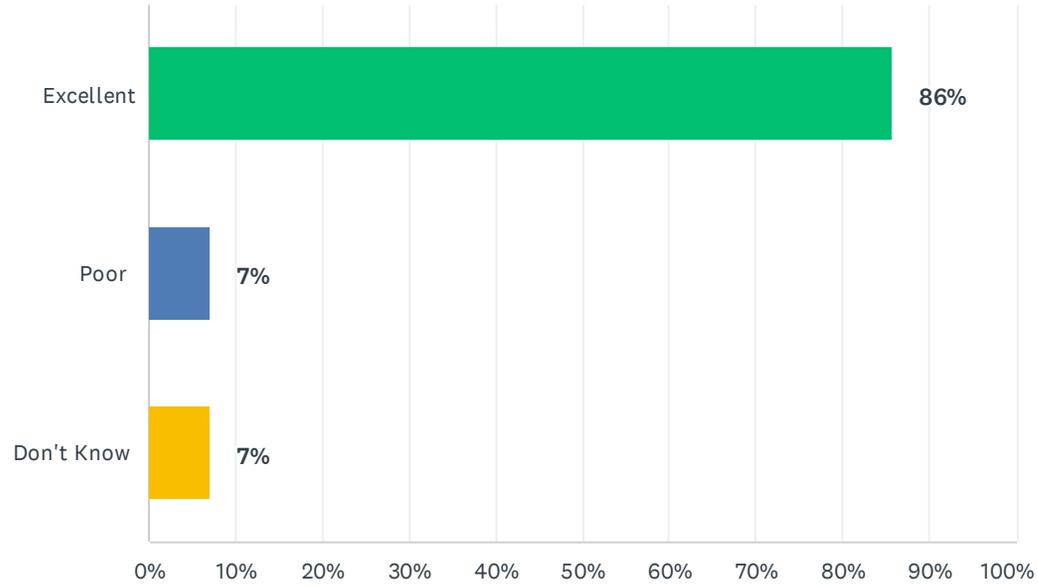
Answered: 15 Skipped: 0



ANSWER CHOICES	RESPONSES	
Excellent	87%	13
Poor	7%	1
Don't Know	7%	1
TOTAL		15

Q4 How do you rate the knowledge and expertise of the Oregon Board of Dentistry employees?

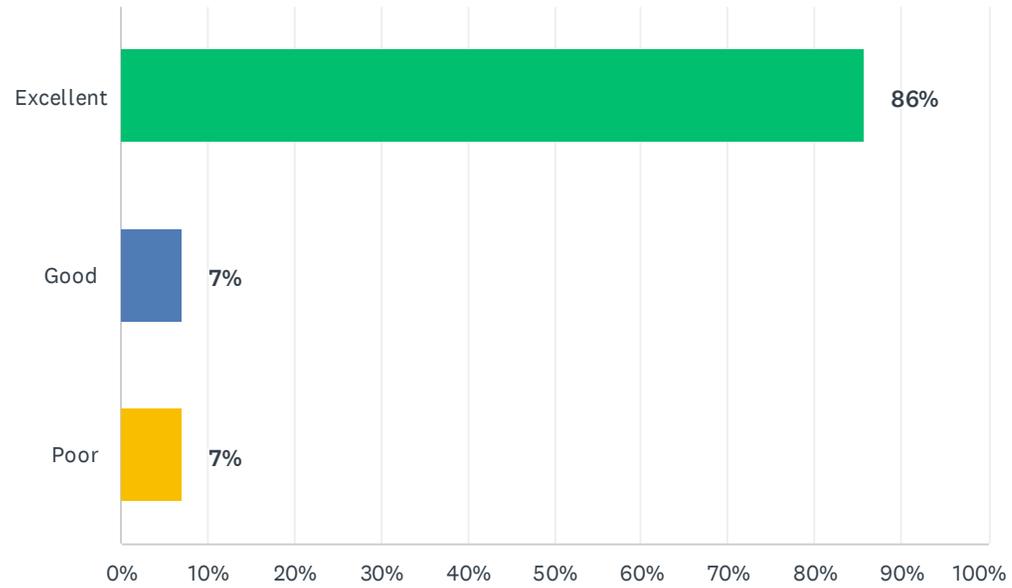
Answered: 14 Skipped: 1



ANSWER CHOICES	RESPONSES	
Excellent	86%	12
Poor	7%	1
Don't Know	7%	1
TOTAL		14

Q5 How do you rate the availability of information at the Oregon Board of Dentistry?

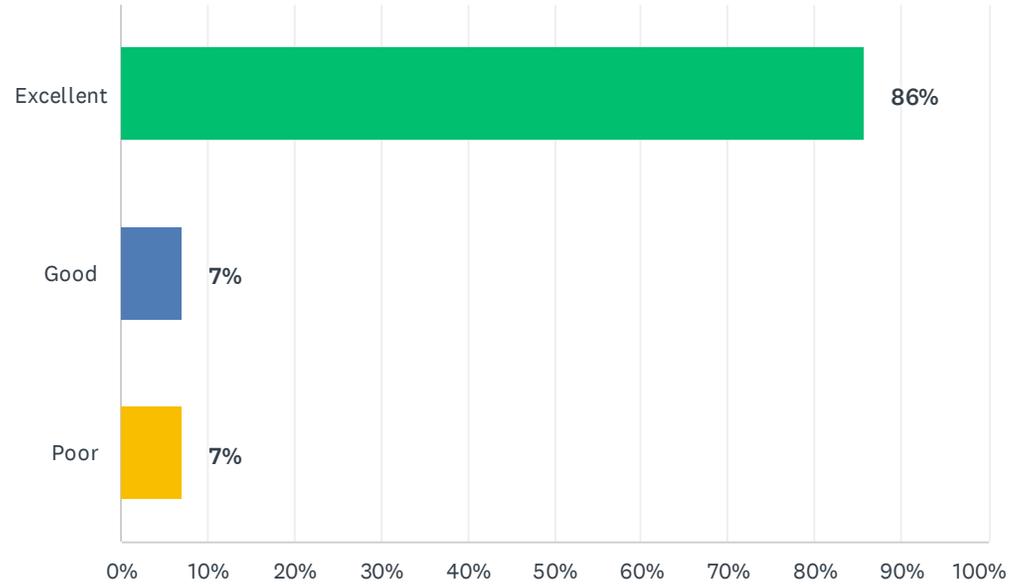
Answered: 14 Skipped: 1



ANSWER CHOICES	RESPONSES	
Excellent	86%	12
Good	7%	1
Poor	7%	1
TOTAL		14

Q6 How do you rate the overall quality of service provided by the Oregon Board of Dentistry?

Answered: 14 Skipped: 1



ANSWER CHOICES	RESPONSES
Excellent	86% 12
Good	7% 1
Poor	7% 1
TOTAL	14

Q7 Do you have any additional comments?

Answered: 7 Skipped: 8

#	RESPONSES	DATE
1	Your website is exceptional compared to most state board of dentistry websites. Easy to navigate, updated info and I am easily able to find what I need. Great job!	2/11/2026 8:35 AM
2	I am still in the dental hygiene licensure application phase, but both Kathleen and Dawn have been extremely helpful throughout the process. I am very thankful to have been able to speak with a live person when I needed guidance, and I truly appreciate the kindness and patience they have shown while helping me navigate each step.	1/20/2026 8:16 AM
3	Ms. Robinson was clear and concise in answering my question, and it was easy to get in touch with the Board. Keep up the great work!	11/26/2025 1:53 PM
4	Clarifying info on what precisely qualifies as "cultural awareness" CE's was hard to obtain. I just kept being referred to the section that is in writing, which s not very clear in real life. Otherwise, have always had great experiences for the business I've needed to do with the OBD	11/10/2025 5:39 PM
5	Kathleen McNeal is tops and Dawn who answered the phones so very polite and helpful too!	10/27/2025 12:18 PM
6	Useful, precise, and timely info provided with a wonderful attitude.	8/12/2025 10:41 AM
7	Office Specialist Dawn Dreasher has processed my data request so fast, really appreciate this!	7/7/2025 12:03 PM



Oregon

Tina Kotek, Governor

Department of Administrative Services

Chief Financial Office
155 Cottage Street NE
Salem, OR 97301
PHONE: 503-378-3106

February 6, 2026

Haley Robinson, Interim Executive Director
Oregon Board of Dentistry
1500 SW 1st Ave, Suite 770
Portland, OR, 97201

Re: FY 2025 ACCOUNTS RECEIVABLE HONOR ROLL CERTIFICATE

It is a great pleasure to inform you that your agency has earned the Chief Financial Office Accounts Receivable (A/R) Honor Roll Certificate for fiscal year 2025.

The Chief Financial Office Accounts Receivable Honor Roll Certificate is awarded to state agencies that submit timely and accurate A/R reports. Achievement of this recognition is due primarily to your agency's diligent efforts to track and report A/R activities.

By meeting the requirements of the Honor Roll Certificate program your agency is an important part of meeting statewide efforts to improve accounts receivable management. Your agency's success in A/R reporting is critical to the Legislative Fiscal Office publication of the *Report on Liquidated and Delinquent Accounts Receivable* and to the Chief Financial Office *Accounts Receivable Management Report*, and the *Statewide Write-off, Abated and Canceled Certification Report*, which are all submitted to the Legislative Assembly each year.

Congratulations to your agency and your fiscal team for this outstanding work!

Sincerely,

Kate Nass, Chief Financial Officer
Chief Financial Office

Robert W. Hamilton, State Controller
Chief Financial Office

A-Engrossed House Bill 4040

Ordered by the House February 16
Including House Amendments dated February 16

Introduced and printed pursuant to House Rule 12.00. Pre-session filed (at the request of House Interim Committee on Health Care for Representative Rob Nosse)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure. The statement includes a measure digest written in compliance with applicable readability standards.

Digest: The Act changes the rules for how certain health care is given in this state. The Act alters how certain health care providers are licensed or regulated. The Act changes some insurance rules. The Act changes some pharmacy and drug rules. The Act takes effect when signed. (Flesch Readability Score: 79.7).

Modifies the requirements for screening a hospital patient for presumptive eligibility for financial assistance.

[Prohibits the Oregon Health Authority from requiring certain home health agencies to comply with Medicare conditions of participation.]

[Modifies the requirements for how the Department of Human Services must publish Residential Care Quality Measurement Program data.]

Removes the requirement that an applicant for a residential care facility administrator license hold a bachelor's degree in a health or social service related field.

Allows a person residing in a correctional facility to receive prerelease medical assistance benefits under certain circumstances.

[Prohibits the authority or a coordinated care organization from requiring prior authorization for medical assistance coverage for repairing complex rehabilitation technology if the repair costs \$1,500 or less.]

Modifies the requirements for meetings held by the Health Evidence Review Commission.

Modifies the composition of the Medicaid Advisory Committee.

Modifies the eligibility requirements for parent providers who are paid to provide attendant care services to their children.

[Prohibits a coordinated care organization or dental subcontractor from preventing an oral health care provider from informing consumers about their choice of providers.]

Allows a full-time dentistry student enrolled in an out-of-state dental education program to practice dentistry without a license if the student is supervised by a faculty member of a dental education program accredited by the Commission on Dental Accreditation of the American Dental Association.

Requires casualty or health insurance policies to provide coverage for medically necessary anesthesia services, regardless of duration, for any covered procedures.

Requires dental insurers to follow certain rules for payment and denial of claims.

Requires the Legislative Policy and Research Director to develop and propose to the *[Legislative Policy and Research Committee]* **committees with jurisdiction over health care** an insurance coverage mandate impact statement policy. Directs the *[committee]* **committees** to perform due diligence in considering the proposal and authorizes the *[committee]* **committees** to modify the proposal if the *[committee]* **committees** so *[determines]* **determine**, and then to adopt the policy.

Repeals requirement that enrollees in individual or group policies or certificates of health insurance *[or members of coordinated care organizations]* be assigned by **their** insurer *[or organization]* to primary care providers under certain circumstances.

Specifies exemptions from the requirement that pharmacy services administrative organizations must register with the Department of Consumer and Business Services as third party administrators.

[Provides that the Governor shall select the chairperson of the Prescription Drug Affordability Board.]

Modifies requirements for the Prescription Drug Affordability Board's annual affordability determination for insulin products.

Allows licensees of the Occupational Therapy Licensing Board and the Oregon Board of Physical Therapy to provide psilocybin services as licensed psilocybin service facilitators while providing occupational therapy or physical therapy services.

[Authorizes a naturopathic physician to prescribe durable medical equipment and admit a patient to a hospital.] Lowers the age at which a naturopathic physician may request a retired license status from 70 years of age to *[60]* **65** years of age.

NOTE: Matter in **boldfaced** type in an amended section is new; matter *[italic and bracketed]* is existing law to be omitted. New sections are in **boldfaced** type.

1 Includes nurse practitioners and physician associates in the definition of “attending physician”
2 for purposes of the treatment of workers’ compensable injuries.
3 Declares an emergency, effective on passage.

4 **A BILL FOR AN ACT**

5 Relating to health care; creating new provisions; amending ORS 411.447, 414.211, 414.690, 427.191,
6 442.615, 475A.325, 475A.338, 475A.372, 646A.694, 656.005, 656.214, 656.245, 656.250, 656.252,
7 656.262, 656.268, 656.325, 656.340, 656.726, 656.797, 657.170, 659A.043, 659A.046, 659A.049,
8 659A.063, 678.733, 679.025, 685.100, 685.102, 743A.145, 743B.456, 744.702, 750.055 and 750.333 and
9 section 5, chapter 575, Oregon Laws 2015; repealing ORS 743B.221; and declaring an emergency.

10 **Be It Enacted by the People of the State of Oregon:**

11 **HOSPITALS**

12 **SECTION 1.** ORS 442.615 is amended to read:

13 442.615. (1) As used in this section:

14 (a) “Financial assistance” includes:

15 (A) Charity care, as defined in ORS 442.601; or

16 (B) An adjustment to a patient’s costs for care under ORS 442.614 (1)(a).

17 (b) “Hospital” has the meaning given that term in ORS 442.612.

18 (2) Using the process prescribed by the Oregon Health Authority under subsection (3) of this
19 section, a hospital licensed under ORS 441.025 shall screen a patient for presumptive eligibility for
20 financial assistance if the patient:

21 (a) Is uninsured;

22 (b) Is enrolled in the state medical assistance program; or

23 (c) Owes the hospital more than [\$500] **\$1,500 for a single hospital encounter.**

24 (3) The authority shall adopt by rule the process for screening a patient for presumptive eligi-
25 bility for financial assistance under subsection (2) of this section. The rules and process must:

26 (a) Prohibit a hospital from requiring a patient to provide documentation or other verification;

27 (b) Ensure that the process will not cause any negative impact on the patient’s credit score;

28 (c) Require a hospital, before sending a bill to the patient, to conduct the screening and apply
29 any financial assistance for which the patient qualifies to the bill; and

30 (d) Require the hospital to notify a patient if the patient has been screened and to explain to
31 the patient, in language approved by the authority, how to apply for financial assistance if financial
32 assistance was denied, or how to apply for additional financial assistance above what the patient
33 received.

34 (4) A patient may apply for financial assistance:

35 (a) If the patient was screened for presumptive eligibility for financial assistance and was found
36 not to be eligible or the patient disagrees with the amount of the financial assistance that was of-
37 fered;

38 (b) If a patient was not screened for presumptive eligibility for financial assistance; or

39 (c) Any time up to 12 months after a patient pays for the services that the hospital provided.

40 (5) A hospital may require a patient who applies for financial assistance under subsection (4)
41 of this section to provide documentation or verification of information reported as necessary for the
42 hospital to determine the patient’s eligibility for financial assistance.

43 (6) If a patient applies for financial assistance after having paid for the services and the patient
44

1 is found to have been eligible for financial assistance when the services were provided:

2 (a) The hospital shall refund the amount of financial assistance for which the patient qualified;

3 (b) If the hospital previously determined, incorrectly, that the patient did not qualify for finan-
4 cial assistance for the services based on information provided by the patient at the time of the in-
5 correct determination, the hospital shall also pay the patient interest on the amount of financial
6 assistance at the rate set by the Federal Reserve and any other associated reasonable costs, such
7 as legal expenses and fees, incurred by the patient in securing financial assistance; and

8 (c) If the hospital sold the debt to a collection agency or authorized a collection agency to col-
9 lect debts on behalf of the hospital, the hospital shall notify the collection agency that the debt is
10 invalid.

11 (7) If a patient applies for financial assistance and the hospital determines that the patient is
12 eligible for financial assistance based on documentation provided by the patient, the patient's eligi-
13 bility for financial assistance continues for nine months following the hospital's determination, and
14 the patient may not be required to reapply for financial assistance for services provided during that
15 nine-month period.

16 (8)(a) A hospital must have a written process that is in plain English, and in other languages
17 as required by law, for a patient to appeal a hospital's denial of financial assistance, in whole or in
18 part, and that allows the patient, or an individual acting on behalf of the patient, to correct any
19 deficiencies in documentation or to request a review of the denial by the hospital's chief financial
20 officer or the chief financial officer's designee. The authority shall prescribe by rule the require-
21 ments for the appeal process.

22 (b) If a hospital denies a patient's application for financial assistance, whether in whole or in
23 part, the hospital must notify the patient of the denial and include in the notice an explanation of
24 the hospital's appeal process.

25 (9) During the pendency of an appeal that is filed using a hospital's appeal process under sub-
26 section (8) of this section, if:

27 (a) The hospital has initiated collection activities, the hospital must suspend all collection ac-
28 tivities; and

29 (b) The hospital sold the debt under appeal to a collection agency or has authorized a collection
30 agency to collect debts on behalf of the hospital, the hospital must notify the collection agency to
31 suspend collection activities.

32
33 **RESIDENTIAL CARE**

34
35 **SECTION 2.** ORS 678.733 is amended to read:

36 678.733. (1) The Health Licensing Office may issue a residential care facility administrator li-
37 cense to an applicant who:

38 (a) Is at least 21 years of age;

39 (b) Has earned at least a high school diploma or its equivalent, as indicated by evidence of the
40 following, in a form deemed sufficient by the office:

41 (A) Completion of high school or an equivalent educational level;

42 (B) Passage of an approved high school equivalency test, including but not limited to the Gen-
43 eral Educational Development (GED) test; or

44 (C) Graduation from a post-secondary institution;

45 (c)(A) For at least two of the last five years has been employed in a professional or managerial

1 capacity in a health or social service related field, or has a combination of experience and education
2 deemed sufficient by the office; or

3 (B) Has earned at least a bachelor's degree [*in a health or social service related field*];

4 (d) Has completed at least 40 hours of training approved by the office by rule;

5 (e) Pays a licensure fee; and

6 (f) Passes an examination described in ORS 678.743.

7 (2) Evidence of the education described in subsection (1)(b) of this section may be provided by
8 a diploma or other document, or by facts, circumstances or other indicators deemed sufficient by the
9 office.

10 (3) When issuing a license under this section, the office shall consider the qualifications for
11 employment under ORS 443.004.

12 **SECTION 3. The amendments to ORS 678.733 by section 2 of this 2026 Act apply to ap-**
13 **plications for licensure under ORS 678.733 submitted to the Health Licensing Office on or**
14 **after the operative date specified in section 4 of this 2026 Act.**

15 **SECTION 4. (1) The amendments to ORS 678.733 by section 2 of this 2026 Act become**
16 **operative on January 1, 2027.**

17 **(2) The Health Licensing Office make take any action before the operative date specified**
18 **in subsection (1) of this section that is necessary to enable the office to exercise, on and**
19 **after the operative date specified in subsection (1) of this section, all of the duties, functions**
20 **and powers conferred on the office by the amendments to ORS 678.733 by section 2 of this**
21 **2026 Act.**

22 MEDICAL ASSISTANCE

23
24
25 **SECTION 5.** ORS 411.447 is amended to read:

26 411.447. (1) As used in this section, "correctional facility" means:

27 (a) A local correctional facility as defined in ORS 169.005;

28 (b) A Department of Corrections institution as defined in ORS 421.005; or

29 (c) A youth correction facility as defined in ORS 162.135.

30 (2) The Department of Human Services or the Oregon Health Authority shall:

31 **(a) Suspend, instead of terminate, the medical assistance of a person who is residing in a**
32 **correctional facility; or**

33 **(b) Enroll the person in the appropriate benefits package based on the person's eligibility**
34 **for prerelease benefits, as authorized by federal law.**

35 (3) Upon notification that a person described in subsection (2) of this section is not residing in
36 a correctional facility or that the person is admitted to a medical institution outside of the
37 correctional facility for a period of hospitalization, the department or the authority shall reinstate
38 the [*person's medical assistance if the person is eligible for medical assistance*] **medical assistance**
39 **benefits for which the person is eligible at the time of release or hospitalization.**

40 (4)(a) A designee of a correctional facility may apply for medical assistance on behalf of a per-
41 son, while the person is residing in the correctional facility, for the purpose of establishing eligi-
42 bility for medical assistance **prior to release, with full benefits** upon the person's release from the
43 correctional facility or during a period of hospitalization that will occur outside of the correctional
44 facility.

45 (b) The designee may obtain information necessary to determine eligibility for medical assist-

1 ance, including the person's Social Security number or information that is not otherwise subject to
2 disclosure under ORS 411.320 or 413.175. The information obtained under this paragraph may be
3 used only for the purpose of assisting the person in applying for medical assistance and may not be
4 redisclosed without the person's authorization.

5 *[(c) If the person is determined eligible for medical assistance, the effective date of the person's*
6 *medical assistance shall be the date the person is released from the correctional facility or the date the*
7 *person begins the period of hospitalization outside of the correctional facility.]*

8 (5) This section does not extend eligibility to an otherwise ineligible person or extend medical
9 assistance to a person if matching federal funds are not available to pay for the medical assistance.

10 **SECTION 6.** ORS 414.690 is amended to read:

11 414.690. (1) The Health Evidence Review Commission shall regularly solicit testimony and in-
12 formation from stakeholders representing consumers, advocates, providers, carriers and employers
13 in conducting the work of the commission.

14 **(2)(a) No less than 14 days before a meeting, the Oregon Health Authority shall post to**
15 **the authority's website and to the website of the commission:**

16 **(A) The agenda for the meeting; and**

17 **(B) A list of all recommendations before the commission for review, including, but not**
18 **limited to:**

19 **(i) A drug or drug class review;**

20 **(ii) A technology review; and**

21 **(iii) Coverage guidance.**

22 **(b) Except as provided by the authority by rule, once the authority has posted an agenda**
23 **under this subsection, the agenda may not be changed.**

24 *[(2)]* **(3)(a) The commission shall actively solicit public involvement through a public meeting**
25 **process to guide health resource allocation decisions** *[that includes, but is not limited to:]*, **in which**
26 **the public is invited to testify in writing and in person. Except when more than 50 written**
27 **comments from the public are received, the authority shall post to the commission's website**
28 **and provide each commission member with the written comments received from the public**
29 **no later than 48 hours after the close of the public comment period.**

30 **(b) The public meeting process described in this subsection shall include, but not be lim-**
31 **ited to:**

32 *[(a)]* **(A) Providing members of the public the opportunity to provide input on the selection of**
33 **any vendor that provides research and analysis to the commission; and**

34 *[(b)]* **(B) Inviting public comment on any research or analysis tool or health economic measures**
35 **to be relied upon by the commission in the commission's decision-making.**

36 *[(3)(a)]* **(4)(a) The commission shall develop and maintain a list of health services ranked by**
37 **priority, from the most important to the least important, representing the comparative benefits of**
38 **each service to the population to be served.**

39 **(b) Except as provided in ORS 414.701, the commission may not rely upon any quality of life in**
40 **general measures, either directly or by considering research or analysis that relies on a quality of**
41 **life in general measure, in determining:**

42 **(A) Whether a service is cost-effective;**

43 **(B) Whether a service is recommended; or**

44 **(C) The value of a service.**

45 **(c) The list must be submitted by the commission pursuant to subsection [(5)] (6) of this section**

1 and is not subject to alteration by any other state agency.

2 [(4)] (5) In order to encourage effective and efficient medical evaluation and treatment, the
3 commission:

4 (a) May include clinical practice guidelines in its prioritized list of services. The commission
5 shall actively solicit testimony and information from the medical community and the public to build
6 a consensus on clinical practice guidelines developed by the commission.

7 (b) May include statements of intent in its prioritized list of services. Statements of intent should
8 give direction on coverage decisions where medical codes and clinical practice guidelines cannot
9 convey the intent of the commission.

10 (c) Shall consider both the clinical effectiveness and cost-effectiveness of health services, in-
11 cluding drug therapies, in determining their relative importance using peer-reviewed medical litera-
12 ture.

13 [(5)] (6) The commission shall report the prioritized list of services to the Oregon Health Au-
14 thority for budget determinations by July 1 of each even-numbered year.

15 [(6)] (7) The commission shall make its report during each regular session of the Legislative
16 Assembly and shall submit a copy of its report to the Governor, the Speaker of the House of Rep-
17 resentatives and the President of the Senate and post to the Oregon Health Authority's website,
18 along with a solicitation of public comment, an assessment of the impact on access to medically
19 necessary treatment and services by persons with disabilities or chronic illnesses resulting from the
20 commission's prior use of any quality of life in general measures or any research or analysis that
21 referred to or relied upon a quality of life in general measure.

22 [(7)] (8) The commission may alter the list during the interim only as follows:

23 (a) To make technical changes to correct errors and omissions;

24 (b) To accommodate changes due to advancements in medical technology or new data regarding
25 health outcomes;

26 (c) To accommodate changes to clinical practice guidelines; and

27 (d) To add statements of intent that clarify the prioritized list.

28 [(8)] (9) If a service is deleted or added during an interim and no new funding is required, the
29 commission shall report to the Speaker of the House of Representatives and the President of the
30 Senate. However, if a service to be added requires increased funding to avoid discontinuing another
31 service, the commission shall report to the Emergency Board to request the funding.

32 [(9)] (10) The prioritized list of services remains in effect for a two-year period beginning no
33 earlier than October 1 of each odd-numbered year.

34 [(10)(a)] (11)(a) As used in this section, "peer-reviewed medical literature" means scientific
35 studies printed in journals or other publications that publish original manuscripts only after the
36 manuscripts have been critically reviewed by unbiased independent experts for scientific accuracy,
37 validity and reliability.

38 (b) "Peer-reviewed medical literature" does not include internal publications of pharmaceutical
39 manufacturers.

40 **SECTION 7.** ORS 414.211 is amended to read:

41 414.211. (1) There is established a Medicaid Advisory Committee consisting of not more than 15
42 members appointed by the Governor.

43 (2) The committee shall be composed of:

44 (a) A physician licensed under ORS chapter 677;

45 (b) Two members of health care consumer groups that include Medicaid recipients;

1 (c) [Two] **Four** Medicaid recipients, [one of whom shall be a] **including one** person with a dis-
2 ability **and one person who qualifies for medical assistance based on modified adjusted gross**
3 **income criteria;**

4 (d) The Director of the Oregon Health Authority or [designee] **a manager of the division of**
5 **the authority that administers the state medical assistance program;**

6 (e) The Director of Human Services or designee;

7 (f) Health care providers;

8 (g) Persons associated with health care organizations, including but not limited to coordinated
9 care organizations under contract to the Medicaid program; and

10 (h) Members of the general public.

11 (3) In making appointments, the Governor shall consult with appropriate professional and other
12 interested organizations. All members appointed to the committee shall be familiar with the medical
13 needs of low income persons.

14 (4) The term of office for each member shall be [two] **three** years, but each member shall serve
15 at the pleasure of the Governor.

16 (5) Members of the committee shall receive no compensation for their services but, subject to
17 any applicable state law, shall be allowed actual and necessary travel expenses incurred in the
18 performance of their duties from the Oregon Health Authority Fund.

19 **SECTION 8. The amendments to ORS 414.211 by section 7 of this 2026 Act become oper-**
20 **ative on July 10, 2027.**

21 **SECTION 9. Notwithstanding ORS 414.211, the Medicaid Advisory Committee shall be**
22 **composed of:**

23 (1) **For the period between the effective date of this 2026 Act and July 9, 2026, at least**
24 **10 percent Medicaid recipients; and**

25 (2) **For the period between July 10, 2026, and July 9, 2027, at least 20 percent Medicaid**
26 **recipients.**

27 **SECTION 10. Section 9 of this 2026 Act is repealed on January 2, 2028.**

28
29 **PARENT PROVIDERS**

30
31 **SECTION 11. ORS 427.191 is amended to read:**

32 427.191. (1) As used in this section:

33 (a) "Agency" means an agency that hires, trains and supervises direct support professionals us-
34 ing state funds received from the Department of Human Services.

35 (b) "Attendant care services" means services provided directly to an individual with a disability
36 to assist with activities of daily living, instrumental activities of daily living and health-related
37 tasks.

38 (c) "Child" means an individual under 18 years of age who:

39 (A) Has a developmental or intellectual disability; or

40 (B) Meets the eligibility criteria to receive services under the Medically Fragile (Hospital)
41 Model Waiver or the Medically Involved Children's Waiver approved by the Centers for Medicare
42 and Medicaid Services under 42 U.S.C. 1396n(c).

43 (d) "Client" means an individual who receives attendant care services.

44 (e) "Client child" means a child who receives attendant care services from the child's parent.

45 (f) "Developmental disability services" has the meaning given that term in ORS 427.101.

1 (g) "Direct support professional" means an individual who is hired, employed, trained, paid and
2 supervised by an agency to provide attendant care services to a client of the agency.

3 (h) "Nonparent caregiver" means a direct support professional, personal support worker or
4 similar provider who is paid to provide attendant care services to clients who are not the provider's
5 children.

6 (i) "Parent" includes a:

7 (A) Natural or adoptive parent of a child;

8 (B) Stepparent of a child; and

9 (C) Legal guardian of a child.

10 (j)(A) "Parent provider" means a parent who is paid to provide attendant care services to the
11 parent's minor child.

12 (B) "Parent provider" does not include a parent who is paid to provide attendant care services
13 to a child who is 18 years of age or older.

14 (k)(A) "Personal support worker" means an individual who is employed by a client or the client's
15 representative and paid to provide attendant care services to the client.

16 (B) "Personal support worker" does not include a direct support professional.

17 (L) "State plan" means Oregon's state plan for medical assistance, described in 42 U.S.C. 1396a,
18 approved by the Centers for Medicare and Medicaid Services.

19 (m) "Very high behavioral needs" means a minor child's extraordinary needs for support due to
20 the child's behavioral condition as indicated by a federally approved functional needs assessment
21 adopted by the department that assigns the child to the highest service level.

22 (n) "Very high medical needs" means a minor child's extraordinary needs for support due to the
23 child's medical condition as indicated by a federally approved functional needs assessment adopted
24 by the department that assigns the child to the highest service level.

25 (2) Subject to rules adopted under subsection (8) of this section, to ORS 427.194 and to available
26 funding, the department shall administer a program to compensate parents to provide attendant care
27 services to the parents' children who have been assessed by the department to have very high
28 medical or very high behavioral needs.

29 (3) To be eligible for the program described in this section:

30 (a) A parent provider must be employed *[by an agency and not by the child or the other parent*
31 *of the child]* **as a direct support professional or a personal support worker;**

32 (b) The parent provider may not be paid to provide attendant care services to the client child
33 by an agency that is owned by the parent, the **client** child or any family member or for which the
34 parent or other family member serves in any administrative or leadership capacity, including as a
35 member of a board of directors; and

36 (c) The agency employing the parent provider to provide attendant care services to the client
37 child:

38 (A) May not employ a parent provider as an independent contractor;

39 (B) Shall pay parent providers overtime at the same rate and under the same circumstances as
40 direct support professionals who are not parent providers;

41 (C) Except as authorized by the department by rule, may not pay providers of attendant care
42 services, including parent providers, to provide services to a [*minor*] child during school hours un-
43 less the [*minor*] child is temporarily at home recovering from surgery or illness and the temporary
44 absence from school is recommended by the child's health care provider; and

45 (D) May not pay providers of attendant care services, including parent providers, to provide

1 services to a [*minor*] child during school hours due to the determination of a school district or due
2 to the choice of a parent of the [*client*] child to:

3 (i) Have the child regularly attend school less than the number of school hours attended by
4 students without disabilities who are in the same grade and the same school district as the [*client*]
5 child;

6 (ii) Homeschool the [*client*] child; or

7 (iii) Enroll the [*client*] child in a private school that offers fewer school hours than the school
8 hours offered by the local public school to the majority of students in the same grade as the
9 [*client*] child.

10 (4) Subsection (3)(c)(D) of this section does not prohibit a school district or other entity from
11 compensating parents of students with disabilities for providing support for educational activities
12 that would otherwise be the responsibility of the school district.

13 (5) A parent provider, during the hours that the parent provider is paid to provide one-on-one
14 attendant care services to the client child:

15 (a) May not be responsible for a vulnerable adult who requires physical care and monitoring;

16 (b) May not be responsible for the care of [*a child*] **an individual**, other than the client child,
17 who is under 10 years of age and shall have another caregiver immediately available at all times
18 to attend to the needs of the [*child*] **individual**; and

19 (c) Unless they are included as a goal or service in the **client** child's individual support plan
20 and related to the **client** child's disability-related support needs, may not perform tasks that are not
21 for the primary benefit of the client child, including but not limited to:

22 (A) Grocery shopping for the household;

23 (B) Housekeeping not required for the disability-related support needs of the client child;

24 (C) Remote work or operation of a home business; or

25 (D) Transporting individuals other than the client child to or from activities or appointments.

26 (6) If required by the Centers for Medicare and Medicaid Services, the department may require
27 a parent provider to assign an alternative legal representative for the client child to make decisions
28 about or manage the development and implementation of the client child's individual support plan.

29 The assignment:

30 (a) Must be on a form prescribed by the department; and

31 (b) Must clearly state that the assignment is limited to decisions regarding the development and
32 implementation of the **client** child's individual support plan and does not limit the authority of the
33 parent provider to make decisions for the client child with respect to health care, education or re-
34 ligious training.

35 (7) A parent provider is subject to the requirements of mandatory reporting of abuse under ORS
36 124.060 and 419B.010, 24 hours per day, seven days per week.

37 (8) The department shall adopt rules for the program described in this section using an advisory
38 committee appointed under ORS 183.333 that represents the interests of parents, children with de-
39 velopmental or intellectual disabilities, adults with disabilities, agencies, organizations of direct
40 support professionals and personal support workers and organizations that advocate for persons with
41 disabilities. The rules must include all of the following:

42 (a) Strategies to safeguard nonparent caregivers and avoid the displacement of nonparent
43 caregivers by parent providers;

44 (b) Requirements for agencies to demonstrate consistent efforts to recruit, train and retain
45 nonparent caregivers;

1 (c) **Requirements for appropriate training, background checks and oversight, including**
2 training requirements for:

3 (A) Parent providers regarding federal and state administrative rules regulating home-based and
4 community-based services, including the impact of the rules on parent-child relationships with re-
5 spect to discipline, supervision, physical intervention and self-determination of client children during
6 the hours that the parent provider is being paid to provide attendant care services;

7 (B) Client children to learn to advocate for themselves with respect to choosing and managing
8 direct support professionals before and after reaching 18 years of age; and

9 (C) Community developmental disability programs related to the employment of parent providers,
10 including on how to support families to manage issues concerning conflicts of interest, provider
11 recruitment and retention and the empowerment of the client child to have a meaningful voice in
12 the selection of the client child's *[direct support professionals]* **caregivers;**

13 (d) A process for a client child to object to the hiring of any caregiver, including the child's
14 parent, or to raise concerns about a provider's caregiving;

15 (e) Procedures to ensure that the program described in this section is implemented consistently
16 and equitably throughout this state;

17 (f) A requirement that any appeal related to the requirements of or benefits under the program
18 is the sole responsibility of the central office staff of the department;

19 **(g) Procedures to ensure program integrity and prevent duplicate payment for the same**
20 **service hours; and**

21 *[(g)]* **(h)** Other requirements that the department deems necessary to carry out the provisions
22 of this section.

23 (9) The department may adopt rules necessary to manage the cost, size and growth rate of the
24 program described in this section that are necessary to protect the eligibility for and levels of ser-
25 vices under programs serving individuals receiving developmental disability services provided for in
26 the state plan, including the development of criteria to limit the number of children eligible to par-
27 ticipate in the program.

28 (10) Annually, the department shall report to the interim committees of the Legislative Assembly
29 related to human services or, if the Legislative Assembly is in session, to the committees of the
30 Legislative Assembly related to human services, in the manner provided in ORS 192.245, updates on
31 the program described in this section, including:

32 (a) The number of client children receiving attendant care services, the number of children re-
33 ceiving the services from parent providers and the number of children receiving the services from
34 nonparent caregivers;

35 (b) The number of hours of attendant care services provided by parent providers and number
36 of hours of attendant care services provided by nonparent caregivers;

37 (c) A comparison of the cost per child of providing attendant care services by parent providers
38 under the program with the cost per child of providing attendant care services by nonparent
39 caregivers; and

40 (d) A report on the adequacy of the direct care workforce in this state to provide services to
41 all children with developmental disability services who are eligible for attendant care services.

42
43 **DENTAL**

44
45 **SECTION 12.** ORS 679.025 is amended to read:

1 679.025. (1) A person may not practice dentistry or purport to be a dentist without a valid li-
2 cense to practice dentistry issued by the Oregon Board of Dentistry.

3 (2) Subsection (1) of this section does not apply to:

4 (a) Dentists licensed in another state or country making a clinical presentation sponsored by a
5 bona fide dental society or association or an accredited dental educational institution approved by
6 the board.

7 (b) Bona fide full-time students of dentistry who, during the period of their enrollment and as a
8 part of the course of study in an Oregon accredited dental education program, engage in clinical
9 studies on the premises of such institution or in a clinical setting located off the premises of the
10 institution if the facility, the instructional staff and the course of study to be pursued at the off-
11 premises location meet minimum requirements prescribed by the rules of the board and the clinical
12 study is performed under the indirect supervision of a member of the faculty.

13 (c) Bona fide full-time students of dentistry who, during the period of their enrollment and as a
14 part of the course of study in a dental education program located outside of Oregon that is accred-
15 ited by the Commission on Dental Accreditation of the American Dental Association or its successor
16 [agency] **organization**, engage in community-based or clinical studies as an elective or required ro-
17 tation in a clinical setting located in Oregon if the community-based or clinical studies meet mini-
18 mum requirements prescribed by the rules of the board and are performed under the indirect
19 supervision of a [member of the faculty of the Oregon Health and Science University School of
20 Dentistry] **faculty member of a dental education program accredited by the Commission on**
21 **Dental Accreditation of the American Dental Association, or its successor organization.**

22 (d) Candidates who are preparing for a licensure examination to practice dentistry and whose
23 application has been accepted by the board or its agent, if the clinical preparation is conducted in
24 a clinic located on premises approved for that purpose by the board and if the procedures are lim-
25 ited to examination only. This exception shall exist for a period not to exceed two weeks imme-
26 diately prior to a regularly scheduled licensure examination.

27 (e) Dentists practicing in the discharge of official duties as employees of the United States
28 Government and any of its agencies.

29 (f) Instructors of dentistry, whether full- or part-time, while exclusively engaged in teaching ac-
30 tivities and while employed in accredited dental educational institutions.

31 (g) Dentists who are employed by public health agencies and who are not engaged in the direct
32 delivery of clinical dental services to patients.

33 (h) Persons licensed to practice medicine in the State of Oregon in the regular discharge of their
34 duties.

35 (i) Persons qualified to perform services relating to general anesthesia or sedation under the
36 direct supervision of a licensed dentist.

37 (j)(A) Dentists licensed in another country and in good standing, while practicing dentistry
38 without compensation for no more than five consecutive days in any 12-month period, provided the
39 dentist submits an application to the board at least 10 days before practicing dentistry under this
40 subparagraph and the application is approved by the board.

41 (B) Dentists licensed in another state or United States territory and practicing in this state
42 under ORS 676.347.

43 (k) Persons practicing dentistry upon themselves as the patient.

44 (L) Dental hygienists, dental assistants or dental technicians performing services under the
45 supervision of a licensed dentist in accordance with the rules adopted by the board.

1 (m) A person licensed as a denturist under ORS 680.500 to 680.565 engaged in the practice of
2 denture technology.

3 (n) An expanded practice dental hygienist who renders services authorized by a permit issued
4 by the board pursuant to ORS 680.200.

5 **SECTION 13.** (1) The amendments to ORS 679.025 by section 12 of this 2026 Act become
6 operative on January 1, 2027.

7 (2) The Oregon Board of Dentistry make take any action before the operative date spec-
8 ified in subsection (1) of this section that is necessary to enable the board to exercise, on
9 and after the operative date specified in subsection (1) of this section, all of the duties,
10 functions and powers conferred on the board by the amendments to ORS 679.025 by section
11 12 of this 2026 Act.

12
13 **COMMERCIAL HEALTH INSURANCE**

14
15 **SECTION 14.** Section 15 of this 2026 Act is added to and made a part of the Insurance
16 Code.

17 **SECTION 15.** (1) A group or individual policy of casualty insurance or health insurance,
18 including a health benefit plan as defined in ORS 743B.005, shall provide coverage for med-
19 ically necessary anesthesia services, regardless of the duration, for any procedure covered
20 by the policy.

21 (2) A policy described in subsection (1) of this section may not deny payment or re-
22 imbursement for anesthesia services solely because the duration of care exceeded a preset
23 time limit.

24 **SECTION 16.** Section 15 of this 2026 Act applies to group or individual policies of casualty
25 insurance or health insurance, including health benefit plans, that are issued, renewed or
26 extended on or after January 1, 2027.

27 **SECTION 17.** Sections 18, 20 and 21 of this 2026 Act are added to and made a part of the
28 Insurance Code.

29 **SECTION 18.** As used in ORS 743B.456 and sections 20 and 21 of this 2026 Act:

30 (1) “Dental insurance plan” means a policy or certificate of insurance or other contract
31 that provides only a dental benefit.

32 (2) “Dental insurer” means an insurer that offers a policy or certificate of insurance or
33 other contract that provides only a dental benefit.

34 (3) “Dental provider” means a person licensed, certified or otherwise permitted by laws
35 of this state to administer dental services in the ordinary course of business or practice of
36 a profession.

37 **SECTION 19.** ORS 743B.456 is amended to read:

38 743B.456. (1) As used in this section, [*“dental insurer” means an insurer that offers a policy or*
39 *certificate of insurance or other contract, that provides only a dental benefit*] “clean claim” means a
40 claim that has no defect or error, is understandable and reasonably legible, includes required
41 substantiating documentation and does not require special treatment that delays timely
42 payment on the claim.

43 (2) A dental insurer may pay a claim for reimbursement made by a dental care provider using
44 a credit card or electronic funds transfer payment method that imposes on the provider a fee or
45 similar charge to process the payment if:

1 (a) The dental insurer notifies the provider, in advance, of the potential fees or other charges
2 associated with the use of the credit card or electronic funds transfer payment method;

3 (b) The dental insurer offers the provider an alternative payment method that does not impose
4 fees or similar charges on the provider; and

5 (c) The provider or a designee of the provider elects to accept a payment of the claim using the
6 credit card or electronic funds transfer payment method.

7 (3) If a dental insurer contracts with a vendor to process payments of dental providers' claims,
8 the dental insurer shall require the vendor to comply with the provisions of subsection (2)(a) of this
9 section.

10 (4) **Except as provided in this subsection, when a claim under a dental insurance plan is**
11 **submitted to a dental insurer by a dental provider on behalf of a beneficiary, the dental**
12 **insurer shall pay a clean claim or deny the claim not later than 45 days after the date on**
13 **which the dental insurer receives the claim. If a dental insurer requires additional informa-**
14 **tion before payment of a claim, not later than 45 days after the date on which the dental**
15 **insurer receives the claim, the dental insurer shall notify the beneficiary and the dental**
16 **provider in writing or electronically, and give the beneficiary and the dental provider an ex-**
17 **planation of the additional information needed to process the claim. The dental insurer shall**
18 **pay a clean claim or deny the claim not later than 45 days after the date on which the dental**
19 **insurer receives the additional information.**

20 (5) **A contract between a dental insurer and a dental provider may not include a provision**
21 **governing payment of claims that limits the rights and remedies available to a provider un-**
22 **der this section or has the effect of relieving either party of its obligations under this sec-**
23 **tion.**

24 (6) **A dental insurer shall establish a method of communicating to dental providers the**
25 **procedures and information necessary to complete claim forms. The procedures and infor-**
26 **mation must be reasonably accessible to dental providers.**

27 (7) **This section does not create an assignment of payment to a dental provider.**

28 **SECTION 20. (1) As used in this section, "refund" means the return, either directly or**
29 **through an offset to a future claim, of some or all of a payment already received by a dental**
30 **provider.**

31 (2) **Except in the case of fraud or abuse of billing, and except as provided in subsections**
32 **(3) and (5) of this section, a dental insurer may not:**

33 (a) **Request from a dental provider a refund of a payment previously made to satisfy a**
34 **claim unless the dental insurer:**

35 (A) **Requests the refund in writing or electronically on or before the last day of the pe-**
36 **riod specified by the contract with the dental provider or 18 months after the date the pay-**
37 **ment was made, whichever is earlier; and**

38 (B) **Specifies in the written or electronic request why the dental insurer believes the**
39 **dental provider owes the refund.**

40 (b) **Request that a contested refund be paid earlier than six months after the dental**
41 **provider receives the request.**

42 (3) **A dental insurer may not do the following for reasons related to coordination of**
43 **benefits with another dental insurer or entity responsible for payment of a claim:**

44 (a) **Request from a dental provider a refund of a payment previously made to satisfy a**
45 **claim unless the dental insurer:**

1 (A) Requests the refund in writing or electronically within 45 days after the date the
2 payment was made;

3 (B) Specifies in the written or electronic request why the dental insurer believes the
4 provider owes the refund; and

5 (C) Includes in the written or electronic request the name and mailing address of the
6 other dental insurer or entity that has primary responsibility for payment of the claim.

7 (b) Request that a contested refund be paid earlier than six months after the dental
8 provider receives the request.

9 (4) If a dental provider fails to contest a refund request in writing or electronically to the
10 dental insurer within 30 days after receiving the request, the request is deemed accepted and
11 the dental provider must pay the refund within 30 days after the request is deemed accepted.
12 If the dental provider has not paid the refund within 30 days after the request is deemed
13 accepted, the dental insurer may recover the amount through an offset to a future claim.

14 (5) A dental insurer may at any time request from a dental provider a refund of a pay-
15 ment previously made to satisfy a claim if:

16 (a) A third party, including a government entity, is found responsible for satisfaction of
17 the claim as a consequence of liability imposed by law; and

18 (b) The dental insurer is unable to recover directly from the third party because the third
19 party has already paid or will pay the provider for the dental services covered by the claim.

20 (6) If a contract between a dental insurer and a dental provider conflicts with this sec-
21 tion, the provisions of this section prevail. However, nothing in this section prohibits a dental
22 provider from choosing at any time to refund to a dental insurer any payment previously
23 made to satisfy a claim.

24 (7) This section neither permits nor precludes a dental insurer from recovering from a
25 subscriber, enrollee or beneficiary any amounts paid to a dental provider for benefits to
26 which the subscriber, enrollee or beneficiary was not entitled under the terms and conditions
27 of the dental insurance plan, insurance policy or other benefit agreement.

28 **SECTION 21.** A dental provider that bills a dental insurer for covered services provided
29 to an individual who is insured under a dental insurance plan shall be reimbursed by the
30 insurer by a direct payment issued to the dental provider.

31 **SECTION 22.** Sections 18, 20 and 21 of this 2026 Act and the amendments to ORS 743B.456
32 by section 19 of this 2026 Act become operative on January 1, 2028.

33 **SECTION 23.** (1) As used in this section and section 24 of this 2026 Act, “insurance cov-
34 erage mandate” means a proposed legislative measure that requires payment for certain
35 services of health care providers or that requires an offering of health insurance coverage
36 by an insurer or a health care service contractor as a component of an individual or group
37 health insurance policy.

38 (2) The Legislative Policy and Research Director shall develop, as a pilot program, an
39 insurance coverage mandate impact statement template. The template must solicit the in-
40 formation sought in section 24 of this 2026 Act and must take into consideration:

41 (a) Sources of data to be considered in the preparation of an insurance coverage mandate
42 impact statement for proposed legislation; and

43 (b) Sources of research to be considered in the preparation of an insurance coverage
44 mandate impact statement.

45 (3) In preparing the template, the director shall consider models used in other states and

1 in academic research for assessing the impacts of proposed insurance coverage mandate
2 legislation and other formal actions undertaken by national, state and local government en-
3 tities and other entities in the United States, including educational institutions.

4 (4) The director shall confer with the chairs and vice chairs of those committees of the
5 Legislative Assembly having jurisdiction over health care and, based on that conferral,
6 select up to three Senate measures and up to three House measures that were enacted
7 during the 2025 regular session of the Legislative Assembly on which to apply the insurance
8 coverage mandate impact statement template.

9 (5) Following selection of the measures described in subsection (4) of this section, the
10 director shall apply the template to each of the selected measures and prepare draft insur-
11 ance coverage mandate impact statements for each measure. The director shall present a
12 preliminary report to the committees with jurisdiction over health care on or before Sep-
13 tember 15, 2026, that reports on:

14 (a) The template methodology and review process;

15 (b) The director's experience in preparing draft impact statements; and

16 (c) The specific findings of the draft impact statements prepared for the test measures.

17 (6) Based on feedback provided by the committees with jurisdiction over health care, the
18 director may modify the template and prepare final insurance coverage mandate impact
19 statements on the test measures. The director shall present the final impact statements and
20 the final process report summarizing the methodology used to prepare and review impact
21 statements to the policy committees that had heard the test measures during the 2025 reg-
22 ular session of the Legislative Assembly. The director shall present the statements and final
23 report to the committees on or before December 15, 2026.

24 (7) Following the presentations described in subsection (5) of this section and following
25 or contemporaneously with the presentations described in subsection (6) of this section and
26 taking into account provided feedback, the director shall propose to the committees with
27 jurisdiction over health care a policy that describes the objectives, content and form of an
28 insurance coverage mandate impact statement and the procedures to be followed in the
29 preparation of those statements. After conducting due deliberations in which the committees
30 may make modifications to the policy, the committees shall adopt a policy on the preparation
31 of insurance coverage mandate impact statements. The policy shall include guidance on when
32 an insurance coverage mandate impact statement must be posted online on the Legislative
33 Assembly website, relative to the location in the legislative process of the associated legis-
34 lative measure.

35 **SECTION 24.** An insurance coverage mandate impact statement required to be developed
36 under section 23 of this 2026 Act shall include but need not be limited to the following:

37 (1) The evidence that exists to document the medical need for the treatment or service
38 covered under the proposed legislative measure;

39 (2) The extent of the coverage under the proposed measure;

40 (3) Whether the proposed measure ensures more or less equitable access to treatment
41 or services by residents of this state;

42 (4) Whether denying the coverage under the proposed measure would disproportionately
43 impact individuals described in ORS 746.021 and, if so, a description of the impact;

44 (5) Whether the coverage under the proposed measure is an essential health benefit as
45 defined in ORS 731.097;

1 **(6) A listing of other state or federal laws that relate to the proposed measure, including**
2 **whether other states are defraying the cost of similar coverage in accordance with 42**
3 **U.S.C. 18031(d)(3), as amended and in effect on the effective date of this 2026 Act;**

4 **(7) The extent to which the coverage in the proposed measure is already provided by the**
5 **Public Employees' Benefit Board, the Oregon Educators Benefit Board or individual, small**
6 **employer group and large employer group health insurance plans;**

7 **(8) The extent to which the coverage in the proposed measure is provided in the state**
8 **medical assistance program as prescribed by the Oregon Health Authority under ORS 414.065**
9 **or in Medicare Parts A through D; and**

10 **(9) The extent to which a lack of the coverage in the proposed measure results in finan-**
11 **cial hardship to residents of this state.**

12 **SECTION 25. No later than September 15, 2027, the Legislative Policy and Research Di-**
13 **rector shall report to the Legislative Assembly in the manner provided under ORS 192.245**
14 **on recommendations for changes to improve upon the review of proposed insurance coverage**
15 **mandates during regular or special sessions of the Legislative Assembly. The recommen-**
16 **dations may include legislative proposals or explanations of the need for additional resources.**

17 **SECTION 26. ORS 743B.221 is repealed.**

18 **SECTION 27. Section 5, chapter 575, Oregon Laws 2015, as amended by section 8, chapter 26,**
19 **Oregon Laws 2016, section 19, chapter 489, Oregon Laws 2017, and section 15, chapter 37, Oregon**
20 **Laws 2022, is amended to read:**

21 **Sec. 5.** (1) Sections 1 to 4, chapter 575, Oregon Laws 2015, are repealed on December 31, 2027.

22 (2) Section 3, chapter 489, Oregon Laws 2017, is repealed on December 31, 2027.

23 *[(3) The amendments to section 8 of this 2022 Act by section 14 of this 2022 Act become operative*
24 *on December 31, 2027.]*

25 **SECTION 28. ORS 750.055 is amended to read:**

26 750.055. (1) The following provisions apply to health care service contractors to the extent not
27 inconsistent with the express provisions of ORS 750.005 to 750.095:

28 (a) ORS 705.137, 705.138 and 705.139.

29 (b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398
30 to 731.430, 731.428, 731.450, 731.454, 731.485, as provided in subsection (2) of this section, ORS
31 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652,
32 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

33 (c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.596, not
34 including ORS 732.582, and ORS 732.650 to 732.689.

35 (d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695
36 to 733.780.

37 (e) ORS 734.014 to 734.440.

38 (f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to
39 742.542.

40 (g) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.022, 743.023, 743.025,
41 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.405, 743.406,
42 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650
43 to 743.656, 743.680 to 743.689, 743.788 and 743.790.

44 (h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036, 743A.040, 743A.044,
45 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,

1 743A.068, 743A.070, 743A.080, 743A.081, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104,
2 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168,
3 743A.169, 743A.170, 743A.171, 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252,
4 743A.260, 743A.310 and 743A.315 and section 2, chapter 771, Oregon Laws 2013.

5 (i) ORS 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195, 743B.197, 743B.200,
6 743B.202, 743B.204, 743B.220, [743B.221,] 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,
7 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.275 to 743B.285, 743B.287, 743B.300, 743B.310,
8 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343 to 743B.347, 743B.400, 743B.403,
9 743B.407, 743B.420, 743B.423, 743B.430, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475,
10 743B.505, 743B.550, 743B.555, 743B.601, 743B.602, 743B.603, 743B.607, 743B.610 and 743B.800.

11 (j) The following provisions of ORS chapter 744:

12 (A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance produc-
13 ers;

14 (B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and

15 (C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.

16 (k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610,
17 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

18 (2) The following provisions of the Insurance Code apply to health care service contractors ex-
19 cept in the case of group practice health maintenance organizations that are federally qualified
20 pursuant to Title XIII of the Public Health Service Act:

21 (a) ORS 731.485, if the group practice health maintenance organization wholly owns and oper-
22 ates an in-house drug outlet.

23 (b) ORS 743A.024, unless the patient is referred by a physician, physician associate or nurse
24 practitioner associated with a group practice health maintenance organization.

25 (3) For the purposes of this section, health care service contractors are insurers.

26 (4) Any for-profit health care service contractor organized under the laws of any other state that
27 is not governed by the insurance laws of the other state is subject to all requirements of ORS
28 chapter 732.

29 (5)(a) A health care service contractor is a domestic insurance company for the purpose of de-
30 termining whether the health care service contractor is a debtor, as defined in 11 U.S.C. 109.

31 (b) A health care service contractor's classification as a domestic insurance company under
32 paragraph (a) of this subsection does not subject the health care service contractor to ORS 734.510
33 to 734.710.

34 (6) The Director of the Department of Consumer and Business Services may, after notice and
35 hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025
36 and 750.045 that are necessary for the proper administration of these provisions.

37 **SECTION 29.** ORS 750.055, as amended by section 7, chapter 388, Oregon Laws 2025, is
38 amended to read:

39 750.055. (1) The following provisions apply to health care service contractors to the extent not
40 inconsistent with the express provisions of ORS 750.005 to 750.095:

41 (a) ORS 705.137, 705.138 and 705.139.

42 (b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398
43 to 731.430, 731.428, 731.450, 731.454, 731.485, as provided in subsection (2) of this section, ORS
44 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652,
45 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

1 (c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.596, not
2 including ORS 732.582, and ORS 732.650 to 732.689.

3 (d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695
4 to 733.780.

5 (e) ORS 734.014 to 734.440.

6 (f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to
7 742.542.

8 (g) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.022, 743.023, 743.025,
9 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.405, 743.406,
10 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650
11 to 743.656, 743.680 to 743.689, 743.788 and 743.790.

12 (h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036, 743A.040, 743A.044,
13 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,
14 743A.068, 743A.070, 743A.080, 743A.081, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104,
15 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168,
16 743A.169, 743A.170, 743A.171, 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252,
17 743A.260, 743A.310 and 743A.315 and section 2, chapter 771, Oregon Laws 2013.

18 (i) ORS 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195, 743B.197, 743B.200,
19 743B.202, 743B.204, 743B.220, [743B.221,] 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,
20 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.275 to 743B.285, 743B.287, 743B.300, 743B.310,
21 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343 to 743B.347, 743B.400, 743B.403,
22 743B.407, 743B.420, 743B.423, 743B.430, 743B.445, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470,
23 743B.475, 743B.505, 743B.550, 743B.555, 743B.601, 743B.602, 743B.603, 743B.607, 743B.610 and
24 743B.800.

25 (j) The following provisions of ORS chapter 744:

26 (A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance produc-
27 ers;

28 (B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and

29 (C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.

30 (k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610,
31 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

32 (2) The following provisions of the Insurance Code apply to health care service contractors ex-
33 cept in the case of group practice health maintenance organizations that are federally qualified
34 pursuant to Title XIII of the Public Health Service Act:

35 (a) ORS 731.485, if the group practice health maintenance organization wholly owns and oper-
36 ates an in-house drug outlet.

37 (b) ORS 743A.024, unless the patient is referred by a physician, physician associate or nurse
38 practitioner associated with a group practice health maintenance organization.

39 (3) For the purposes of this section, health care service contractors are insurers.

40 (4) Any for-profit health care service contractor organized under the laws of any other state that
41 is not governed by the insurance laws of the other state is subject to all requirements of ORS
42 chapter 732.

43 (5)(a) A health care service contractor is a domestic insurance company for the purpose of de-
44 termining whether the health care service contractor is a debtor, as defined in 11 U.S.C. 109.

45 (b) A health care service contractor's classification as a domestic insurance company under

1 paragraph (a) of this subsection does not subject the health care service contractor to ORS 734.510
2 to 734.710.

3 (6) The Director of the Department of Consumer and Business Services may, after notice and
4 hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025
5 and 750.045 that are necessary for the proper administration of these provisions.

6 **SECTION 30.** ORS 750.055, as amended by section 21, chapter 771, Oregon Laws 2013, section
7 7, chapter 25, Oregon Laws 2014, section 82, chapter 45, Oregon Laws 2014, section 9, chapter 59,
8 Oregon Laws 2015, section 7, chapter 100, Oregon Laws 2015, section 7, chapter 224, Oregon Laws
9 2015, section 11, chapter 362, Oregon Laws 2015, section 10, chapter 470, Oregon Laws 2015, section
10 30, chapter 515, Oregon Laws 2015, section 10, chapter 206, Oregon Laws 2017, section 6, chapter
11 417, Oregon Laws 2017, section 22, chapter 479, Oregon Laws 2017, section 10, chapter 7, Oregon
12 Laws 2018, section 69, chapter 13, Oregon Laws 2019, section 38, chapter 151, Oregon Laws 2019,
13 section 5, chapter 441, Oregon Laws 2019, section 85, chapter 97, Oregon Laws 2021, section 12,
14 chapter 37, Oregon Laws 2022, section 5, chapter 111, Oregon Laws 2023, section 2, chapter 152,
15 Oregon Laws 2023, section 4, chapter 24, Oregon Laws 2024, section 5, chapter 35, Oregon Laws
16 2024, section 22, chapter 70, Oregon Laws 2024, section 163, chapter 73, Oregon Laws 2024, sections
17 6 and 8, chapter 388, Oregon Laws 2025, section 6, chapter 536, Oregon Laws 2025, and section 19,
18 chapter 539, Oregon Laws 2025, is amended to read:

19 750.055. (1) The following provisions apply to health care service contractors to the extent not
20 inconsistent with the express provisions of ORS 750.005 to 750.095:

21 (a) ORS 705.137, 705.138 and 705.139.

22 (b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398
23 to 731.430, 731.428, 731.450, 731.454, 731.485, as provided in subsection (2) of this section, ORS
24 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652,
25 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

26 (c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.596, not
27 including ORS 732.582, and ORS 732.650 to 732.689.

28 (d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695
29 to 733.780.

30 (e) ORS 734.014 to 734.440.

31 (f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to
32 742.542.

33 (g) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.022, 743.023, 743.025,
34 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.405, 743.406,
35 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650
36 to 743.656, 743.680 to 743.689, 743.788 and 743.790.

37 (h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036, 743A.040, 743A.044,
38 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,
39 743A.068, 743A.070, 743A.080, 743A.081, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104,
40 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168,
41 743A.169, 743A.170, 743A.171, 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252,
42 743A.260, 743A.310 and 743A.315.

43 (i) ORS 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195, 743B.197, 743B.200,
44 743B.202, 743B.204, 743B.220, [743B.221,] 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,
45 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.275 to 743B.285, 743B.287, 743B.300, 743B.310,

1 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343 to 743B.347, 743B.400, 743B.403,
2 743B.407, 743B.420, 743B.423, 743B.430, 743B.445, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470,
3 743B.475, 743B.505, 743B.550, 743B.555, 743B.601, 743B.602, 743B.603, 743B.607, 743B.610 and
4 743B.800.

5 (j) The following provisions of ORS chapter 744:

6 (A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance produc-
7 ers;

8 (B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and

9 (C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.

10 (k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610,
11 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

12 (2) The following provisions of the Insurance Code apply to health care service contractors ex-
13 cept in the case of group practice health maintenance organizations that are federally qualified
14 pursuant to Title XIII of the Public Health Service Act:

15 (a) ORS 731.485, if the group practice health maintenance organization wholly owns and oper-
16 ates an in-house drug outlet.

17 (b) ORS 743A.024, unless the patient is referred by a physician, physician associate or nurse
18 practitioner associated with a group practice health maintenance organization.

19 (3) For the purposes of this section, health care service contractors are insurers.

20 (4) Any for-profit health care service contractor organized under the laws of any other state that
21 is not governed by the insurance laws of the other state is subject to all requirements of ORS
22 chapter 732.

23 (5)(a) A health care service contractor is a domestic insurance company for the purpose of de-
24 termining whether the health care service contractor is a debtor, as defined in 11 U.S.C. 109.

25 (b) A health care service contractor's classification as a domestic insurance company under
26 paragraph (a) of this subsection does not subject the health care service contractor to ORS 734.510
27 to 734.710.

28 (6) The Director of the Department of Consumer and Business Services may, after notice and
29 hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025
30 and 750.045 that are necessary for the proper administration of these provisions.

31 **SECTION 31.** ORS 750.333 is amended to read:

32 750.333. (1) The following provisions apply to trusts carrying out a multiple employer welfare
33 arrangement:

34 (a) ORS 705.137, 705.138 and 705.139.

35 (b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.268, 731.296 to 731.316, 731.324, 731.328,
36 731.378, 731.386, 731.390, 731.398, 731.406, 731.410, 731.414, 731.418 to 731.434, 731.454, 731.484,
37 731.486, 731.488, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.804, 731.808 and 731.844 to
38 731.992.

39 (c) ORS 733.010 to 733.050, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

40 (d) ORS 734.014 to 734.440.

41 (e) ORS 742.001 to 742.009, 742.013, 742.016, 742.061 and 742.065.

42 (f) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.023, 743.028, 743.029,
43 743.053, 743.405, 743.406, 743.524, 743.526[,] **and** 743.535 [*and 743B.221*].

44 (g) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.024, 743A.034, 743A.036, 743A.040,
45 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,

1 743A.068, 743A.070, 743A.080, 743A.081, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104,
2 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168,
3 743A.169, 743A.170, 743A.171, 743A.175, 743A.180, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250,
4 743A.252, 743A.260 and 743A.310.

5 (h) ORS 743B.001, 743B.003 to 743B.127 (except 743B.125 to 743B.127), 743B.195, 743B.197,
6 743B.200, 743B.202, 743B.204, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,
7 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.320, 743B.321, 743B.330, 743B.340,
8 743B.341, 743B.342, 743B.343, 743B.344, 743B.345, 743B.347, 743B.400, 743B.403, 743B.407, 743B.420,
9 743B.423, 743B.430, 743B.451, 743B.453, 743B.470, 743B.505, 743B.550, 743B.555, 743B.601, 743B.607
10 and 743B.610.

11 (i) The following provisions of ORS chapter 744:

12 (A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance produc-
13 ers;

14 (B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and

15 (C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.

16 (j) ORS 746.005 to 746.140, 746.160 and 746.220 to 746.370.

17 (2) For the purposes of this section:

18 (a) A trust carrying out a multiple employer welfare arrangement is an insurer.

19 (b) References to certificates of authority are references to certificates of multiple employer
20 welfare arrangement.

21 (c) Contributions are premiums.

22 (3) The provision of health benefits under ORS 750.301 to 750.341 is the transaction of health
23 insurance.

24 (4) The Department of Consumer and Business Services may adopt rules that are necessary to
25 implement the provisions of ORS 750.301 to 750.341.

26 **SECTION 32.** ORS 750.333, as amended by section 10, chapter 388, Oregon Laws 2025, is
27 amended to read:

28 750.333. (1) The following provisions apply to trusts carrying out a multiple employer welfare
29 arrangement:

30 (a) ORS 705.137, 705.138 and 705.139.

31 (b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.268, 731.296 to 731.316, 731.324, 731.328,
32 731.378, 731.386, 731.390, 731.398, 731.406, 731.410, 731.414, 731.418 to 731.434, 731.454, 731.484,
33 731.486, 731.488, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.804, 731.808 and 731.844 to
34 731.992.

35 (c) ORS 733.010 to 733.050, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

36 (d) ORS 734.014 to 734.440.

37 (e) ORS 742.001 to 742.009, 742.013, 742.016, 742.061 and 742.065.

38 (f) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.023, 743.028, 743.029,
39 743.053, 743.405, 743.406, 743.524, 743.526[,] **and** 743.535 [*and 743B.221*].

40 (g) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.024, 743A.034, 743A.036, 743A.040,
41 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,
42 743A.068, 743A.070, 743A.080, 743A.081, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104,
43 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168,
44 743A.169, 743A.170, 743A.171, 743A.175, 743A.180, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250,
45 743A.252, 743A.260 and 743A.310.

1 (h) ORS 743B.001, 743B.003 to 743B.127 (except 743B.125 to 743B.127), 743B.195, 743B.197,
2 743B.200, 743B.202, 743B.204, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,
3 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.320, 743B.321, 743B.330, 743B.340,
4 743B.341, 743B.342, 743B.343, 743B.344, 743B.345, 743B.347, 743B.400, 743B.403, 743B.407, 743B.420,
5 743B.423, 743B.430, 743B.445, 743B.451, 743B.453, 743B.470, 743B.505, 743B.550, 743B.555, 743B.601,
6 743B.607 and 743B.610.

7 (i) The following provisions of ORS chapter 744:

8 (A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance produc-
9 ers;

10 (B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and

11 (C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.

12 (j) ORS 746.005 to 746.140, 746.160 and 746.220 to 746.370.

13 (2) For the purposes of this section:

14 (a) A trust carrying out a multiple employer welfare arrangement is an insurer.

15 (b) References to certificates of authority are references to certificates of multiple employer
16 welfare arrangement.

17 (c) Contributions are premiums.

18 (3) The provision of health benefits under ORS 750.301 to 750.341 is the transaction of health
19 insurance.

20 (4) The Department of Consumer and Business Services may adopt rules that are necessary to
21 implement the provisions of ORS 750.301 to 750.341.

22 **SECTION 33.** ORS 743A.145 is amended to read:

23 743A.145. (1) As used in this section:

24 (a) "Device" means:

25 (A) An orthotic device.

26 (B) A prosthetic device.

27 (b) "Orthotic device" means a rigid or semirigid device supporting a weak or deformed leg, foot,
28 arm, hand, back or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm,
29 hand, back or neck.

30 (c) "Prosthetic device" means an artificial limb device or appliance designed to replace in whole
31 or in part an arm or a leg.

32 (2) All individual and group health insurance policies providing coverage for the expenses of
33 hospital, medical or surgical services or supplies shall provide coverage for devices. The coverage
34 required by this subsection includes:

35 (a) Devices that are determined to be medically necessary to restore or maintain the ability to
36 complete activities of daily living or essential job-related activities [*and that are not solely for com-
37 fort or convenience*].

38 (b) All services and supplies medically necessary for the effective use of a device, including de-
39 sign formulation, fabrication, material and component selection, measurements, fittings, static and
40 dynamic alignments and patient instruction in the use of the device.

41 (c) Replacement of a device or any part of a device, if the replacement is determined to be
42 medically necessary, based on:

43 (A) A change in the physiological condition of the insured;

44 (B) An irreparable change in the condition of the device or part of the device; or

45 (C) The device, or a part of the device, requiring repair and the cost of the repair would be more

1 than 60 percent of the cost of the replacement device or replacement part of the device.

2 (d) Repair of a device or any part of a device, if the repair is determined to be medically nec-
3 essary, based on:

4 (A) A change in the physiological condition of the insured; or

5 (B) A change in the condition of the device or part of the device.

6 (e) Devices that are determined to be medically necessary and the most appropriate model that
7 meets the medical needs of the insured for purposes of performing physical activities, including but
8 not limited to running, biking, swimming and strength training, and that maximizes the insured's
9 whole-body health, including lower and upper limb function.

10 (3) The Director of the Department of Consumer and Business Services shall adopt and annually
11 update rules listing the devices covered under this section. The list shall be no more restrictive than
12 the list of devices and supplies in the Medicare fee schedule for Durable Medical Equipment, Pros-
13 thetics, Orthotics and Supplies, but only to the extent consistent with this section.

14 (4) The coverage required by subsection (2) of this section may be made subject to, and no more
15 restrictive than, the provisions of a health insurance policy that apply to other benefits under the
16 policy.

17 (5) If the coverage under subsection (2) of this section is provided through a managed care or-
18 ganization, the insured shall have access to medically necessary clinical care and to devices and
19 technology from not fewer than two distinct Oregon prosthetic and orthotic providers in the man-
20 aged care organization's provider network.

21 (6) An individual or group health plan may not deny coverage for a prosthetic or orthotic benefit
22 for an insured with limb loss, impairment or absence to restore or maintain the ability to perform
23 a physical activity if a benefit would be covered for medical or surgical intervention for a person
24 without limb loss, impairment or absence to restore or maintain the ability to perform the same
25 physical activity.

26 (7) For coverage described in subsection (2)(c) of this section, an insurer may require confirma-
27 tion from the prescribing health care provider that the coverage is medically necessary if the device,
28 or any part of the device, requires replacement and is less than three years old.

29 (8) This section is exempt from ORS 743A.001.

30 (9) The coverage requirements described in subsections (2)(e), (6) and (7) of this section do not
31 apply to a health benefit plan offered by the Public Employees' Benefit Board or the Oregon Edu-
32 cators Benefit Board, unless the plans offered by the Public Employees' Benefit Board or the Oregon
33 Educators Benefit Board elect to provide the coverage and provide notice to the Department of
34 Consumer and Business Services in the form and manner described by the department by rule.

35
36 **PHARMACY**

37
38 **SECTION 34.** ORS 744.702 is amended to read:

39 744.702. (1) Subject to ORS 744.704, a person shall not transact business or purport or offer to
40 transact business as a third party administrator in this state unless the person holds a third party
41 administrator license issued by the Director of the Department of Consumer and Business Services.

42 (2) For purposes of ORS 744.700 to 744.740, a person transacts or purports or offers to transact
43 business as a third party administrator if the person:

44 (a) Directly or indirectly solicits or effects coverage of, underwrites, collects charges or premi-
45 ums from, or adjusts or settles claims on, residents of this state or residents of another state from

1 offices in this state, in connection with life insurance or health insurance coverage; or

2 (b) Acts as a pharmacy services administrative organization, as defined in ORS 735.538, or as
3 an organization that advises or represents pharmacies that are members of the organization, or that
4 enters into contracts on behalf of members, in matters that are related to procuring or supplying
5 prescription drugs.

6 (3) A pharmacy services administrative organization, as defined in ORS 735.538, is exempt from
7 the requirement to obtain a license under [ORS 735.538] **subsection (2) of this section**, if the
8 pharmacy services administrative organization is not owned by a pharmacy benefit manager and
9 generates revenue only from monthly service fees that a pharmacy pays for services that are not
10 connected to drug pricing or volume.

11 (4) Nothing in ORS 744.700 to 744.740 exempts a third party administrator from any other ap-
12 plicable licensing requirement when the third party administrator performs the functions of an in-
13 surance producer, adjuster or insurance consultant.

14 **SECTION 35.** ORS 646A.694 is amended to read:

15 646A.694. (1) The Department of Consumer and Business Services shall provide to the Pre-
16 scription Drug Affordability Board each calendar year a list of prescription drugs included in re-
17 ports submitted to the department under ORS 646A.689 (2) and (6), a list of drugs included in reports
18 submitted to the department under ORS 646A.683 and 743.025 and a list of insulin drugs marketed
19 in this state during the previous calendar year. Each calendar year, the board shall identify up to
20 nine drugs and **may identify** at least one insulin product from the lists provided under this sub-
21 section that the board determines may create affordability challenges for health care systems or
22 high out-of-pocket costs for patients in this state based on criteria adopted by the board by rule,
23 including but not limited to:

24 (a) Whether the prescription drug has led to health inequities in communities of color;

25 (b) The number of residents in this state prescribed the prescription drug;

26 (c) The price for the prescription drug sold in this state;

27 (d) The estimated average monetary price concession, discount or rebate the manufacturer pro-
28 vides to health insurance plans in this state or is expected to provide to health insurance plans in
29 this state, expressed as a percentage of the price for the prescription drug under review;

30 (e) The estimated total amount of the price concession, discount or rebate the manufacturer
31 provides to each pharmacy benefit manager licensed in this state for the prescription drug under
32 review, expressed as a percentage of the prices;

33 (f) The estimated price for therapeutic alternatives to the drug that are sold in this state;

34 (g) The estimated average price concession, discount or rebate the manufacturer provides or is
35 expected to provide to health insurance plans and pharmacy benefit managers in this state for
36 therapeutic alternatives;

37 (h) The estimated costs to health insurance plans based on patient use of the drug consistent
38 with the labeling approved by the United States Food and Drug Administration and recognized
39 standard medical practice;

40 (i) The impact on patient access to the drug considering standard prescription drug benefit de-
41 signs in health insurance plans offered in this state;

42 (j) The relative financial impacts to health, medical or social services costs as can be quantified
43 and compared to the costs of existing therapeutic alternatives;

44 (k) The estimated average patient copayment or other cost-sharing for the prescription drug in
45 this state;

1 (L) Any information a manufacturer chooses to provide; and

2 (m) Any other factors as determined by the board in rules adopted by the board.

3 (2) A drug that is designated by the Secretary of the United States Food and Drug Adminis-
4 tration, under 21 U.S.C. 360bb, as a drug for a rare disease or condition is not subject to review
5 under subsection (1) of this section.

6 (3) The board shall accept testimony from patients and caregivers affected by a condition or
7 disease that is treated by a prescription drug under review by the board and from individuals with
8 scientific or medical training with respect to the disease or condition.

9 (4)(a) If the board considers the cost-effectiveness of a prescription drug in criteria adopted by
10 the board under subsection (1) of this section, the board may not use quality-adjusted life-years, or
11 similar formulas that take into account a patient's age or severity of illness or disability, to identify
12 subpopulations for which a prescription drug would be less cost-effective. For any prescription drug
13 that extends life, the board's analysis of cost-effectiveness must weigh the value of the quality of life
14 equally for all patients, regardless of the patients' age or severity of illness or disability.

15 (b) As used in this subsection:

16 (A) "Health utility" means a measure of the degree to which having a particular form of disease
17 or disability or having particular functional limitations negatively impacts the quality of life as
18 compared to a state of perfect health, expressed as a number between zero and one.

19 (B) "Quality-adjusted life-year" is the product of a health utility multiplied by the extra months
20 or years of life that a patient might gain as a result of a treatment.

21 (5) To the extent practicable, the board shall access pricing information for prescription drugs
22 by:

23 (a) Accessing pricing information collected by the department under ORS 646A.689 and 743.025;

24 (b) Accessing data reported to the Oregon Health Authority under ORS 442.373;

25 (c) Entering into a memorandum of understanding with another state to which manufacturers
26 already report pricing information; and

27 (d) Accessing other publicly available pricing information.

28 (6) The information used to conduct an affordability review may include any document and re-
29 search related to the introductory price or price increase of a prescription drug, including life cycle
30 management, net average price in this state, market competition and context, projected revenue and
31 the estimated value or cost-effectiveness of the prescription drug.

32 (7) The department and the board shall keep strictly confidential any information collected, used
33 or relied upon for the review conducted under this section if the information is:

34 (a) Information submitted to the department by a manufacturer under ORS 646A.689; and

35 (b) Confidential, proprietary or a trade secret as defined in ORS 192.345.

36
37 **PSILOCYBIN**

38
39 **SECTION 36.** ORS 475A.325 is amended to read:

40 475A.325. *[Facilitator license; fees; rules.]* (1) The facilitation of psilocybin services is subject to
41 regulation by the Oregon Health Authority.

42 (2) A psilocybin service facilitator must have a facilitator license issued by the authority. To
43 hold a facilitator license issued under this section, a psilocybin service facilitator **shall**:

44 (a) *[Must]* Apply for a license in the manner described in ORS 475A.245;

45 (b) *[Must]* Provide proof that the applicant is 21 years of age or older;

1 [(c) *Must, until January 1, 2025, provide proof that the applicant has been a resident of this state*
2 *for two or more years;*]

3 [(d)] (c) [*Must*] Have a high school diploma or equivalent education;

4 [(e)] (d) [*Must*] Submit evidence of completion of education and training prescribed and approved
5 by the authority;

6 [(f)] (e) [*Must*] Have passed an examination approved, administered or recognized by the au-
7 thority; and

8 [(g)] (f) [*Must*] Meet the requirements of any rule adopted by the authority under subsection (4)
9 of this section.

10 (3) The authority may not require a psilocybin service facilitator to have a degree from a uni-
11 versity, college, post-secondary institution[,] or other institution of higher education.

12 (4) The authority shall adopt rules that:

13 (a) Require a psilocybin service facilitator to annually renew a license issued under this section;

14 (b) Establish application, licensure and renewal of licensure fees for psilocybin service
15 facilitators; [*and*]

16 (c) Require a psilocybin service facilitator to meet any public health and safety standards and
17 industry best practices established by the authority by rule[.]; **and**

18 **(d) In order to meet the requirement described in subsection (2)(d) of this section, allow**
19 **an applicant to submit proof of completion of a psilocybin service facilitator training program**
20 **in another state if the training program is approved by the regulatory body responsible for**
21 **regulating psilocybin service facilitator training programs in that state, and the authority**
22 **determines that the training program’s curriculum meets or exceeds the standards adopted**
23 **under ORS 475A.380.**

24 (5) Fees adopted under subsection (4)(b) of this section:

25 (a) May not exceed, together with other fees collected under ORS 475A.210 to 475A.722, the cost
26 of administering ORS 475A.210 to 475A.722; and

27 (b) Shall be deposited in the Psilocybin Control and Regulation Fund established under ORS
28 475A.492.

29 (6) A psilocybin service facilitator may be, [*but need not be,*] **but is not required to be,** an
30 employee, manager, director, officer, partner, member, shareholder[,] or direct or indirect owner of
31 one or more psilocybin service center operators.

32 (7) A license issued to a psilocybin service facilitator under this section is not limited to any
33 one or more premises.

34 **SECTION 37.** ORS 475A.338 is amended to read:

35 475A.338. (1)(a) As used in this subsection, “board” means:

36 **(A) The Occupational Therapy Licensing Board;**

37 [(A)] **(B) The Oregon Board of Licensed Professional Counselors and Therapists;**

38 [(B)] **(C) The Oregon Board of Naturopathic Medicine;**

39 **(D) The Oregon Board of Physical Therapy;**

40 [(C)] **(E) The Oregon Board of Psychology;**

41 [(D)] **(F) The Oregon Medical Board;**

42 [(E)] **(G) The Oregon State Board of Nursing;**

43 [(F)] **(H) The State Board of Licensed Social Workers; and**

44 [(G)] **(I) The State Board of Pharmacy.**

45 (b) A person who is licensed or otherwise authorized by a board to provide health care or be-

1 behavioral health care services and who holds a license under ORS 475A.325 may, in accordance with
2 the provisions of ORS 475A.210 to 475A.722 and rules adopted under ORS 475A.210 to 475A.722:

3 (A) Conduct preparation sessions and integration sessions with clients in addition to and while
4 providing health care or behavioral health care services.

5 (B) Conduct administration sessions with clients, so long as the person does not provide health
6 care or behavioral health care services while providing psilocybin services.

7 (2) A health care provider, as defined in ORS 127.505, may not be subject to a civil penalty or
8 other disciplinary action by the state agency that regulates the health care provider for:

9 (a) Discussing with a client or patient, as a treatment option, psilocybin services provided by a
10 psilocybin service facilitator that holds a license issued under ORS 475A.325 at a psilocybin service
11 center for which a license is issued under ORS 475A.305; or

12 (b) If the health care provider holds a license issued under ORS 475A.325, providing psilocybin
13 services in accordance with the provisions of ORS 475A.210 to 475A.722 and rules adopted under
14 ORS 475A.210 to 475A.722, so long as the health care provider does not provide health care services
15 while providing psilocybin services.

16 **SECTION 38.** ORS 475A.372 is amended to read:

17 475A.372. (1) As used in this section, “adverse behavioral reaction” and “adverse medical re-
18 action” have the meanings given those terms by rule by the Oregon Health Authority.

19 (2) A psilocybin service center operator that holds a license issued under ORS 475A.305 shall:

20 (a) Collect and maintain the following information, in addition to the information required to
21 complete a client information form described in ORS 475A.350:

22 (A) The race, ethnicity, preferred spoken and written languages, disability status, sexual orien-
23 tation, gender identity, income, age, veteran status and county of residence of each client; and

24 (B) The reasons for which a client requests psilocybin services;

25 (b) Compile and maintain the following information that pertains to the three-month period im-
26 mediately preceding a quarterly submission under subsection (4) of this section:

27 (A) The number of clients served;

28 (B) The number of individual administration sessions provided;

29 (C) The number of group administration sessions provided;

30 (D) The number of individuals to whom the psilocybin service center or a psilocybin service
31 facilitator practicing at the psilocybin service center denied psilocybin services and the reasons for
32 which psilocybin services were denied;

33 (E) The number and severity of:

34 (i) Adverse behavioral reactions experienced by clients, of which the psilocybin service center
35 operator is aware; and

36 (ii) Adverse medical reactions experienced by clients, of which the psilocybin service center
37 operator is aware; and

38 (F) Any additional information required by the authority by rule as described in subsection (7)
39 of this section; and

40 (c) Compute, for the period described in paragraph (b) of this subsection, and maintain the fol-
41 lowing information:

42 (A) The average number of times per client that psilocybin services were received;

43 (B) The average number of clients participating in each group administration session; [and]

44 (C) **For doses higher than five milligrams of psilocybin analyte, the total average dose of**
45 **psilocybin per client per administration session[.]; and**

1 stored by the board upon receipt, not more than 30 days after the license lapses, of a completed
2 renewal application and payment of the restoration fee under subsection (8) of this section.

3 (4) A license that has lapsed for more than one month may be restored by the board upon pay-
4 ment of the restoration fee established by the board and submission of a completed renewal appli-
5 cation and any other information required by the board.

6 (5) A person holding an active license under this chapter may convert the license to inactive
7 status by meeting the requirements set by rule of the board and paying any required fees. A person
8 holding a license issued under this chapter who is at least [70] 65 years of age and retired from the
9 practice of naturopathic medicine may convert the license to retired status by meeting the require-
10 ments set by rule of the board and paying any required fees.

11 (6)(a) A person who chooses to allow a license to become inactive may file a written application
12 to reactivate a license that has been inactive for one year or less by paying the restoration fee and
13 the renewal fee for an active license and demonstrating compliance with ORS 685.102. A fee paid
14 to place the license in inactive status may not be credited toward payment of the renewal fee for
15 an active license. The board may prorate the renewal fee.

16 (b) A person who chooses to allow a license to become inactive may file a written application
17 to reactivate a license that has been inactive for more than one year by paying the renewal fee for
18 an active license and demonstrating compliance with the continuing education requirement set by
19 rule of the board under ORS 685.102 (6). The board may prorate the renewal fee.

20 (7) The executive director of the board shall issue a renewal notice to each person holding a
21 license under this chapter at least 60 days before the renewal application is due.

22 (8) The board shall assess fees for:

23 (a) An initial license.

24 (b) Examination.

25 (c) Renewal of an active license.

26 (d) Yearly renewal of an inactive or retired license.

27 (e) Restoration of an inactive, lapsed or revoked license.

28 (f) A certificate of special competency in natural childbirth.

29 (g) A duplicate license.

30 (h) A wall certificate.

31 (i) Copies of public documents, mailing labels, lists and diskettes.

32 (9) Subject to prior approval of the Oregon Department of Administrative Services, the fees and
33 charges established under this section may not exceed the cost of administering the regulatory
34 program of the [board] **Oregon Board of Naturopathic Medicine** pertaining to the purpose for
35 which the fee or charge is established, as authorized by the Legislative Assembly within the board's
36 budget, as the budget may be modified by the Emergency Board.

37 **SECTION 41.** ORS 685.102 is amended to read:

38 685.102. (1) Except as provided in subsections (2) and (5) of this section, each person holding a
39 license under this chapter shall submit annually by December 31, evidence satisfactory to the
40 Oregon Board of Naturopathic Medicine of successful completion of an approved program of con-
41 tinuing education of at least 25 hours in naturopathic medicine, completed in the calendar year
42 preceding the date on which the evidence is submitted, and completion during the renewal period,
43 or documentation of completion within the previous 36 months, of:

44 (a) A pain management education program approved by the board and developed based on rec-
45 ommendations of the Pain Management Commission; or

1 (b) An equivalent pain management education program, as determined by the board.

2 (2) The board may exempt any person holding a license under this chapter from the require-
3 ments of subsection (1) of this section upon application showing evidence satisfactory to the board
4 of inability to comply with the requirements because of physical or mental condition or because of
5 other unusual or extenuating circumstances. However, a person may not be exempted from the re-
6 quirements of subsection (1) of this section more than once in any five-year period.

7 (3) Notwithstanding subsection (2) of this section, a person holding a license under this chapter
8 may be exempted from the requirements of subsection (1) of this section upon application showing
9 evidence satisfactory to the board that the applicant is or will be in the next calendar year at least
10 [70] 65 years of age and is retired or will retire in the next calendar year from the practice of
11 naturopathic medicine.

12 (4) The board shall require licensees to obtain continuing education for the use of
13 pharmacological substances for diagnostic, preventive and therapeutic purposes in order to maintain
14 current licensure.

15 (5) A person whose license is in inactive status must submit by December 31 of each year evi-
16 dence satisfactory to the board of completion of 10 hours of approved continuing education in the
17 calendar year preceding the date on which the evidence is submitted.

18 (6) Notwithstanding subsections (1), (2) and (5) of this section, in the case of an applicant under
19 ORS 685.100 (6)(b) for reactivation of an inactive license, the continuing education requirement for
20 reactivation shall be set by rule of the board.

21 **SECTION 42.** (1) **The amendments to ORS 685.100 and 685.102 by sections 40 and 41 of this**
22 **2026 Act become operative on January 1, 2027.**

23 **(2) The Oregon Board of Naturopathic Medicine may take any action before the operative**
24 **date specified in subsection (1) of this section that is necessary to enable the board to exer-**
25 **cise, on and after the operative date specified in subsection (1) of this section, all of the du-**
26 **ties, functions and powers conferred on the board by the amendments to ORS 685.100 and**
27 **685.102 by sections 40 and 41 of this 2026 Act.**

28
29 **WORKERS' COMPENSATION RECLASSIFICATION OF**
30 **PHYSICIAN ASSOCIATES AND NURSE PRACTITIONERS**
31

32 **SECTION 43.** ORS 656.005 is amended to read:

33 656.005. (1) "Average weekly wage" means the Oregon average weekly wage in covered em-
34 ployment, as determined by the Employment Department, for the last quarter of the calendar year
35 preceding the fiscal year in which the injury occurred.

36 (2)(a) "Beneficiary" means an injured worker, and the spouse in a marriage, child or dependent
37 of a worker, who is entitled to receive payments under this chapter.

38 (b) "Beneficiary" does not include a person who intentionally causes the compensable injury to
39 or death of an injured worker.

40 (3) "Board" means the Workers' Compensation Board.

41 (4) "Carrier-insured employer" means an employer who provides workers' compensation cover-
42 age with the State Accident Insurance Fund Corporation or an insurer authorized under ORS
43 chapter 731 to transact workers' compensation insurance in this state.

44 (5) "Child" means a child of an injured worker, including:

45 (a) A posthumous child;

1 (b) A child legally adopted before the injury;

2 (c) A child toward whom the worker stands in loco parentis;

3 (d) A child born out of wedlock;

4 (e) A stepchild, if the stepchild was, at the time of the injury, a member of the worker's family
5 and substantially dependent upon the worker for support; and

6 (f) A child of any age who was incapacitated at the time of the accident and thereafter remains
7 incapacitated and substantially dependent on the worker for support.

8 (6) "Claim" means a written request for compensation from a subject worker or someone on the
9 worker's behalf, or any compensable injury of which a subject employer has notice or knowledge.

10 (7)(a) A "compensable injury" is an accidental injury, or accidental injury to prosthetic appli-
11 ances, arising out of and in the course of employment requiring medical services or resulting in
12 disability or death. An injury is accidental if the result is an accident, whether or not due to acci-
13 dental means, if it is established by medical evidence supported by objective findings, subject to the
14 following limitations:

15 (A) An injury or disease is not compensable as a consequence of a compensable injury unless
16 the compensable injury is the major contributing cause of the consequential condition.

17 (B) If an otherwise compensable injury combines at any time with a preexisting condition to
18 cause or prolong disability or a need for treatment, the combined condition is compensable only if,
19 so long as and to the extent that the otherwise compensable injury is the major contributing cause
20 of the disability of the combined condition or the major contributing cause of the need for treatment
21 of the combined condition.

22 (b) "Compensable injury" does not include:

23 (A) Injury to any active participant in assaults or combats that are not connected to the job
24 assignment and that amount to a deviation from customary duties;

25 (B) Injury incurred while engaging in or performing, or as the result of engaging in or per-
26 forming, any recreational or social activities primarily for the worker's personal pleasure; or

27 (C) Injury the major contributing cause of which is demonstrated to be by a preponderance of
28 the evidence the injured worker's consumption of alcoholic beverages or cannabis or the unlawful
29 consumption of any controlled substance, unless the employer permitted, encouraged or had actual
30 knowledge of such consumption.

31 (c) A "disabling compensable injury" is an injury that entitles the worker to compensation for
32 disability or death. An injury is not disabling if no temporary benefits are due and payable, unless
33 there is a reasonable expectation that permanent disability will result from the injury.

34 (d) A "nondisabling compensable injury" is any injury that requires medical services only.

35 (8) "Compensation" includes all benefits, including medical services, provided for a compensable
36 injury to a subject worker or the worker's beneficiaries by an insurer or self-insured employer pur-
37 suant to this chapter.

38 (9) "Department" means the Department of Consumer and Business Services.

39 (10) "Dependent" means any of the following individuals who, at the time of an accident, de-
40 pended in whole or in part for the individual's support on the earnings of a worker who dies as a
41 result of an injury:

42 (a) A parent of a worker or the parent's spouse or domestic partner;

43 (b) A grandparent of a worker or the grandparent's spouse or domestic partner;

44 (c) A grandchild of a worker or the grandchild's spouse or domestic partner;

45 (d) A sibling or stepsibling of a worker or the sibling's or stepsibling's spouse or domestic

1 partner; and

2 (e) Any individual related by blood or affinity whose close association with a worker is the
3 equivalent of a family relationship.

4 (11) "Director" means the Director of the Department of Consumer and Business Services.

5 (12)(a) [*“Doctor” or “physician”*] **“Doctor,” “physician,” “nurse practitioner” or “physician**
6 **associate”** means a person duly licensed to practice one or more of the healing arts in any country
7 or in any state, territory or possession of the United States within the limits of the license of the
8 licensee.

9 (b) Except as otherwise provided for workers subject to a managed care contract, “attending
10 physician” means a doctor, physician, **nurse practitioner** or physician associate who is primarily
11 responsible for the treatment of a worker’s compensable injury and who is:

12 [(A) *A physician licensed under ORS 677.100 to 677.228 by the Oregon Medical Board, or a*
13 *podiatric physician and surgeon licensed under ORS 677.805 to 677.840 by the Oregon Medical Board,*
14 *an oral and maxillofacial surgeon licensed by the Oregon Board of Dentistry or a similarly licensed*
15 *doctor in any country or in any state, territory or possession of the United States;]*

16 (A)(i) **A physician licensed under ORS 677.100 to 677.228 by the Oregon Medical Board or**
17 **a similarly licensed physician in any country or in any state, territory or possession of the**
18 **United States;**

19 (ii) **A podiatric physician and surgeon licensed under ORS 677.805 to 677.840 by the Oregon**
20 **Medical Board or a similarly licensed physician and surgeon in any country or in any state,**
21 **territory or possession of the United States;**

22 (iii) **An oral and maxillofacial surgeon licensed by the Oregon Board of Dentistry or a**
23 **similarly licensed surgeon in any country or in any state, territory or possession of the**
24 **United States;**

25 (iv) **A nurse practitioner licensed under ORS 678.375 to 678.390 or a similarly licensed**
26 **nurse practitioner in any country or in any state, territory or possession of the United**
27 **States; or**

28 (v) **A physician associate licensed by the Oregon Medical Board in accordance with ORS**
29 **677.505 to 677.525 or a similarly licensed physician associate in any country or in any state,**
30 **territory or possession of the United States; or**

31 (B) For a cumulative total of 60 days from the first visit on the initial claim or for a cumulative
32 total of 18 visits, whichever occurs first, to any of the medical service providers listed in this sub-
33 paragraph, a:

34 (i) Doctor or physician licensed by the State Board of Chiropractic Examiners for the State of
35 Oregon under ORS chapter 684 or a similarly licensed doctor or physician in any country or in any
36 state, territory or possession of the United States; or

37 (ii) Doctor of naturopathy or naturopathic physician licensed by the Oregon Board of
38 Naturopathic Medicine under ORS chapter 685 or a similarly licensed doctor or physician in any
39 country or in any state, territory or possession of the United States.[: or]

40 [(C) *For a cumulative total of 180 days from the first visit on the initial claim, a physician associate*
41 *licensed by the Oregon Medical Board in accordance with ORS 677.505 to 677.525 or a similarly li-*
42 *icensed physician associate in any country or in any state, territory or possession of the United*
43 *States.]*

44 (c) Except as otherwise provided for workers subject to a managed care contract, “attending
45 physician” does not include a physician who provides care in a hospital emergency room and refers

1 the injured worker to a primary care physician for follow-up care and treatment.

2 (d) "Consulting physician" means a doctor or physician who examines a worker or the worker's
3 medical record to advise the attending physician [*or nurse practitioner authorized to provide*
4 *compensable medical services under ORS 656.245*] regarding treatment of a worker's compensable
5 injury.

6 (13)(a) "Employer" means any person, including receiver, administrator, executor or trustee, and
7 the state, state agencies, counties, municipal corporations, school districts and other public corpo-
8 rations or political subdivisions, that contracts to pay a remuneration for the services of any
9 worker.

10 (b) Notwithstanding paragraph (a) of this subsection, for purposes of this chapter, the client of
11 a temporary service provider is not the employer of temporary workers provided by the temporary
12 service provider.

13 (c) As used in paragraph (b) of this subsection, "temporary service provider" has the meaning
14 given that term in ORS 656.850.

15 (d) For the purposes of this chapter, "subject employer" means an employer that is subject to
16 this chapter as provided in ORS 656.023.

17 (14) "Insurer" means the State Accident Insurance Fund Corporation or an insurer authorized
18 under ORS chapter 731 to transact workers' compensation insurance in this state or an assigned
19 claims agent selected by the director under ORS 656.054.

20 (15) "Consumer and Business Services Fund" means the fund created by ORS 705.145.

21 (16) "Incapacitated" means an individual is physically or mentally unable to earn a livelihood.

22 (17) "Medically stationary" means that no further material improvement would reasonably be
23 expected from medical treatment or the passage of time.

24 (18) "Noncomplying employer" means a subject employer that has failed to comply with ORS
25 656.017.

26 (19) "Objective findings" in support of medical evidence are verifiable indications of injury or
27 disease that may include, but are not limited to, range of motion, atrophy, muscle strength and
28 palpable muscle spasm. "Objective findings" does not include physical findings or subjective re-
29 sponses to physical examinations that are not reproducible, measurable or observable.

30 (20) "Palliative care" means medical service rendered to reduce or moderate temporarily the
31 intensity of an otherwise stable medical condition, but does not include those medical services ren-
32 dered to diagnose, heal or permanently alleviate or eliminate a medical condition.

33 (21) "Party" means a claimant for compensation, the employer of the injured worker at the time
34 of injury and the insurer, if any, of the employer.

35 (22) "Payroll" means a record of wages payable to workers for their services and includes
36 commissions, value of exchange labor and the reasonable value of board, rent, housing, lodging or
37 similar advantage received from the employer. However, "payroll" does not include overtime pay,
38 vacation pay, bonus pay, tips, amounts payable under profit-sharing agreements or bonus payments
39 to reward workers for safe working practices. Bonus pay is limited to payments that are not antic-
40 ipated under the contract of employment and that are paid at the sole discretion of the employer.
41 The exclusion from payroll of bonus payments to reward workers for safe working practices is only
42 for the purpose of calculations based on payroll to determine premium for workers' compensation
43 insurance, and does not affect any other calculation or determination based on payroll for the pur-
44 poses of this chapter.

45 (23) "Person" includes a partnership, joint venture, association, limited liability company and

1 corporation.

2 (24)(a) "Preexisting condition" means, for all industrial injury claims, any injury, disease, con-
3 genital abnormality, personality disorder or similar condition that contributes to disability or need
4 for treatment, provided that:

5 (A) Except for claims in which a preexisting condition is arthritis or an arthritic condition, the
6 worker has been diagnosed with the condition, or has obtained medical services for the symptoms
7 of the condition regardless of diagnosis; and

8 (B)(i) In claims for an initial injury or omitted condition, the diagnosis or treatment precedes
9 the initial injury;

10 (ii) In claims for a new medical condition, the diagnosis or treatment precedes the onset of the
11 new medical condition; or

12 (iii) In claims for a worsening pursuant to ORS 656.273 or 656.278, the diagnosis or treatment
13 precedes the onset of the worsened condition.

14 (b) "Preexisting condition" means, for all occupational disease claims, any injury, disease, con-
15 genital abnormality, personality disorder or similar condition that contributes to disability or need
16 for treatment and that precedes the onset of the claimed occupational disease, or precedes a claim
17 for worsening in such claims pursuant to ORS 656.273 or 656.278.

18 (c) For the purposes of industrial injury claims, a condition does not contribute to disability or
19 need for treatment if the condition merely renders the worker more susceptible to the injury.

20 (25) "Self-insured employer" means an employer or group of employers certified under ORS
21 656.430 as meeting the qualifications set out by ORS 656.407.

22 (26) "State Accident Insurance Fund Corporation" and "corporation" mean the State Accident
23 Insurance Fund Corporation created under ORS 656.752.

24 (27) "Wages" means the money rate at which the service rendered is recompensed under the
25 contract of hiring in force at the time of the accident, including reasonable value of board, rent,
26 housing, lodging or similar advantage received from the employer, and includes the amount of tips
27 required to be reported by the employer pursuant to section 6053 of the Internal Revenue Code of
28 1954, as amended, and the regulations promulgated pursuant thereto, or the amount of actual tips
29 reported, whichever amount is greater. The State Accident Insurance Fund Corporation may estab-
30 lish assumed minimum and maximum wages, in conformity with recognized insurance principles, at
31 which any worker shall be carried upon the payroll of the employer for the purpose of determining
32 the premium of the employer.

33 (28)(a) "Worker" means any person, other than an independent contractor, who engages to fur-
34 nish services for a remuneration, including a minor whether lawfully or unlawfully employed and
35 salaried, elected and appointed officials of the state, state agencies, counties, cities, school districts
36 and other public corporations, but does not include any person whose services are performed as an
37 adult in custody or ward of a state institution or as part of the eligibility requirements for a general
38 or public assistance grant.

39 (b) For the purpose of determining entitlement to temporary disability benefits or permanent
40 total disability benefits under this chapter, "worker" does not include a person who has withdrawn
41 from the workforce during the period for which such benefits are sought.

42 (c) For the purposes of this chapter, "subject worker" means a worker who is subject to this
43 chapter as provided in ORS 656.027.

44 (29) "Independent contractor" has the meaning given that term in ORS 670.600.

45 **SECTION 44.** ORS 656.005, as amended by section 22, chapter 78, Oregon Laws 2025, is

1 amended to read:

2 656.005. (1) "Average weekly wage" means the Oregon average weekly wage in covered em-
3 ployment, as determined by the Employment Department, for the last quarter of the calendar year
4 preceding the fiscal year in which the injury occurred.

5 (2)(a) "Beneficiary" means an injured worker, and the spouse in a marriage, child or dependent
6 of a worker, who is entitled to receive payments under this chapter.

7 (b) "Beneficiary" does not include a person who intentionally causes the compensable injury to
8 or death of an injured worker.

9 (3) "Board" means the Workers' Compensation Board.

10 (4) "Carrier-insured employer" means an employer who provides workers' compensation cover-
11 age with the State Accident Insurance Fund Corporation or an insurer authorized under ORS
12 chapter 731 to transact workers' compensation insurance in this state.

13 (5) "Child" means a child of an injured worker, including:

14 (a) A posthumous child;

15 (b) A child legally adopted before the injury;

16 (c) A child toward whom the worker stands in loco parentis;

17 (d) A child born out of wedlock;

18 (e) A stepchild, if the stepchild was, at the time of the injury, a member of the worker's family
19 and substantially dependent upon the worker for support; and

20 (f) A child of any age who was incapacitated at the time of the accident and thereafter remains
21 incapacitated and substantially dependent on the worker for support.

22 (6) "Claim" means a written request for compensation from a subject worker or someone on the
23 worker's behalf, or any compensable injury of which a subject employer has notice or knowledge.

24 (7)(a) A "compensable injury" is an accidental injury, or accidental injury to prosthetic appli-
25 ances, arising out of and in the course of employment requiring medical services or resulting in
26 disability or death. An injury is accidental if the result is an accident, whether or not due to acci-
27 dental means, if it is established by medical evidence supported by objective findings, subject to the
28 following limitations:

29 (A) An injury or disease is not compensable as a consequence of a compensable injury unless
30 the compensable injury is the major contributing cause of the consequential condition.

31 (B) If an otherwise compensable injury combines at any time with a preexisting condition to
32 cause or prolong disability or a need for treatment, the combined condition is compensable only if,
33 so long as and to the extent that the otherwise compensable injury is the major contributing cause
34 of the disability of the combined condition or the major contributing cause of the need for treatment
35 of the combined condition.

36 (b) "Compensable injury" does not include:

37 (A) Injury to any active participant in assaults or combats that are not connected to the job
38 assignment and that amount to a deviation from customary duties;

39 (B) Injury incurred while engaging in or performing, or as the result of engaging in or per-
40 forming, any recreational or social activities primarily for the worker's personal pleasure; or

41 (C) Injury the major contributing cause of which is demonstrated to be by a preponderance of
42 the evidence the injured worker's consumption of alcoholic beverages or cannabis or the unlawful
43 consumption of any controlled substance, unless the employer permitted, encouraged or had actual
44 knowledge of such consumption.

45 (c) A "disabling compensable injury" is an injury that entitles the worker to compensation for

1 disability or death. An injury is not disabling if no temporary benefits are due and payable, unless
2 there is a reasonable expectation that permanent disability will result from the injury.

3 (d) A “nondisabling compensable injury” is any injury that requires medical services only.

4 (8) “Compensation” includes all benefits, including medical services, provided for a compensable
5 injury to a subject worker or the worker’s beneficiaries by an insurer or self-insured employer pur-
6 suant to this chapter.

7 (9) “Department” means the Department of Consumer and Business Services.

8 (10) “Dependent” means any of the following individuals who, at the time of an accident, de-
9 pended in whole or in part for the individual’s support on the earnings of a worker who dies as a
10 result of an injury:

11 (a) A parent of a worker or the parent’s spouse or domestic partner;

12 (b) A grandparent of a worker or the grandparent’s spouse or domestic partner;

13 (c) A grandchild of a worker or the grandchild’s spouse or domestic partner;

14 (d) A sibling or stepsibling of a worker or the sibling’s or stepsibling’s spouse or domestic
15 partner; and

16 (e) Any individual related by blood or affinity whose close association with a worker is the
17 equivalent of a family relationship.

18 (11) “Director” means the Director of the Department of Consumer and Business Services.

19 (12)(a) [*“Doctor” or “physician”*] **“Doctor,” “physician,” “nurse practitioner” or “physician**
20 **associate”** means a person duly licensed to practice one or more of the healing arts in any country
21 or in any state, territory or possession of the United States within the limits of the license of the
22 licensee.

23 (b) Except as otherwise provided for workers subject to a managed care contract, “attending
24 physician” means a doctor, physician, **nurse practitioner** or physician associate who is primarily
25 responsible for the treatment of a worker’s compensable injury and who is:

26 [*A physician licensed under ORS 677.100 to 677.228 by the Oregon Medical Board, or a*
27 *podiatric physician and surgeon licensed under ORS 677.805 to 677.840 by the Oregon Medical Board,*
28 *an oral and maxillofacial surgeon licensed by the Oregon Board of Dentistry or a similarly licensed*
29 *doctor in any country or in any state, territory or possession of the United States;]*

30 (A)(i) **A physician licensed under ORS 677.100 to 677.228 by the Oregon Medical Board or**
31 **a similarly licensed physician in any country or in any state, territory or possession of the**
32 **United States;**

33 (ii) **A podiatric physician and surgeon licensed under ORS 677.805 to 677.840 by the Oregon**
34 **Medical Board or a similarly licensed physician and surgeon in any country or in any state,**
35 **territory or possession of the United States;**

36 (iii) **An oral and maxillofacial surgeon licensed by the Oregon Board of Dentistry or a**
37 **similarly licensed surgeon in any country or in any state, territory or possession of the**
38 **United States;**

39 (iv) **A nurse practitioner licensed under ORS 678.375 to 678.390 or a similarly licensed**
40 **nurse practitioner in any country or in any state, territory or possession of the United**
41 **States; or**

42 (v) **A physician associate licensed by the Oregon Medical Board in accordance with ORS**
43 **677.505 to 677.525 or a similarly licensed physician associate in any country or in any state,**
44 **territory or possession of the United States; or**

45 (B) For a cumulative total of 60 days from the first visit on the initial claim or for a cumulative

1 total of 18 visits, whichever occurs first, to any of the medical service providers listed in this sub-
2 paragraph, a:

3 (i) Doctor or physician licensed by the State Board of Chiropractic Examiners for the State of
4 Oregon under ORS chapter 684 or a similarly licensed doctor or physician in any country or in any
5 state, territory or possession of the United States; or

6 (ii) Doctor of naturopathy or naturopathic physician licensed by the Oregon Board of
7 Naturopathic Medicine under ORS chapter 685 or a similarly licensed doctor or physician in any
8 country or in any state, territory or possession of the United States.]; *or*]

9 [(C) *For a cumulative total of 180 days from the first visit on the initial claim, a physician associate*
10 *licensed by the Oregon Medical Board in accordance with ORS 677.505 to 677.525 or a similarly li-*
11 *icensed physician associate in any country or in any state, territory or possession of the United*
12 *States.*]

13 (c) Except as otherwise provided for workers subject to a managed care contract, “attending
14 physician” does not include a physician who provides care in a hospital emergency room and refers
15 the injured worker to a primary care physician for follow-up care and treatment.

16 (d) “Consulting physician” means a doctor or physician who examines a worker or the worker’s
17 medical record to advise the attending physician [*or nurse practitioner authorized to provide*
18 *compensable medical services under ORS 656.245*] regarding treatment of a worker’s compensable
19 injury.

20 (13)(a) “Employer” means any person, including receiver, administrator, executor or trustee, and
21 the state, state agencies, counties, municipal corporations, school districts and other public corpo-
22 rations or political subdivisions, that contracts to pay a remuneration for the services of any
23 worker.

24 (b) Notwithstanding paragraph (a) of this subsection, for purposes of this chapter, the client of
25 a temporary service provider is not the employer of temporary workers provided by the temporary
26 service provider.

27 (c) As used in paragraph (b) of this subsection, “temporary service provider” has the meaning
28 given that term in ORS 656.849.

29 (d) For the purposes of this chapter, “subject employer” means an employer that is subject to
30 this chapter as provided in ORS 656.023.

31 (14) “Insurer” means the State Accident Insurance Fund Corporation or an insurer authorized
32 under ORS chapter 731 to transact workers’ compensation insurance in this state or an assigned
33 claims agent selected by the director under ORS 656.054.

34 (15) “Consumer and Business Services Fund” means the fund created by ORS 705.145.

35 (16) “Incapacitated” means an individual is physically or mentally unable to earn a livelihood.

36 (17) “Medically stationary” means that no further material improvement would reasonably be
37 expected from medical treatment or the passage of time.

38 (18) “Noncomplying employer” means a subject employer that has failed to comply with ORS
39 656.017.

40 (19) “Objective findings” in support of medical evidence are verifiable indications of injury or
41 disease that may include, but are not limited to, range of motion, atrophy, muscle strength and
42 palpable muscle spasm. “Objective findings” does not include physical findings or subjective re-
43 sponses to physical examinations that are not reproducible, measurable or observable.

44 (20) “Palliative care” means medical service rendered to reduce or moderate temporarily the
45 intensity of an otherwise stable medical condition, but does not include those medical services ren-

1 dered to diagnose, heal or permanently alleviate or eliminate a medical condition.

2 (21) "Party" means a claimant for compensation, the employer of the injured worker at the time
3 of injury and the insurer, if any, of the employer.

4 (22) "Payroll" means a record of wages payable to workers for their services and includes
5 commissions, value of exchange labor and the reasonable value of board, rent, housing, lodging or
6 similar advantage received from the employer. However, "payroll" does not include overtime pay,
7 vacation pay, bonus pay, tips, amounts payable under profit-sharing agreements or bonus payments
8 to reward workers for safe working practices. Bonus pay is limited to payments that are not antic-
9 ipated under the contract of employment and that are paid at the sole discretion of the employer.
10 The exclusion from payroll of bonus payments to reward workers for safe working practices is only
11 for the purpose of calculations based on payroll to determine premium for workers' compensation
12 insurance, and does not affect any other calculation or determination based on payroll for the pur-
13 poses of this chapter.

14 (23) "Person" includes a partnership, joint venture, association, limited liability company and
15 corporation.

16 (24)(a) "Preexisting condition" means, for all industrial injury claims, any injury, disease, con-
17 genital abnormality, personality disorder or similar condition that contributes to disability or need
18 for treatment, provided that:

19 (A) Except for claims in which a preexisting condition is arthritis or an arthritic condition, the
20 worker has been diagnosed with the condition, or has obtained medical services for the symptoms
21 of the condition regardless of diagnosis; and

22 (B)(i) In claims for an initial injury or omitted condition, the diagnosis or treatment precedes
23 the initial injury;

24 (ii) In claims for a new medical condition, the diagnosis or treatment precedes the onset of the
25 new medical condition; or

26 (iii) In claims for a worsening pursuant to ORS 656.273 or 656.278, the diagnosis or treatment
27 precedes the onset of the worsened condition.

28 (b) "Preexisting condition" means, for all occupational disease claims, any injury, disease, con-
29 genital abnormality, personality disorder or similar condition that contributes to disability or need
30 for treatment and that precedes the onset of the claimed occupational disease, or precedes a claim
31 for worsening in such claims pursuant to ORS 656.273 or 656.278.

32 (c) For the purposes of industrial injury claims, a condition does not contribute to disability or
33 need for treatment if the condition merely renders the worker more susceptible to the injury.

34 (25) "Self-insured employer" means an employer or group of employers certified under ORS
35 656.430 as meeting the qualifications set out by ORS 656.407.

36 (26) "State Accident Insurance Fund Corporation" and "corporation" mean the State Accident
37 Insurance Fund Corporation created under ORS 656.752.

38 (27) "Wages" means the money rate at which the service rendered is recompensed under the
39 contract of hiring in force at the time of the accident, including reasonable value of board, rent,
40 housing, lodging or similar advantage received from the employer, and includes the amount of tips
41 required to be reported by the employer pursuant to section 6053 of the Internal Revenue Code of
42 1954, as amended, and the regulations promulgated pursuant thereto, or the amount of actual tips
43 reported, whichever amount is greater. The State Accident Insurance Fund Corporation may estab-
44 lish assumed minimum and maximum wages, in conformity with recognized insurance principles, at
45 which any worker shall be carried upon the payroll of the employer for the purpose of determining

1 the premium of the employer.

2 (28)(a) "Worker" means any person, other than an independent contractor, who engages to fur-
3 nish services for a remuneration, including a minor whether lawfully or unlawfully employed and
4 salaried, elected and appointed officials of the state, state agencies, counties, cities, school districts
5 and other public corporations, but does not include any person whose services are performed as an
6 adult in custody or ward of a state institution or as part of the eligibility requirements for a general
7 or public assistance grant.

8 (b) For the purpose of determining entitlement to temporary disability benefits or permanent
9 total disability benefits under this chapter, "worker" does not include a person who has withdrawn
10 from the workforce during the period for which such benefits are sought.

11 (c) For the purposes of this chapter, "subject worker" means a worker who is subject to this
12 chapter as provided in ORS 656.027.

13 (29) "Independent contractor" has the meaning given that term in ORS 670.600.

14 **SECTION 45.** ORS 656.214 is amended to read:

15 656.214. (1) As used in this section:

16 (a) "Impairment" means the loss of use or function of a body part or system due to the
17 compensable industrial injury or occupational disease determined in accordance with the standards
18 provided under ORS 656.726, expressed as a percentage of the whole person.

19 (b) "Loss" includes permanent and complete or partial loss of use.

20 (c) "Permanent partial disability" means:

21 (A) Permanent impairment resulting from the compensable industrial injury or occupational
22 disease; or

23 (B) Permanent impairment and work disability resulting from the compensable industrial injury
24 or occupational disease.

25 (d) "Regular work" means the job the worker held at injury.

26 (e) "Work disability" means impairment modified by age, education and adaptability to perform
27 a given job.

28 (2) When permanent partial disability results from a compensable injury or occupational disease,
29 benefits shall be awarded as follows:

30 (a) If the worker has been released to regular work by the attending physician [*or nurse prac-*
31 *titioner authorized to provide compensable medical services under ORS 656.245*] or has returned to
32 regular work [*at the job held at the time of injury*], the award shall be for impairment only. Impair-
33 ment shall be determined in accordance with the standards provided by the Director of the Depart-
34 ment of Consumer and Business Services pursuant to ORS 656.726 (4). Impairment benefits are
35 determined by multiplying the impairment value times 100 times the average weekly wage as defined
36 by ORS 656.005.

37 (b) If the worker has not been released to regular work by the attending physician [*or nurse*
38 *practitioner authorized to provide compensable medical services under ORS 656.245*] or has not re-
39 turned to regular work [*at the job held at the time of injury*], the award shall be for impairment and
40 work disability. Work disability shall be determined in accordance with the standards provided by
41 the director pursuant to ORS 656.726 (4). Impairment shall be determined as provided in paragraph
42 (a) of this subsection. Work disability benefits shall be determined by multiplying the impairment
43 value, as modified by the factors of age, education and adaptability to perform a given job, times
44 150 times the worker's weekly wage for the job at injury as calculated under ORS 656.210 (2). The
45 factor for the worker's weekly wage used for the determination of the work disability may be no

1 more than 133 percent or no less than 50 percent of the average weekly wage as defined in ORS
2 656.005.

3 (3) Impairment benefits awarded under subsection (2)(a) of this section shall be expressed as a
4 percentage of the whole person. Impairment benefits for the following body parts may not exceed:

5 (a) For the loss of one arm at or above the elbow joint, 60 percent.

6 (b) For the loss of one forearm at or above the wrist joint, or the loss of one hand, 47 percent.

7 (c) For the loss of one leg, at or above the knee joint, 47 percent.

8 (d) For the loss of one foot, 42 percent.

9 (e) For the loss of a great toe, six percent; for loss of any other toe, one percent.

10 (f) For partial or complete loss of hearing in one ear, that proportion of 19 percent which the
11 loss bears to normal monaural hearing.

12 (g) For partial or complete loss of hearing in both ears, that proportion of 60 percent which the
13 combined binaural hearing loss bears to normal combined binaural hearing. For the purpose of this
14 paragraph, combined binaural hearing loss shall be calculated by taking seven times the hearing loss
15 in the less damaged ear plus the hearing loss in the more damaged ear and dividing that amount
16 by eight. In the case of individuals with compensable hearing loss involving both ears, either the
17 method of calculation for monaural hearing loss or that for combined binaural hearing loss shall be
18 used, depending upon which allows the greater award of impairment.

19 (h) For partial or complete loss of vision of one eye, that proportion of 31 percent which the loss
20 of monocular vision bears to normal monocular vision. For the purposes of this paragraph, the term
21 "normal monocular vision" shall be considered as Snellen 20/20 for distance and Snellen 14/14 for
22 near vision with full sensory field.

23 (i) For partial loss of vision in both eyes, that proportion of 94 percent which the combined
24 binocular visual loss bears to normal combined binocular vision. In all cases of partial loss of sight,
25 the percentage of said loss shall be measured with maximum correction. For the purpose of this
26 paragraph, combined binocular visual loss shall be calculated by taking three times the visual loss
27 in the less damaged eye plus the visual loss in the more damaged eye and dividing that amount by
28 four. In the case of individuals with compensable visual loss involving both eyes, either the method
29 of calculation for monocular visual loss or that for combined binocular visual loss shall be used,
30 depending upon which allows the greater award of impairment.

31 (j) For the loss of a thumb, 15 percent.

32 (k) For the loss of a first finger, eight percent; of a second finger, seven percent; of a third fin-
33 ger, three percent; of a fourth finger, two percent.

34 (4) The loss of one phalange of a thumb, including the adjacent epiphyseal region of the proximal
35 phalange, is considered equal to the loss of one-half of a thumb. The loss of one phalange of a finger,
36 including the adjacent epiphyseal region of the middle phalange, is considered equal to the loss of
37 one-half of a finger. The loss of two phalanges of a finger, including the adjacent epiphyseal region
38 of the proximal phalange of a finger, is considered equal to the loss of 75 percent of a finger. The
39 loss of more than one phalange of a thumb, excluding the epiphyseal region of the proximal
40 phalange, is considered equal to the loss of an entire thumb. The loss of more than two phalanges
41 of a finger, excluding the epiphyseal region of the proximal phalange of a finger, is considered equal
42 to the loss of an entire finger. A proportionate loss of use may be allowed for an uninjured finger
43 or thumb where there has been a loss of effective opposition.

44 (5) A proportionate loss of the hand may be allowed where impairment extends to more than one
45 digit, in lieu of ratings on the individual digits.

1 (6) All permanent disability contemplates future waxing and waning of symptoms of the condi-
2 tion. The results of waxing and waning of symptoms may include, but are not limited to, loss of
3 earning capacity, periods of temporary total or temporary partial disability, or inpatient
4 hospitalization.

5 **SECTION 46.** ORS 656.245 is amended to read:

6 656.245. (1)(a) For every compensable injury, the insurer or the self-insured employer shall cause
7 to be provided medical services for conditions caused in material part by the injury for such period
8 as the nature of the injury or the process of the recovery requires, subject to the limitations in ORS
9 656.225, including such medical services as may be required after a determination of permanent
10 disability. In addition, for consequential and combined conditions described in ORS 656.005 (7), the
11 insurer or the self-insured employer shall cause to be provided only those medical services directed
12 to medical conditions caused in major part by the injury.

13 (b) Compensable medical services shall include medical, surgical, hospital, nursing, ambulances
14 and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and
15 supports and where necessary, physical restorative services. A pharmacist or dispensing physician
16 shall dispense generic drugs to the worker in accordance with ORS 689.515. The duty to provide
17 such medical services continues for the life of the worker.

18 (c) Notwithstanding any other provision of this chapter, medical services after the worker's
19 condition is medically stationary are not compensable except for the following:

20 (A) Services provided to a worker who has been determined to be permanently and totally dis-
21 abled.

22 (B) Prescription medications.

23 (C) Services necessary to administer prescription medication or monitor the administration of
24 prescription medication.

25 (D) Prosthetic devices, braces and supports.

26 (E) Services necessary to monitor the status, replacement or repair of prosthetic devices, braces
27 and supports.

28 (F) Services provided pursuant to an accepted claim for aggravation under ORS 656.273.

29 (G) Services provided pursuant to an order issued under ORS 656.278.

30 (H) Services that are necessary to diagnose the worker's condition.

31 (I) Life-preserving modalities similar to insulin therapy, dialysis and transfusions.

32 (J) With the approval of the insurer or self-insured employer, palliative care that the worker's
33 attending physician referred to in ORS 656.005 (12)(b)(A) prescribes and that is necessary to enable
34 the worker to continue current employment or a vocational training program. If the insurer or
35 self-insured employer does not approve, the attending physician or the worker may request approval
36 from the Director of the Department of Consumer and Business Services for such treatment. The
37 director may order a medical review by a physician or panel of physicians pursuant to ORS 656.327
38 (3) to aid in the review of such treatment. The decision of the director is subject to review under
39 ORS 656.704.

40 (K) With the approval of the director, curative care arising from a generally recognized, non-
41 experimental advance in medical science since the worker's claim was closed that is highly likely
42 to improve the worker's condition and that is otherwise justified by the circumstances of the claim.
43 The decision of the director is subject to review under ORS 656.704.

44 (L) Curative care provided to a worker to stabilize a temporary and acute waxing and waning
45 of symptoms of the worker's condition.

1 (d) When the medically stationary date in a disabling claim is established by the insurer or
2 self-insured employer and is not based on the findings of the attending physician, the insurer or
3 self-insured employer is responsible for reimbursement to affected medical service providers for
4 otherwise compensable services rendered until the insurer or self-insured employer provides written
5 notice to the attending physician of the worker's medically stationary status.

6 (e) Except for services provided under a managed care contract, out-of-pocket expense re-
7 imbursement to receive care from the attending physician [*or nurse practitioner*] authorized to pro-
8 vide compensable medical services under this section shall not exceed the amount required to seek
9 care from an [*appropriate nurse practitioner or*] attending physician of the same specialty who is in
10 a medical community geographically closer to the worker's home. For the purposes of this para-
11 graph, all **attending** physicians [*and nurse practitioners*] within a metropolitan area are considered
12 to be part of the same medical community.

13 (2)(a) The worker may choose an attending [*doctor, physician or nurse practitioner*] **physician**
14 within the State of Oregon. The worker may choose the initial attending physician [*or nurse practi-*
15 *tioner*] and may subsequently change attending physician [*or nurse practitioner*] two times without
16 approval from the director. If the worker thereafter selects another attending physician [*or nurse*
17 *practitioner*], the insurer or self-insured employer may require the director's approval of the se-
18 lection. The decision of the director is subject to review under ORS 656.704. The worker also may
19 choose an attending doctor or physician in another country or in any state or territory or possession
20 of the United States with the prior approval of the insurer or self-insured employer.

21 (b) A medical service provider who is not a member of a managed care organization is subject
22 to the following provisions:

23 (A) A medical service provider who is not qualified to be an attending physician may provide
24 compensable medical service to an injured worker for a period of 30 days from the date of the first
25 visit on the initial claim or for 12 visits, whichever first occurs, without the authorization of an
26 attending physician. Thereafter, medical service provided to an injured worker without the written
27 authorization of an attending physician is not compensable.

28 (B) A medical service provider who is not an attending physician cannot authorize the payment
29 of temporary disability compensation. However, an emergency room physician who is not authorized
30 to serve as an attending physician under ORS 656.005 (12)(c) may authorize temporary disability
31 benefits for a maximum of 14 days. A medical service provider qualified to serve as an attending
32 physician under ORS 656.005 (12)(b)(B) may authorize the payment of temporary disability compen-
33 sation for a period not to exceed 30 days from the date of the first visit on the initial claim.

34 (C) Except as otherwise provided in this chapter, only a physician qualified to serve as an at-
35 tending physician under ORS 656.005 (12)(b)(A) or (B)(i) who is serving as the attending physician
36 at the time of claim closure may make findings regarding the worker's impairment for the purpose
37 of evaluating the worker's disability.

38 [(D) Notwithstanding subparagraphs (A) and (B) of this paragraph, a nurse practitioner licensed
39 under ORS 678.375 to 678.390 or a physician associate licensed by the Oregon Medical Board in ac-
40 cordance with ORS 677.505 to 677.525 or a similarly licensed physician associate in any country or in
41 any state, territory or possession of the United States:]

42 [(i) May provide compensable medical services for 180 days from the date of the first visit on the
43 initial claim;]

44 [(ii) May authorize the payment of temporary disability benefits for a period not to exceed 180 days
45 from the date of the first visit on the initial claim; and]

1 *[(iii) When an injured worker treating with a nurse practitioner or physician associate authorized*
 2 *to provide compensable services under this section becomes medically stationary within the 180-day*
 3 *period in which the nurse practitioner or physician associate is authorized to treat the injured worker,*
 4 *shall refer the injured worker to a physician qualified to be an attending physician as defined in ORS*
 5 *656.005 for the purpose of making findings regarding the worker's impairment for the purpose of*
 6 *evaluating the worker's disability. If a worker returns to the nurse practitioner or physician associate*
 7 *after initial claim closure for evaluation of a possible worsening of the worker's condition, the nurse*
 8 *practitioner or physician associate shall refer the worker to an attending physician and the insurer*
 9 *shall compensate the nurse practitioner or physician associate for the examination performed.]*

10 (3) Notwithstanding any other provision of this chapter, the director, by rule, upon the advice
 11 of the committee created by ORS 656.794 and upon the advice of the professional licensing boards
 12 of practitioners affected by the rule, may exclude from compensability any medical treatment the
 13 director finds to be unscientific, unproven, outmoded or experimental. The decision of the director
 14 is subject to review under ORS 656.704.

15 (4) Notwithstanding subsection (2)(a) of this section, when a self-insured employer or the insurer
 16 of an employer contracts with a managed care organization certified pursuant to ORS 656.260 for
 17 medical services required by this chapter to be provided to injured workers:

18 (a) Those workers who are subject to the contract shall receive medical services in the manner
 19 prescribed in the contract. Workers subject to the contract include those who are receiving medical
 20 treatment for an accepted compensable injury or occupational disease, regardless of the date of in-
 21 jury or medically stationary status, on or after the effective date of the contract. If the managed
 22 care organization determines that the change in provider would be medically detrimental to the
 23 worker, the worker shall not become subject to the contract until the worker is found to be med-
 24 ically stationary, the worker changes physicians [*or nurse practitioners*], or the managed care or-
 25 ganization determines that the change in provider is no longer medically detrimental, whichever
 26 event first occurs. A worker becomes subject to the contract upon the worker's receipt of actual
 27 notice of the worker's enrollment in the managed care organization, or upon the third day after the
 28 notice was sent by regular mail by the insurer or self-insured employer, whichever event first oc-
 29 curs. A worker shall not be subject to a contract after it expires or terminates without renewal. A
 30 worker may continue to treat with the attending physician [*or nurse practitioner*] authorized to
 31 provide compensable medical services under this section under an expired or terminated managed
 32 care organization contract if the **attending** physician [*or nurse practitioner*] agrees to comply with
 33 the rules, terms and conditions regarding services performed under any subsequent managed care
 34 organization contract to which the worker is subject. A worker shall not be subject to a contract
 35 if the worker's primary residence is more than 100 miles outside the managed care organization's
 36 certified geographical area. Each such contract must comply with the certification standards pro-
 37 vided in ORS 656.260. However, a worker may receive immediate emergency medical treatment that
 38 is compensable from a medical service provider who is not a member of the managed care organ-
 39 ization. Insurers or self-insured employers who contract with a managed care organization for med-
 40 ical services shall give notice to the workers of eligible medical service providers and such other
 41 information regarding the contract and manner of receiving medical services as the director may
 42 prescribe. Notwithstanding any provision of law or rule to the contrary, a worker of a noncomplying
 43 employer is considered to be subject to a contract between the State Accident Insurance Fund
 44 Corporation as a processing agent or the assigned claims agent and a managed care organization.

45 (b)(A) For initial or aggravation claims filed after June 7, 1995, the insurer or self-insured em-

1 ployer may require an injured worker, on a case-by-case basis, immediately to receive medical ser-
2 vices from the managed care organization.

3 (B) If the insurer or self-insured employer gives notice that the worker is required to receive
4 treatment from the managed care organization, the insurer or self-insured employer must guarantee
5 that any reasonable and necessary services so received, that are not otherwise covered by health
6 insurance, will be paid as provided in ORS 656.248, even if the claim is denied, until the worker
7 receives actual notice of the denial or until three days after the denial is mailed, whichever event
8 first occurs. The worker may elect to receive care from a primary care physician, nurse practitioner
9 or physician associate authorized to provide compensable medical services under this section who
10 agrees to the conditions of ORS 656.260 (4)(g). However, guarantee of payment is not required by the
11 insurer or self-insured employer if this election is made.

12 (C) If the insurer or self-insured employer does not give notice that the worker is required to
13 receive treatment from the managed care organization, the insurer or self-insured employer is under
14 no obligation to pay for services received by the worker unless the claim is later accepted.

15 (D) If the claim is denied, the worker may receive medical services after the date of denial from
16 sources other than the managed care organization until the denial is reversed. Reasonable and
17 necessary medical services received from sources other than the managed care organization after
18 the date of claim denial must be paid as provided in ORS 656.248 by the insurer or self-insured em-
19 ployer if the claim is finally determined to be compensable.

20 (5)(a) A nurse practitioner[,] or a physician associate described in ORS 656.005 [(12)(b)(C)],
21 **(12)(b)(A)(iv) or (v)** who is not a member of the managed care organization is authorized to provide
22 the same level of services as a primary care physician as established by ORS 656.260 (4) if the nurse
23 practitioner or physician associate:

24 (A) Maintains the worker's medical records;

25 (B) Has a documented history of treatment with the worker;

26 (C) Agrees to refer the worker to the managed care organization for any specialized treatment,
27 including physical therapy, to be furnished by another provider that the worker may require; and

28 (D) Agrees to comply with all the rules, terms and conditions regarding services performed by
29 the managed care organization.

30 (b)[(A)] A nurse practitioner or physician associate authorized to provide medical services to a
31 worker enrolled in the managed care organization may:

32 [(i)] **(A)** Provide medical treatment to the worker if the treatment is determined to be medically
33 appropriate according to the service utilization review process of the managed care organization;
34 and

35 [(ii)] **(B)** Authorize temporary disability payments [*as provided in subsection (2)(b)(D) of this*
36 *section*].

37 [(B) *The managed care organization may also authorize the nurse practitioner or physician asso-*
38 *ciate to provide medical services and authorize temporary disability payments beyond the periods es-*
39 *tablished in subsection (2)(b)(D) of this section.*]

40 (6) Subject to the provisions of ORS 656.704, if a claim for medical services is disapproved, the
41 injured worker, insurer or self-insured employer may request administrative review by the director
42 pursuant to ORS 656.260 or 656.327.

43 **SECTION 47.** ORS 656.250 is amended to read:

44 656.250. A physical therapist [*shall*] **may** not provide compensable services to injured workers
45 governed by this chapter except as allowed by a governing managed care organization contract or

1 as authorized by the worker's attending physician [*or nurse practitioner authorized to provide*
2 *compensable medical services under ORS 656.245*].

3 **SECTION 48.** ORS 656.252 is amended to read:

4 656.252. (1) In order to ensure the prompt and correct reporting and payment of compensation
5 in compensable injuries, the Director of the Department of Consumer and Business Services shall
6 make rules governing audits of medical service bills and reports by attending and consulting physi-
7 cians and other personnel of all medical information relevant to the determination of a claim to the
8 injured worker's representative, the worker's employer, the employer's insurer and the Department
9 of Consumer and Business Services. Such rules shall include, but not necessarily be limited to:

10 (a) Requiring attending physicians [*and nurse practitioners authorized to provide compensable*
11 *medical services under ORS 656.245*] to make the insurer or self-insured employer a first report of
12 injury within 72 hours after the first service rendered.

13 (b) Requiring attending physicians [*and nurse practitioners authorized to provide compensable*
14 *medical services under ORS 656.245*] to submit follow-up reports within specified time limits or upon
15 the request of an interested party.

16 (c) Requiring examining physicians [*and nurse practitioners authorized to provide compensable*
17 *medical services under ORS 656.245*] to submit their reports, and to whom, within a specified time.

18 (d) Such other reporting requirements as the director may deem necessary to insure that pay-
19 ments of compensation be prompt and that all interested parties be given information necessary to
20 the prompt determination of claims.

21 (e) Requiring insurers and self-insured employers to audit billings for all medical services, in-
22 cluding hospital services.

23 (2) The attending physician [*or nurse practitioner authorized to provide compensable medical ser-*
24 *vices under ORS 656.245*] shall do the following:

25 (a) Cooperate with the insurer or self-insured employer to expedite diagnostic and treatment
26 procedures and with efforts to return injured workers to appropriate work.

27 (b) Advise the insurer or self-insured employer of the anticipated date for release of the injured
28 worker to return to employment, the anticipated date that the worker will be medically stationary,
29 and the next appointment date. Except when the attending physician [*or nurse practitioner author-*
30 *ized to provide compensable medical services under ORS 656.245*] has previously indicated that tem-
31 porary disability will not exceed 14 days, the insurer or self-insured employer may request a medical
32 report every 15 days, and the attending physician [*or nurse practitioner*] shall forward such reports.

33 (c) Advise the insurer or self-insured employer within five days of the date the injured worker
34 is released to return to work. Under no circumstances shall the physician [*or nurse practitioner*
35 *authorized to provide compensable medical services under ORS 656.245*] notify the insurer or employer
36 of the worker's release to return to work without notifying the worker at the same time.

37 (d) After a claim has been closed, advise the insurer or self-insured employer within five days
38 after the treatment is resumed or the reopening of a claim is recommended. The attending physician
39 under this paragraph need not be the same attending physician who released the worker when the
40 claim was closed.

41 (3) In promulgating the rules regarding medical reporting the director may consult and confer
42 with physicians and members of medical associations and societies.

43 (4) No person who reports medical information to a person referred to in subsection (1) of this
44 section, in accordance with department rules, shall incur any legal liability for the disclosure of
45 such information.

1 (5) Whenever an injured worker changes attending [*physicians or nurse practitioners authorized*
2 *to provide compensable medical services under ORS 656.245*] **physician**, the newly selected attending
3 physician [*or nurse practitioner*] shall so notify the responsible insurer or self-insured employer not
4 later than five days after the date of the change or the date of first treatment. Every attending
5 physician [*or nurse practitioner authorized to provide compensable medical services under ORS*
6 *656.245*] who refers a worker to a consulting physician promptly shall notify the responsible insurer
7 or self-insured employer of the referral.

8 (6) A provider of medical services, including hospital services, that submits a billing to the
9 insurer or self-insured employer shall also submit a copy of the billing to the worker for whom the
10 service was performed after receipt from the injured worker of a written request for such a copy.

11 **SECTION 49.** ORS 656.262 is amended to read:

12 656.262. (1) Processing of claims and providing compensation for a worker shall be the respon-
13 sibility of the insurer or self-insured employer. All employers shall assist their insurers in processing
14 claims as required in this chapter.

15 (2) The compensation due under this chapter shall be paid periodically, promptly and directly
16 to the person entitled thereto upon the employer's receiving notice or knowledge of a claim, except
17 where the right to compensation is denied by the insurer or self-insured employer.

18 (3)(a) Employers shall, immediately and not later than five days after notice or knowledge of any
19 claims or accidents which may result in a compensable injury claim, report the same to their
20 insurer. The report shall include:

21 (A) The date, time, cause and nature of the accident and injuries.

22 (B) Whether the accident arose out of and in the course of employment.

23 (C) Whether the employer recommends or opposes acceptance of the claim, and the reasons
24 therefor.

25 (D) The name and address of any health insurance provider for the injured worker.

26 (E) Any other details the insurer may require.

27 (b) Failure to so report subjects the offending employer to a charge for reimbursing the insurer
28 for any penalty the insurer is required to pay under subsection (11) of this section because of such
29 failure. As used in this subsection, "health insurance" has the meaning for that term provided in
30 ORS 731.162.

31 (4)(a) The first installment of temporary disability compensation shall be paid no later than the
32 14th day after the subject employer has notice or knowledge of the claim and of the worker's disa-
33 bility, if the attending physician [*or nurse practitioner authorized to provide compensable medical*
34 *services under ORS 656.245*] authorizes the payment of temporary disability compensation. There-
35 after, temporary disability compensation shall be paid at least once each two weeks, except where
36 the Director of the Department of Consumer and Business Services determines that payment in in-
37 stallments should be made at some other interval. The director may by rule convert monthly benefit
38 schedules to weekly or other periodic schedules.

39 (b) Notwithstanding any other provision of this chapter, if a self-insured employer pays to an
40 injured worker who becomes disabled the same wage at the same pay interval that the worker re-
41 ceived at the time of injury, such payment shall be deemed timely payment of temporary disability
42 payments pursuant to ORS 656.210 and 656.212 during the time the wage payments are made.

43 (c) Notwithstanding any other provision of this chapter, when the holder of a public office is
44 injured in the course and scope of that public office, full official salary paid to the holder of that
45 public office shall be deemed timely payment of temporary disability payments pursuant to ORS

1 656.210 and 656.212 during the time the wage payments are made. As used in this subsection, “public
2 office” has the meaning for that term provided in ORS 260.005.

3 (d) Temporary disability compensation is not due and payable for any period of time for which
4 the insurer or self-insured employer has requested from the worker’s attending physician [*or nurse
5 practitioner authorized to provide compensable medical services under ORS 656.245*] verification of the
6 worker’s inability to work resulting from the claimed injury or disease and the **attending** physician
7 [*or nurse practitioner*] cannot verify the worker’s inability to work, unless the worker has been un-
8 able to receive treatment for reasons beyond the worker’s control.

9 (e) If a worker fails to appear at an appointment with the worker’s attending physician [*or nurse
10 practitioner authorized to provide compensable medical services under ORS 656.245*], the insurer or
11 self-insured employer shall notify the worker by certified mail that temporary disability benefits may
12 be suspended after the worker fails to appear at a rescheduled appointment. If the worker fails to
13 appear at a rescheduled appointment, the insurer or self-insured employer may suspend payment of
14 temporary disability benefits to the worker until the worker appears at a subsequent rescheduled
15 appointment.

16 (f) If the insurer or self-insured employer has requested and failed to receive from the worker’s
17 attending physician [*or nurse practitioner authorized to provide compensable medical services under
18 ORS 656.245*] verification of the worker’s inability to work resulting from the claimed injury or
19 disease, medical services provided by the attending physician [*or nurse practitioner*] are not
20 compensable until the attending physician [*or nurse practitioner*] submits such verification.

21 (g)(A) Temporary disability compensation is not due and payable pursuant to ORS 656.268 after
22 the worker’s attending physician [*or nurse practitioner authorized to provide compensable medical
23 services under ORS 656.245*] ceases to authorize temporary disability or for any period of time not
24 authorized by the attending physician [*or nurse practitioner*]. No authorization of temporary disabil-
25 ity compensation by the attending physician [*or nurse practitioner*] under ORS 656.268 shall be ef-
26 fective to retroactively authorize the payment of temporary disability more than 45 days prior to its
27 issuance.

28 (B) Subparagraph (A) of this paragraph does not apply:

29 (i) During periods in which there is a denial under the jurisdiction of the Workers’ Compens-
30 ation Board that affects the worker’s ability to obtain authorization of temporary disability;

31 (ii) During periods in which there is a dispute over the identity of, or treatment by, an attending
32 physician [*or nurse practitioner*] that affects the worker’s ability to obtain authorization of temporary
33 disability; or

34 (iii) When notice has not been given pursuant to paragraph (j) of this subsection.

35 (h) The worker’s disability may be authorized only by [*a person described*] **an attending physi-
36 cian as defined** in ORS 656.005 (12)(b)(B), or **a person described in ORS 656.245**, for the period
37 of time permitted by those sections. The insurer or self-insured employer may unilaterally suspend
38 payment of temporary disability benefits to the worker at the expiration of the period until tempo-
39 rary disability is reauthorized by [*an*] **the** attending physician [*or nurse practitioner authorized to
40 provide compensable medical services under ORS 656.245*].

41 (i) The insurer or self-insured employer may unilaterally suspend payment of all compensation
42 to a worker enrolled in a managed care organization if the worker continues to seek care from an
43 attending physician [*or nurse practitioner authorized to provide compensable medical services under
44 ORS 656.245*] that is not authorized by the managed care organization more than seven days after
45 the mailing of notice by the insurer or self-insured employer.

1 (j)(A) The insurer or self-insured employer may not end temporary disability benefits until writ-
2 ten notice has been mailed or delivered to the worker and the worker's attorney, if the worker is
3 represented. The notice must state the reason that temporary disability benefits are no longer due
4 and payable.

5 (B) The worker's attending physician [*or nurse practitioner*] may retroactively authorize tempo-
6 rary disability for up to 45 days prior to the date of the notice.

7 (C) If the notice required under subparagraph (A) of this paragraph is given more than 45 days
8 after the worker was no longer eligible for benefits, the attending physician [*or nurse practitioner*]
9 may retroactively authorize temporary disability back to the date on which benefits were no longer
10 due and payable, provided the authorization is made within 30 days following the earlier of the date
11 of mailing or delivery of the written notice that the eligibility ended to the worker and the worker's
12 attorney, if the worker is represented.

13 (5)(a) Payment of compensation under subsection (4) of this section or payment, in amounts per
14 claim not to exceed the maximum amount established annually by the Director of the Department
15 of Consumer and Business Services, for medical services for nondisabling claims, may be made by
16 the subject employer if the employer so chooses. The making of such payments does not constitute
17 a waiver or transfer of the insurer's duty to determine entitlement to benefits. If the employer
18 chooses to make such payment, the employer shall report the injury to the insurer in the same
19 manner that other injuries are reported. However, an insurer shall not modify an employer's expe-
20 rience rating or otherwise make charges against the employer for any medical expenses paid by the
21 employer pursuant to this subsection.

22 (b) To establish the maximum amount an employer may pay for medical services for nondisabling
23 claims under paragraph (a) of this subsection, the director shall use \$1,500 as the base compensation
24 amount and shall adjust the base compensation amount annually to reflect changes in the United
25 States City Average Consumer Price Index for All Urban Consumers for Medical Care for July of
26 each year as published by the Bureau of Labor Statistics of the United States Department of Labor.
27 The adjustment shall be rounded to the nearest multiple of \$100.

28 (c) The adjusted amount established under paragraph (b) of this subsection shall be effective on
29 January 1 following the establishment of the amount and shall apply to claims with a date of injury
30 on or after the effective date of the adjusted amount.

31 (6)(a) Written notice of acceptance or denial of the claim shall be furnished to the claimant by
32 the insurer or self-insured employer within 60 days after the employer has notice or knowledge of
33 the claim. Once the claim is accepted, the insurer or self-insured employer shall not revoke accept-
34 ance except as provided in this section. The insurer or self-insured employer may revoke acceptance
35 and issue a denial at any time when the denial is for fraud, misrepresentation or other illegal ac-
36 tivity by the worker. If the worker requests a hearing on any revocation of acceptance and denial
37 alleging fraud, misrepresentation or other illegal activity, the insurer or self-insured employer has
38 the burden of proving, by a preponderance of the evidence, such fraud, misrepresentation or other
39 illegal activity. Upon such proof, the worker then has the burden of proving, by a preponderance
40 of the evidence, the compensability of the claim. If the insurer or self-insured employer accepts a
41 claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the
42 worker, and later obtains evidence that the claim is not compensable or evidence that the insurer
43 or self-insured employer is not responsible for the claim, the insurer or self-insured employer may
44 revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of ac-
45 ceptance and denial is issued no later than two years after the date of the initial acceptance. If the

1 worker requests a hearing on such revocation of acceptance and denial, the insurer or self-insured
2 employer must prove, by a preponderance of the evidence, that the claim is not compensable or that
3 the insurer or self-insured employer is not responsible for the claim. Notwithstanding any other
4 provision of this chapter, if a denial of a previously accepted claim is set aside by an Administrative
5 Law Judge, the Workers' Compensation Board or the court, temporary total disability benefits are
6 payable from the date any such benefits were terminated under the denial. Except as provided in
7 ORS 656.247, pending acceptance or denial of a claim, compensation payable to a claimant does not
8 include the costs of medical benefits or funeral expenses. The insurer shall also furnish the employer
9 a copy of the notice of acceptance.

10 (b) The notice of acceptance shall:

11 (A) Specify what conditions are compensable.

12 (B) Advise the claimant whether the claim is considered disabling or nondisabling.

13 (C) Inform the claimant of the Expedited Claim Service and of the hearing and aggravation
14 rights concerning nondisabling injuries, including the right to object to a decision that the injury
15 of the claimant is nondisabling by requesting reclassification pursuant to ORS 656.277.

16 (D) Inform the claimant of employment reinstatement rights and responsibilities under ORS
17 chapter 659A.

18 (E) Inform the claimant of assistance available to employers and workers from the Reemploy-
19 ment Assistance Program under ORS 656.622.

20 (F) Be modified by the insurer or self-insured employer from time to time as medical or other
21 information changes a previously issued notice of acceptance.

22 (c) An insurer's or self-insured employer's acceptance of a combined or consequential condition
23 under ORS 656.005 (7), whether voluntary or as a result of a judgment or order, shall not preclude
24 the insurer or self-insured employer from later denying the combined or consequential condition if
25 the otherwise compensable injury ceases to be the major contributing cause of the combined or
26 consequential condition.

27 (d) An injured worker who believes that a condition has been incorrectly omitted from a notice
28 of acceptance, or that the notice is otherwise deficient, first must communicate in writing to the
29 insurer or self-insured employer the worker's objections to the notice pursuant to ORS 656.267. The
30 insurer or self-insured employer has 60 days from receipt of the communication from the worker to
31 revise the notice or to make other written clarification in response. A worker who fails to comply
32 with the communication requirements of this paragraph or ORS 656.267 may not allege at any
33 hearing or other proceeding on the claim a de facto denial of a condition based on information in
34 the notice of acceptance from the insurer or self-insured employer. Notwithstanding any other pro-
35 vision of this chapter, the worker may initiate objection to the notice of acceptance at any time.

36 (7)(a) After claim acceptance, written notice of acceptance or denial of claims for aggravation
37 or new medical or omitted condition claims properly initiated pursuant to ORS 656.267 shall be
38 furnished to the claimant by the insurer or self-insured employer within 60 days after the insurer
39 or self-insured employer receives written notice of such claims. A worker who fails to comply with
40 the communication requirements of subsection (6) of this section or ORS 656.267 may not allege at
41 any hearing or other proceeding on the claim a de facto denial of a condition based on information
42 in the notice of acceptance from the insurer or self-insured employer.

43 (b) Once a worker's claim has been accepted, the insurer or self-insured employer must issue a
44 written denial to the worker when the accepted injury is no longer the major contributing cause
45 of the worker's combined condition before the claim may be closed.

1 (c) When an insurer or self-insured employer determines that the claim qualifies for claim clo-
2 sure, the insurer or self-insured employer shall issue at claim closure an updated notice of accept-
3 ance that specifies which conditions are compensable. The procedures specified in subsection (6)(d)
4 of this section apply to this notice. Any objection to the updated notice or appeal of denied condi-
5 tions shall not delay claim closure pursuant to ORS 656.268. If a condition is found compensable
6 after claim closure, the insurer or self-insured employer shall reopen the claim for processing re-
7 garding that condition.

8 (8) The assigned claims agent in processing claims under ORS 656.054 shall send notice of ac-
9 ceptance or denial to the noncomplying employer.

10 (9) If an insurer or any other duly authorized agent of the employer for such purpose, on record
11 with the Director of the Department of Consumer and Business Services denies a claim for com-
12 pensation, written notice of such denial, stating the reason for the denial, and informing the worker
13 of the Expedited Claim Service and of hearing rights under ORS 656.283, shall be given to the
14 claimant. The insurer shall issue a copy of the notice of denial to the employer. The insurer shall
15 notify the director of the denial in the manner the director prescribes by rule. The worker may re-
16 quest a hearing pursuant to ORS 656.319.

17 (10) Merely paying or providing compensation shall not be considered acceptance of a claim or
18 an admission of liability, nor shall mere acceptance of such compensation be considered a waiver
19 of the right to question the amount thereof. Payment of permanent disability benefits pursuant to a
20 notice of closure, reconsideration order or litigation order, or the failure to appeal or seek review
21 of such an order or notice of closure, shall not preclude an insurer or self-insured employer from
22 subsequently contesting the compensability of the condition rated therein, unless the condition has
23 been formally accepted.

24 (11)(a) If the insurer or self-insured employer unreasonably delays or unreasonably refuses to
25 pay compensation, attorney fees or costs, or unreasonably delays acceptance or denial of a claim,
26 the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the
27 amounts then due plus any attorney fees assessed under this section. The fees assessed by the di-
28 rector, an Administrative Law Judge, the board or the court under this section shall be reasonable
29 attorney fees. In assessing fees, the director, an Administrative Law Judge, the board or the court
30 shall consider the proportionate benefit to the injured worker. The board shall adopt rules for es-
31 tablishing the amount of the attorney fee, giving primary consideration to the results achieved and
32 to the time devoted to the case. An attorney fee awarded pursuant to this subsection may not exceed
33 \$4,000 absent a showing of extraordinary circumstances. The maximum attorney fee awarded under
34 this paragraph shall be adjusted annually on July 1 by the same percentage increase as made to the
35 average weekly wage defined in ORS 656.211, if any. Notwithstanding any other provision of this
36 chapter, the director shall have exclusive jurisdiction over proceedings regarding solely the assess-
37 ment and payment of the additional amount and attorney fees described in this subsection. The
38 action of the director and the review of the action taken by the director shall be subject to review
39 under ORS 656.704.

40 (b) When the director does not have exclusive jurisdiction over proceedings regarding the as-
41 sessment and payment of the additional amount and attorney fees described in this subsection, the
42 provisions of this subsection shall apply in the other proceeding.

43 (12)(a) If payment is due on a disputed claim settlement authorized by ORS 656.289 and the
44 insurer or self-insured employer has failed to make the payment in accordance with the requirements
45 specified in the disputed claim settlement, the claimant or the claimant's attorney shall clearly no-

1 tify the insurer or self-insured employer in writing that the payment is past due. If the required
2 payment is not made within five business days after receipt of the notice by the insurer or self-
3 insured employer, the director may assess a penalty and attorney fee in accordance with a matrix
4 adopted by the director by rule.

5 (b) The director shall adopt by rule a matrix for the assessment of the penalties and attorney
6 fees authorized under this subsection. The matrix shall provide for penalties based on a percentage
7 of the settlement proceeds allocated to the claimant and for attorney fees based on a percentage of
8 the settlement proceeds allocated to the claimant's attorney as an attorney fee.

9 (13) The insurer may authorize an employer to pay compensation to injured workers and shall
10 reimburse employers for compensation so paid.

11 (14)(a) Injured workers have the duty to cooperate and assist the insurer or self-insured em-
12 ployer in the investigation of claims for compensation. Injured workers shall submit to and shall
13 fully cooperate with personal and telephonic interviews and other formal or informal information
14 gathering techniques. Injured workers who are represented by an attorney shall have the right to
15 have the attorney present during any personal or telephonic interview or deposition. If the injured
16 worker is represented by an attorney, the insurer or self-insured employer shall pay the attorney a
17 reasonable attorney fee based upon an hourly rate for actual time spent during the personal or
18 telephonic interview or deposition. After consultation with the Board of Governors of the Oregon
19 State Bar, the Workers' Compensation Board shall adopt rules for the establishment, assessment and
20 enforcement of an hourly attorney fee rate specified in this subsection.

21 (b) If the attorney is not willing or available to participate in an interview at a time reasonably
22 chosen by the insurer or self-insured employer within 14 days of the request for interview and the
23 insurer or self-insured employer has cause to believe that the attorney's unwillingness or unavail-
24 ability is unreasonable and is preventing the worker from complying within 14 days of the request
25 for interview, the insurer or self-insured employer shall notify the director. If the director deter-
26 mines that the attorney's unwillingness or unavailability is unreasonable, the director shall assess
27 a civil penalty against the attorney of not more than \$1,000.

28 (15) If the director finds that a worker fails to reasonably cooperate with an investigation in-
29 volving an initial claim to establish a compensable injury or an aggravation claim to reopen the
30 claim for a worsened condition, the director shall suspend all or part of the payment of compen-
31 sation after notice to the worker. If the worker does not cooperate for an additional 30 days after
32 the notice, the insurer or self-insured employer may deny the claim because of the worker's failure
33 to cooperate. The obligation of the insurer or self-insured employer to accept or deny the claim
34 within 60 days is suspended during the time of the worker's noncooperation. After such a denial, the
35 worker shall not be granted a hearing or other proceeding under this chapter on the merits of the
36 claim unless the worker first requests and establishes at an expedited hearing under ORS 656.291
37 that the worker fully and completely cooperated with the investigation, that the worker failed to
38 cooperate for reasons beyond the worker's control or that the investigative demands were unrea-
39 sonable. If the Administrative Law Judge finds that the worker has not fully cooperated, the Ad-
40 ministrative Law Judge shall affirm the denial, and the worker's claim for injury shall remain
41 denied. If the Administrative Law Judge finds that the worker has cooperated, or that the investi-
42 gative demands were unreasonable, the Administrative Law Judge shall set aside the denial, order
43 the reinstatement of interim compensation if appropriate and remand the claim to the insurer or
44 self-insured employer to accept or deny the claim.

45 (16) In accordance with ORS 656.283 (3), the Administrative Law Judge assigned a request for

1 hearing for a claim for compensation involving more than one potentially responsible employer or
2 insurer may specify what is required of an injured worker to reasonably cooperate with the inves-
3 tigation of the claim as required by subsection (14) of this section.

4 **SECTION 50.** ORS 656.268 is amended to read:

5 656.268. (1) One purpose of this chapter is to restore the injured worker as soon as possible and
6 as near as possible to a condition of self support and maintenance as an able-bodied worker. The
7 insurer or self-insured employer shall close the worker's claim, as prescribed by the Director of the
8 Department of Consumer and Business Services, and determine the extent of the worker's permanent
9 disability, provided the worker is not enrolled and actively engaged in training according to rules
10 adopted by the director pursuant to ORS 656.340 and 656.726, when one of the following conditions
11 is met:

12 (a) The worker has become medically stationary and there is sufficient information to determine
13 permanent disability. Notwithstanding any other provision of this chapter, a physician [*or nurse*
14 *practitioner*] may not retroactively determine a worker to be medically stationary more than 60 days
15 prior to the date of the determination except in the case of claims that are subject to subsection (13)
16 of this section. An insurer or self-insured employer must mail or deliver written notice to a worker
17 and to the worker's attorney, if the worker is represented, within seven days following receipt of
18 information that the worker is medically stationary.

19 (b) The accepted injury is no longer the major contributing cause of the worker's combined or
20 consequential condition or conditions pursuant to ORS 656.005 (7). When the claim is closed because
21 the accepted injury is no longer the major contributing cause of the worker's combined or conse-
22 quential condition or conditions, and there is sufficient information to determine permanent disabil-
23 ity, the likely permanent disability that would have been due to the current accepted condition shall
24 be estimated.

25 (c) Without the approval of the attending physician [*or nurse practitioner authorized to provide*
26 *compensable medical services under ORS 656.245*], the worker fails to seek medical treatment for a
27 period of 30 days or the worker fails to attend a closing examination, unless the worker
28 affirmatively establishes that such failure is attributable to reasons beyond the worker's control.

29 (d) An insurer or self-insured employer finds that a worker who has been receiving permanent
30 total disability benefits has materially improved and is capable of regularly performing work at a
31 gainful and suitable occupation.

32 (2) If the worker is enrolled and actively engaged in training according to rules adopted pursu-
33 ant to ORS 656.340 and 656.726, the temporary disability compensation shall be proportionately re-
34 duced by any sums earned during the training.

35 (3) A copy of all medical reports and reports of vocational rehabilitation agencies or counselors
36 shall be furnished to the worker, if requested by the worker.

37 (4) Temporary total disability benefits shall continue until whichever of the following events
38 first occurs:

39 (a) The worker returns to regular or modified employment;

40 (b) The attending physician [*or nurse practitioner who has authorized temporary disability benefits*
41 *for the worker under ORS 656.245*] advises the worker and documents in writing that the worker is
42 released to return to regular employment;

43 (c) The attending physician [*or nurse practitioner who has authorized temporary disability benefits*
44 *for the worker under ORS 656.245*] advises the worker and documents in writing that the worker is
45 released to return to modified employment, such employment is offered in writing to the worker and

1 the worker fails to begin such employment. However, an offer of modified employment may be re-
2 fused by the worker without the termination of temporary total disability benefits if the offer:

3 (A) Requires a commute that is beyond the physical capacity of the worker according to the
4 worker's attending physician [*or the nurse practitioner who may authorize temporary disability under*
5 *ORS 656.245*];

6 (B) Is at a work site more than 50 miles one way from where the worker was injured unless the
7 site is less than 50 miles from the worker's residence or the intent of the parties at the time of hire
8 or as established by the pattern of employment prior to the injury was that the employer had mul-
9 tiple or mobile work sites and the worker could be assigned to any such site;

10 (C) Is not with the employer at injury;

11 (D) Is not at a work site of the employer at injury;

12 (E) Is not consistent with the existing written shift change policy or is not consistent with
13 common practice of the employer at injury or aggravation; or

14 (F) Is not consistent with an existing shift change provision of an applicable collective bar-
15 gaining agreement;

16 (d) Any other event that causes temporary disability benefits to be lawfully suspended, withheld
17 or terminated under ORS 656.262 (4) or other provisions of this chapter; or

18 (e) Notwithstanding paragraph (c)(C), (D), (E) and (F) of this subsection, the attending physician
19 [*or nurse practitioner who has authorized temporary disability benefits under ORS 656.245*] for a home
20 care worker or a personal support worker who has been made a subject worker pursuant to ORS
21 656.039 advises the home care worker or personal support worker and documents in writing that the
22 home care worker or personal support worker is released to return to modified employment, appro-
23 priate modified employment is offered in writing by the Home Care Commission or a designee of the
24 commission to the home care worker or personal support worker for any client of the Department
25 of Human Services who employs a home care worker or personal support worker and the worker
26 fails to begin the employment.

27 (5)(a) Findings by the insurer or self-insured employer regarding the extent of the worker's dis-
28 ability in closure of the claim shall be pursuant to the standards prescribed by the director.

29 (b) The insurer or self-insured employer shall issue a notice of closure of the claim to the worker
30 and to the worker's attorney if the worker is represented. The insurer or self-insured employer shall
31 notify the director of the closure in the manner the director prescribes by rule. If the worker is
32 deceased at the time the notice of closure is issued, the insurer or self-insured employer shall mail
33 the worker's copy of the notice of closure, addressed to the estate of the worker, to the worker's last
34 known address and may mail copies of the notice of closure to any known or potential beneficiaries
35 to the estate of the deceased worker.

36 (c) The notice of closure must inform:

37 (A) The parties, in boldfaced type, of the proper manner in which to proceed if they are dissat-
38 isfied with the terms of the notice of closure;

39 (B) The worker of:

40 (i) The amount of any further compensation, including permanent disability compensation to be
41 awarded;

42 (ii) The duration of temporary total or temporary partial disability compensation;

43 (iii) The right of the worker or beneficiaries of the worker who were mailed a copy of the notice
44 of closure under paragraph (b) of this subsection to request reconsideration by the director under
45 this section within 60 days of the date of the notice of closure;

1 (iv) The right of beneficiaries who were not mailed a copy of the notice of closure under para-
2 graph (b) of this subsection to request reconsideration by the director under this section within one
3 year of the date the notice of closure was mailed to the estate of the worker under paragraph (b)
4 of this subsection;

5 (v) The right of the insurer or self-insured employer to request reconsideration by the director
6 under this section within seven days of the date of the notice of closure;

7 (vi) The aggravation rights; and

8 (vii) Any other information as the director may require; and

9 (C) Any beneficiaries of death benefits to which they may be entitled pursuant to ORS 656.204
10 and 656.208.

11 (d) If the insurer or self-insured employer has not issued a notice of closure, the worker may
12 request closure. Within 10 days of receipt of a written request from the worker, the insurer or
13 self-insured employer shall issue a notice of closure if the requirements of this section have been
14 met or a notice of refusal to close if the requirements of this section have not been met. A notice
15 of refusal to close shall advise the worker of:

16 (A) The decision not to close;

17 (B) The right of the worker to request a hearing pursuant to ORS 656.283 within 60 days of the
18 date of the notice of refusal to close;

19 (C) The right to be represented by an attorney; and

20 (D) Any other information as the director may require.

21 (e) If a worker, a worker's beneficiary, an insurer or a self-insured employer objects to the no-
22 tice of closure, the objecting party first must request reconsideration by the director under this
23 section. A worker's request for reconsideration must be made within 60 days of the date of the no-
24 tice of closure. If the worker is deceased at the time the notice of closure is issued, a request for
25 reconsideration by a beneficiary of the worker who was mailed a copy of the notice of closure under
26 paragraph (b) of this subsection must be made within 60 days of the date of the notice of closure.
27 A request for reconsideration by a beneficiary to the estate of a deceased worker who was not
28 mailed a copy of the notice of closure under paragraph (b) of this subsection must be made within
29 one year of the date the notice of closure was mailed to the estate of the worker under paragraph
30 (b) of this subsection. A request for reconsideration by an insurer or self-insured employer may be
31 based only on disagreement with the findings used to rate impairment and must be made within
32 seven days of the date of the notice of closure.

33 (f) If an insurer or self-insured employer has closed a claim or refused to close a claim pursuant
34 to this section, if the correctness of that notice of closure or refusal to close is at issue in a hearing
35 on the claim and if a finding is made at the hearing that the notice of closure or refusal to close
36 was not reasonable, a penalty shall be assessed against the insurer or self-insured employer and paid
37 to the worker in an amount equal to 25 percent of all compensation determined to be then due the
38 claimant.

39 (g) If, upon reconsideration of a claim closed by an insurer or self-insured employer, the director
40 orders an increase by 25 percent or more of the amount of compensation to be paid to the worker
41 for permanent disability and the worker is found upon reconsideration to be at least 20 percent
42 permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and
43 paid to the worker in an amount equal to 25 percent of all compensation determined to be then due
44 the claimant. If the increase in compensation results from information that the insurer or self-
45 insured employer demonstrates the insurer or self-insured employer could not reasonably have

1 known at the time of claim closure, from new information obtained through a medical arbiter ex-
2 amination or from a determination order issued by the director that addresses the extent of the
3 worker's permanent disability that is not based on the standards adopted pursuant to ORS 656.726
4 (4)(f), the penalty shall not be assessed.

5 (6)(a) Notwithstanding any other provision of law, only one reconsideration proceeding may be
6 held on each notice of closure. At the reconsideration proceeding:

7 (A) A deposition arranged by the worker, limited to the testimony and cross-examination of the
8 worker about the worker's condition at the time of claim closure, shall become part of the recon-
9 sideration record. The deposition must be conducted subject to the opportunity for cross-examination
10 by the insurer or self-insured employer and in accordance with rules adopted by the director. The
11 cost of the court reporter, interpreter services, if necessary, and one original of the transcript of the
12 deposition for the Department of Consumer and Business Services and one copy of the transcript
13 of the deposition for each party shall be paid by the insurer or self-insured employer. The recon-
14 sideration proceeding may not be postponed to receive a deposition taken under this subparagraph.
15 A deposition taken in accordance with this subparagraph may be received as evidence at a hearing
16 even if the deposition is not prepared in time for use in the reconsideration proceeding.

17 (B) Pursuant to rules adopted by the director, the worker or the insurer or self-insured employer
18 may correct information in the record that is erroneous and may submit any medical evidence that
19 should have been but was not submitted by the attending physician [*or nurse practitioner authorized*
20 *to provide compensable medical services under ORS 656.245*] at the time of claim closure.

21 (C) If the director determines that a claim was not closed in accordance with subsection (1) of
22 this section, the director may rescind the closure.

23 (b) If necessary, the director may require additional medical or other information with respect
24 to the claims and may postpone the reconsideration for not more than 60 additional calendar days.

25 (c) In any reconsideration proceeding under this section in which the worker was represented
26 by an attorney, the director shall order the insurer or self-insured employer to pay to the attorney,
27 out of the additional compensation awarded, an amount equal to 10 percent of any additional com-
28 pensation awarded to the worker.

29 (d) Except as provided in subsection (7) of this section, the reconsideration proceeding shall be
30 completed within 18 working days from the date the reconsideration proceeding begins, and shall
31 be performed by a special evaluation appellate unit within the department. The deadline of 18
32 working days may be postponed by an additional 60 calendar days if within the 18 working days the
33 department mails notice of review by a medical arbiter. If an order on reconsideration has not been
34 mailed on or before 18 working days from the date the reconsideration proceeding begins, or within
35 18 working days plus the additional 60 calendar days where a notice for medical arbiter review was
36 timely mailed or the director postponed the reconsideration pursuant to paragraph (b) of this sub-
37 section, or within such additional time as provided in subsection (8) of this section when reconsid-
38 eration is postponed further because the worker has failed to cooperate in the medical arbiter
39 examination, reconsideration shall be deemed denied and any further proceedings shall occur as
40 though an order on reconsideration affirming the notice of closure was mailed on the date the order
41 was due to issue.

42 (e) The period for completing the reconsideration proceeding described in paragraph (d) of this
43 subsection begins upon receipt by the director of a worker's or a beneficiary's request for recon-
44 sideration pursuant to subsection (5)(e) of this section. If the insurer or self-insured employer re-
45 quests reconsideration, the period for reconsideration begins upon the earlier of the date of the

1 request for reconsideration by the worker or beneficiary, the date of receipt of a waiver from the
2 worker or beneficiary of the right to request reconsideration or the date of expiration of the right
3 of the worker or beneficiary to request reconsideration. If a party elects not to file a separate re-
4 quest for reconsideration, the party does not waive the right to fully participate in the reconsider-
5 ation proceeding, including the right to proceed with the reconsideration if the initiating party
6 withdraws the request for reconsideration.

7 (f) Any medical arbiter report may be received as evidence at a hearing even if the report is
8 not prepared in time for use in the reconsideration proceeding.

9 (g) If any party objects to the reconsideration order, the party may request a hearing under ORS
10 656.283 within 30 days from the date of the reconsideration order.

11 (7)(a) The director may delay the reconsideration proceeding and toll the reconsideration
12 timeline established under subsection (6) of this section for up to 45 calendar days if:

13 (A) A request for reconsideration of a notice of closure has been made to the director within
14 60 days of the date of the notice of closure;

15 (B) The parties are actively engaged in settlement negotiations that include issues in dispute
16 at reconsideration;

17 (C) The parties agree to the delay; and

18 (D) Both parties notify the director before the 18th working day after the reconsideration pro-
19 ceeding has begun that they request a delay under this subsection.

20 (b) A delay of the reconsideration proceeding granted by the director under this subsection ex-
21 pires:

22 (A) If a party requests the director to resume the reconsideration proceeding before the expi-
23 ration of the delay period;

24 (B) If the parties reach a settlement and the director receives a copy of the approved settlement
25 documents before the expiration of the delay period; or

26 (C) On the next calendar day following the expiration of the delay period authorized by the di-
27 rector.

28 (c) Upon expiration of a delay granted under this subsection, the timeline for the completion of
29 the reconsideration proceeding shall resume as if the delay had never been granted.

30 (d) Compensation due the worker shall continue to be paid during the period of delay authorized
31 under this subsection.

32 (e) The director may authorize only one delay period for each reconsideration proceeding.

33 (8)(a) If the basis for objection to a notice of closure issued under this section is disagreement
34 with the impairment used in rating of the worker's disability, the director shall refer the claim to
35 a medical arbiter appointed by the director.

36 (b) If the director determines that insufficient medical information is available to determine
37 disability, the director may appoint, and refer the claim to, a medical arbiter.

38 (c) At the request of either of the parties, the director shall appoint a panel of as many as three
39 medical arbiters in accordance with criteria that the director sets by rule.

40 (d) The arbiter, or panel of medical arbiters, must be chosen from among a list of physicians
41 qualified to be attending physicians referred to in ORS 656.005 (12)(b)(A) whom the director selected
42 in consultation with the Oregon Medical Board, **the Oregon State Board of Nursing** and the
43 committee referred to in ORS 656.790.

44 (e)(A) The medical arbiter or panel of medical arbiters may examine the worker and perform
45 such tests as may be reasonable and necessary to establish the worker's impairment.

1 (B) If the director determines that the worker failed to attend the examination without good
2 cause or failed to cooperate with the medical arbiter, or panel of medical arbiters, the director shall
3 postpone the reconsideration proceedings for up to 60 days from the date of the determination that
4 the worker failed to attend or cooperate, and shall suspend all disability benefits resulting from this
5 or any prior opening of the claim until such time as the worker attends and cooperates with the
6 examination or the request for reconsideration is withdrawn. Any additional evidence regarding
7 good cause must be submitted prior to the conclusion of the 60-day postponement period.

8 (C) At the conclusion of the 60-day postponement period, if the worker has not attended and
9 cooperated with a medical arbiter examination or established good cause, the worker may not attend
10 a medical arbiter examination for this claim closure. The reconsideration record must be closed, and
11 the director shall issue an order on reconsideration based upon the existing record.

12 (D) All disability benefits suspended under this subsection, including all disability benefits
13 awarded in the order on reconsideration, or by an Administrative Law Judge, the Workers' Com-
14 pensation Board or upon court review, are not due and payable to the worker.

15 (f) The insurer or self-insured employer shall pay the costs of examination and review by the
16 medical arbiter or panel of medical arbiters.

17 (g) The findings of the medical arbiter or panel of medical arbiters must be submitted to the
18 director for reconsideration of the notice of closure.

19 (h) After reconsideration, no subsequent medical evidence of the worker's impairment is admis-
20 sible before the director, the Workers' Compensation Board or the courts for purposes of making
21 findings of impairment on the claim closure.

22 (i)(A) If the basis for objection to a notice of closure issued under this section is a disagreement
23 with the impairment used in rating the worker's disability, and the director determines that the
24 worker is not medically stationary at the time of the reconsideration or that the closure was not
25 made pursuant to this section, the director is not required to appoint a medical arbiter before
26 completing the reconsideration proceeding.

27 (B) If the worker's condition has substantially changed since the notice of closure, upon the
28 consent of all the parties to the claim, the director shall postpone the proceeding until the worker's
29 condition is appropriate for claim closure under subsection (1) of this section.

30 (9) No hearing shall be held on any issue that was not raised and preserved before the director
31 at reconsideration. However, issues arising out of the reconsideration order may be addressed and
32 resolved at hearing.

33 (10) If, after the notice of closure issued pursuant to this section, the worker becomes enrolled
34 and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726,
35 any permanent disability payments due for work disability under the closure shall be suspended, and
36 the worker shall receive temporary disability compensation and any permanent disability payments
37 due for impairment while the worker is enrolled and actively engaged in the training. When the
38 worker ceases to be enrolled and actively engaged in the training, the insurer or self-insured em-
39 ployer shall again close the claim pursuant to this section if the worker is medically stationary or
40 if the worker's accepted injury is no longer the major contributing cause of the worker's combined
41 or consequential condition or conditions pursuant to ORS 656.005 (7). The closure shall include the
42 duration of temporary total or temporary partial disability compensation. Permanent disability
43 compensation shall be redetermined for work disability only. If the worker has returned to work or
44 the worker's attending physician has released the worker to return to regular or modified employ-
45 ment, the insurer or self-insured employer shall again close the claim. This notice of closure may

1 be appealed only in the same manner as are other notices of closure under this section.

2 (11) If the attending physician [*or nurse practitioner authorized to provide compensable medical*
3 *services under ORS 656.245*] has approved the worker's return to work and there is a labor dispute
4 in progress at the place of employment, the worker may refuse to return to that employment without
5 loss of reemployment rights or any vocational assistance provided by this chapter.

6 (12) Any notice of closure made under this section may include necessary adjustments in com-
7 pensation paid or payable prior to the notice of closure, including disallowance of permanent disa-
8 bility payments prematurely made, crediting temporary disability payments against current or future
9 permanent or temporary disability awards or payments and requiring the payment of temporary
10 disability payments which were payable but not paid.

11 (13) An insurer or self-insured employer may take a credit or offset of previously paid workers'
12 compensation benefits or payments against any further workers' compensation benefits or payments
13 due a worker from that insurer or self-insured employer when the worker admits to having obtained
14 the previously paid benefits or payments through fraud, or a civil judgment or criminal conviction
15 is entered against the worker for having obtained the previously paid benefits through fraud. Bene-
16 fits or payments obtained through fraud by a worker may not be included in any data used for
17 ratemaking or individual employer rating or dividend calculations by an insurer, a rating organiza-
18 tion licensed pursuant to ORS chapter 737, the State Accident Insurance Fund Corporation or the
19 director.

20 (14)(a) An insurer or self-insured employer may offset any compensation payable to the worker
21 to recover an overpayment from a claim with the same insurer or self-insured employer. When
22 overpayments are recovered from temporary disability or permanent total disability benefits, the
23 amount recovered from each payment shall not exceed 25 percent of the payment, without prior
24 authorization from the worker.

25 (b) An insurer or self-insured employer may suspend and offset any compensation payable to the
26 beneficiary of the worker, and recover an overpayment of permanent total disability benefits caused
27 by the failure of the worker's beneficiaries to notify the insurer or self-insured employer about the
28 death of the worker.

29 (15) Conditions that are direct medical sequelae to the original accepted condition shall be in-
30 cluded in rating permanent disability of the claim unless they have been specifically denied.

31 (16)(a) Except as provided under subsection (13) of this section, an insurer or self-insured em-
32 ployer may not recover an overpayment from a worker's permanent partial disability compensation
33 for overpayments, offsets or credits of wage loss in an amount that exceeds 50 percent of the total
34 compensation awarded to the worker.

35 (b) An insurer or self-insured employer may not declare an overpayment of any compensation
36 that was paid more than two years prior to the date of the declaration.

37 **SECTION 51.** ORS 656.325 is amended to read:

38 656.325. (1)(a) Any worker entitled to receive compensation under this chapter is required, if
39 requested by the Director of the Department of Consumer and Business Services, the insurer or
40 self-insured employer, to submit to a medical examination at a time reasonably convenient for the
41 worker as may be provided by the rules of the director. No more than three independent medical
42 examinations may be requested except after notification to and authorization by the director. If the
43 worker refuses to submit to any such examination, or obstructs the same, the rights of the worker
44 to compensation shall be suspended with the consent of the director until the examination has taken
45 place, and no compensation shall be payable during or for account of such period. The provisions

1 of this paragraph are subject to the limitations on medical examinations provided in ORS 656.268.

2 (b) When a worker is requested by the director, the insurer or self-insured employer to attend
3 an independent medical examination, the examination must be conducted by a physician selected
4 from a list of qualified physicians established by the director under ORS 656.328.

5 (c) The director shall adopt rules applicable to independent medical examinations conducted
6 pursuant to paragraph (a) of this subsection that:

7 (A) Provide a worker the opportunity to request review by the director of the reasonableness
8 of the location selected for an independent medical examination. Upon receipt of the request for
9 review, the director shall conduct an expedited review of the location selected for the independent
10 medical examination and issue an order on the reasonableness of the location of the examination.
11 The director shall determine if there is substantial evidence for the objection to the location for the
12 independent medical examination based on a conclusion that the required travel is medically
13 contraindicated or other good cause establishing that the required travel is unreasonable. The de-
14 terminations of the director about the location of independent medical examinations are not subject
15 to review.

16 (B) Impose a monetary penalty against a worker who fails to attend an independent medical
17 examination without prior notification or without justification for not attending the examination. A
18 penalty imposed under this subparagraph may be imposed only on a worker who is not receiving
19 temporary disability benefits under ORS 656.210 or 656.212. An insurer or self-insured employer may
20 offset any future compensation payable to the worker to recover any penalty imposed under this
21 subparagraph from a claim with the same insurer or self-insured employer. When a penalty is re-
22 covered from temporary disability or permanent total disability benefits, the amount recovered from
23 each payment may not exceed 25 percent of the benefit payment without prior authorization from
24 the worker.

25 (C) Impose a sanction against a medical service provider that unreasonably fails to provide in
26 a timely manner diagnostic records required for an independent medical examination.

27 (d) Notwithstanding ORS 656.262 (6), if the director determines that the location selected for an
28 independent medical examination is unreasonable, the insurer or self-insured employer shall accept
29 or deny the claim within 90 days after the employer has notice or knowledge of the claim.

30 (e) If the worker has made a timely request for a hearing on a denial of compensability as re-
31 quired by ORS 656.319 (1)(a) that is based on one or more reports of examinations conducted pur-
32 suant to paragraph (a) of this subsection and the worker's attending physician [*or nurse practitioner*
33 *authorized to provide compensable medical services under ORS 656.245*] does not concur with the re-
34 port or reports, the worker may request an examination to be conducted by a physician selected by
35 the director from the list described in ORS 656.328. The cost of the examination and the examination
36 report shall be paid by the insurer or self-insured employer.

37 (f) The insurer or self-insured employer shall pay the costs of the medical examination and re-
38 lated services which are reasonably necessary to allow the worker to submit to any examination
39 requested under this section. As used in this paragraph, "related services" includes, but is not lim-
40 ited to, child care, travel, meals, lodging and an amount equivalent to the worker's net lost wages
41 for the period during which the worker is absent if the worker does not receive benefits pursuant
42 to ORS 656.210 (4) during the period of absence. A claim for "related services" described in this
43 paragraph shall be made in the manner prescribed by the director.

44 (g) A worker who objects to the location of an independent medical examination must request
45 review by the director under paragraph (c)(A) of this subsection within six business days of the date

1 the notice of the independent medical examination was mailed.

2 (2) For any period of time during which any worker commits insanitary or injurious practices
3 which tend to either imperil or retard recovery of the worker, or refuses to submit to such medical
4 or surgical treatment as is reasonably essential to promote recovery, or fails to participate in a
5 program of physical rehabilitation, the right of the worker to compensation shall be suspended with
6 the consent of the director and no payment shall be made for such period. The period during which
7 such worker would otherwise be entitled to compensation may be reduced with the consent of the
8 director to such an extent as the disability has been increased by such refusal.

9 (3) A worker who has received an award for permanent total or permanent partial disability
10 should be encouraged to make a reasonable effort to reduce the disability; and the award shall be
11 subject to periodic examination and adjustment in conformity with ORS 656.268.

12 (4) When the employer of an injured worker, or the employer's insurer determines that the in-
13 jured worker has failed to follow medical advice from the attending physician [*or nurse practitioner*
14 *authorized to provide compensable medical services under ORS 656.245*] or has failed to participate
15 in or complete physical restoration or vocational rehabilitation programs prescribed for the worker
16 pursuant to this chapter, the employer or insurer may petition the director for reduction of any
17 benefits awarded the worker. Notwithstanding any other provision of this chapter, if the director
18 finds that the worker has failed to accept treatment as provided in this subsection, the director may
19 reduce any benefits awarded the worker by such amount as the director considers appropriate.

20 (5)(a) Except as provided by ORS 656.268 (4)(c) and (11), an insurer or self-insured employer shall
21 cease making payments pursuant to ORS 656.210 and shall commence making payment of such
22 amounts as are due pursuant to ORS 656.212 when an injured worker refuses wage earning em-
23 ployment prior to claim determination and the worker's attending physician [*or nurse practitioner*
24 *authorized to provide compensable medical services under ORS 656.245*], after being notified by the
25 employer of the specific duties to be performed by the injured worker, agrees that the injured
26 worker is capable of performing the employment offered.

27 (b) If the worker has been terminated for violation of work rules or other disciplinary reasons,
28 the insurer or self-insured employer shall cease payments pursuant to ORS 656.210 and commence
29 payments pursuant to ORS 656.212 when the attending physician [*or nurse practitioner authorized to*
30 *provide compensable medical services under ORS 656.245*] approves employment in a modified job that
31 would have been offered to the worker if the worker had remained employed, provided that the
32 employer has a written policy of offering modified work to injured workers.

33 (c) If the worker is a person present in the United States in violation of federal immigration
34 laws, the insurer or self-insured employer shall cease payments pursuant to ORS 656.210 and com-
35 mence payments pursuant to ORS 656.212 when the attending physician [*or nurse practitioner au-*
36 *thorized to provide compensable medical services under ORS 656.245*] approves employment in a
37 modified job whether or not such a job is available.

38 (6) Any party may request a hearing on any dispute under this section pursuant to ORS 656.283.

39 **SECTION 52.** ORS 656.340 is amended to read:

40 656.340. (1)(a) The insurer or self-insured employer shall cause vocational assistance to be pro-
41 vided to an injured worker who is eligible for assistance in returning to work.

42 (b) For this purpose the insurer or self-insured employer shall contact a worker with a claim for
43 a disabling compensable injury or claim for aggravation for evaluation of the worker's eligibility for
44 vocational assistance within five days of:

45 (A) Having knowledge of the worker's likely eligibility for vocational assistance, from a medical

1 or investigation report, notification from the worker, or otherwise; or

2 (B) The time the worker is medically stationary, if the worker has not returned to or been re-
3 leased for the worker's regular employment or has not returned to other suitable employment with
4 the employer at the time of injury or aggravation and the worker is not receiving vocational as-
5 sistance.

6 (c) Eligibility may be redetermined by the insurer or self-insured employer upon receipt of new
7 information that would change the eligibility determination.

8 (2) Contact under subsection (1) of this section shall include informing the worker about reem-
9 ployment rights, the responsibility of the worker to request reemployment, and wage subsidy and job
10 site modification assistance and the provisions of the preferred worker program pursuant to rules
11 adopted by the Director of the Department of Consumer and Business Services.

12 (3) Within five days after notification that the attending physician [*or nurse practitioner author-*
13 *ized to provide compensable medical services under ORS 656.245*] has released a worker to return to
14 work, the insurer or self-insured employer shall inform the worker about the opportunity to seek
15 reemployment or reinstatement under ORS 659A.043 and 659A.046. The insurer shall inform the
16 employer of the worker's reemployment rights, wage subsidy and the job site modification assistance
17 and the provisions of the preferred worker program.

18 (4) As soon as possible, and not more than 30 days after the contact required by subsection (1)
19 of this section, the insurer or self-insured employer shall cause an individual certified by the direc-
20 tor to provide vocational assistance to determine whether the worker is eligible for vocational as-
21 sistance. The insurer or self-insured employer shall notify the worker of the decision regarding the
22 worker's eligibility for vocational assistance. If the insurer or self-insured employer decides that the
23 worker is not eligible, the worker may apply to the director for review of the decision as provided
24 in subsection (16) of this section. A worker determined ineligible upon evaluation under subsection
25 (1)(b)(B) of this section, or because the worker's eligibility has fully and finally expired under stan-
26 dards prescribed by the director, may not be found eligible thereafter unless that eligibility deter-
27 mination is rejected by the director under subsection (16) of this section or the worker's condition
28 worsens so as to constitute an aggravation claim under ORS 656.273. A worker is not entitled to
29 vocational assistance benefits when possible eligibility for such benefits arises from a worsening of
30 the worker's condition that occurs after the expiration of the worker's aggravation rights under ORS
31 656.273.

32 (5) The objectives of vocational assistance are to return the worker to employment which is as
33 close as possible to the worker's regular employment at a wage as close as possible to the weekly
34 wage currently being paid for employment which was the worker's regular employment even though
35 the wage available following employment may be less than the wage prescribed by subsection (6)
36 of this section. As used in this subsection and subsection (6) of this section, "regular employment"
37 means the employment the worker held at the time of the injury or the claim for aggravation under
38 ORS 656.273, whichever gave rise to the potential eligibility for vocational assistance; or, for a
39 worker not employed at the time of the aggravation, the employment the worker held on the last
40 day of work prior to the aggravation.

41 (6)(a) A worker is eligible for vocational assistance if the worker will not be able to return to
42 the previous employment or to any other available and suitable employment with the employer at
43 the time of injury or aggravation, and the worker has a substantial handicap to employment.

44 (b) As used in this subsection:

45 (A) A "substantial handicap to employment" exists when the worker, because of the injury or

1 aggravation, lacks the necessary physical capacities, knowledge, skills and abilities to be employed
2 in suitable employment.

3 (B) "Suitable employment" means:

4 (i) Employment of the kind for which the worker has the necessary physical capacity, knowl-
5 edge, skills and abilities;

6 (ii) Employment that is located where the worker customarily worked or is within reasonable
7 commuting distance of the worker's residence; and

8 (iii) Employment that produces a weekly wage within 20 percent of that currently being paid for
9 employment that was the worker's regular employment as defined in subsection (5) of this section.
10 The director shall adopt rules providing methods of calculating the weekly wage currently being
11 paid for the worker's regular employment for use in determining eligibility and for providing as-
12 sistance to eligible workers. If the worker's regular employment was seasonal or temporary, the
13 worker's wage shall be averaged based on a combination of the worker's earned income and any
14 unemployment insurance payments. Only earned income evidenced by verifiable documentation such
15 as federal or state tax returns shall be used in the calculation. Earned income does not include
16 fringe benefits or reimbursement of the worker's employment expenses.

17 (7) Vocational evaluation, help in directly obtaining employment and training shall be available
18 under conditions prescribed by the director. The director may establish other conditions for pro-
19 viding vocational assistance, including those relating to the worker's availability for assistance,
20 participation in previous assistance programs connected with the same claim and the nature and
21 extent of assistance that may be provided. Such conditions shall give preference to direct employ-
22 ment assistance over training.

23 (8) An insurer or self-insured employer may utilize its own staff or may engage any other indi-
24 vidual certified by the director to perform the vocational evaluation required by subsection (4) of
25 this section.

26 (9) The director shall adopt rules providing:

27 (a) Standards for and methods of certifying individuals qualified by education, training and ex-
28 perience to provide vocational assistance to injured workers;

29 (b) Standards for registration of vocational assistance providers;

30 (c) Conditions and procedures under which the certification of an individual to provide voca-
31 tional assistance services or the registration of a vocational assistance provider may be suspended
32 or revoked for failure to maintain compliance with the certification or registration standards;

33 (d) Standards for the nature and extent of services a worker may receive, for plans for return
34 to work and for determining when the worker has returned to work; and

35 (e) Procedures, schedules and conditions relating to the payment for services performed by a
36 vocational assistance provider, that are based on payment for specific services performed and not
37 fees for services performed on an hourly basis. Fee schedules shall reflect a reasonable rate for
38 direct worker purchases and for all vocational assistance providers and shall be the same within
39 suitable geographic areas.

40 (10) Insurers and self-insured employers shall maintain records and make reports to the director
41 of vocational assistance actions at times and in the manner as the director may prescribe. The re-
42 quirements prescribed shall be for the purpose of assisting the Department of Consumer and Busi-
43 ness Services in monitoring compliance with this section to insure that workers receive timely and
44 appropriate vocational assistance. The director shall minimize to the greatest extent possible the
45 number, extent and kinds of reports required. The director shall compile a list of organizations or

1 agencies registered to provide vocational assistance. A current list shall be distributed by the di-
2 rector to all insurers and self-insured employers. The insurer shall send the list to each worker with
3 the notice of eligibility.

4 (11) When a worker is eligible to receive vocational assistance, the worker and the insurer or
5 self-insured employer shall attempt to agree on the choice of a vocational assistance provider. If the
6 worker agrees, the insurer or self-insured employer may utilize its own staff to provide vocational
7 assistance. If they are unable to agree on a vocational assistance provider, the insurer or self-
8 insured employer shall notify the director and the director shall select a provider. Any change in
9 the choice of vocational assistance provider is subject to the approval of the director.

10 (12) Notwithstanding ORS 656.268, a worker actively engaged in training may receive temporary
11 disability compensation for a maximum of 16 months. The insurer or self-insured employer may vol-
12 untarily extend the payment of temporary disability compensation to a maximum of 21 months. The
13 director may order the payment of temporary disability compensation for up to 21 months upon good
14 cause shown by the injured worker. The costs related to vocational assistance training programs
15 may be paid for periods longer than 21 months, but in no event may temporary disability benefits
16 be paid for a period longer than 21 months.

17 (13) As used in this section, "vocational assistance provider" means a public or private organ-
18 ization or agency that provides vocational assistance to injured workers.

19 (14)(a) Determination of eligibility for vocational assistance does not entitle all workers to the
20 same type or extent of assistance.

21 (b) Training shall not be provided to an eligible worker solely because the worker cannot obtain
22 employment, otherwise suitable, that will produce the wage prescribed in subsection (6) of this sec-
23 tion unless such training will enable the worker to find employment which will produce a wage
24 significantly closer to that prescribed in subsection (6) of this section.

25 (c) Nothing in this section shall be interpreted to expand the availability of training under this
26 section.

27 (15) A physical capacities evaluation shall be performed in conjunction with vocational assist-
28 ance or determination of eligibility for such assistance at the request of the insurer or self-insured
29 employer or worker. The request shall be made to the attending physician [*or nurse practitioner*
30 *authorized to provide compensable medical services under ORS 656.245*]. [*The attending physician or*
31 *nurse practitioner,*] Within 20 days of the request, **the attending physician** shall perform a physical
32 capacities evaluation or refer the worker for such evaluation or advise the insurer or self-insured
33 employer and the worker in writing that the injured worker is incapable of participating in a phys-
34 ical capacities evaluation.

35 (16)(a) The Legislative Assembly finds that vocational rehabilitation of injured workers requires
36 a high degree of cooperation between all of the participants in the vocational assistance process.
37 Based on this finding, the Legislative Assembly concludes that disputes regarding eligibility for and
38 extent of vocational assistance services should be resolved through nonadversarial procedures to the
39 greatest extent possible consistent with constitutional principles. The director shall adopt by rule
40 a procedure for resolving vocational assistance disputes in the manner provided in this subsection.

41 (b) If a worker is dissatisfied with an action of the insurer or self-insured employer regarding
42 vocational assistance, the worker must apply to the director for administrative review of the matter.
43 Application for review must be made not later than the 60th day after the date the worker was
44 notified of the action. The director shall complete the review within a reasonable time.

45 (c) If the worker's dissatisfaction is resolved by agreement of the parties, the agreement shall

1 be reduced to writing, and the director and the parties shall review the agreement and either ap-
2 prove or disapprove it. The agreement is subject to reconsideration by the director under limitations
3 prescribed by the director, but is not subject to review by any other forum.

4 (d) If the worker's dissatisfaction is not resolved by agreement of the parties, the director shall
5 resolve the matter in a written order based on a record sufficient to permit review. The order is
6 subject to review under ORS 656.704. The request for a hearing must be filed within 60 days of the
7 date the order was issued. At the hearing, the order of the director shall be modified only if it:

8 (A) Violates a statute or rule;

9 (B) Exceeds the statutory authority of the agency;

10 (C) Was made upon unlawful procedure; or

11 (D) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion.

12 (e) For purposes of this subsection, the term "parties" does not include a noncomplying em-
13 ployer.

14 **SECTION 53.** ORS 656.726 is amended to read:

15 656.726. (1) The Workers' Compensation Board in its name and the Director of the Department
16 of Consumer and Business Services in the director's name as director may sue and be sued, and each
17 shall have a seal.

18 (2) The board hereby is charged with reviewing appealed orders of Administrative Law Judges
19 in controversies concerning a claim arising under this chapter, exercising own motion jurisdiction
20 under this chapter and providing such policy advice as the director may request, and providing such
21 other review functions as may be prescribed by law. To that end any of its members or assistants
22 authorized thereto by the members shall have power to:

23 (a) Hold sessions at any place within the state.

24 (b) Administer oaths.

25 (c) Issue and serve by the board's representatives, or by any sheriff, subpoenas for the attend-
26 ance of witnesses and the production of papers, contracts, books, accounts, documents and testimony
27 before any hearing under ORS 654.001 to 654.295, 654.412 to 654.423, 654.750 to 654.780 and this
28 chapter.

29 (d) Generally provide for the taking of testimony and for the recording of proceedings.

30 (3) The board chairperson is hereby charged with the administration of and responsibility for the
31 Hearings Division.

32 (4) The director hereby is charged with duties of administration, regulation and enforcement of
33 ORS 654.001 to 654.295, 654.412 to 654.423, 654.750 to 654.780 and this chapter. To that end the di-
34 rector may:

35 (a) Make and declare all rules and issue orders which are reasonably required in the perform-
36 ance of the director's duties. Unless otherwise specified by law, all reports, claims or other docu-
37 ments shall be deemed timely provided to the director or board if mailed by regular mail or
38 delivered within the time required by law. Notwithstanding any other provision of this chapter, the
39 director may adopt rules to allow for the electronic transmission and filing of reports, claims or
40 other documents required to be filed under this chapter and to require the electronic transmission
41 and filing of proof of coverage required under ORS 656.419, 656.423 and 656.427. Notwithstanding
42 ORS 183.310 to 183.410, if a matter comes before the director that is not addressed by rule and the
43 director finds that adoption of a rule to accommodate the matter would be inefficient, unreasonable
44 or unnecessarily burdensome to the public, the director may resolve the matter by issuing an order,
45 subject to review under ORS 656.704. Such order shall not have precedential effect as to any other

1 situation.

2 (b) Hold sessions at any place within the state.

3 (c) Administer oaths.

4 (d) Issue and serve by representatives of the director, or by any sheriff, subpoenas for the at-
5 tendance of witnesses and the production of papers, contracts, books, accounts, documents and tes-
6 timony in any inquiry, investigation, proceeding or rulemaking hearing conducted by the director
7 or the director's representatives. The director may require the attendance and testimony of em-
8 ployers, their officers and representatives in any inquiry under this chapter, and the production by
9 employers of books, records, papers and documents without the payment or tender of witness fees
10 on account of such attendance.

11 (e) Generally provide for the taking of testimony and for the recording of such proceedings.

12 (f) Provide standards for the evaluation of disabilities. The following provisions apply to the
13 standards:

14 (A) The criterion for evaluation of permanent impairment under ORS 656.214 is the loss of use
15 or function of a body part or system due to the compensable industrial injury or occupational dis-
16 ease. Permanent impairment is expressed as a percentage of the whole person. The impairment value
17 may not exceed 100 percent of the whole person.

18 (B) Impairment is established by a preponderance of medical evidence based upon objective
19 findings.

20 (C) The criterion for evaluation of work disability under ORS 656.214 is permanent impairment
21 as modified by the factors of age, education and adaptability to perform a given job.

22 (D) When, upon reconsideration of a notice of closure pursuant to ORS 656.268, it is found that
23 the worker's disability is not addressed by the standards adopted pursuant to this paragraph,
24 notwithstanding ORS 656.268, the director shall, in the order on reconsideration, determine the ex-
25 tent of permanent disability that addresses the worker's impairment.

26 (E) Notwithstanding any other provision of this section, only impairment benefits shall be
27 awarded under ORS 656.214 if the worker has been released to regular work by the attending phy-
28 sician [*or nurse practitioner authorized to provide compensable medical services under ORS 656.245*]
29 or has returned to regular work at the job held at the time of injury.

30 (g) Prescribe procedural rules for and conduct hearings, investigations and other proceedings
31 pursuant to ORS 654.001 to 654.295, 654.412 to 654.423, 654.750 to 654.780 and this chapter regarding
32 all matters other than those specifically allocated to the board or the Hearings Division.

33 (h) Participate fully in any proceeding before the Hearings Division, board or Court of Appeals
34 in which the director determines that the proceeding involves a matter that affects or could affect
35 the discharge of the director's duties of administration, regulation and enforcement of ORS 654.001
36 to 654.295, 654.412 to 654.423, 654.750 to 654.780 and this chapter.

37 (5)(a) The board may make and declare all rules which are reasonably required in the perform-
38 ance of its duties, including but not limited to rules of practice and procedure in connection with
39 hearing and review proceedings and exercising its authority under ORS 656.278. The board shall
40 adopt standards governing the format and timing of the evidence. The standards shall be uniformly
41 followed by all Administrative Law Judges and practitioners. The rules may provide for informal
42 prehearing conferences in order to expedite claim adjudication, amicably dispose of controversies,
43 if possible, narrow issues and simplify the method of proof at hearings. The rules shall specify who
44 may appear with parties at prehearing conferences and hearings.

45 (b) Notwithstanding any other provision of this chapter, the board may adopt rules to allow for

1 the electronic transmission of filings, reports, notices and other documents required to be filed under
2 the board's authority.

3 (6) The director and the board chairperson may incur such expenses as they respectively de-
4 termine are reasonably necessary to perform their authorized functions.

5 (7) The director, the board chairperson and the State Accident Insurance Fund Corporation shall
6 have the right, not subject to review, to contract for the exchange of, or payment for, such services
7 between them as will reduce the overall cost of administering this chapter.

8 (8) The director shall have lien and enforcement powers regarding assessments to be paid by
9 subject employers in the same manner and to the same extent as is provided for lien and enforce-
10 ment of collection of premiums and assessments by the corporation under ORS 656.552 to 656.566.

11 (9) The director shall have the same powers regarding inspection of books, records and payrolls
12 of employers as are granted the corporation under ORS 656.758. The director may disclose infor-
13 mation obtained from such inspections to the Director of the Department of Revenue to the extent
14 the Director of the Department of Revenue requires such information to determine that a person
15 complies with the revenue and tax laws of this state and to the Director of the Employment De-
16 partment to the extent the Director of the Employment Department requires such information to
17 determine that a person complies with ORS chapter 657.

18 (10) The director shall collect hours-worked data information in addition to total payroll for
19 workers engaged in various jobs in the construction industry classifications described in the job
20 classification portion of the Workers' Compensation and Employers Liability Manual and the Oregon
21 Special Rules Section published by the National Council on Compensation Insurance. The informa-
22 tion shall be collected in the form and format necessary for the National Council on Compensation
23 Insurance to analyze premium equity.

24 **SECTION 54.** ORS 656.797 is amended to read:

25 656.797. On or after October 1, 2004, **prior to providing compensable medical services or**
26 **authorizing temporary disability benefits**, a nurse practitioner licensed under ORS 678.375 to
27 678.390[*prior to providing compensable medical services or authorizing temporary disability benefits*
28 *under ORS 656.245,*] **or a similarly licensed nurse practitioner in any country or in any state,**
29 **territory or possession of the United States** must certify in a form acceptable to the Director
30 of the Department of Consumer and Business Services that the nurse practitioner has reviewed the
31 materials developed under ORS 656.795.

32 **SECTION 55.** ORS 659A.043 is amended to read:

33 659A.043. (1) A worker who has sustained a compensable injury shall be reinstated by the
34 worker's employer to the worker's former position of employment upon demand for such rein-
35 statement, if the position exists and is available and the worker is not disabled from performing the
36 duties of such position. A worker's former position is available even if that position has been filled
37 by a replacement while the injured worker was absent. If the former position is not available, the
38 worker shall be reinstated in any other existing position that is vacant and suitable. A certificate
39 by the attending physician, **as defined in ORS 656.005 (12)**, [*or a nurse practitioner authorized to*
40 *provide compensable medical services under ORS 656.245*] that the **attending** physician [*or nurse*
41 *practitioner*] approves the worker's return to the worker's regular employment or other suitable
42 employment shall be prima facie evidence that the worker is able to perform such duties.

43 (2) Such right of reemployment shall be subject to the provisions for seniority rights and other
44 employment restrictions contained in a valid collective bargaining agreement between the employer
45 and a representative of the employer's employees.

1 (3) Notwithstanding subsection (1) of this section:

2 (a) The right to reinstatement to the worker's former position under this section terminates
3 when whichever of the following events first occurs:

4 [(A) *A medical determination by the attending physician or, after an appeal of such determination*
5 *to a medical arbiter or panel of medical arbiters pursuant to ORS chapter 656, has been made that the*
6 *worker cannot return to the former position of employment.*]

7 **(A) The worker cannot return to the former position of employment according to:**

8 **(i) The medical determination of the attending physician; or**

9 **(ii) Upon appeal of the attending physician's determination, the determination of a med-**
10 **ical arbiter or panel of medical arbiters pursuant to ORS chapter 656.**

11 (B) The worker is eligible and participates in vocational assistance under ORS 656.340.

12 (C) The worker accepts suitable employment with another employer after becoming medically
13 stationary.

14 (D) The worker refuses a bona fide offer from the employer of light duty or modified employment
15 that is suitable prior to becoming medically stationary.

16 (E) Seven days elapse from the date that the worker is notified by the insurer or self-insured
17 employer by certified mail that the worker's attending physician [*or a nurse practitioner authorized*
18 *to provide compensable medical services under ORS 656.245*] has released the worker for employment
19 unless the worker requests reinstatement within that time period.

20 (F) Three years elapse from the date of injury.

21 (b) The right to reinstatement under this section does not apply to:

22 (A) A worker hired on a temporary basis as a replacement for an injured worker.

23 (B) A seasonal worker employed to perform less than six months' work in a calendar year.

24 (C) A worker whose employment at the time of injury resulted from referral from a hiring hall
25 operating pursuant to a collective bargaining agreement.

26 (D) A worker whose employer employs 20 or fewer workers at the time of the worker's injury
27 and at the time of the worker's demand for reinstatement.

28 (4) Notwithstanding ORS 659A.165, a worker who refuses an offer of employment under sub-
29 section (3)(a)(D) of this section and who otherwise is entitled to family leave under ORS 659A.150
30 to 659A.186:

31 (a) Automatically commences a period of family leave under ORS 659A.150 to 659A.186 upon
32 refusing the offer of employment; and

33 (b) Need not give additional written or oral notice to the employer that the employee is com-
34 mencing a period of family leave.

35 (5) Any violation of this section is an unlawful employment practice.

36 **SECTION 56.** ORS 659A.046 is amended to read:

37 659A.046. (1) A worker who has sustained a compensable injury and is disabled from performing
38 the duties of the worker's former regular employment shall, upon demand, be reemployed by the
39 worker's employer at employment which is available and suitable.

40 (2) A certificate of the worker's attending physician, **as defined in ORS 656.005 (12)**, [*or a nurse*
41 *practitioner authorized to provide compensable medical services under ORS 656.245*] that the worker
42 is able to perform described types of work shall be prima facie evidence of such ability.

43 (3) Notwithstanding subsection (1) of this section, the right to reemployment under this section
44 terminates when whichever of the following events first occurs:

45 [(a) *The worker cannot return to reemployment at any position with the employer either by deter-*

1 *mination of the attending physician or a nurse practitioner authorized to provide compensable medical*
2 *services under ORS 656.245 or upon appeal of that determination, by determination of a medical arbiter*
3 *or panel of medical arbiters pursuant to ORS chapter 656.]*

4 **(a) The worker cannot return to reemployment at any position with the employer ac-**
5 **cording to:**

6 **(A) The determination of the attending physician; or**

7 **(B) Upon appeal of the attending physician's determination, the determination of a med-**
8 **ical arbiter or panel of medical arbiters pursuant to ORS chapter 656.**

9 (b) The worker is eligible and participates in vocational assistance under ORS 656.340.

10 (c) The worker accepts suitable employment with another employer after becoming medically
11 stationary.

12 (d) The worker refuses a bona fide offer from the employer of light duty or modified employment
13 that is suitable prior to becoming medically stationary.

14 (e) Seven days elapse from the date that the worker is notified by the insurer or self-insured
15 employer by certified mail that the worker's attending physician [*or a nurse practitioner authorized*
16 *to provide compensable medical services under ORS 656.245*] has released the worker for reemploy-
17 ment unless the worker requests reemployment within that time period.

18 (f) Three years elapse from the date of injury.

19 (4) Such right of reemployment shall be subject to the provisions for seniority rights and other
20 employment restrictions contained in a valid collective bargaining agreement between the employer
21 and a representative of the employer's employees.

22 (5) Notwithstanding ORS 659A.165, a worker who refuses an offer of employment under sub-
23 section (3)(d) of this section and who otherwise is entitled to family leave under ORS 659A.150 to
24 659A.186:

25 (a) Automatically commences a period of family leave under ORS 659A.150 to 659A.186 upon
26 refusing the offer of employment; and

27 (b) Need not give additional written or oral notice to the employer that the employee is com-
28 mencing a period of family leave.

29 (6) Any violation of this section is an unlawful employment practice.

30 (7) This section applies only to employers who employ six or more persons.

31 **SECTION 57.** ORS 659A.049 is amended to read:

32 659A.049. The rights of reinstatement **and reemployment** afforded by ORS 659A.043 and
33 659A.046 shall not be forfeited if the worker refuses to return to the worker's regular or other of-
34 fered employment without release to such employment by the worker's attending physician **as de-**
35 **defined in ORS 656.005 (12)** [*or a nurse practitioner authorized to provide compensable medical services*
36 *under ORS 656.245*].

37 **SECTION 58.** ORS 659A.063 is amended to read:

38 659A.063. (1) The State of Oregon shall cause group health benefits to continue in effect with
39 respect to that worker and any covered dependents or family members by timely payment of the
40 premium that includes the contribution due from the state under the applicable benefit plan, subject
41 to any premium contribution due from the worker that the worker paid before the occurrence of the
42 injury or illness. If the premium increases or decreases, the State of Oregon and worker contribu-
43 tions shall be adjusted to remain consistent with similarly situated active employees. The State of
44 Oregon shall continue the worker's health benefits in effect until whichever of the following events
45 occurs first:

1 (a) The worker's attending physician **as defined in ORS 656.005 (12)** [*or a nurse practitioner*
2 *authorized to provide compensable medical services under ORS 656.245*] has determined the worker
3 to be medically stationary and a notice of closure has been entered;

4 (b) The worker returns to work for the State of Oregon, after a period of continued coverage
5 under this section, and satisfies any probationary or minimum work requirement to be eligible for
6 group health benefits;

7 (c) The worker takes full- or part-time employment with another employer that is comparable in
8 terms of the number of hours per week the worker was employed with the State of Oregon or the
9 worker retires;

10 (d) Twelve months have elapsed since the date the State of Oregon received notice that the
11 worker filed a workers' compensation claim pursuant to ORS chapter 656;

12 (e) The claim is denied and the claimant fails to appeal within the time provided by ORS 656.319
13 or the Workers' Compensation Board or a workers' compensation hearings referee or a court issues
14 an order finding the claim is not compensable;

15 (f) The worker does not pay the required premium or portion thereof in a timely manner in ac-
16 cordance with the terms and conditions under this section;

17 (g) The worker elects to discontinue coverage under this section and notifies the State of
18 Oregon in writing of this election;

19 (h) The worker's attending physician [*or a nurse practitioner authorized to provide compensable*
20 *medical services under ORS 656.245*] has released the worker to modified or regular work, the work
21 has been offered to the worker and the worker refuses to return to work; or

22 (i) The worker has been terminated from employment for reasons unrelated to the workers'
23 compensation claim.

24 (2) If the workers' compensation claim of a worker for whom health benefits are provided pur-
25 suant to subsection (1) of this section is denied and the worker does not appeal or the worker ap-
26 peals and does not prevail, the State of Oregon may recover from the worker the amount of the
27 premiums plus interest at the rate authorized by ORS 82.010. The State of Oregon may recover the
28 payments through a payroll deduction not to exceed 10 percent of gross pay for each pay period.

29 (3) The State of Oregon shall notify the worker of the provisions of ORS 659A.060 to 659A.069,
30 and of the remedies available for breaches of ORS 659A.060 to 659A.069, within a reasonable time
31 after the State of Oregon receives notice that the worker will be absent from work as a result of
32 an injury or illness for which a workers' compensation claim has been filed pursuant to ORS chapter
33 656. The notice from the State of Oregon shall include the terms and conditions of the continuation
34 of health benefits and what events will terminate the coverage.

35 (4) If the worker fails to make timely payment of any premium contribution owing, the State of
36 Oregon shall notify the worker of impending cancellation of the health benefits and provide the
37 worker with 30 days to pay the required premium prior to canceling the policy.

38 (5) It is an unlawful employment practice for the State of Oregon to discriminate against a
39 worker, as defined in ORS 659A.060, by terminating the worker's group health benefits while that
40 worker is absent from the place of employment as a result of an injury or illness for which a
41 workers' compensation claim has been filed pursuant to ORS chapter 656, except as provided for in
42 this section.

43 **SECTION 59.** ORS 657.170 is amended to read:

44 657.170. (1) If the Director of the Employment Department finds that during the base year of the
45 individual any individual has been incapable of work during the greater part of any calendar quar-

1 ter, such base year shall be extended a calendar quarter. Except as provided in subsection (2) of
2 this section, no such extension of an individual's base year shall exceed four calendar quarters.

3 (2) If the director finds that during and prior to the individual's base year the individual has
4 had a period of temporary total disability caused by illness or injury and has received compensation
5 under ORS chapter 656 for a period of temporary total disability during the greater part of any
6 calendar quarter, the individual's base year shall be extended as many calendar quarters as neces-
7 sary to establish a valid claim, up to a maximum of four calendar quarters prior to the quarter in
8 which the illness or injury occurred, if the individual:

9 (a) Files a claim for benefits not later than the fourth calendar week of unemployment following
10 whichever is the latest of the following dates:

11 (A) The date the individual is released to return to work by the attending physician[, *as defined*
12 *in ORS chapter 656, or a nurse practitioner authorized to provide compensable medical services under*
13 *ORS 656.245*] **as defined in ORS 656.005 (12)**; or

14 (B) The date of mailing of a notice of claim closure pursuant to ORS chapter 656; and

15 (b) Files such a claim within the three-year period immediately following the commencement of
16 such period of illness or injury.

17 (3) Notwithstanding the provisions of this section, benefits payable as a result of the use of
18 wages paid in a calendar quarter prior to the individual's current base year shall not exceed one-
19 third of such wages less benefits paid previously as a result of the use of such wages in computing
20 a previous benefit determination.

21
22 **CAPTIONS**

23
24 **SECTION 60. The unit captions used in this 2026 Act are provided only for the conven-**
25 **ience of the reader and do not become part of the statutory law of this state or express any**
26 **legislative intent in the enactment of this 2026 Act.**

27
28 **EFFECTIVE DATE**

29
30 **SECTION 61. This 2026 Act being necessary for the immediate preservation of the public**
31 **peace, health and safety, an emergency is declared to exist, and this 2026 Act takes effect**
32 **on its passage.**

AADB 2026 Mid-Year Meeting Program

Doubletree by Hilton O'Hare - Rosemont
5460 North River Road
Rosemont, Illinois 60018



Friday, April 24, 2026
General Session 1:00 pm - 5:30 pm
All times are Central Time

8:00 a.m. – 5:00 p.m.

Registration *Signature Foyer*

8:00 a.m. – 1:00 p.m.

AADB Attorney Round Table Meeting *Othello Room*
This closed session is for Attorneys who represent State/Territory Dental Boards, State Board Members, Investigators & Executive Directors.

General Session

Signature Ballroom

1:00 p.m. – 1:30 p.m.

AADB President's Opening Remarks
Clifford Feingold, DDS, *AADB President*

1:30 p.m. – 1:35 p.m.

Executive Director's Welcome & Report
Kimber Cobb, RDH, *Executive Director*

1:35 p.m. – 2:15 p.m.

TBD

2:15 p.m. – 3:15 p.m.

AADB State Dental Board Forum: State/Jurisdictions Board Issues
Bobby J. Carmen, DDS, MAGD, *AADB Vice President and Moderator*

3:15 p.m. – 3:30 p.m.

Exhibits & Networking Break *Signature Foyer*

3:30 p.m. – 4:30 p.m.

CE Session

4:30 p.m. – 5:30 p.m.

CE Session

6:30 p.m.

Presidential Reception *Mezzanine Foyer*
Please join President Clifford Feingold, DDS, the AADB Board of Directors, AADB team, and invited speakers for light hors d'oeuvres and drinks in the Mezzanine Foyer.

From: [Amelia](#)
Subject: Save the Date - CRDTS Annual Meeting!
Date: Tuesday, December 2, 2025 12:56:43 PM
Attachments: [image001.png](#)



Amelia Hursey

CAMP Coordinator & Office Administration
Central Regional Dental Testing Service, Inc.
1725 SW Gage Blvd|Topeka, KS|66604
[785.273.0380](tel:785.273.0380) | amelia@crdts.org www.crdts.org

[Follow us on Instagram](#)

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UNFINISHED
BUSINESS
&
RULES



Oregon

Tina Kotek, Governor

Oregon State Police

Headquarters

3565 Trelstad Ave SE

Salem, Oregon 97317

503-378-3720

503-378-8282 Fax

503-585-1452 TTY

February 11, 2026

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

Re: Oregon Health Licensing Office and Boards authority to perform fingerprint-based criminal records checks under ORS 676.303 and 676.612.

Dear Director Prisby,

On January 13, 2026, the Oregon State Police Criminal Justice Information Services Division was notified that several Oregon statutes authorizing for fingerprint-based background checks, including ORS 181A.195, do not meet the requirements under Pub. L. 92-544. After reviewing all previously approved and submitted Oregon statutes we have determined that the ORS(s) for your agency, ORS 676.303 and ORS 676.612, require an amendment to be considered compliant with the FBI criteria for compliance with Pub. L. 92-544.

Under the guidance received from the FBI Office of General Counsel (OGC) Criminal Justice Information Law Unit (CJILU), ORS 676.303 and ORS 676.612 contain language that indicates that fingerprinting for a national criminal history check is discretionary, as opposed to compulsory.

ORS 676.303 section (3) reads, *"For the purpose of requesting a state or nationwide criminal records check under ORS 181A.195, a health professional regulatory board **may** require the fingerprints of a licensee seeking renewal of a license, an applicant for a license, a board employee or volunteer or an applicant for employment with the board."*

ORS 676.612 section (3) reads, *"For the purpose of requesting a state or nationwide criminal records check under ORS 181A.195, the office **may** require the fingerprints of a person who is: (a) Applying for an authorization; (b) Applying for renewal of an authorization; or (c) Under investigation by the office."*

Under Pub. L. 92-544 criteria, statutes authorizing for fingerprint-based background checks must require that the subject individual submit fingerprints and that those fingerprints are forwarded to the FBI. Language that indicates an agency "may" request fingerprints as opposed to language stating that the agency "shall" require fingerprints does not meet the compulsory standard set by the FBI.

The FBI has come to this decision after conducting a comprehensive review of its processes and standards to improve efficiency, compliance, consistency, and reduce processing times. During the review the OGC observed that its guidance concerning the acceptance of discretionary language may have been overbroadly applied, as well as contrary to US DOJ guidance.

The OGC has granted a grace period to Oregon to allow for statutory amendments until **January 1, 2031**. During this grace period, previously approved statutes will continue to be authorized to submit fingerprints for a nationwide criminal history check for the subject individual categories that exist in the current statute as approved. New statutes, or amendments to currently approved statutes, must include compulsory language to gain approval. This means that if your agency decides to create a new category of subject individuals in your pre-approved statute, those individuals will not be able to have a national criminal history records check unless the statute was also amended to include compulsory language.

Oregon State Police will be working to amend ORS 181A.195 to meet the criteria for approval under Pub. L. 92-544.

For your reference the guidance for statutes to meet the criteria of Pub. L. 92-544 is as follows:

- a. The statute must exist as a result of a legislative enactment
- b. It must require the fingerprinting of applicants who are subject to a national criminal history background check
- c. It must, expressly (“submit to the FBI”) or by implication (“submit for a national check”). Authorize the use of FBI records for the screening of applicants
- d. It must identify the specific category(ies) of licensees/employees falling within its purview, thereby avoiding overbreadth
- e. It must not be against public policy
- f. It may not authorize the receipt of the CHRI by a private party

“Subject individuals” may not be determined by a, agency, commission, or committee outside of statute. Statutes may not reference that “subject individuals” are defined by rule, by commission, by committee, or by commissioner.

For licenses, certifications, or permits, the license, certification, or permit must be defined in a statute. If the licensing statute is separate from the statute authorizing a fingerprint-based background check, the licensing statute must be referenced in the authorizing statute and submitted to the FBI for review.

We believe that the amendment needed to bring these statutes back into compliance with Pub. L. 92-544 is to update the sections of the statute that contain “may” when outlining the requirements for fingerprinting for the purpose of a state or national background check, to “shall”. Further the CJILU

letter also outlines that 676.303 does not meet criteria "d" above. Specifically, 676.303(3) contains the language "...of a licensee seeking renewal of a license, an applicant for a license, a board employee or volunteer or an applicant for employment with the board." CJILU objects to the overly broad language in respect to licenses issued by the board. OSP CJIS believes that if the license type is defined in a statute, no further amendment is needed to this statute to meet the criteria. The boards, and the Health Licensing office would be responsible for identifying the specific statute which contains the license type so that OSP CJIS can forward those statutes to CJILU for review and approval.

We have also notified the Oregon Health Authority Health Licensing Office of the amendments required in ORS 676.303 and 676.612. We recommend that amendments to these statutes be done in collaboration with all interested parties.

Sincerely,



Wendy Landers, Deputy Director of Core Services,
Oregon State Police, CJIS Division
503-910-7239

Wendy.landiers@osp.oregon.gov

cc: Haley Robinson, CJIS Representative

CORRESPONDENCE

From: [Stephen Prisby](#)
To: [ROBINSON Haley * OBD](#)
Subject: ADEX supports State Dental Boards
Date: Thursday, February 12, 2026 6:20:31 AM
Attachments: [image002.png](#)

Haley,

I wanted to reach out to reach out and to let you know that I'm always happy to be a resource for you and your board. In my current role as Regulatory and Educational Affairs Director, I work closely with state boards to support open communication, regulator-informed decision-making and examination processes that are responsive to board needs.

As you may know, the American Board of Dental Examiners (ADEX) recently completed the organizational merger of CDCA-WREB-CITA and ADEX. The unified organization now operates solely as the American Board of Dental Examiners, bringing national licensure exam development and administration, examiner calibration, candidate services, and state board support together within a single, streamlined structure.

Having been in your seat, I understand the scope of the work and how much more demanding it can be - especially when the legislature is in session. That experience gives me a strong appreciation for the responsibilities boards carry and for the relationships that support consumer protection, effective regulation and high standards of care. I also had the opportunity to work closely with many state dental board executive directors through my service with the American Association of Dental Administrators, including as a past president.

I welcome opportunities to engage with your board and stakeholders on examination standards, governance, and broader licensure considerations. Please don't hesitate to reach out if a conversation would be helpful. I would also be happy to attend a future board meeting if you feel that would be helpful and useful for your board.

Most Sincerely,
Stephen

Stephen Prisby | Regulatory and Educational Affairs Director



Direct: 503-810-5992 (call or text)
Email: spisby@adextesting.org





AMERICAN BOARD of DENTAL EXAMINERS

American Board of Dental Examiners (ADEX)

Report of the ADEX Licensure Examinations

Date: February 5, 2026

Prepared by: American Board of Dental Examiners (ADEX)

Prepared for: Oregon Board of Dentistry

1. Executive Summary

The American Board of Dental Examiners (ADEX) is pleased to announce the successful completion of the organizational merger between CDCA-WREB-CITA and ADEX. The unified organization now operates exclusively as the American Board of Dental Examiners (ADEX), further linking national licensure exam development and administration, examiner calibration, candidate services, and state board support within a single, streamlined structure.

This combination strengthens ADEX’s capacity to deliver a consistent, nationally recognized standard for psychomotor licensure examinations in dentistry, dental hygiene, and dental therapy. It also expands and formalizes state dental board representation in the licensure process. Each ADEX member state and jurisdiction is now eligible to appoint both a dentist and a dental hygienist to the **ADEX Council on Examinations**, reinforcing a licensure framework that is board-driven, evidence-based, and focused on public protection.

ADEX and the **American Dental Association (ADA)** have recently engaged in conversations that reflect a shared commitment to ensure that dental licensure assessments continue to evolve alongside advancements in clinical education, technology, and patient care. Through this collaboration, the ADEX and the ADA aim to identify opportunities for alignment in examination content, evaluation methods, and candidate experience—ultimately strengthening the process by which new dentists demonstrate their readiness for practice.

“By working together, we are advancing our mutual goal of ensuring every licensed dentist enters the profession with proven competence and the highest standards of patient safety,” said Dr. Richard Rosato, President, ADA.

ADEX Chair Dr. Mark Armstrong adds, “Our dialogue with the ADA highlights our commitment to a modern, equitable licensure standard—grounded in rigorous clinical hand skills assessment and reflective of today’s dental practice.”

We anticipate continued engagement over the coming months as both organizations explore best practices and potential innovations to further the dental licensure examination standards nationwide.

2. Strengthening Direct Engagement with State Dental Boards

ADEX is deepening direct engagement with state dental boards as licensure standards and regulatory expectations evolve. To advance this work, ADEX has strengthened its leadership resources with the addition of **Stephen Prisby as Regulatory and Educational Affairs Director**, bringing significant prior state dental board executive experience to enhance regulator-informed support.

ADEX will continue targeted outreach focused on open dialogue, collaboration, and alignment. We remain committed to providing high-quality examinations, transparent communication, and data-driven licensure resources, while working closely with state boards to ensure licensure pathways protect the public and support the profession.

3. National Candidate Activity and Exam Utilization

ADEX is proud to support the licensure needs of dental boards and commissions across 50+ U.S. states and jurisdictions. In 2025, ADEX offered more than 570 examination dates at 312 testing locations, serving over 466 individual dental education programs nationwide.

ADEX Examinations Utilized Nationally:

ADEX Dental Licensure Examination
ADEX Dental Hygiene Licensure Examination
Dental Therapy Clinical Examination
Local Anesthesia Examination for Dental Hygienists
Dental Assisting (where applicable)

2025 Statistical Report

All Candidates Tested

Dental	13,859
Dental Hygiene	7,209
Local Anesthesia (+DA)	2,934
DH Restorative	183
Auxiliary	73
Dental Therapy	47
Nitrous Oxide	607

**Dental Exam Pass Rate
(2025 Grads only)**

	# Cands	First Attempt	End of Yr
DSE OSCE	6,694	99.48%	99.91%
Endodontics	6,750	77.10%	99.29%
Prosthodontics	6,752	87.81%	99.50%
Periodontics	6,738	99.23%	99.99%
Anterior Rest.	6,725	93.77%	99.69%
Posterior Rest.	6,726	88.91%	99.49%

**Dental Hygiene Exam Pass Rate
(2025 Grads only)**

	# Cands	First Attempt	End of Yr
CSCE OSCE	5,330	99.47%	99.77%
DH Clinical Exam, SPTCE	5,470	95.76%	99.63%

4. Licensing and Examination Updates

National Score Database:

ADEX provides state dental boards with secure access to candidate performance data for all ADEX and legacy CDCA, WREB, CITA and NERB exams.

The National Standard in Examination Acceptance & Portability:

ADEX represents the most widely accepted licensure examination pathway nationwide, serving 98% of dental candidates and approximately 85% of dental hygiene candidates.

5. Organizational Highlights and Strategic Initiatives

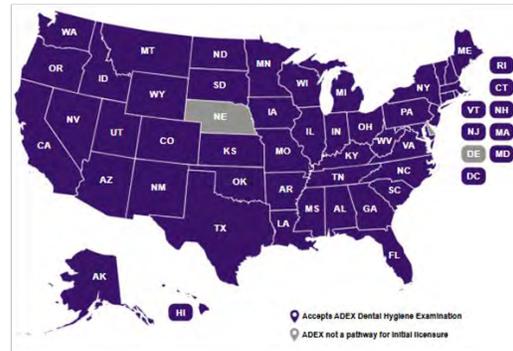
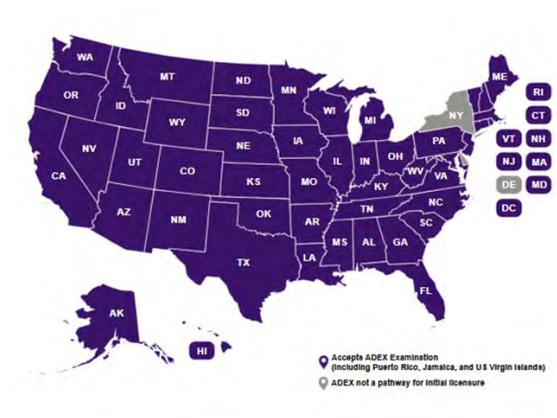
- ADEX debuted its Dental Testing System 2.0 (DTS) technology, further streamlining examination delivery and communication processes.
- The American Board of Dental Examiners administered the first-ever ADEX Dental examination at King Abdulaziz University (KAU) in Jeddah, Saudi Arabia in January 2026. KAU is the first CODA-approved program in the eastern hemisphere.

6. Licensure Compact Monitoring

ADEX continues to monitor and participate in discussions regarding oral health compacts and national mobility initiatives.

7. Upcoming Priorities

- ADEX will provide ongoing support for boards in all 51 jurisdictions where its examinations are accepted.



- Materials regarding examining with the American Board of Dental Examiners and serving on the Council on Examinations are currently in production and will be shared with boards in the coming weeks.
- The 3rd Annual Dental Testing and Regulatory Summit will take place October 14-18, 2026, at the Gaylord National Harbor just outside of Washington, DC. The Summit includes the Annual Meetings for the American Board of Dental Examiners, the American Association of Dental Administrators and the American Association of Dental Boards. Additional details about the Summit will be shared in the coming months.

For questions or additional information, please contact:

Stephen Prisby
 Regulatory and Education Affairs Director
sprisby@adextesting.org

Stephanie Beeler
 Director of Communications, Board Affairs & Events
sbeeler@adextesting.org

Alex Vandiver
 Chief Executive Officer
avandiver@adextesting.org

Please see the announcement below and forward to clinicians (and any others involved in clinical care) who may be interested. Thank you!

The Oregon Health Authority (OHA) Medicaid Medical Directors warmly invite you to the OHP Clinical Connections series. Designed specifically for clinicians, such as chief medical officers, dental directors, behavioral health clinical directors, nurse practitioners, oral health clinicians, doctors, and physician assistants, this new quarterly series will serve as a platform to:

- Engage in dialogue with us about Oregon Health Plan (OHP) program updates.
- Share your questions, concerns and insights about OHP coverage and service delivery.
- Provide feedback on how changes to OHP may affect your work and the OHP members you serve.
- Support inclusive planning of future changes to OHP.

Upcoming sessions will be from 1:05 to 2 p.m. Pacific Time on these dates:

- December 16, 2025
- March 16, 2026
- June 16, 2026
- September 15, 2026
- December 15, 2026

Please click here to [register for the 2025–2026 series via Zoom](#)

If you are unable to attend, please encourage someone from your organization to attend on your behalf.

Agenda highlights for the December 16, 2025 session include:

- Your questions, answered
- Recent Medicaid policy updates
 - Medicaid provider enrollment modernization
 - [Ensuring Oregon Health Plan coverage of medical-grade formula](#)
 - Standing order for OHP coverage of over-the-counter oral contraception and emergency contraception
 - Veteran dental program intake screening
 - [Lane County CCO transition](#)
- Open Q&A and discussion

We also want to learn the best ways to connect and share information with you throughout the year.

Please make accommodation requests related to disability or requests for language interpreter services by December 8, 2025, to Dan Cox at Dan.Cox@oha.oregon.gov or

503-979-8594 (voice and text). We will make every effort to accommodate requests received after December 8, 2025. We accept all relay calls.

If you have questions about the webinar, please contact Dan Cox at Dan.Cox@oha.oregon.gov or 503-979-8594 (voice and text).

Thank you for your commitment to improving health for Oregonians. We look forward to connecting.

----Respectfully,

The Medicaid Medical Leadership Team:

Dr. Ahmed Farag, Oral Health and Dental Director

Dr. Dawn Mautner, Medicaid Medical Director

Dr. Meg Cary, Behavioral Health Medical Director

From: [Bradley Guye](#)
To: [ROBINSON Haley * OBD](#)
Subject: Request to Present at Board Meeting
Date: Friday, February 13, 2026 2:05:53 PM

You don't often get email from bguye@ebas.org. [Learn why this is important](#)

Haley,

I am reaching out to explore the possibility of providing a brief, in-person educational presentation to the Oregon Dental Board during an upcoming meeting. The presentation is designed to be informational and practical, focusing on how other medical boards are incorporating ethics assessment and education into their regulatory frameworks, along with outcomes and lessons learned.

Ethics Boundaries Assessment Services (EBAS), an ethics-focused assessment and education program used by healthcare boards and regulators across the United States. EBAS is currently utilized by multiple medical boards and more than 150 healthcare regulatory boards nationwide as an objective tool to assess ethical reasoning, professionalism, and boundary decision-making in regulated practice. Boards most often leverage EBAS as part of disciplinary remediation, licensure conditions, or proactive education efforts.

Respectfully,
Bradley

Bradley Guye
Business Development Manager
Ethics Boundaries Assessment Services

What Is EBAS?

EBAS is a scenario-based ethics assessment tool developed to help regulatory boards make informed, confident decisions after a licensee violation.

Unlike traditional multiple-choice ethics exams, EBAS presents real-world, open-ended case scenarios that assess how a licensee critically thinks through complex ethical dilemmas. There is never a cost for the board to receive results or refer their licensees, and results are typically sent to licensees and the referring board within 5-7 business days.

With any questions about EBAS assessments or inquiries about partnership, please **reach out to us online** or email Bradley Guye at BGuye@ebas.org. Thank you!

About Our Evidence-Backed assessments

EBAS has five unique categories of assessment areas: Fraud, Boundaries, Substance, Unprofessional Conduct, and Professional Standards.

Your licensee is required to provide essay-based answers that are specific to four unique sections: Introduction, Consequences, Solutions, and Public Protection. We assess not only the individual's ethical decision-making as it relates to their own actions, but also how those decisions impact secondary stakeholders, including patients, colleagues, and the broader community.

Each assessment costs \$400 per scenario and is paid directly by the licensee.

How EBAS Empowers Regulatory Boards

Boards appreciate EBAS because it provides:

- Objective, third-party evaluation
- Detailed scoring rubrics tied to professional judgment, risk assessment, and ethics
- Clear documentation to support board decisions and case closure
- Flexibility to customize scenarios to a specific profession or type of violation

EBAS assessments are designed to help boards:

- Evaluate a licensee's insight into a violation
- Understand their reasoning and recognition of consequences
- Determine their readiness for continued or reinstated practice

EBAS is used by regulatory boards across professions as part of:

- Consent Orders
- Remediation Strategies
- Reinstatement Requirements
- Monitoring Agreements
- Disciplinary Orders



Boards frequently assign the EBAS assessment to licensees who have violated ethical or professional boundaries. It becomes a **key component of a corrective action plan**, helping boards assess not only whether the licensee acknowledges the infraction, but also whether they've gained the ethical insight needed to avoid future violations.

Assessment Logistics

On the day of the EBAS assessment, the licensee will arrive at a secure, proctored Prometric testing center. They must bring a valid, government-issued photo ID that matches the name used during registration. They should arrive at least 30 minutes early to allow time for check-in and security procedures.

The assessment will be administered in a quiet, monitored environment and must be completed within 60 minutes. The licensee will be presented with a real-world ethical scenario that is related to their violation and asked to provide written responses that demonstrate their reasoning, boundary recognition, and professional judgment.

Once complete, their responses will be submitted for review and scored by trained assessors, then sent to both the licensee and their regulatory board within 5-7 business days.

Interested in Partnership?

EBAS provides an efficient, objective foundation for your organization to make sound decisions. If you'd like to take the next step, [reach out online](#) or email Bradley Guye at BGuye@ebas.org

Thank you!





Setting the Standard in Professional Ethics

EBAS delivers evidence-based insight into an examinee's ethical reasoning, decision making and critical thinking so your board can make confident, informed decisions about your licensee's path back to licensure.

Our rigorous assessments ask professionals to navigate real, complex moral dilemmas, revealing how they think critically and solve nuanced problems.

Whether you're a leader in healthcare, law, financial services, or beyond, we'll help you make disciplinary decisions with confidence, build public trust in your profession, and chart a course to industry-wide growth.

FAQ

Our Evidence-Backed Approach, Explained

› **How does the EBAS assessment process work?**

The board will select which EBAS assessment domains are required for their examinee. The examinee then registers for the assessment at ebas.org.

The assessment is conducted at proctored testing centers nationwide. Examinees have 60 minutes to complete the assessment, and results are sent to the board and the examinee within 7-10 business days. The examinee is responsible for the assessment cost.

› **Can we customize the assessment to a specific profession or violation?**

Yes. EBAS scenarios can be tailored to professions and violations, ensuring that each examinee is evaluated on situations relevant to their own conduct and scope of practice. The strength of EBAS lies in how it measures an examinee's ability to apply critical thinking and sound judgment to scenarios that mirror the types of violations they've faced in a professional setting.

› **What happens if an examinee fails the EBAS assessment?**

A failing score indicates that an examinee doesn't fully understand a violation, its consequences, and how to work toward a solution. If a test-taker fails, they have the option to redo the assessment one time within a three-month window to demonstrate adequate improvement in their ethical reasoning abilities.

› **How do examinees prepare for the EBAS assessment? Is there a study guide?**

While we don't provide a detailed study guide, as that would interfere with the validity of the assessment, we encourage examinees to review the example scenarios and assessment prompts posted on our website. This will give them an idea of the types of critical thinking we'll be assessing in our exam.



› **How is the EBAS assessment graded? By Whom? How do you ensure objectivity and fairness in the grading process?**

Multiple graders with regulatory experience thoroughly review each EBAS exam and quantify how well the examinees' responses adhere to the scoring rubric.

› **How often do scenarios get evaluated and updated?**

Continuously. EBAS is committed to staying in stride with ethical best practices across all sectors, and our exams evolve to fulfill that commitment.

› **How does EBAS ensure that the assessment accurately measures an examinee's moral and ethical compass?**

The EBAS assessment is designed to go beyond basic ethics questions and scenarios, instead evaluating how the examinee thinks through real-world ethical challenges. The assessment presents realistic scenarios where the correct answer isn't obvious, mirroring the daily challenges examinees face. Each assessment is graded by trained evaluators using a structured rubric to quantify boundary recognition, professional judgment, and ethical reasoning.

› **Does the EBAS assessment accurately measure recidivism?**

The EBAS assessment is not designed to measure recidivism. However, it plays a vital role in helping boards understand a professional's grasp of ethical reasoning. EBAS evaluates whether an examinee can recognize violations, understand their consequences, and articulate corrective solutions.

EBAS strengthens your board's ability to make informed, defensible decisions.

› **How many EBAS assessments do you recommend examinees take?**

We recommend administering at least three EBAS assessments during the examinee's monitoring or remediation period. However, we've seen strong benefits when boards choose to implement four or more assessments.

Assigning more EBAS assessments provides a clearer, more consistent picture of an examinee's ethical decision-making patterns and a more accurate baseline of their ethical and moral compass. By conducting multiple assessments, the board gains a more reliable understanding of how the examinee comprehends ethical principles and applies them.

Take the Guesswork Out of Ethics with EBAS

EBAS empowers regulatory boards to make confident, defensible decisions by providing clear insight into how professionals approach real-world ethical challenges. **Ready to elevate your board's ethical oversight?** Email us at admin@ebas.org or [reach out to us online](#).

Thank you!





Taking an EBAS Assessment? **Here's What to Expect**

BACKGROUND

The Ethics Boundaries Assessment Services (EBAS) exam is a specialized tool that evaluates your ethical reasoning and understanding of professional boundaries after a disciplinary action or ethics-related concern.

It was designed in collaboration with experts to help licensing boards and regulatory agencies as part of remediation, reinstatement, or disciplinary resolution processes, and to allow professionals to demonstrate their ethical reasoning abilities in an objective setting.

Our team has compiled the below information and attached documents so your assessment can go as smoothly as possible. With any questions, please reach out to admin@ebas.org, and we'll get back to you shortly. Thank you!

SCHEDULING YOUR ASSESSMENT

To get started with your EBAS assessments, follow these steps:

- 1 Go to ebas.org
- 2 Click Login on the top menu
- 3 Click "Click Here" to create an account (below the password)
- 4 Make sure to select your corresponding regulatory board
- 5 Select the specific assessments you are required to take
- 6 Pay for the assessments
- 7 Receive an eligibility ID (usually within 24 hours) to register for the exam through ProMetric on their website

ASSESSMENT DETAILS

Key Information

- **EBAS assessments are open-ended and essay-based.**
- **You will be given 60 minutes to complete each assessment.**
- **Your assessment will be taken at a Prometric testing center in your community.**

How to Prepare

Because EBAS assessments are designed to evaluate how you think rather than what you know, there is no set study guide. However, we recommend that licensees review [this sample assessment](#) to familiarize themselves with the format.



After Your Assessment

Your completed assessment will be reviewed, and results will be sent directly to the referring licensing board or regulatory body within 5-7 business days. If you have questions regarding your results, you must follow up with that organization directly.

We appreciate your cooperation and professionalism as you complete this important assessment!



Sample Scenario

A physician engaged in a personal relationship with a patient. During the course of the personal relationship, the physician prescribed Ativan, Tylenol III, Lorazepam, and, Vicodin medications. The physician wrote a prescription order to the patient for Ativan on a prescription order form from one of the medical offices which had been closed for some time. The physician did not record or maintain a patient record of his evaluation and treatment of this patient, nor chart prescription orders prescribed to this patient.

EXAMINEE INSTRUCTIONS

Compose an essay response for the case scenario below. The essay response is divided into four components: introductory opinion statements, consequences, public protection, and solutions. One hour is allotted for completion. While grammar, punctuation, and spelling are considered, the content and expression of your response carry more weight in scoring.

Introductory Opinion Statements

Present statements about the ethical issues and concerns involved in the given scenario. Additionally, identify when and how the licensee in the scenario disregarded professional conduct standards.

Consequences

Discuss the consequences that could arise from the scenario to all direct and indirect parties.

Public Protection

Explain how and why the actions of the licensee in the scenario compromise community safety and welfare.

Solutions

Identify the actions needed to resolve the ethical violation(s) described in the scenario and include what could prevent such violation(s) from occurring in the future.

Rubric

Intro opinion statements

Consequences

Public protection

Solutions

Outstanding

SCORE: 4

- comprehensively identifies and summarizes the ethical issues
- comprehensively explains when and how the ethical issues are problematic or questionable
- identifies embedded or implicit issues, addressing their relationships to each other

- comprehensively identifies short-term, long-term, tangible, and intangible consequences of the ethical violation(s), including those implicit in the assumptions and implications of positions and arguments
- identifies all directly involved parties
- comprehensively identifies indirectly involved parties

- provides comprehensive explanation on how and why the ethical violation(s) compromise community safety and welfare

- comprehensively explains how, why, and which main methods are needed to resolve and prevent the ethical violation(s)
- describes potential alternative methods of working on the problem(s)

Sufficient to pass

SCORE: 3

- identifies and summarizes the main ethical issues
- explains when and how the ethical issues are problematic or questionable

- identifies the main short-term, long-term, tangible, and intangible consequences of the ethical violation(s)
- identifies all directly involved parties
- identifies the majority of indirectly involved parties

- explains how and why the ethical violation(s) compromise community safety and welfare

- explains how, why, and which methods are most relevant for resolving and preventing the ethical violation(s)

Insufficient to pass

SCORE: 2

- identifies the main ethical issues
- fails to summarize or adequately explain when and how the ethical issues are problematic or questionable

- fails to adequately identify the main short-term, long-term, tangible, and intangible consequences of the ethical violation(s)
- identifies all directly involved parties
- fails to adequately identify indirectly involved parties.

- provides an incomplete explanation on how and why the ethical violation(s) compromise community safety and welfare

- incompletely explains how, why, and which methods are most relevant for resolving and preventing the ethical violation(s)

Extremely insufficient

SCORE: 1

- fails to identify, summarize, and explain any of the ethical issues

- fails to identify any of the short-term, long-term, tangible, and intangible consequences of the ethical violation(s)
- fails to identify all directly involved parties
- fails to identify any of the indirectly involved parties

- fails to provide any explanation on how and why the ethical violation(s) compromise community safety and welfare

- fails to provide any explanation on how, why, and which methods are most relevant for resolving and preventing the ethical violation(s)



The Science Behind EBAS

How Our Ethics Assessment Gives Boards a Strong, Objective Foundation for Decision-Making

The Ethics and Boundaries Assessment (EBAS) is designed to measure how well professionals understand and respond to ethical challenges.

It covers five key areas: Boundaries, Fraud, Professional Standards, Substance Abuse, and Unprofessional Conduct. In this study, over 100 participants completed the full assessment, and each response was scored by multiple trained graders. Overall, the scores were solid as most responses were relevant and thoughtful, showing that the tool can capture a range of ethical thinking and judgment.

100

Participants

562

Total Evaluations

KEY FINDINGS

- > **Excellent Validity and Reliability**
- > **Strong Structure**
- > **Appropriate Dimensionality**

Generating Detailed Insights

EBAS uses several research methods to confirm the strength of its design. Together, they show the assessment delivers both detailed category-level insights and a reliable overall picture of ethical awareness.

CONFIRMATORY FACTOR ANALYSIS

A confirmatory factor analysis tested whether the five domains stand independently while still forming one larger picture of ethical awareness. Results confirmed both: the test provides clarity within each domain and also captures an overall measure of ethical mindset.

RELIABILITY ACROSS DOMAINS

Each domain showed high internal consistency, meaning items within a domain measure the same skill without redundancy. The domains are related yet distinct, striking the right balance of overlap and separation so EBAS captures different dimensions of ethics without repetition.

ITEM RESPONSE THEORY

A modern scoring method, item response theory, showed the assessment distinguishes performance across a wide range, from early understanding to advanced reasoning.

Thoughtfully Structured

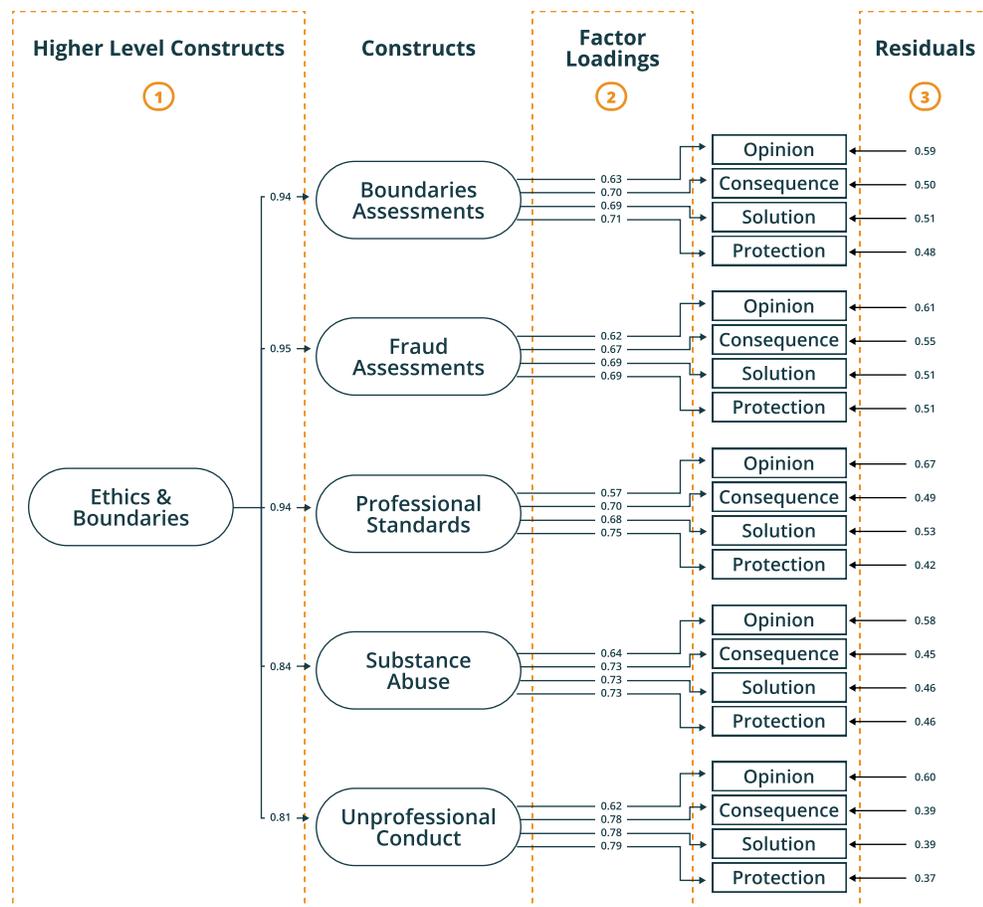
The EBAS structure is multi-dimensional and unified. Scores can highlight where someone excels or struggles, while an overall score captures their broader ethical approach. This flexibility serves many contexts, from screening to post-violation evaluation.

RECOMMENDED NUMBER OF ASSESSMENTS

Research shows EBAS yields the clearest insights when examinees complete at least three assessments during monitoring or remediation. Boards that assign four or more often see stronger results because patterns become clearer and single outliers matter less. Multiple data points create a more consistent picture of ethical reasoning and a more reliable baseline for decisions.

The Evidence-Backed Power of EBAS: A Visual Breakdown

FACTOR ANALYSIS: PROVING EBAS'S FIVE DISTINCT DOMAINS



1

All five domains connect to one overall picture of ethical awareness.

2

Numbers above 0.6 indicate strong reliability within each domain.

3

Lower numbers indicate minimal noise and bias across unrelated categories.



WHAT THIS MEANS

The factor analysis confirms EBAS measures five distinct ethical domains with strong reliability. Each domain stands on its own while also connecting to a broader picture of ethical awareness. Minimal residuals indicate the assessment avoids bias and redundancy, producing dependable, balanced results.

MULTITRAIT-MULTIMETHOD MATRIX (MTMMM): CONFIRMING CONSISTENCY, VALIDITY, RELIABILITY, AND FAIRNESS

	Boundaries Assessments				Fraud Assessments				Professional Standards				Substance Abuse				Unprofessional Conduct				
	O	C	S	P	O	C	S	P	O	C	S	P	O	C	S	P	O	C	S	P	
BA	Opinion	(0.79)																			
	Consequence	0.47	(0.78)																		
	Solution	0.37	0.50	(0.8)																	
	Protection	0.42	0.46	0.56	(0.81)																
FA	Opinion	0.45	0.33	0.37	0.44	(0.84)															
	Consequence	0.40	0.51	0.40	0.39	0.36	(0.81)														
	Solution	0.44	0.39	0.47	0.43	0.48	0.48	(0.84)													
	Protection	0.44	0.43	0.45	0.56	0.43	0.45	0.49	(0.87)												
PS	Opinion	0.42	0.34	0.30	0.39	0.44	0.34	0.41	0.35	(0.81)											
	Consequence	0.39	0.52	0.43	0.41	0.32	0.55	0.41	0.45	0.94	(0.81)										
	Solution	0.39	0.46	0.44	0.42	0.42	0.41	0.44	0.42	0.94	0.94	(0.82)									
	Protection	0.41	0.45	0.42	0.54	0.46	0.49	0.51	0.54	0.94	0.94	0.94	(0.86)								
SA	Opinion	0.36	0.31	0.32	0.26	0.35	0.28	0.28	0.30	0.34	0.31	0.31	0.31	(0.82)							
	Consequence	0.33	0.42	0.36	0.34	0.32	0.40	0.32	0.33	0.33	0.42	0.35	0.42	0.54	(0.83)						
	Solution	0.29	0.34	0.46	0.32	0.33	0.34	0.37	0.31	0.31	0.32	0.37	0.35	0.55	0.62	(0.82)					
	Protection	0.32	0.39	0.40	0.42	0.32	0.36	0.35	0.37	0.31	0.36	0.35	0.51	0.54	0.58	0.58	(0.82)				
UC	Opinion	0.32	0.24	0.27	0.19	0.27	0.24	0.22	0.24	0.26	0.21	0.23	0.23	0.48	0.40	0.47	0.41	(0.81)			
	Consequence	0.38	0.40	0.42	0.35	0.32	0.45	0.35	0.34	0.31	0.45	0.36	0.42	0.48	0.57	0.55	0.50	0.59	(0.84)		
	Solution	0.32	0.35	0.45	0.33	0.28	0.31	0.30	0.31	0.28	0.34	0.38	0.35	0.47	0.50	0.63	0.50	0.62	0.68	(0.87)	
	Protection	0.37	0.39	0.42	0.39	0.29	0.33	0.32	0.39	0.31	0.36	0.37	0.45	0.47	0.52	0.57	0.57	0.62	0.66	0.70	(0.86)



WHAT THIS MEANS

The MTMMM is a psychometric method that checks whether an assessment measures what it claims. For EBAS, the matrix shows:

- **Consistency:** Responses within each domain line up reliably.
- **Validity:** The five domains remain distinct, not blurred together.
- **Reliability:** Patterns hold steady across method variants.
- **Fairness:** Minimal overlap between unrelated categories reduces bias.

Together, these results confirm EBAS produces trustworthy, repeatable outcomes across professions.

The Bottom Line

EBAS is a trustworthy, research-backed tool that delivers a clear view of ethical decision-making across five key areas.

It is reliable, well structured, and grounded in solid data. For professional regulation, HR, and healthcare administration, it offers a defensible way to measure and support decisions about ethical behavior.



OTHER ISSUES



RECEIVED

JAN 13 2026

Oregon Board
of Dentistry

Dear Wellbeing First Champion,

Congratulations again for being recognized as a 2025 Wellbeing First Champion! This remarkable achievement means your organization is committed to supporting access to mental health care for your workforce.

The ALL IN: Wellbeing First for Healthcare coalition, which is led by the Dr. Lorna Breen Heroes' Foundation, applauds your commitment to championing equal privacy in mental health care for health workers!

Please find enclosed a certificate and decal to further showcase your achievement. The Wellbeing First Champion Badge serves as a visual recognition for health workers. When health workers are deciding in which state or organization to work, the Badge serves as a standardized form of communication that an organization is committed to supporting access to mental health care.

In early Summer 2026, our team will be in touch to renew your recognition and be distinguished as a 2026 Wellbeing First Champion. At that time, your organization will be asked to attest your applications have not changed and share at least three examples of how you've communicated/educated your workforce about your recognition and available mental health resources and support.

Our ALL IN for Mental Health initiative (www.allinformentalhealth.org) curates mental health resources, services, and programs specific for the healthcare workforce. We highly encourage sharing these (or similar mental health resources you have within your organization) as part of your communication and education.

Additionally, we have enclosed an overview of other resources and programs available to support your organization in building a thriving and sustainable workforce where health workers have the support, structures, and culture they need to deliver exceptional care today and for generations to come

Congratulations again!

With gratitude,

Melissa Zuckerman

Melissa Zuckerman
Chief Experience Officer
Dr. Lorna Breen Heroes' Foundation



Certificate

OF ACHIEVEMENT

This certificate recognizes
Oregon Board of Dentistry

as a **Wellbeing First Champion**,
verifying that their applications do not include
intrusive mental health questions — making it safer
for their workforce to seek mental health care.

Melissa Zuckerman

Signature

12/22/25

Date

ALL IN
Wellbeing First for Healthcare
a coalition led by





OPMC Membership Recruitment Notice

Oregon Health Authority sent this update at 02/12/2026 12:15 PM PST

The Oregon Pain Management Commission is opening recruitment for two members who are licensed healthcare professionals in Oregon.

If you are interested in applying, please answer the survey questions, submit your CV or Resume and a letter of recommendation. We request the letters of recommendation include a description of the applicant's lived or professional experience with pain or supporting people in pain, and in working to improve pain care in Oregon. Please provide application and letter at the following link:

https://www.surveymonkey.com/r/OPMC-Application?utm_medium=email&utm_source=govdelivery

Recruitment for open positions has been extended and will close at 5:00 PM on Tuesday, March 31, 2026.

If you would like to submit a recommendation for a candidate who will be applying, you can send a letter of recommendation to: PMC.INFO@odhsoha.oregon.gov

If you have any further questions about the application process please contact mark.g.altenhofen@oha.oregon.gov

Draft Rule on Criminal Background Checks

To ensure public safety, many state licensing boards and commissions require license applicants to submit to a criminal background check. Similarly, the Dentist and Dental Hygienist Compact requires participating states to implement and use criminal background checks in making licensing decisions as a means of ensuring public safety.

1.0 Purpose:

Pursuant to Section 3.A.5, and Section 3.C, in order to join and to continue as a Participating State in the Compact, a State must fully implement a Criminal Background Check requirement, within a time frame established by Commission Rule, by receiving the results of a qualifying Criminal Background Check. A qualifying Criminal Background Check means the submission of fingerprints or other biometric-based information for a License applicant for the purpose of obtaining that applicant's criminal history record information, as defined in 28 C.F.R. § 20.3(d) from the Federal Bureau of Investigation and the State's criminal history record repository as defined in 28 C.F.R. § 20.3(f). When conducting a Criminal Background Check the State Licensing Authority shall: Consider that information in making a licensure decision; Maintain documentation of completion of the Criminal Background Check and background check information to the extent allowed by State and federal law; and Report to the Commission whether it has completed the Criminal Background Check and whether the individual was granted or denied a License.

1.1 Criminal Background Checks

Participating States must fully implement a Criminal Background Check requirement on new Dentist and Dental Hygienist license applicants within six years of the effective date of the enactment of the compact within their state. A Participating State cannot participate in the issuing of Compact Privileges for the state's Licensees until the state has completed the requirements to fully implement the Criminal Background Check requirement established

DDH Dentist and Dental Hygienist Compact

in Section 3.C. of the Compact. However, a Remote State shall accept a Licensee with a Compact Privilege based on a license issued pursuant to a qualifying Criminal Background Check.

Licensees from Participating States whose Qualifying Licenses were not based on the consideration of information obtained in a Criminal Background Check may seek a Compact Privilege once their Participating State establishes a process for a review and consideration of a subsequent Criminal Background Check.

1.2 Clinical Assessment

As set forth in Section 2-D, satisfaction of the Clinical Assessment requirement shall be interpreted to include pathways that provide licensure based on the successful completion of a psychomotor performance examination that involves hand skills, along with successful completion of an objective structured clinical examination.

Rationale:

By defining this way, it would include all current exam pathways for licensure.

ADEX- psychomotor and offers an OSCE component

CRDTS-SRTA- psychomotor and offers an OSCE component

DLOSCE- satisfies the OSCE component of the clinical assessment requirement

DDH Dentist and Dental Hygienist Compact

Dear _____,

The DDH Compact Commission respectfully requests support from _____ to advance the Compact's continued implementation. Your support will help deliver national license portability for dental professionals, strengthening the workforce, enabling providers to practice where they are needed most.

The DDH Compact will allow qualified dentists and dental hygienists to practice across state lines with a privilege to practice—improving access to care, supporting relocating professionals, aiding military families, and reducing barriers for providers.

To oversee this initiative, the DDH Compact Commission was established as an interstate governing body made up of representatives from each member state. The Commission is currently focused on building the compact's operational infrastructure. This includes developing the rules, regulations, and secure data system necessary to support license portability and information sharing across states—an essential tool for promoting public protection.

While the Commission will eventually be self-funded through compact privilege license fees, it currently requires start-up support to implement the compact. This support would be used for:

- Designing and procuring a national data system for verifying licenses and sharing disciplinary information.
- Supporting governance activities such as rulemaking, commission meetings, and legal review.
- Providing administrative services to launch and maintain compact operations.

These activities will cost an estimated **\$314,000 through June 2027**.

We are seeking funding partners who share an interest in strengthening the health workforce by accelerating the implementation of the compact. Please consider a contribution to help us expand access to dental services across the country.

If you are interested in learning more, we would be happy to provide additional details and explore opportunities for collaboration.

Sincerely,

DDH Commission Chair
Dr. Matt Bistan

DDH Commission Treasurer
Corey Schaal

**NEWSLETTERS
&
ARTICLES OF
INTEREST**

Review

Artificial Intelligence in Dentistry: A Descriptive Review

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Abstract: Artificial intelligence (AI) is an area of computer science that focuses on designing machines or systems that can perform operations that would typically need human intelligence. AI is a rapidly developing technology that has grabbed the interest of researchers from all across the globe in the healthcare industry. Advancements in machine learning and data analysis have revolutionized oral health diagnosis, treatment, and management, making it a transformative force in healthcare, particularly in dentistry. Particularly in dentistry, AI is becoming increasingly prevalent as it contributes to the diagnosis of oro-facial diseases, offers treatment modalities, and manages practice in the dental operatory. All dental disciplines, including oral medicine, operative dentistry, pediatric dentistry, periodontology, orthodontics, oral and maxillofacial surgery, prosthodontics, and forensic odontology, have adopted AI. The majority of AI applications in dentistry are for diagnoses based on radiographic or optical images, while other tasks are less applicable due to constraints such as data availability, uniformity, and computational power. Evidence-based dentistry is considered the gold standard for decision making by dental professionals, while AI machine learning models learn from human expertise. Dentistry AI and technology systems can provide numerous benefits, such as improved diagnosis accuracy and increased administrative task efficiency. Dental practices are already implementing various AI applications, such as imaging and diagnosis, treatment planning, robotics and automation, augmented and virtual reality, data analysis and predictive analytics, and administrative support. The dentistry field has extensively used artificial intelligence to assist less-skilled practitioners in reaching a more precise diagnosis. These AI models effectively recognize and classify patients with various oro-facial problems into different risk categories, both individually and on a group basis. The objective of this descriptive review is to review the most recent developments of AI in the field of dentistry.

Keywords: artificial intelligence; dentistry; dental caries; oral health

1. Introduction

Artificial intelligence (AI) is a technology that mimics human behavior using machines, with increased usage in numerous industries since 2020, including healthcare. It can replicate human intelligence and evolve based on retrieved information [1]. In the field of dentistry, clinicians collaborate with researchers to develop algorithms for measuring and analyzing clinical assessments, photographs, radiographs, and chart notes. AI can allow patients to regulate their care and to refine the accessibility to health information [2,3]. AI also focuses on neural networks modeled after human brains, forming a data processing system to address precise issues. AI is rapidly evolving, enabling robots to perform previously human-only tasks. Dentistry has recently begun using AI, leading to exceptional achievements in analyzing clinical dental data. Advances in AI demonstrate possible benefits for healthcare, such as improved decision making, fewer unneeded therapies, improved quality of life, and fewer postoperative problems. Machine learning seeks to forecast outcomes from a dataset without human involvement, whereas AI refers to a computer's capacity to solve issues using data. Neural networks use artificial neurons to compute signals in a manner analogous to the human brain, whereas deep learning employs multiple computational layers to enhance detection. Data science is the process of examining and drawing conclusions from data, while big data is the practice of analyzing massive datasets in order to deliver precise consumer insights, and grasping the core components of contemporary AI systems is critical for gaining a comprehensive grasp of AI.

In engineering science, the field of AI studies how effectively processors understand calculations and how they may imitate patients' cognitive abilities to behave sensibly and to efficiently perform tasks. An essential element of artificial intelligence, an intelligent network simulates the judgment processes of a patient's knowledge and displays an experience as information or a standard inside the system. These recommendations and data may be used to resolve any concerns. In an intelligent network, a selection of dental patients is retained in a separate database called prototypes. The data form the basis for analysis, diagnosis, and recommendations and is taken from academic publications and human-subject-matter experts. The information is represented by combining the design of manufacturing rules with neural networks [4]. Artificial intelligence in dentistry can support the dentist in generating clinical decisions and assist in client diagnosis to provide the best care possible. Additionally, it could examine any unusual alterations to the oral mucosa. The application of intraoral scanners and cameras in dentistry offices nowadays has significantly aided the evaluation and scheduling of care [5]. The adoption of convolutional neural networks (CNNs) will also contribute to the simplification of diagnostic processes in dental offices. An artificial neural network (ANN), a statistical model or computer program, can mimic the neural network of the human brain to carry out cognitive functions like problem-solving [6]. In the healthcare industry, AI systems are often used to evaluate pictures by removing elements from specific images and carrying out thorough research. For example, AI systems may reduce the amount of effort the radiologist must spend diagnosing images and expedite treatment decisions by studying collections of chest radiographs and lung images obtained from patients with dental problems. Furthermore, while they are still modest compared with healthcare technology, technical developments in dentistry are becoming more noticeable [7]. Conventional digital dental techniques are utilized more often in typical treatment plans [8]. Artificial intelligence offers innovative decision-supporting technology in the field of dentistry. Focusing on artificial intelligence will only raise the level of treatment since people desire more extensive and detailed medical care.

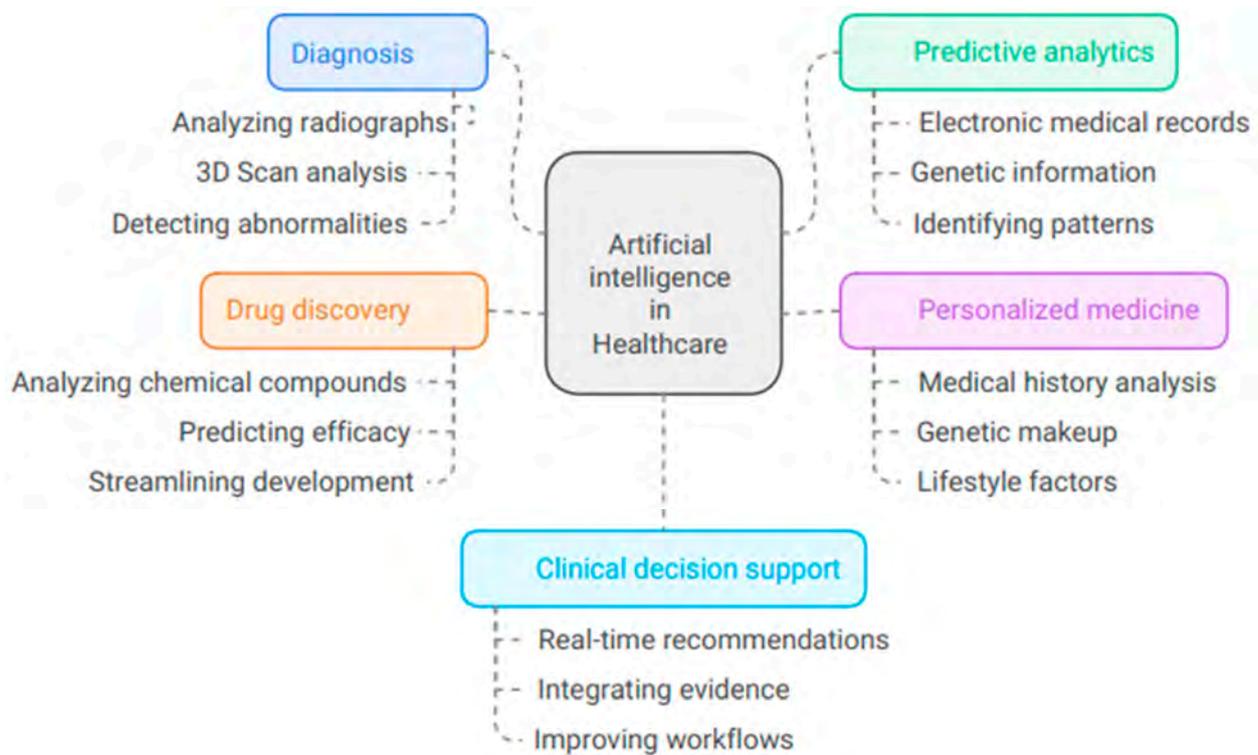


Figure 2: Illustrates the uses of artificial intelligence in health care.

3.1. Diagnosis

AI algorithms are adept at analyzing medical images like radiographs and 3D scans to detect abnormalities, aiding healthcare professionals in making more accurate diagnoses, which potentially lead to earlier interventions and improved patient outcomes.

3.2. Predictive Analytics

By using vast data like medical records and genetic information, AI can predict disease likelihood, enabling healthcare providers to anticipate patient outcomes and implement preventive measures, thereby improving patient care and resource allocation.

3.3. Personalized Medicine

AI is crucial in creating personalized treatment plans by analyzing a patient’s medical history, genetic makeup, and lifestyle factors, suggesting effective therapies that not only enhance treatment efficacy but that also minimize adverse effects.

3.4. Drug Discovery

AI is revolutionizing the drug discovery process by analyzing chemical compounds and predicting their therapeutic efficacy, thereby accelerating the pipeline and potentially bringing new treatments to the system faster.

3.5. Clinical Decision Support

AI provides real-time medical recommendations to doctors, enhancing decision-making, clinical workflows, and patient safety. They integrate updated information with patient data, revolutionizing diagnosis, treatment, and patient management. As technology evolves, AI integration in healthcare is expected to expand, leading to further improvements in patient care and outcomes. This demonstrates the potential to revolutionize healthcare delivery and improve patient outcomes.

possibility mapping. Software was produced to view identified dental caries as a region on the bitewing radiograph and objectively represent the proportion of dental caries. This was accomplished by displaying the program's output in numerical form [17].

4.2. Artificial Intelligence in Therapeutic Management

In a classification of teeth to "gold standard" based on the National Institutes of Health (NIH) general agreement transformation plan, which explains well-established requirements for the separation of third molars, it was discovered that neural networks, when ideally trained on lower third molars, have elevated particularity and responsiveness comparable to specialized consultation [18]. It may also be used to decide if separations are required before receiving orthodontic therapy. Furthermore, depending on their immunological system response pattern, it may be utilized to divide patients into groups with aggressive and chronic periodontitis [19].

4.3. Artificial Intelligence in Patient Management

Virtual dental attendants may handle patients in the dental operatory with fewer human inaccuracies and more precision while using fewer resources. Artificial intelligence technology aids in more effective data preservation, and extensive digital information may be utilized afterward to provide individuals with dental problems with the best care possible as and when needed [20]. It may also be used to gather all necessary dental data and to manage consultations, licensing, and scheduling. Scheduling consultations for individuals with dental problems at the clinic, gathering the patient's complete health and oral history, handling financing, and aiding the dentistry dentist with a suitable assessment and therapeutic plan may all be possible [21]. Additionally, it operates by alerting the dental expert about the patient's healthcare record and routine habits, such as their usage of alcohol or cigarettes. In this manner, a digital record of each patient can be produced, aiding the dentist in illness therapy and evolution. Additionally, it will help with patient follow-up and virtual critical medical consultation [22].

4.4. Artificial Intelligence in the Dental Education System

Clinical dentistry is crucial for dental students to develop their abilities and improve patients' utmost care. Preclinical operational training has historically included conceptual and hands-on instruction for dental learners. In recent years, intelligent education and dental training teaching systems have included artificial intelligence [23]. Through these innovations, real-world operations may be virtually recreated in three dimensions, allowing for the assessment of clinical and surgical methods. Before managing actual clinical situations, students may participate in practice rounds as often as necessary to become experts in the field and to lower the danger of iatrogenic harm. This training approach is more effective, affordable, and trustworthy [24].

5. Artificial Intelligence in Clinical Dentistry

5.1. Artificial Intelligence in Pediatric Dentistry

The adoption of artificial intelligence is gaining traction across all industries and is also breaking new ground in pediatric dentistry. Artificial intelligence offers a diverse range of promising solutions, starting from investigation and diagnostic testing and extending to behavioral administration, pain management, prosthodontic tooth mobility, and regenerative dental care [25]. These implementations hold the potential to revolutionize the learning and practice of modern dental care. The integration of AI with other emerging innovations, such as virtual reality (VR) in the form of a virtual education environment, has the potential to assist more children and to provide a customized learning experience [26]. A recent systematic review states that AI and ML are mostly used to create tools for checking people's health, like the Children's Oral Health Score (COHSI) and the Referral for Treatment Needs of Oral Health (RFTN); they are also used to find extra teeth, plaque, and to assess the suitability of fissure sealants; to predict early childhood cavities; to guess dental age;

to find submerged teeth; and to find teeth that are erupting in the wrong place [27]. A systematic review categorized five clinical applications of AI, which include assessing genetic risk, analyzing dental characteristics and the relationship between the upper and lower jaws, detecting hypernasality, performing cleft-lip palate surgery, and diagnosing and forecasting oral clefts. AI aids in clinical decision making, cephalometric analysis, and treatment prediction [28]. Dental infections are prevalent chronic childhood illnesses and are a serious public health concern for young people of all ages in industrialized and emerging cultures. These disorders may severely impact a child's dental health and overall welfare. Thus, their quick identification and management are essential. Although dental illnesses are inherently controllable, rapid and precise potential risk detection may be crucial for creating prevention strategies against expensive diseases. Researchers have established caries probability estimation techniques to identify warning indicators for oral illnesses like dental caries, potentially leading to the development of preventative interventions that could improve medical therapy [29]. The most popular cavity risk screening models are the cariogram, the "Caries Risk Assessment Tool (CAT)", and caries treatment by hazard analysis. Reports recognize the cariogram as a reliable tool for predicting cavity danger, with a sensitivity range of 41–75% and a specificity range of 65.8–88% [30]. Dental cavities are a persistent, complex, and sugar-dependent bacterial infection of the teeth. The disease arises from a discrepancy between the processes of demineralization and remineralization. Certain caries-causing bacteria, the host's preparedness, a diet rich in unfermented sugars and carbohydrates, and the duration of the host's exposure to this potentially cariogenic diet are the main causes of this difference. Modifiable variables such as socioeconomic status, lifestyle, food habits, and inadequate cleanliness can also contribute to the spread of the disease [31]. Al-Jallad et al. [9] developed an AI-processed application to detect caries using children's photos. The Caries app received a score of 78.4 on the System Usability Scale (SUS), indicating excellent acceptance. This app enables parents to use smartphones to take pictures of their children and can be a useful tool in preventing caries.

5.2. Artificial Intelligence in Prosthodontics

AI assists prosthodontics by utilizing computer-assisted layout and fabrication software to ensure the accuracy and suitability of crowns and removal appliances for tooth replacement. However, researchers are using AI to instantly develop innovative dental reconstructions for personalized suitability, perfect activity, and improved structural systems, thanks to the advancements in confrontational conceptual networks [32]. The software will likely guide the dentist through the entire process of creating a digital imprint and aid in creating a high-quality impression through the application of artificial intelligence. This will significantly enhance the patient's perception of prosthodontics. It assists in the analysis of arch patterns and contributes to the construction of detachable partial or complete prostheses [33]. Because of advances in virtual reality, the procedure of delivering esthetic prosthetics and attending to patients' requirements has become much more straightforward. The client can attempt a digital prosthesis with AI systems and simulated reality [34]. The patient can customize these virtual prosthetics to their preferences until they are satisfied. These specifications precisely sculpt the finalized prosthesis [35]. The application of AI to the study of implantology has made it possible to build prostheses in an accurate and automated way. Additionally, it has simplified the process of determining the optimal placement of implants. The tongue-driving technology's artificial intelligence is capable of monitoring tongue movements in the oral cavity and responding to instructions [36]. Alharbi et al. [37] developed four ML algorithms to identify the necessity of dental implants. They used the improved AdaBoost algorithm for dental implant prediction. Among these models were the AdaBoost method, the Random Forest, the Bayesian network, and the enhanced AdaBoost algorithm. It is clear from analyzing the findings that the built machine learning performed exceptionally well. This study's modified AdaBoost algorithm achieved 91.7% accuracy in predictions, which is far higher than the other methods tested, and yielded much better performance overall [37]. To examine the use of AI in implant-

supported therapy, Bornes et al. [38] conducted a comprehensive literature analysis of sixteen papers. Thirteen publications demonstrated the evolution of AI algorithms for ML, DL, and CNNs. To better diagnose damage, optimize implant placement, and improve oral rehabilitation, most studies have used 2D imaging to identify implants.

The combination of AI algorithms and omics sciences has resulted in the creation of bioinformatics tools, which not only reduce misdiagnosis but also enable the prediction of potential outcomes. Desktop manufacturing and design processes, specifically “computer-aided design (CAD/CAM)”, have found their way into standard laboratory and hospital practice. One novel concept that is beginning to surface as dentistry digitalization progresses is AI [7]. Artificial intelligence may also be utilized to evaluate the debonding of dental repairs based on flat imaging. In removal prosthodontics, convolutional neural networks (CNNs) may classify dental arches. Building denture teeth in edentulous patients that meet both functional and esthetic requirements is never simple for dental professionals. Machine learning in CAD/CAM software may restore sound inter-maxillary connections by placing the teeth correctly. When it comes to difficult esthetic situations like having several front teeth or only one central incisor, AI may help with proper color matching. Implant placements may be quickly detected by intraoral detectors and entered into CAD software in implant dentistry. AI can potentially enhance dental implant conception and implementation [8].

5.3. Artificial Intelligence in Orthodontics

The use of AI to customize orthodontic treatment is one of the most recent innovations that has attracted an abundance of interest (Figure 4). Using accurate 3D photographs and simulated representations, it is simple to 3D-print the appliances [39]. Using a patient’s unique set of dental information, this system intelligently computes the required adjustments, finds the optimal force, and locates the pressure sites [40]. The AI-assisted aligners not only provide exact therapy implementation but also assist in evaluating the progression of the therapy. They promise to shorten the time required for medicines while simultaneously reducing the number of necessary consultations [41]. Researchers have found that cephalometric analysis is more reliable and consistent than manual analyses, which depend a lot on how well the operator can identify landmarks and often show big differences [42–45]. Accurate cephalometric analysis results depend on precise and consistent landmark identification. Artificial intelligence has shown effectiveness in identifying cephalometric landmarks in multiple experiments. The most common method for cephalometric analysis is lateral radiography; however, CBCT has recently seen a renaissance with AI developments [46]. In cervical vertebral maturation evaluations, models based on CNNs achieved accuracy rates of over 90%, as reported by Seo and colleagues. [47] The authors reported that, as a result, lateral cephalometric radiographs may be useful for the automated identification of a child’s bone maturity status. It is crucial to proceed with caution when analyzing AI outcomes in cervical vertebral maturation evaluations. There have been other studies that have found significant differences, especially during the growth peak and other critical times of orthodontic therapy when the accuracy is typically lower [48,49]. Recent research findings demonstrate the exceptional diagnostic capabilities of AI in detecting and staging temporomandibular joint osteoarthritis [50–52]. Researchers used several imaging techniques, including panoramic radiographs, cone-beam computerized tomography, and magnetic resonance imaging, to demonstrate the feasibility of an automated, comprehensive evaluation of joint morphology. Researchers believe that using AI systems for diagnostic imaging of the temporomandibular joint will make it easier to detect arthritis early and to find the best treatment for each person. Several reviews and meta-analyses in this area have demonstrated the models’ moderate to high accuracy in identifying temporomandibular joint osteoarthritis [53–55].

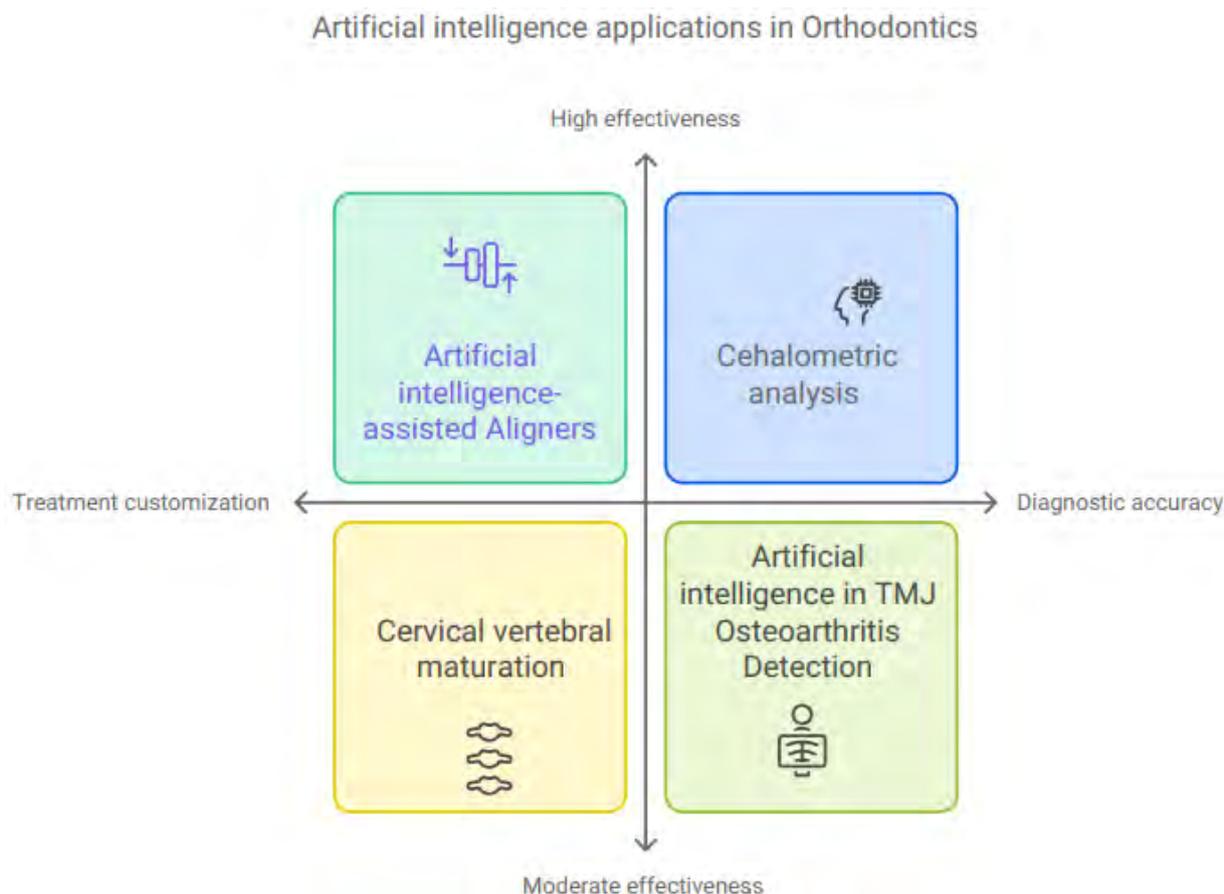


Figure 4. Illustration of the use of artificial intelligence in orthodontics.

5.4. Artificial Intelligence in Oral Medicine and Radiology

Kabir et al. [56] created an AI framework to recognize tooth numbers in panoramic and intraoral radiographs and to organize full-mouth radiographs according to an FMS layout template. The procedure has two stages. The initial step involves assigning a tooth number to each tooth in periapical and bitewing radiographs, followed by organizing the intraoral radiographs in a full-mouth series (FMS) configuration. The study's primary findings encompass the introduction of a model that surpasses earlier models in both specificity and sensitivity. Connecting this model with other dental diagnostic models and EHR systems enables the validation of clinical charting through deep-learning-based clinical reporting [56]. Song et al. [57] evaluated the efficacy of AI-based techniques in identifying soft-tissue calcifications. The study randomly chose 60 participants with sialoliths and carotid artery calcifications, respectively. The research examined three forms of calcification: carotid artery calcification, sialolith calcification, and lymph node calcification. The objective was to evaluate the impact of the AI system on general dentists' visual interpretation skills. As expected, using AI increased the number of calcification corrections performed by both general dentists and oral medicine radiologists. However, reading time increased for general dentists while it decreased for oral medicine radiologists. The results suggest that, when effectively employed, panoramic imaging can serve as a valuable screening instrument for diagnosing other disorders [57]. Ari et al. [58] conducted an assessment of periapical radiographs utilizing a U-Net-based artificial intelligence model grounded in convolutional neural networks. The study's main results showed that the deep-learning models were able to separate the periapical test images made by the AI model, with an F1 score of up to 80% for sensitivity and accuracy. The study's limitations include its reliance on a single radiographic machine for imaging, the absence of an external dataset, the lack of observers with diverse backgrounds, and the omission of multiple CNN models. This AI

model, which is based on the U-Net architecture, made it more accurate in differentiating cavities, crowns, dental fillings, dental pulp, periapical lesions, and root canal fillings in pictures of the back of the tooth [58,59]. Baydar et al. [59] evaluated bitewing photos using AI applications trained with deep-learning techniques, thereby establishing the trustworthiness of the U-Net model. The diagnosis of caries had the lowest success rate, but other dental diagnoses, such as dental crowns, restorations with filling material, and root canal fillings, attained a success rate of 95% [59]. The study by Hung et al. [60] emphasizes the application of deep learning and radiomics in CT and CBCT for the diagnosis and management of maxillofacial disorders. They suggest different ways to automatically find, separate, and label jaw cysts, tumors, problems with the salivary glands, the temporomandibular joint, the maxillary sinuses, broken jaws, deformities of the dentomaxillofacial area (Figure 5), and problems with the mandible. Shahnavaizi and Mohamadrahimi [61] devised a deep-learning algorithm that autonomously detects mandibular fractures and injuries, evaluating its efficacy against that of general dentists. This research utilized a dual-phase deep-learning system. The authors initially employed a Unet model to segment the mandible as the area of interest. The authors employed a model known as the Faster Region-Based Convolutional Neural Network (Faster R-CNN) to analyze panoramic radiographs and to identify fractures in the mandible, along with their specific locations. The authors assessed the categorization model's accuracy at 91.67%. On average, the model outperformed humans in diagnostic accuracy (91.67 vs. 87.22 ± 8.91) and sensitivity (82.22 ± 16.39) [61]. Mohammad et al. [62] conducted a scoping assessment of 28 papers to ascertain the uses of artificial intelligence in forensic odontology. Four categories delineate the prospective applications of AI technology in forensic odontology: (1) analysis of human bite marks, (2) sex determination, (3) age estimation, and (4) dental comparisons. This powerful tool can help solve the world's problems by providing enough datasets, the right way to use algorithmic architecture, and the right way to distribute hyperparameters that assist the model to make accurate predictions [62]. Alsomali et al. [63] created an AI model that autonomously locates markers in radiographic stents to determine prospective implant sites within CBCT images. The testing dataset comprised 50 picture segments, with 193 including gutta-percha (GP) markers and 2284 lacking them. That study introduced the inaugural AI model designed for the identification of GP markers utilized to pinpoint potential dental implant locations within CBCT images. The existing system successfully identified the majority of GP markers; nevertheless, it produced 2.8% false positives and overlooked 17% of cases. Relying just on axial images to train an AI program is insufficient to ensure proper performance of the AI model [64]. Choi et al. [65] developed an AI tool that uses deep learning to automatically find natural teeth and dental treatment patterns in dental panoramic radiographs (DPRs). This makes DPRs more useful as identifiers of people. The researchers employed a pre-trained object identification network that utilized an efficient Det-D3 convolutional neural network to identify natural teeth, dental treatment patterns, and tooth numbers. The objective metrics for average precision utilizing dental panoramic radiography were 99.1% for natural teeth, 80.6% for prostheses, 81.2% for treated root canals, and 96.8% for implants. This study demonstrated that convolutional neural networks excel at autonomously identifying tooth numbers and locating natural teeth, dentures, implants, and treated root canals. The growing focus on diagnostic techniques, such as digital RVGS/IOPA, 3D scans, and CBCT, is facilitating the gradual integration of AI into dental radiology. It is feasible to acquire and assess extensive data to create an AI that facilitates prompt diagnosis and therapeutic scheduling [66].

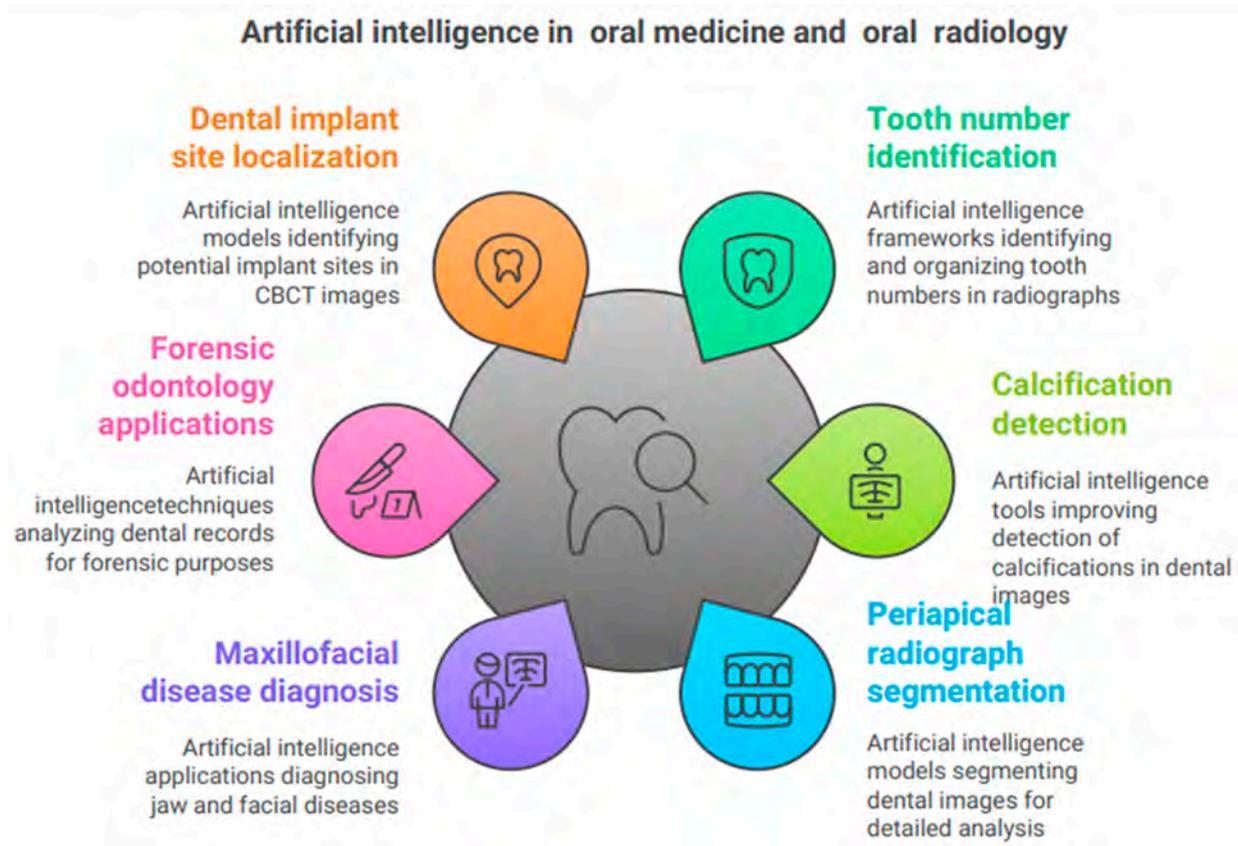


Figure 5. The use of artificial intelligence in oral medicine and radiology.

5.5. Artificial Intelligence in Periodontics

In recent years, dentistry and sophisticated education systems have incorporated AI into their instruction and learning systems. These technologies create virtual realities, allowing the modeling of functional processes in three dimensions and, thereby, facilitating access to medical and therapeutic methods before the actual management of a medical setting, students may participate in training exercises as many times as necessary until they have developed experience in the relevant matters. This lowers the likelihood that they will cause iatrogenic injury [68,69]. This kind of instruction is more effective to mention more cost-effective and trustworthy. Periodontal hazard analysis has effectively utilized AI [69]. The approach incorporates various factors such as aging, bleeding during probing, the average depth of the pocket under investigation, the presence of root plaque, and the degree of lateral bone deterioration observed on dental radiographs [70]. Periodontitis is the sixth most prevalent disease worldwide. Microbes and the host cause inflammation that results in the loss of alveolar bone and periodontal attachment, potentially leading to tooth loss [71]. Periodontitis remains a significant oral health challenge, with high rates of untreated disease exhibited among certain high-risk and disadvantaged groups [72]. An estimated 20% to 50% of the world's population suffers from this chronic dental disease [73], and its incidence positively correlates with age. However, there is a lack of standardization relating to periodontitis diagnosis and management, resulting in instances of undiagnosed and untreated oral disease [74,75]. Progressive approaches to care, such as incorporating AI technology into dental practice software, can assist dental providers in standardizing the diagnosis of periodontitis and increasing treatment acceptance by improving patients' health literacy and understanding of their periodontal condition. New technology and innovative approaches to care, such as incorporating AI technology into dental practice software, can improve patient education as incorporating AI technology into dental practice software, can improve patient education methods, facilitate clinical decision making, enhance clinical efficiency, and promote intra- and interprofessional collaboration [76]. Some types of AI-powered radiograph

can measure from the cemento-enamel junction (CEJ) to the crestal bone, which assists dentists in their clinical decision making and diagnostic consistency. The use of AI can also help improve patient engagement, thereby facilitating optimal health outcomes and health service utilization [77]. Further, improving health literacy via patient education enables patients to better understand their condition, which can further reduce treatment costs by improving health behaviors [78]. Researchers currently find AI useful in diagnosing periodontal disease, predicting a specific condition, and creating treatment plans tailored to each patient [77,78]. Also, algorithms and AI-enhanced software can help dentists improve patient communication and demonstrate the necessity for treatment. Research shows that one AI model can accurately diagnose periodontal disease in premolars and molars with accuracy rates of 81% and 76.7%, respectively. Another model can identify periodontitis by analyzing a patient's subgingival plaque to distinguish microbial profiles [79]. Nakano et al. [80] used deep learning to detect oral malodor from microbiota with a predictive accuracy of 97%. Danks et al. [81] used a deep neural network to measure periodontal bone loss by analyzing periapical radiographs. The system achieved a total percentage of correct key points of 89.9%. Tonetti et al. [70] utilized a deep-learning model to identify and quantify periodontal bone loss in panoramic images, subsequently aiding in the staging of periodontitis.

5.6. Artificial Intelligence in Oral and Maxillofacial Surgery

The most significant utilization of AI in dental surgery is the advancement of robot operations, which involve the recreation of human body movements and cognition (Figure 6). In medical settings, image-guided cranial functions can be used to successfully place dental implants, remove tumors and foreign bodies, conduct investigations, and perform tasks on the temporomandibular joint [82,83]. Even when carried out by skilled surgeons, close examination of oral surgical treatments reveals a much-increased level of reliability compared with the freehand approach. In contrast, there was no noticeable difference between students and professional physicians in terms of the outcomes [84]. Documentation generally shows shorter operation times, more intraoperative precision, and gentler handling around fragile tissues. Image guidance makes it feasible to perform a complete surgical resection, which might reduce the need for further revision procedures. Currently, multiple robotic physicians can perform semi-automated surgical operations with increasing efficiency, all under the supervision of a qualified surgeon. Advances in AI have enabled this transformation in surgery [85]. Clinical expertise helps orthognathic surgeons create complete treatment strategies that improve outcomes [86]. When designing and building splints, surgeons use CT or CBCT models to automatically register 3D craniomaxillofacial features [87,88]. Thus, three-dimensional assessments of hard- and soft-tissue movements before orthognathic surgery can guide technique selection. Due to defects and scar tissue, cleft patients' soft tissues behave differently from those of non-cleft patients, making treatment helpful [89]. Software using AI may identify landmarks, analyze quick digital cephalometric data, advise healthcare decisions, and forecast treatment outcomes. Presurgical orthopedics, speech pathology detection, and the prediction of cleft lip and palate surgery outcomes all employ AI. The results have shown 85–95.6% model accuracy [90]. AI models predict perioperative blood loss, systemic infections, and orthognathic surgery [90–92]. Hong et al. [93] developed 75% of the cephalometric landmarks that have been crucially useful in orthognathic surgeries. This was true even when orthodontic brackets, surgical plates, screws, fixed retainers, genioplasty, and bone remodeling were in place. A CNN model using lateral and frontal cephalograms diagnosed orthognathic surgery cases with 94.4% accuracy [94]. Jeong et al. [95] showed that deep-learning CNNs can identify surgery patients based on frontal and lateral facial photos. A study by Tanikawa et al. [96] looked at AI's ability to guess 3D facial shapes after orthodontic and orthognathic surgery. Researchers found that AI systems capable of guessing post-treatment face morphology are both safe and effective.

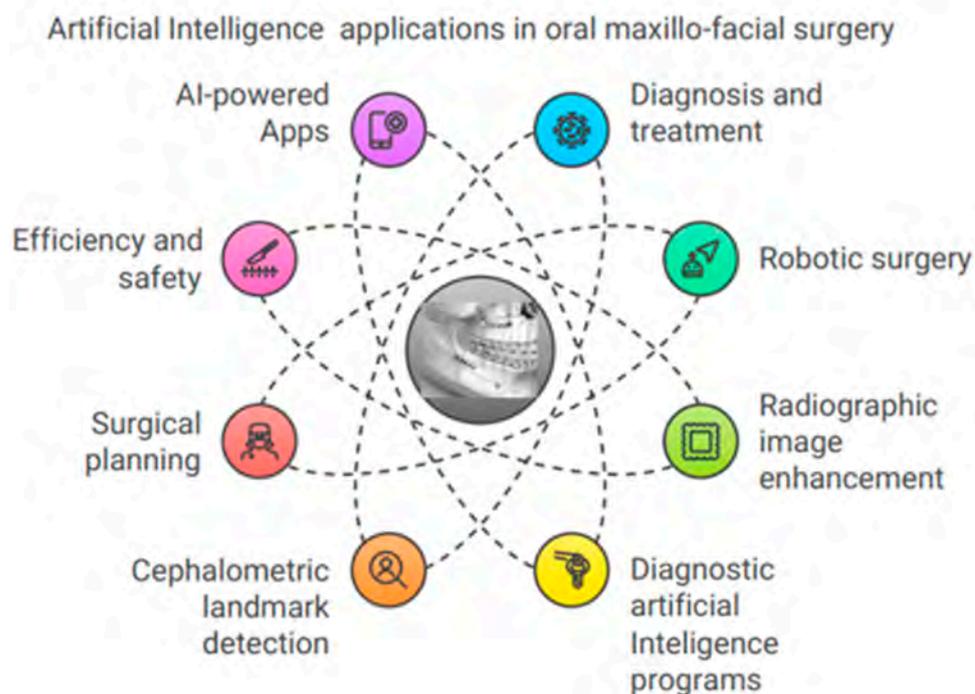


Figure 6. The use of artificial intelligence in oral maxillofacial surgery.

5.7. Artificial Intelligence in Endodontics

AI has shown promise in distinguishing pulpal diseases using radiographs, but radiographic assessment has limits. Considering pulpal diseases using radiographs and radiographic investigations in conjunction with pulp and periapical tests. This integrated diagnostic strategy can be a completely investigation pulp diagnosis (Figure 7). Based on a according to research, AI has been used [97] to predict pulpal diagnosis (Figure 7). Based on pulp and pulpitis radiographs, Pimpalawattana [97] et al. [96] used a deep learning-based neural network for pulpitis detection and to detect [98]. The researchers applied the convolutional neural network for caries and pulpitis detection. The researchers applied the 25% to 50% to 29.00% of the dataset. The major 19,760 test of which studies were used; the AI-based 100%, 25%, 50%, and 100% of the data set highly accurate in context of the study. However, the AI-based tool processes to be cost-effective training data for AI applications in dentistry. This was the every [99] proposed deep learning technique for caries detection on dental radiographs. People widely used dental radiographs for caries detection, but the detection process of these images is mostly a time-consuming task. They presented a dataset of 141 images using a semi-supervised learning model and achieved high accuracy in caries evaluation. This model achieved a performance improvement of 6% in pulpitis diagnosis accuracy with self-supervised learning. According to Korhani et al. [100], new AI applications of AI tools include tracing the apical foramen, measuring the working length, detecting periapical lesions, and predicting appropriate treatments. AI methods such as CNN-based DL, detecting with DGGT version 5, Pyramids Attention Convolutional Neural Network (FPAGNN), and machine learning with DGGT version 5, Pyramids Attention Convolutional Neural Network (FPAGNN), and machine learning were used to detect vertical root fractures. This study illustrates the AI tools' superiority compared with conventional techniques. Other AI tools, such as neural network models and DL-based computer vision techniques, were used to detect the apical foramen and to predict root canal morphology. Digitizing direct-reading radiography improved pulpal diagnosis validation in their 20-tooth trial. Zheng et al. [101] used CNNs like VGG19, Inception V3, and ResNet18 to diagnose deep caries and pulpitis on panoramic radiographs. They examined 844 panoramic radiographs and discovered that a multi-modal CNN named ResNet18, in conjunction with clinical factors, enhanced the diagnosis of deep cavities and pulpitis. Endodontic treatments need accurate working length; discovered that a multi-modal CNN named ResNet18, in conjunction with clinical factors,

enhanced the diagnosis of deep cavities and pulpitis. Endodontic treatments need accurate working length determination. Saghir et al. [102] employed a deep artificial neural network (ANN) for automatic root canal (RC) identification to analyze the periapical radiographs of the single-rooted teeth of 50 single-rooted teeth to identify radiographic features. The study found that the ANN model improved the radiographic working length determination accuracy. Another study by Saghir et al. [103] investigated the accuracy of the ANN in evaluating the models by positioning the ANN in a file concerning the post-formation file. The study found that the ANN outperforms radiologists in working length determination using human data with 50 single-rooted teeth. Additionally, 50 ANNs were tested to assess working length, more accurately than humans in some cases.

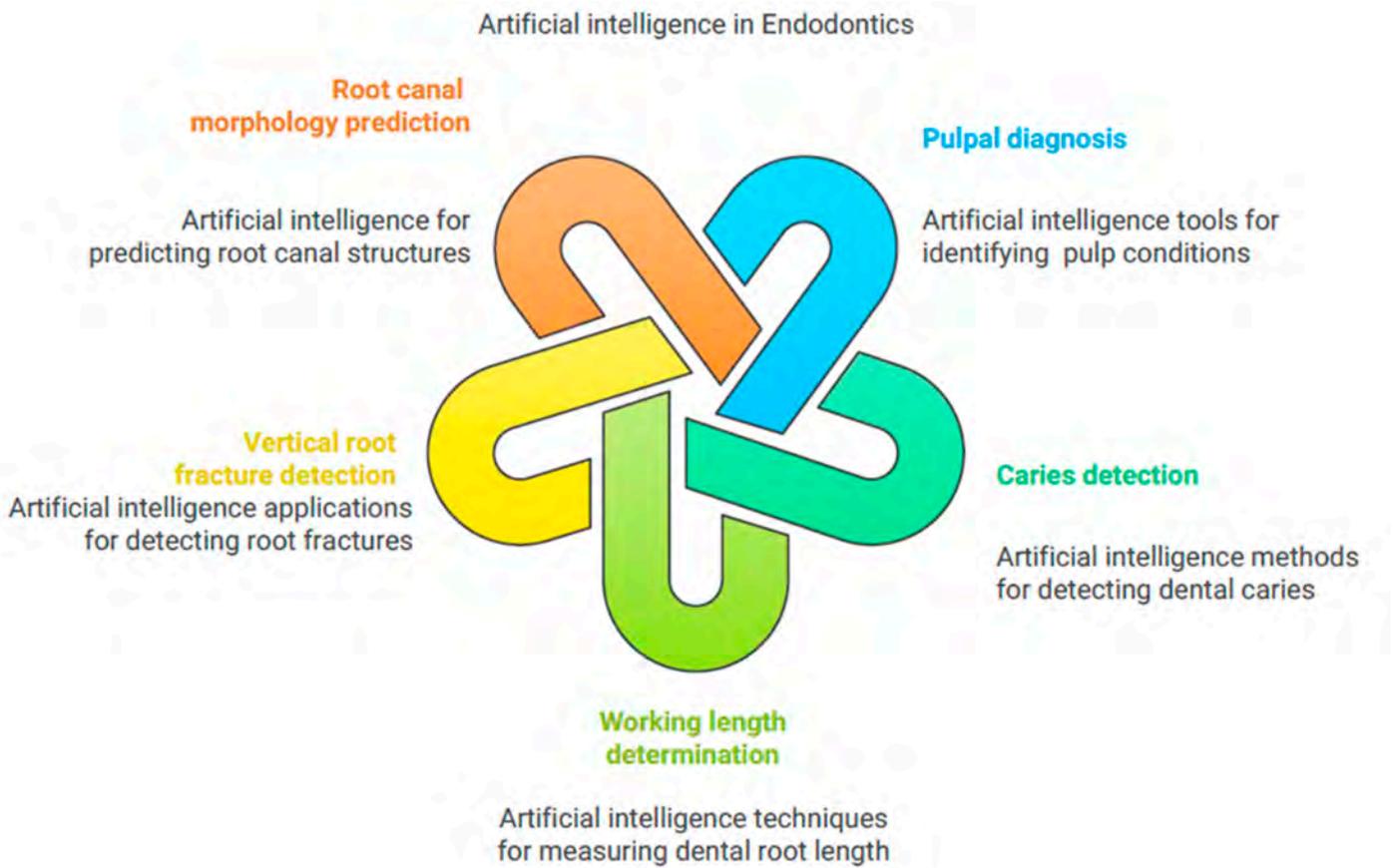


Figure 7. The use of artificial intelligence in endodontics and conservative dentistry.

Qiao et al. [104] used multifrequency impedance to measure the working length L with ANNs. They incorporated impedance ratios, tooth types, and file properties into the circuit system. Although the number of examples was not given, the multifrequency impedance approach employing ANNs enhanced the working length measuring accuracy and robustness. These studies show that AI could revolutionize endodontic working length determination, providing more accurate and dependable results. A study created and compared two independent CNN algorithms in estimating the number of distal roots of mandibular first molars on panoramic radiographs [105,106]. Fukuda et al. [107] suggest using a CNN to detect vertical root fractures in panoramic radiography. Shah et al. [108] developed a method to automatically detect, quantify, and locate vertical root fractures in high-resolution CBCT (hr-CBCT) scans. In a different study, periapical radiographs and CBCT images were used to teach a neural network how to find vertical root fractures in teeth that were whole or had roots filled in [109,110]. The authors found that CBCT fracture detection of roots is more specific, accurate, and sensitive than 2D radiography. Khanagar et al. [111] conducted a systematic review and reported on the use of AI models in endodontics. The major outcome of the study was that the CNN-based AI models

demonstrated excellent efficiency in diagnosing pulpal diseases and working length. Asiri and Altuwalah [112] reported that AI-based networks such as CNN, ANN, and DCNN have been a significant aid for diagnosis and treatment planning. Teleassistance has successfully used these models. These neural networks will be valuable tools for dental specialists to diagnose effectively.

5.8. Artificial Intelligence in Forensic Odontology

Artificial intelligence (AI) is a scientific advancement that has seen significant use in forensic medicine. It successfully identifies the biological age and gender of healthy and unwell patients with dental problems. Moreover, it has the potential to evaluate tooth marks and to predict mandibular anatomy [113]. The field of dentistry stands to gain from some of the most exciting applications of AI. A substantial change occurred in the dental chair, which went from a physiological, hydrostatic pressure seat with a mechanical compressor to an electronic one with various sensors connected. The dental chair is an essential component of the dental office. The most recent advancement in dental technology is a voice-controlled chair that eliminates the dentist's need for manual tasks [114]. Voice commands complete all tasks. Soon, dentist chairs will be capable of monitoring patient's vital signs, anxiety level, weight, and the duration of the procedure while also consoling the patients and alerting the operating physicians if any differences are observed. This will make dental procedures much more efficient. This is due to the fact that every intellectual mind is currently dedicated to the advancement of AI. One of the most creative uses of AI is bioprinting. The sector of "bioprinting", which enables the generation of living cells and organs in consecutive thin layers of cells, is one of the most innovative applications of AI. One day, we may apply this technology to recreate hard and soft tissues that have failed due to pathophysiological or inadvertent reasons [115].

6. Discussion

AI has several potential uses in dentistry that may transform current behavioral dental practices. Additionally, machine learning algorithms will continue to advance with the aid of huge databases. Another area where machine learning algorithms are gaining traction is the mobility of adolescent orthodontic teeth with personalized AI-driven equipment. These appliances would be more popular with the younger population. The field of dentistry has previously used AI-enabled regenerative dentistry and computer-aided design and production technologies [116]. The condition of permanent teeth and gums is essential to general wellness and quality of life. The primary goal of dentistry is to achieve the highest possible level of dental hygiene in young adolescents by concentrating on diagnosing, providing therapy, and avoiding a wide range of oral illnesses, beginning in infancy and continuing through early childhood. Dental caries, pulpal and periapical lesions, gingivitis, and other problems, such as dental trauma and inadequate dental hygiene, are among the most prevalent oral illnesses impacting adolescents. Chronic oral conditions, particularly tooth caries, may make treatment more difficult, cause discomfort, reduce masticatory performance, or cause asymmetrical mastication [117]. This may potentially lead to impaired facial formation, which would contribute afterward to malocclusion and orofacial abnormalities. Studies also reveal a connection between severe dental caries during childhood and more extensive dental caries in adulthood. Technological improvements have led to the extensive use of innovative AI-based apps for the identification, diagnosis, and prognostic forecasting of dental disorders [118]. This study sought to address the challenges associated with assessing facial structure in cleft lip and/or palate patients as a component of a therapeutic outcome evaluation. For this purpose, a face detector and CNNs that had previously been trained on facial appearance were given facial scans of healed cleft lip and/or palate patients and standards. This finding demonstrates that the existing panel-based assessments of face beauty have dispersion-related problems and are essentially inaccessible to sufferers. Although the recent findings suggest that significant interchanges with AI models are required to better understand the influence of cleft charac-

teristics on face attraction, AI might reveal itself as a useful method for describing facial beauty [119]. A recently developed deep-learning method classified temporomandibular joint osteoarthritis using a 3D interface model, which included 250 auricular parameters at varying levels in the training database. Once the software receives a fresh patient's condyle interface model, the Slicer Shape Variation Analyzer (SVA) component should be able to categorize the degree of rheumatic deterioration of a condyle into five categories of morphological variance. Training on high-spatial-image data with architectural form characteristics enhanced the design of the present neural network [120]. The study aimed to develop an AI framework based on deep learning to identify plaque on baby teeth and to evaluate the model's diagnostic efficacy. Compared with a skilled dental clinician, the AI model demonstrated medically satisfactory accuracy in identifying dental plaque on primary teeth. This result shows the promise of such uses of AI in enhancing children's dental hygiene [121]. This study assessed the application of a deep-learning method for automatically identifying and counting permanent teeth as shown on transverse radiographs. The AI approach proved effective in identifying and cataloging children's decaying teeth as shown on panoramic radiographs. High rates of sensitivity and accuracy were observed. The estimates for the F1 score, sensitivity, and accuracy were 0.9804, 0.9571, and 0.9686, respectively [122]. One of the main reasons people undertake orthodontic therapy is for an improved facial appearance. AI is utilized to assess the influence of dental alignment on various alterations, such as the application of glasses, jewelry, or lipstick on the beauty of the face and the estimation of age. Similar to applying lipstick, maintaining dental symmetry enhances facial beauty, but it does not significantly affect the estimated age. Although wearing glasses significantly affects one's appearance, this impact fades with age [123]. Ethical frameworks and regulatory compliance are crucial for balancing innovation and patient rights. This involves securing informed consent, upholding patient autonomy, and safeguarding data integrity [124]. Emerging privacy-preserving methods, such as federated learning, present effective solutions for safeguarding data privacy while facilitating advancements in AI [125]. The incorporation of AI in dental operatories poses considerable challenges with regard to patient consent, data privacy, and the potential biases inherent in AI algorithms. The significance of these issues lies in their influence on patient trust, ethical standards, and the efficacy of AI-driven healthcare solutions. Ensuring strong data privacy and mitigating biases are critical for the ethical implementation of AI technologies in dental clinical settings. This document examines the challenges and explores potential solutions. Data privacy is essential, with regulations such as Health Insurance Portability and Accountability (HIPAA) and General Data Protection Regulation (GDPR) directing the safeguarding of sensitive patient information. Encryption, anonymization, and differential privacy are essential techniques for data protection [125–127]. Patient consent constitutes a fundamental ethical obligation; however, AI systems frequently utilize patient data retrospectively without obtaining explicit consent for particular tasks, thereby raising ethical issues [128]. AI in health care might yield improved therapeutic choices at reduced costs if the technology improves practitioners' assessment performance. However, it remains unclear if this would incur additional costs. The financial benefit of reducing the expenditure on AI or the unpredictability of its accuracy was modest. However, data on the danger characteristics of the population were more pertinent. Hence, knowledge with sophisticated training is required to use AI in dentistry.

To maximize economic efficiency, a study into the personalized use of AI for cavity diagnosis appears desirable [20,21,23]. The authors utilized deep-learning techniques centered on convolutional neural networks (CNNs) to identify adolescents who had supernumerary teeth during the initial stages of tooth development. Owing to its accuracy, sensitivity, specificity, and region under the ROC curve, the VGG16-TL prototype performed best, while the additional models also performed well. CNN-based deep learning is a potential method for identifying extra teeth in the initial stages of heterogeneous dentistry. These programs have demonstrated exceptional effectiveness, achieving online accuracy comparable to that of skilled and knowledgeable dental specialists. Dentistry has

best, while the additional models also performed well. CNN-based deep learning is a potential method for identifying extra teeth in the initial stages of heterogeneous dentition [174]. These programs have demonstrated exceptional effectiveness, achieving online accuracy comparable to that of skilled and knowledgeable dental specialists. Dentistry has used these AI-based systems to identify oral plaque, which is believed to be a precursor to most oral disorders, including tooth decay and periodontal disorders. Patients should not be subjected to the usual approach of finding dental plaque via exploration. An AI strategy based on CNNs can identify oral plaque in a child's teeth. Compared with a skilled dentist, an AI system showed greater precision in recognizing dental plaque [178]. The field of dentistry has extensively utilized AI technologies. Investigations into the application of AI in dentistry have found that neural networks outperform dental specialists with more reliability and efficiency. In several types of research, AI models have also performed better than experts. AI has advantages and disadvantages that are summarized in Figure 8.

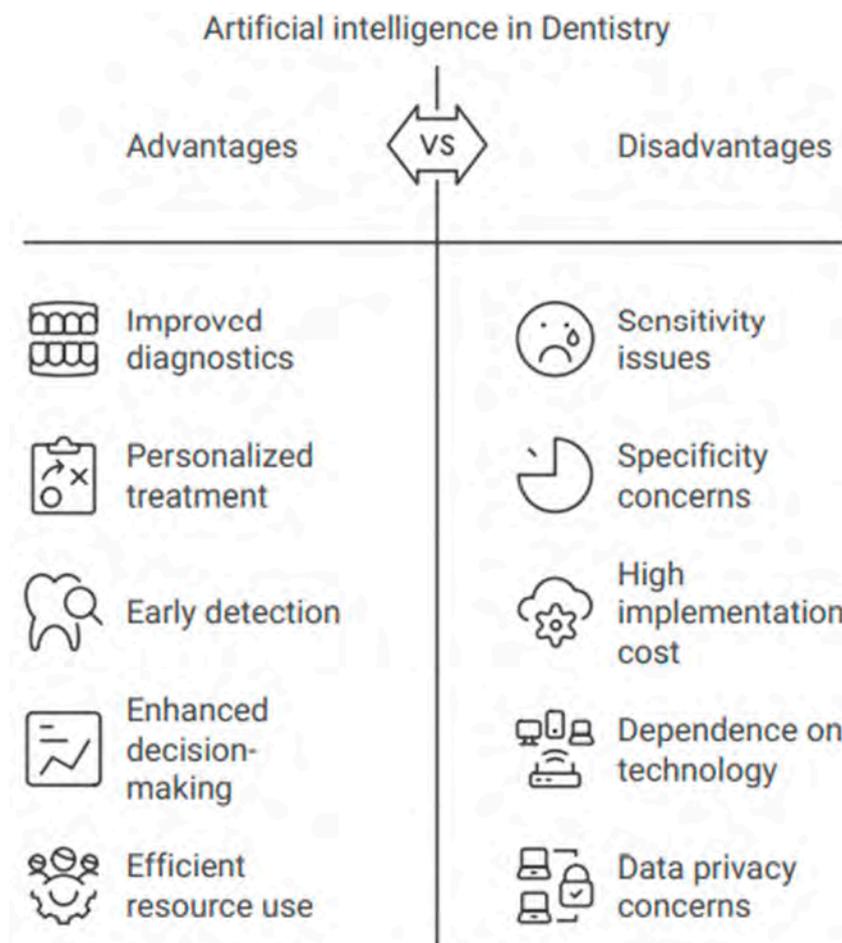


Figure 8. The advantages and disadvantages of artificial intelligence in dentistry.

The incorporation of generative AI, especially GPT-like models, in dentistry is an emerging trend that is revolutionizing patient communication and decision-making support [119]. Diagnostics, patient interaction, and instruction, including ChatGPT, utilize these AI models. They can improve patient communication, clinical decision making, healthcare accessibility, and efficacy. However, privacy concerns and the need for training and supervision make these technologies difficult to implement. Generative AI in dentistry requires these components. Generated AI models like ChatGPT can help dentists and patients connect by answering inquiries, scheduling appointments, and providing treatment information. This boosts patient happiness and engagement [130,131]. Personalized health information and reminders from these models can improve treatment adherence [130–132]. Surana et al. [133] opined that generative AI helps dentists determine dental restorations and issues on radiographs, improving clinical diagnostics. AI models can evaluate patient data and suggest viable therapy options, especially in complex cases [119,130,132]. To increase critical thinking and problem solving, dental education uses generative AI [134].

This tool provides immediate feedback and simulates clinical situations, preparing trainees for practical applications [131]. It also aids in literature evaluation and discovery, advancing dental knowledge [132]. Nevertheless, we must address data privacy concerns and the overreliance on AI-generated recommendations, given the great potential of generative AI in dentistry. Institutions must set rules and procedures to ensure AI use, emphasizing human control and the critical evaluation of AI outputs. AI apps can assist dentists not only in providing professional advice but also in supplementing and occasionally relieving them of tasks such as incorporating patient information and establishing professional connections [119,130]. AI is proficient at exploiting organized information and extracting inferences from large amounts of data, but it cannot make complex decisions like the human brain can [135,136]. Higher-level comprehension is essential in ambiguous scenarios such as physical examinations, integrating medical histories, appraising esthetic findings, and promoting discourse. Effective patient–dentist engagement necessitates a multimodal assessment of the child’s preferences, concerns, and goals. Despite disagreements about the incorporation of empathy into AI systems, these modes of communication are characterized by impulsivity and illogical behavior. AI can enhance patient care and reduce healthcare system strain by automating routine tasks and allowing clinicians to focus on complex cases. However, ethical principles should guide AI, as it cannot replace human expertise. Despite challenges like data collection, interpretation, and computational power, AI is a valuable tool for dentists due to its unbiased, reproducible, user-friendly, and transparent design. Future AI development should prioritize human interests while improving big-data processing. As dentistry is a multidisciplinary field, dentists must make the final decisions. AI is progressing rapidly and has the potential to become a standard tool in dentistry.

7. Conclusions

AI is a promising and growing technology in the field of dentistry, and it can reduce dental practitioners’ workloads and improve precision in diagnosis, decision making, treatment planning, and disease prognosis. In reality, AI is just a tool that may be programmed to perform exceptionally well and rapidly. Its successful integration necessitates a safe and controlled integration process, which, in turn, requires dental and continuing education training. AI also plays a critical role in incorporating aspects of these technologies. As various dental disciplines develop AI systems, their future in the healthcare system is promising, offering significant aid to oral health professionals. However, further research is required to more fully adopt AI in the dental field.

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American Dental Association
SCDI White Paper No. 1106

Dentistry — Overview of Artificial and Augmented Intelligence Uses in Dentistry

AMERICAN DENTAL ASSOCIATION STANDARDS COMMITTEE ON DENTAL INFORMATICS WHITE PAPER NO. 1106 FOR DENTISTRY – OVERVIEW OF ARTIFICIAL AND AUGMENTED INTELLIGENCE USES IN DENTISTRY

The ADA Standards Committee on Dental Informatics (SCDI) has approved ADA SCDI White Paper No. 1106 for Dentistry – Overview of Artificial and Augmented Intelligence Uses in Dentistry. Working Groups of the ADA SCDI formulate this and other specifications and technical reports for the application of information technology and other electronic technologies to dentistry’s clinical and administrative operations. The ADA SCDI has representation from appropriate interests in the United States in the standardization of information and electronic technologies used in dental practice. The ADA SCDI confirmed approval of ADA SCDI White Paper No. 1106 on December 30, 2022.

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AMERICAN DENTAL ASSOCIATION STANDARDS COMMITTEE ON DENTAL INFORMATICS WHITE PAPER NO. 1106 FOR DENTISTRY – OVERVIEW OF ARTIFICIAL AND AUGMENTED INTELLIGENCE USES IN DENTISTRY

Foreword

(This Foreword does not form a part of the ADA SCDI White Paper No. 1106 for Dentistry – Overview of Artificial and Augmented Intelligence Uses in Dentistry).

Artificial Intelligence (AI) and Augmented Intelligence (AuI) has been used throughout industry for several years already. If anything, its use and adoption is increasing. This white paper is designed to provide the best available information on AI available (as of early 2022) in dental imaging and other areas of dentistry where imaging may impact the use of AI (or vice versa). Dentistry will likely see many more advancements in imaging and elsewhere quickly.

The reader may find some very pertinent and useful information on where and how AI/AuI in dental imaging is currently used and impacting our profession and where it may go in the foreseeable future. It is a first step by the ADA SCDI, with much more specific detail to follow.

AI/AuI in dental imaging remains a dynamic area with considerable change taking place. This paper includes several images from various AI/AuI dental imaging vendors. Please note that no acknowledgements are provided for specific images in the document. The Working Group that developed this paper believes that the variations available in visualizations, styles or key tools provided by the vendors will change over time. Additionally, different tools and visualizations may have greater utility for one practice than another.

It is strongly recommended that anyone interested in AI dental imaging review more than one vendor in order to identify the system that best suits their needs. Therefore, the Working Group elected to “deidentify” the vendor from the image in order to prevent the potential interpretation that this document endorses a specific vendor system or that any one vendor system is superior for a specific task or tasks over another. In full disclosure, some AI vendors were involved in the development of this paper and are listed in the authorship section and their involvement provided for more comprehensive insight. Several others provided important but more limited content.

Further, this has been a collaboration of many world class experts from academia, industry and the profession in the field of AI. It is due to their dedication and efforts that this paper was possible. They contributed far more than what this summary paper can include. Much of that knowledge and information will be used in further technical reports and standards that will follow and help guide the profession forward in this exciting addition to our patient care efforts. The ADA SCDI wishes to thank everyone who contributed.

This white paper was developed at the request of the ADA SCDI Subcommittee on Knowledge Management, Gary Guest, chairman. The ADA SCDI is grateful to Mark Jurkovich for his leadership role in the development of this document.

AMERICAN DENTAL ASSOCIATION STANDARDS COMMITTEE ON DENTAL INFORMATICS WHITE PAPER NO. 1106 FOR DENTISTRY – OVERVIEW OF ARTIFICIAL AND AUGMENTED INTELLIGENCE USES IN DENTISTRY

Introduction

Artificial Intelligence (AI) and Augmented Intelligence (Aul) (defined below in definitions) are increasingly used as tools in dentistry in the area where computer science supports clinical and administrative tasks that aid dental care. AI and Aul both utilize algorithms extensively.

The *Merriam-Webster Online Dictionary* defines an algorithm as a finite sequence of well-defined instructions, typically used to solve a class of specific problems or to perform a computation.[1] Wikipedia states that, “Algorithms are used as specifications for performing calculations and data processing.” Even algorithms programmed to “learn to perform a task using training data” are designed by humans to perform the designated task of decision support (defined below), thus making the AI and Aul computer system tools to support people. [Algorithms vs A.I: What's the Difference & What They Mean for Medicine (medicalfuturist.com)]

Everyday life offers many examples of AI/Aul in use such as Alexa, Siri, robotics, and gaming including chess matches featuring computers versus human chess masters. Automobiles implement AI/Aul in adaptive cruise control, parking assistance, and “self-driving” vehicles. Countless other examples of AI/Aul implementations exist in daily life including numerous systems that apply AI with imaging for facial recognition or for biometrics such as retinal scans and fingerprint scans.

At the core, AI/Aul systems comprise a computer science designed to mimic human intelligence. There are a number of approaches to AI/Aul systems, which include machine learning, deep learning, cognitive computing, computer vision, and natural language processing. Machine learning involves training computing systems to look for hidden patterns in data to build analytical models. Deep learning utilizes more complex neural networks of computing systems that loosely mimic the human brain to discover and analyze complicated patterns in very large “big data” databases. Cognitive computing refers to the use of computer systems to simulate human thought processes. Computer vision uses deep learning to recognize patterns in images and videos. Natural language processing (NLP) and intelligent document processing (IDP) use AI/Aul to recognize ideas in speech and written language and to capture these ideas as digital data elements as well as to communicate with system users in ordinary language.

Forbes stated in 2018 that the most important AI and Aul areas for healthcare would be administrative workflows, image analysis, robotic surgery, virtual assistants and clinical decision support.[1]] A 2018 report by Accenture mentioned the same areas and also included connected machines, dosage error reduction, and cybersecurity.[2] A 2019 report from McKinsey states important areas being connected are cognitive devices, targeted and personalized medicine, robotics-assisted surgery and electroceuticals.[3]

A recently published systematic review[4] states, “AI models have been used in detection and diagnosis of dental caries, vertical root fractures, apical lesions, salivary gland diseases, maxillary sinusitis, maxillofacial cysts, cervical lymph nodes metastasis, osteoporosis, cancerous lesions,

diagnosis of dental caries, vertical root fractures, apical lesions, salivary gland diseases, maxillary sinusitis, maxillofacial cysts, cervical lymph nodes metastasis, osteoporosis, cancerous lesions, alveolar bone loss, predicting orthodontic extractions, need for orthodontic treatments, cephalometric analysis, age and gender determination.”[4] The authors also state that these dental AI tools, “...mimic the precision and accuracy of trained specialists. In some studies it was found that these systems were even able to outmatch dental specialists in terms of performance and accuracy.”[4]

The first robotic dental surgery system was cleared by the Food and Drug Administration for dental implant procedures in 2017. At the end of 2017, the world's first autonomous guided dental implant placement system was developed by Zhao and colleagues in China.[5] While dentistry has seen the increasing development of AI/AuI to support clinical care as well as administrative functions, electronic dental record systems (EDRs) used in many general dental practices have fallen far behind those used by our medical colleagues, in large part because they have less standardized “structured” information available for processing. Dentistry does not regularly record diagnostic codes, various patient observables, structured health history information, risk assessment tools filled out by patients, images with standardized metadata such as patient name, date of exposure, and type of image modality, and a host of other information data points that are now common within electronic medical record systems (EMRs).

In the EMR, using AI/AuI, the collected structured data is collated and compared across populations to provide medical clinicians with more information and “*decision support*” to assist the provider in determination of issues such as recommended tests, appropriate prescribing, and differential diagnosis. It is critical to note that, while AI/AuI systems can provide the clinician with great information on population health patterns, the clinician always must decide how this information applies to the individual patient. Human providers are always in control of care decisions and may receive support from AI/AuI systems in making those decisions. As dental systems improve and allow for greater structured documentation, increased computable decision support options will become available to the profession, including evidence-based guidelines to support defined standards of care.

As AI/AuI are incorporated into the EDR, additional considerations such as security, privacy, trust, quality, safety, and data standardization will ultimately determine the reliability and validity of AI/AuI tools applied to dentistry. In addition, consumers will, in the near future, expect access to their EDR digital data, including images, as required in the federal regulations surrounding information blocking included in the 21st Century Cures Act.

This white paper will introduce the use of Artificial Intelligence and Augmented Intelligence in clinical disciplines that include prevention, caries and periodontal disease, implants, oral and maxillofacial surgery, endodontics, prosthetics, dentomaxillofacial imaging, orthodontics, temporomandibular joint disorder and sleep disorders. Promising developments in teledentistry, electronic dental records, dental laboratory uses, and scanning are additional clinical topics. The clinical section concludes with a discussion of how AI and AuI related to dental imaging might impact clinical workflow and benefit the patient, both now and in the future.

Next, the white paper provides information on non-clinical areas with an initial focus on payor topics, such as claims processing, payment integrity, and quality assurance and on dental practice administrative issues involving claims preparation, including attachments. Additional non-clinical

topics include a discussion of the regulatory environment, including the global framework and the U.S. regulatory landscape, with particular focus on the U.S. Food and Drug Administration.

In addition, the white paper includes two Appendices. Appendix 1 is “Imaging and Algorithms,” which discusses key principles of machine learning training and validation and which offers the reader key questions to consider about intended use and system performance. Appendix 2 is “FDA’s Ten Principles of Good AI/Machine Learning Practices,” which details present and potential future legislation and regulations related to AI.

AMERICAN DENTAL ASSOCIATION STANDARDS COMMITTEE ON DENTAL INFORMATICS WHITE PAPER NO. 1106 FOR DENTISTRY – OVERVIEW OF ARTIFICIAL AND AUGMENTED INTELLIGENCE USES IN DENTISTRY

1 Scope

This document introduces the use of Artificial Intelligence (AI) and Augmented Intelligence (AuI) in clinical disciplines including prevention, caries and periodontal disease, implants, oral and maxillofacial surgery, endodontics, prosthetics, dentomaxillofacial imaging, orthodontics, temporomandibular joint disorder and sleep disorders. Promising developments in teledentistry, electronic dental records, dental laboratory uses and scanning also are included.

This paper further provides information on non-clinical areas, with a focus on payor topics, such as claims processing, payment integrity and quality assurance, and on dental practice administrative issues involving claims preparation, including attachments. The document also provides information on the current regulatory environment, including the U.S. Food and Drug Administration (FDA) and the global framework.

2 Terms and Definitions

In this document, the following definitions are applied to these specific terms:

Artificial Intelligence (AI) – Intelligence demonstrated by machines as opposed to natural intelligence displayed by humans. Some AI textbooks define the field as the study of any system that perceives its environment and takes actions that maximize the chance of achieving its goals.

Augmented Intelligence (AuI) – Sometimes referred to as intelligence amplification, AuI plays a similar role to AI except that it keeps human intelligence elements in its procedure. Rather than performing an assignment for a clinician like AI might do, AuI acts as a tool to assist the clinician in the task. One aspect of The American Medical Association House of Delegates' definition emphasizes that AuI's design *enhances* human intelligence rather than replacing it.

Clinical Decision Support (CDS) – Clinical decision support provides timely information, usually at the point of care, to help inform decisions about a patient's care. CDS tools and systems help clinical teams by taking over some routine tasks, warning of potential problems, or providing suggestions for the clinical team and patient to consider.

Machine Learning (ML) – IBM defines machine learning as a branch of AI and computer science which focuses on the use of data and algorithms to imitate the way that humans learn, gradually and automatically improving its accuracy.

Training Dataset – In dental imaging, the training dataset is typically a collection of dental images, such as intraoral radiographs. The samples in the dataset will provide examples of the kinds of finding the network is to detect. For instance, the sample radiographs might have a variety of already labeled class II lesions. It is then hoped the resulting network detects those lesions as effectively as the humans who originally identified them.

Validation Dataset – For a system to be validated, there must be a reference standard to which it's held. For a human clinician, that standard may be the opinion of teachers or of a review board. But for a software system, validation is typically achieved through testing against a validation dataset of

test cases, which operates as a gold standard. And because the system cannot be interrogated as to its methods, the only way to evaluate the system is by its effectiveness in those test cases.

Testing Dataset – After an algorithm is created using the training dataset and validation dataset, the testing dataset (also known as a “holdout dataset” because it is a set of data never before seen by the algorithm) may be used to verify the algorithm’s ability to perform on new data.

Ground Truth (also referred to as gold standard classification) – In machine learning, the term “ground truth” refers to the accuracy of the training set’s classification for supervised learning techniques. This is used in statistical models to prove or disprove research hypotheses. It is critical for each validation test case that expected findings be correct and that the *ground truth* for each case is well established. In the case of dental imaging, analysis by oral and maxillofacial radiologists (OMR) to set this *ground truth* is highly regarded, but their participation in establishing this ground truth for any specific product or service is not guaranteed.

3 How is Artificial Intelligence (AI)/Augmented Intelligence (AuI) Being Used Clinically in Dentistry?

General Dental Anatomy Use

AI/AuI is used to identify anatomy and disease.

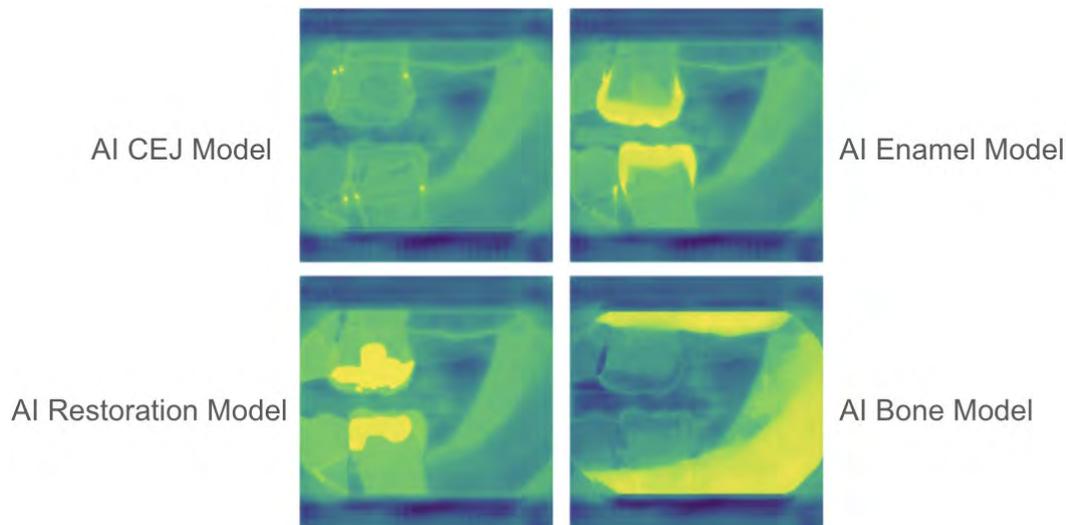


Figure 1 – Computer Vision Models Identifying Basic Oral Features

The panel illustrates images being processed by machine learning algorithms in order to detect and predict various findings of clinical importance highlighted in yellow.

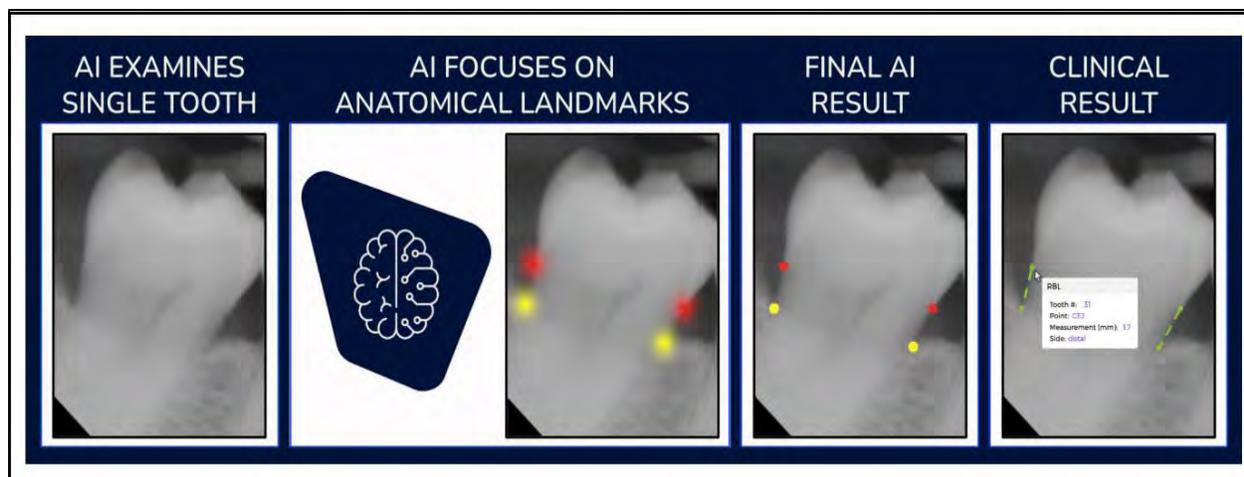


Figure 2 – Basic Example of How AI Provides a Clinical View from an Intraoral Image

Preventative and Maintenance Use

AI/AuI assisted diagnosis could allow for earlier intervention and preventative treatment with a diagnosis that can also be monitored. AI/AuI may assist dentists in many ways through continuous evaluation of their existing data. For example, periodontal disease is best treated through early intervention. Monitoring of existing data, including images, through AI/AuI will help identify changes and allow for preventative or early treatment.

AI/AuI assessment of images may also be incorporated into the treatment planning for certain preventative services, such as preventative resin restoration and space maintenance.

For the former, the decision to place a preventive resin restoration is based on clinical evaluations, patient dental history, and interpretation of diagnostic materials such as radiographic images. AI can detect and quantify the radiographic extent of caries. It could potentially generate treatment proposals, including assisting clinicians in determining the most effective and least invasive course of treatment.

For the latter, AI/AuI, using images, can aid in the detection of conditions that can lead to loss of space within a dental arch; ectopic eruption, ankylosis of a primary tooth; dental impaction, congenitally missing teeth, or other abnormal dental morphology.

Caries Detection Use

How dentists may best incorporate AI/AuI as a tool within their practices is ultimately the dentist's decision, but, as an aid to diagnosis, the technology has the potential to improve caries detection by clinicians.

Historically, caries detection was and still is achieved by clinical examination using a mirror and explorer in conjunction with a bitewing radiograph. Present use of digital imaging and scanners has improved detection, but AI/AuI has the potential to quantify and transform previous measures to improve patient treatment and outcomes.



Figure 3 – AI-enabled Caries Detections and Tooth Part Segmentations, Provided by a Real-Time Chair-Side AI Radiology Interface

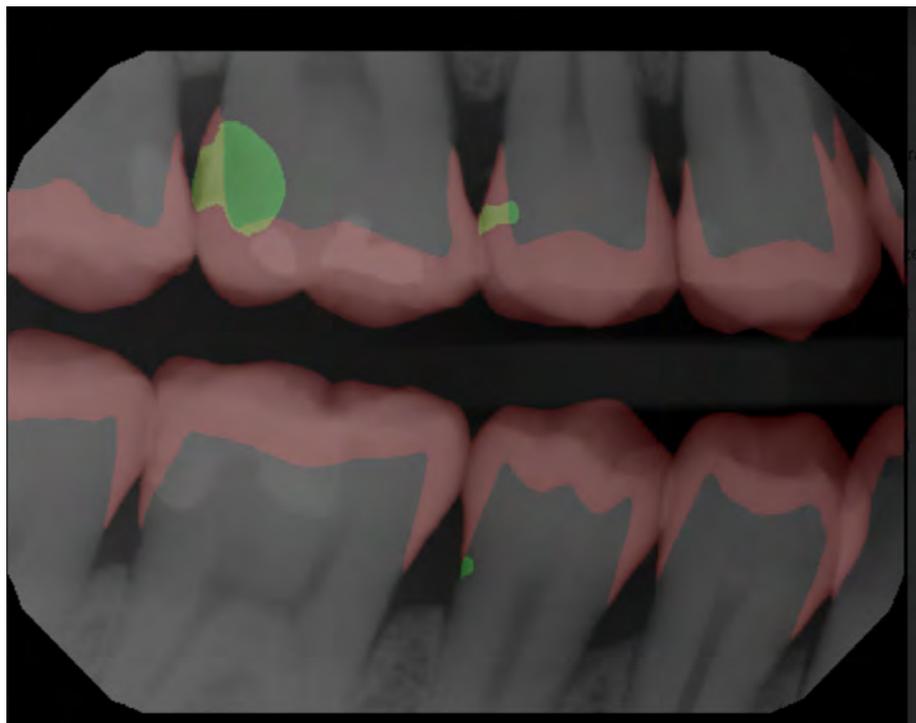


Figure 4 – AI-enhanced Image Which Shows Models Applied for Caries Identification and Quantification (Yellow) and Enamel (Red)
The ability to identify the DEJ allows for representation of carious lesion classification as well as progression or resolution in accordance with evidence-based literature.

Detection of early caries in enamel prior to formation of dentinal caries may enhance minimally invasive approaches to early caries. According to a study published in the Journal of Dentistry in December 2021, “The increase in sensitivity enabled by the use of AI was demonstrated in enamel caries, but not early or advanced dentin lesions.”[7]

Currently, none of the existing dental imaging systems can differentiate active from arrested caries. One exciting opportunity for AI/AuI is to provide objective measures for baseline and follow-up for remineralization. The ability of AI/AuI to quantify the percentage of demineralization and assess trends could establish the validity of longitudinal data assessment over time as compared to a one-time, cross-sectional evaluation. AI/AuI has the capacity to “autocorrect” dental images and could not only assist in detection of active and arrested caries, but also in longitudinal patient database monitoring.

Periodontic Use

One purpose of a periodontal examination is to obtain data about clinical conditions. Common tools to obtain this data are a periodontal probe and various types of radiographic images. Several factors affect accuracy of the data using these tools.[8]

Data from a periodontal examination is required to determine diagnosis, risk, and prognosis as well as care choices. The appropriateness of the care choices is dependent on the comprehensiveness and measurement accuracy of clinical conditions assessed. Comprehensiveness and measurement accuracy are subject to clinician bias, skill, tools, and time. An inaccurate diagnosis, risk, or prognosis may occur because none are established using a standard method, set of clinical conditions, or weight for each clinical condition.[9]

Comprehensiveness and measurement accuracy of clinical conditions may be improved by AI/AuI applied to images by developing a method to automatically measure clinical conditions (Table 1).[9]

Accuracy of a diagnosis, risk, and prognosis may be improved by AI/AuI applied to images by developing a method that correlates a pattern in images to a similar pattern associated with a diagnosis, risk, or prognosis. This is important because gingival inflammation and loss of periodontal support can occur for reasons other than periodontitis. There are also many patterns of severity and distribution of clinical conditions that occur in periodontitis. Further, several categories of risk and prognosis are possible for a diagnosis of periodontitis.[10]

Using AI/AuI to assist in obtaining data about clinical conditions and establishing a diagnosis, risk and prognosis may be more efficient and accurate compared to current tools and techniques.

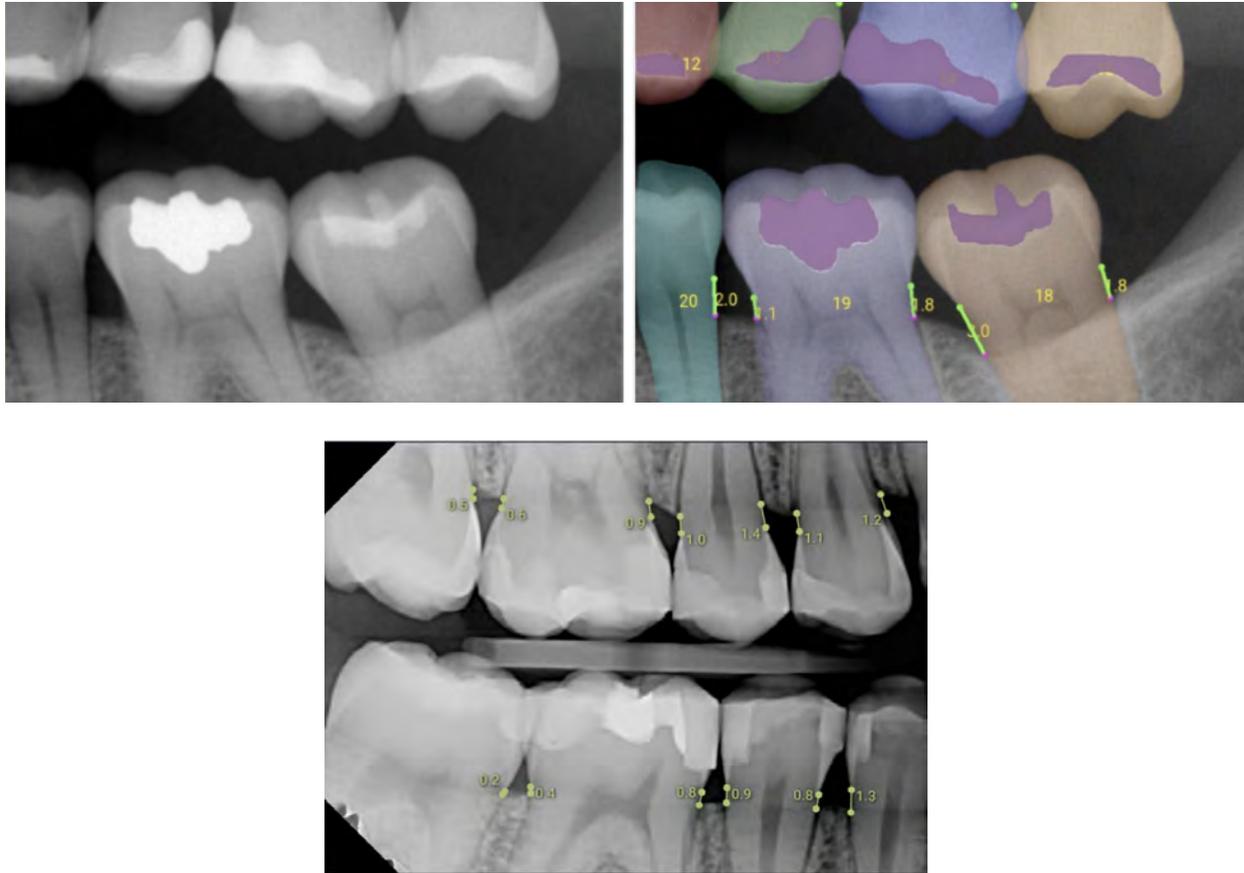


Figure 5 – Bitewing Radiograph Illustration Output

Bone level measured from CEJ to alveolar bone crest, without outputs displayed in millimeters. Additional models to detect tooth #, surface and associated restorations also visualized. Lower image indicates bone level loss with an estimated millimeter level.

Other evolutions of AI/AuI have been used to determine clinical attachment levels (CAL) and radiographic bone level. However, some challenges are encountered in evaluating dental bitewings and periapical radiographs due to the limited field-of-view of these images. A recent study using additional AI/AuI-related tools improved prediction of CAL from standard types of radiographs.

Determining radiographic bone level is important for making a periodontal diagnosis. We must also recognize that accurate interpretation of radiographic bone level is affected by individual experience and knowledge. Deep learning models, another AI/AuI tool, have been developed to assist clinicians in interpreting and measuring alveolar bone, allowing for a more accurate and reliable periodontal diagnosis. Studies have been published that describe measuring alveolar bone level on panoramic[11-13] or intraoral[14] radiographs using deep learning models. Specifically, one study demonstrated that a reliable periodontal diagnosis can be made based on interproximal bone level percentage and distance of each tooth measured by the deep learning model. Studies suggest the use of deep learning not only improves diagnosis accuracy but also significantly enhances clinical efficiency.[14]

These models require good image quality. Even with good quality, current radiographic images may lack the sensitivity necessary to capture the earliest stage of bone loss.

Additionally, many imaging capabilities are under investigation regarding the efficacy of monitoring and resolving inflammation. Future investigations are warranted to evaluate the application of AI/AuI imaging regarding measures and analyses used in the care for periodontitis (Table 1).

Table 1 – Examples of Measures, Calculations, and Analyses relevant for clinical care that may be obtained by AI applied to images

Measures	Calculations	Analysis
Severity and extent of inflammation	Rate of bone loss	Likelihood of a diagnosis of periodontitis
Pocket depth	Number of extracted teeth	Likelihood of risk for a periodontitis for its natural history
Clinical attachment level	Crown to root ratio	Likelihood of a prognosis for the natural history of periodontitis
Gingival margin from CEJ	Percent bone support	Effectiveness of treatment to prevent bone loss
Attached gingiva	Percent bone loss	Likelihood of proposed treatment to prevent bone loss
Gingival thickness	Surface area of bone support	

NOTE: Measures and calculations may apply to a tooth, sextant or other segment of a dentition, or to the entire dentition. A calculation may require images from different periods of time. Also, an analysis may require data regarding proposed or completed treatment.

Dental Implant Use

Dental implants have been broadly used to replace missing teeth since 1980. Challenges remain in design, performance monitoring and understanding of implant types and how well they work.

Various AI/AuI models have been developed to recognize the implant type in periapical and panoramic radiographs.[15-20] Similarly, AI models have been presented as reliable tools in determining the osteointegration success or implant prognosis[21-27] along with optimizing dental implant design [15-17]. In addition, a recent study showed the effectiveness of an AI/AuI model in identifying fractured dental implants using panoramic and radiographical images.[28]

The overall accuracy for AI/AuI models applied for implant type recognition ranges from 93.8 % to 98 % for prediction of osteointegration, while implant success varied between 62.4 % to 80.5 % among the related studies.

The future of implant dentistry could be focused on integration of radiographic implant images with cone beam computed tomography (CBCT) scans to enhance the accuracy of implant type recognitions. Moreover, standardization of dental imaging systems can provide a data set with higher quality for AI/AuI models, which could increase the accuracy of those models in identifying the implant type or predicting implant success.

Oral and Maxillofacial Surgery Use

Although the application of AI/AuI in oral and maxillofacial surgery is currently limited, the scope in the future may be vast. AI/AuI tools may assist Oral and Maxillofacial Surgeons (OMS) in diagnosing and planning treatment with the least possible errors.[29]

The ability to accurately classify individuals with cancer (true positives) among a pool of individuals in which a few have cancer is called sensitivity. The ability to accurately classify individuals without cancer (true negatives) is called specificity.

One study demonstrated that the use of AI/AuI tools was able to accurately predict the subgroups of internal derangements of the temporomandibular joint with very high specificity and sensitivity. The use of AI/AuI tools may help reduce the dilemma that dentists and surgeons have while diagnosing these conditions and help in the accurate prediction of treatment.[30]

Additional research has shown other promising results from the use of AI/AuI tools in the oral and maxillofacial specialty. Work has been done effectively by many researchers demonstrating that AI/AuI has great potential in simplifying the diagnosis and treatment of odontogenic cysts and tumors.[31, 32] AI/AuI tools have also been shown to aid in the early diagnosis of oral cancer detection. This can help to reduce the mortality associated with missed or late diagnosis. [31, 32] OMS are using AI technologies to assist them in precise diagnosis, the need of surgery, type of surgery, and postoperative outcomes following orthognathic surgery, with a high degree of accuracy and reproducibility.[33]

Additionally, Operation Smile and Microsoft are developing a tool that uses AI to improve outcomes after a cleft lip operation. This technology uses standardized pictures of the patient before and after the procedure to grade the result and inform the surgeon whether the outcome was satisfactory or not.[34]

The future applications of this technology can make oral and maxillofacial surgery potentially more efficient. Robotic assisted placement of implants is already a part of dental armamentarium. Trans-oral robotic surgery has gathered a lot of attention for oropharyngeal cancer surgery. Although currently no clinical trial has been done to compare the effectiveness of this technology, the initial results are very heartening.[35] With the right motivation and acceptance of new technology, the future of AI/AuI in oral and maxillofacial surgery appears bright.

Endodontic Use

AuI in endodontics is at a nascent stage [43, 44] however there are several areas where AI can support clinicians in endodontic treatment. Clinicians who do not have a strong background in interpreting radiographs will benefit immensely from these systems by helping them reach diagnostic accuracy potentially similar to that of specialists or experts.[43, 44] Dental specialists remain a critical part of not only developing AI/AuI further, but to provide sound patient outcomes in many complex cases.

In endodontics, imaging is of paramount importance as a diagnostic tool and as a modality to assess treatment outcomes. A clinician's ability to correctly interpret radiographic findings is central to the practice of endodontics. A significant issue facing dentists is the lack of consistency in

interpreting radiographs among clinicians, sometimes due to the use of different imaging modalities.[36, 37]

Overall, extensive evidence shows that CBCT volumetric analysis is more accurate than periapical radiographs when detecting periapical lesions.[38-42] Dentistry is experiencing growth of the use and acceptance of CBCT.

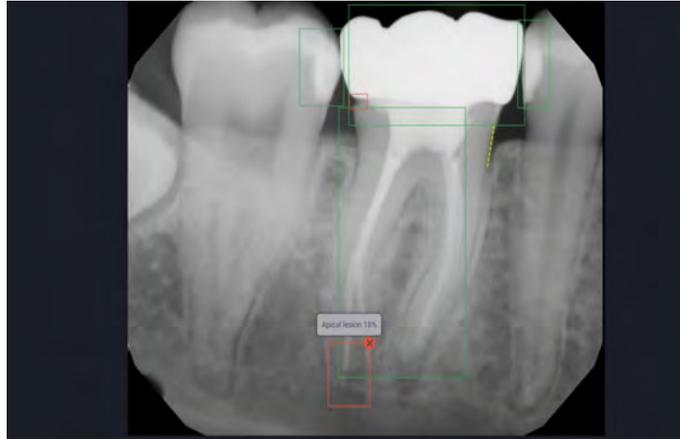


Figure 6 – Screen Shot of a Periapical Radiograph that Includes an Endodontically Treated Tooth and has been Analyzed by their AI Algorithms.

Current advances in the use of AI/AuI systems in endodontics appear to focus on the following areas:

- 1) Detection** – A diagnostic support tool to aid clinicians in identifying periapical lesions, crown and root fractures, apical foramen determination, or assessing the quality of an existing root canal filling.
- 2) Pre-treatment planning** – A tool to provide information such as working length determination, root and root canal system morphology such as the degree of canal curvature.
- 3) Prediction** – AI is currently used in predicting outcome of endodontic retreatment and viability of stem cells.

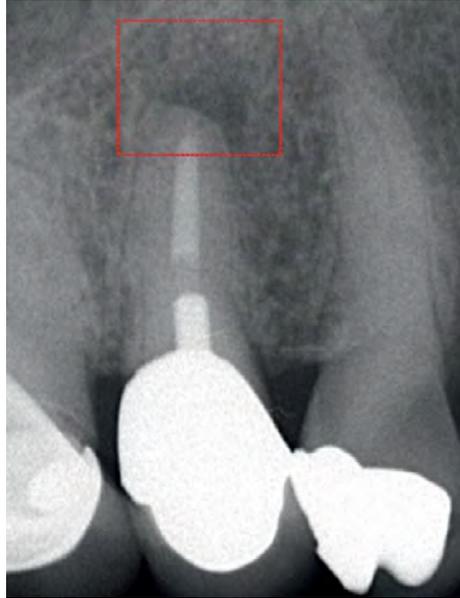


Figure 7 – Periapical Radiolucency on an Image without AI Definition

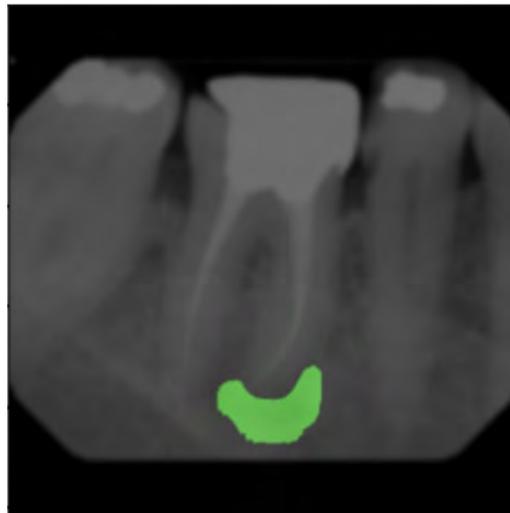


Figure 8 – Image using AI Visualization to Identify the Periapical Radiolucency (PARL)

Tracking progression or resolution of PARL's over time is a powerful tool for the clinician to have at their disposal.

AI/AuI has shown to be promising in identifying periapical pathologies. With CBCT as the imaging modality, an AI/AuI tool was successful in detecting 142 of a total of 153 periapical lesions and the reliability of correctly detecting a periapical lesion was 92.8%.[43]

Another area where AI/AuI has shown to help is in the detection of vertical root fractures (VRF). It is challenging to detect VRFs when looking at a two-dimensional radiograph without separation of the root fragments. However, there may be changes to the bone pattern suggestive of a VRF that can be identified by CBCT. Generally, CBCT is a better imaging modality for the detection of VRFs.

Using CBCT images, AI/AuI technology has demonstrated accurate diagnosis of VRFs in endodontically treated teeth, as well as intact teeth.[44]

Other areas include differentiating single vs. multiple roots in the distal root of a lower mandibular molar where one study showed high accuracy with the use of AI/AuI. [45]. Another study showed superior accuracy (96%) in locating the minor apical constriction, as compared to an endodontist (76%) using periapical radiographs.[46] For clinicians, it is very useful to obtain an accurate working length prior to endodontic treatment.

While the use of AI/AuI in endodontics is still in its infancy, the above examples show that incorporation into various aspects of endodontic care have the potential to improve accuracy in the information needed for the best care for their patients.

Dental Prosthetic Use

The laboratory side of dentistry has been a leader in technology and AI/AuI for the past 20+ years. This first started with the introduction of chairside scanning in conjunction with chairside design and milling. AI/AuI technology has been used in designing final restorations for decades. It is increasingly rare that laboratory technicians are doing traditional wax-ups for cases when a digital AI-based wax-up can be completed in seconds on most dental design software. The speed, reproducibility, and cost savings makes it efficient for the laboratory industry to incorporate these types of software into their ecosystem.

In addition, AI/AuI-based tools can assist in design of surgical guides and occlusal guards. With surgical guides being designed with only a few clicks on the intraoral scan, the dental team could place implants in an ideal position based on the restorative plan and ensure a proper fit on the digital patient model. With these digitally AI/AuI-designed surgical guides, practitioners could also utilize 3D printing in their practices to save cost and time on their implant cases.

The most recent AI/AuI-based technology to enter the laboratory space is case scoring, routing and automated margin marking. A big problem with large labs is routing their cases. A lab owner would want their best lab technician to get the most difficult cases and less experienced lab technicians to get more predictable cases that require very little guessing.

In addition, if a scan is of a minimum threshold, it can be automatically margin marked and sent to the AI/AuI-design phase without human intervention.

By utilizing AI/AuI algorithms throughout the lab process, the dental community can benefit from consistency, reproducibility, cost savings, and added intelligence to give patients the best restorations possible in the shortest amount of time.

Dental Radiology and Other Forms of Imaging Use

Applications of AI/AuI in radiology provide automatic recognition of complex patterns in imaging data and provide quantitative and qualitative radiographic assessment. The use of AI/AuI has shown very promising results in the field of oral and maxillofacial radiology.[47]

The potential clinical uses of AI/AuI in dentomaxillofacial radiologic imaging span a spectrum of end user applications. These include but are not limited to:

- Providing clinical data-driven decision trees to select the appropriate imaging examination.
- Identifying radiologic manifestations of disease. Examples: Coronal radiolucencies, periodontal bone loss, apical radiolucency, erosion of mandibular condyle.
- Interpreting radiologic findings. Examples: Caries lesions, marginal discrepancies, widened PDL's, calculus detection, periodontal bone loss, apical periodontal inflammation, TMJ pathology. Such automated interpretations may be based on radiologic image analysis alone, or may be combined information from historical, clinical, and laboratory findings.
- Applying radiomic information to predict therapeutic response and assess prognosis.
- Screening for potential disease. Examples: Osteoporosis.
- Annotating and/or segmenting anatomic structures. Examples: nerve canals, jaw bone segmentations, cephalometric analyses.
- Image enhancement and manipulation. Examples: Artifact reduction, low-dose imaging.
- Quality analysis and improvement. Example: Automated analysis of 2D- and 3D-image datasets to identify artifacts and technical errors.

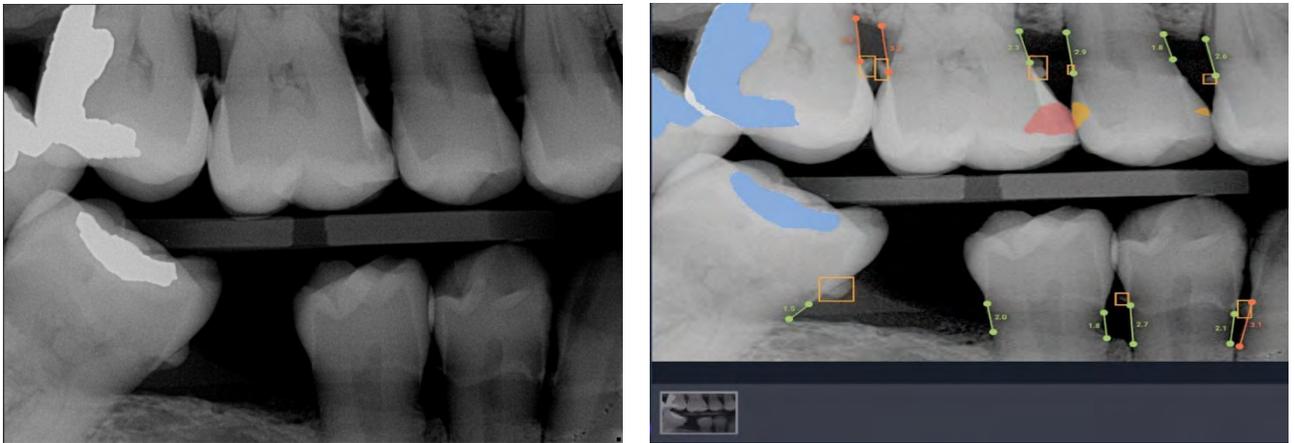


Figure 9 – Example of how AI Technology can Illuminate a Black, White and Grey Radiograph with Quantified, Precision Outputs for Doctor Communication and Patient Education

Key Questions to consider as you explore AI/AuI in dental imaging:

- 1) What tasks are claimed as part of the system's intended use?
- 2) How was it established that the validation dataset had enough images for each classification task claimed as part of intended use?
- 3) How was it established that the validation dataset had sufficient variety in gender, age, and ethnicity? And how was it established that there were enough images for each subpopulation?
- 4) Was the validation dataset sequestered from the training and testing processes?

- 5) If the system's intended use includes treatment planning, what rate of false positives should be expected?
- 6) If the system's intended use includes radiographic screening, what rate of false negatives should be expected?

Information describing how to evaluate systems using these questions can be found in Appendix 1. Additional questions for consideration can be found at the end of Appendix 1.

Future applications

Extending current techniques such as lesion detection and early lesion prediction may have major impacts on patient care.[48, 49] Image quality and quality analysis are poised for significant improvement.[50, 51] Patients may potentially see reductions in radiation exposure through application of some of these changes.[52]

Orthodontic Use

Orthodontic care has already seen significant impact from the application of various AI/AuI technologies. The dental community is well aware of the introduction and growing use of remote orthodontic care, both by those directly providing the care and by others using increasing levels of patient involvement and remote monitoring.

Growth assessment, an important element in identifying appropriate treatment has been an area of significant study in the orthodontic field. Currently, two of the most prevalent ways of growth assessment are cervical vertebrae maturation (CVM) on the lateral cephalometric image and the use of an additional x-ray, the hand-wrist radiograph. One current CVM analysis using AI/AuI algorithms reported a mean accuracy of 77.02%, which is considered very high.[53] Another AI study, using dental age, had an accuracy of over 90%, surpassing dental experts at age classification.[54]

The lateral cephalometric image is a sine qua non of a diagnostic orthodontic workup. Clinicians often spend several minutes tracing this image and variability can be high on certain radiographic landmarks, even among expert clinicians. A study on an AI/AuI-powered algorithm using convolutional neural network (CNN) showed tracing accuracy exceeding 90% and concluded that automated identification was more consistent than manual identification.[55] CNN is a network architecture for deep learning that learns directly from data. CNNs are particularly useful for finding patterns in images to recognize objects, classes, and categories.

This is just part of the story of AI/AuI use in orthodontics, however. Orthodontic care is increasingly using AI/AuI technologies for facial analysis, improving diagnostic accuracy, case design and treatment planning. Scans, model design and retainer construction are other areas where AI/AuI supported technologies are changing the care patterns and office treatment used in orthodontics.

Temporomandibular Joint Disorder (TMD) Use

We have already learned that oral and maxillofacial surgeons and others treating joint disorders can use AI/AuI-assisted imaging in accurately predicting internal derangements. Other areas of AI

use in dentistry not directly associated with imaging may also assist clinicians in reaching both a proper diagnosis and best treatment plan.

Another area experiencing significant change is using AI/AuI-based nightguard design associated with intraoral scanning. These designs take into account the opposing occlusion to verify a proper bite for the patient when an appliance is worn. This AI/AuI-based design takes a very manual and challenging lab product and turns it into a highly scalable and repeatable procedure for all involved. If a patient were to lose their nightguard, or their dog decides to have a snack of plastic, the lab can simply reprint or mill the nightguard and have it shipped overnight for the patient to wear the next day.

Sleep Disorder Use

While it may not be intuitive that our various forms of imaging (radiographic, scans, visible, etc.) would be of use in addressing sleep disorders, increasingly the use of AI/AuI technologies are being investigated, along with imaging, to help clinicians and patients in this regard. Imaging helps identify the airways, obstructions, different designs, etc. As the amount and variety of imaging grows, identifying patterns through AI/AuI technologies will help in determining risk and identifying patients that would benefit from interventions.

Imaging coupled with various AI/AuI tools are already helping to do morphological analyses, classification of obstructive sleep apnea (OSA), screening and automation of landmark documentation. Future uses potentially include enhanced risk identification, remote monitoring and identification of the most effective treatment paths for patients.

Teledentistry Use

The use of both AI/AuI-based technologies paves the way for precision dentistry, focusing on providing tailored dental treatment plans and therapies for patients based on the integrated and analyzed information. Images, including radiographs, clinical photos and scanned models, are generally important for dental diagnosis, outcome evaluation and planned procedures. AI/AuI can interpret images and improve image quality to facilitate clinical decisions.

Although dental treatment cannot be remotely provided, teledentistry provides a newer approach to screen, diagnose oral diseases, and potentially help patients manage oral diseases when immediate dental care is not available. For some aspects of treatment, such as consultation and disease screening, teledentistry is comparable with face-to-face visits.[55-57]

When the data and information are collected during remote conversations or through online platforms in teledentistry, images are the most useful resources to evaluate the clinical conditions. AI can assist clinicians in interpreting these images to provide timely feedback. Additionally, many dental offices have digital records of their patients such as digital radiographs, intraoral scans, digital CBCT scans and intraoral and extraoral photographs. These existing images can aid the clinician and the AI in diagnosis and treatment planning in teledentistry.

Consultation, Triage and Diagnosis

During remote consultations, clinicians can make preliminary diagnoses and treatment plans based on the screening questionnaire, EHR/EDR and images. In addition to consultations, teledentistry can be used to triage patients who have active diseases or screen the patient's need for dental care. With the popularity of smartphones, patients can easily take clinical photos and share them with clinicians before or during teledentistry.

It is well known that radiographic images are essential to diagnose caries, periodontitis and other oral diseases. The literature has shown that radiographic images were used to triage patients who have maxillofacial trauma and decide whether these patients need surgery or other proper treatments.[58] The clinical photos taken by a smartphone were used to screen the dental conditions of children to make a preliminary diagnosis and suggest a treatment plan.[59, 60]

The clinical photos and scanned images can also be used for dental smile design.[61] These approaches are not only cost-effective but also have acceptable accuracy compared to the standard in-person screening and examination. Using AI/AuI-based technologies can further improve efficiency and efficacy in image processing and interpretation.

Monitoring

Teledentistry can also be used to monitor patient compliance and progress of treatment.[62, 63] During the COVID pandemic, clinicians used photos to remotely monitor surgically and non-surgically treated dental patients to decide whether they needed a clinical visit.[64] Photos were also used to monitor the oral hygiene of the patients who received orthodontic treatment.[65] AI/AuI can analyze and interpret these clinical photos in advance to help clinicians more efficiently screen these clinical pictures and make proper clinical suggestions, prepare their schedule and preplan for when orthodontic treatment isn't progressing as planned.

Electronic Dental Record (EDR) Use

In conjunction with reading radiographic imagery of patients and cross-referencing that output with data from the EDR/EHR, AI can help assist the dental team with understanding who has unscheduled treatment, potentially missed diagnoses and clinical opportunities to better serve their patients, based on complicated personal, medical, dental and behavioral information and the already established database in the electronic records system.

Data collection and repository

A large amount of high-quality data and a large number of images are required to develop AI/AuI-powered tools. The EDR/EHR is a great platform to store and integrate these data and images. To ensure quality and facilitate data sharing, a large and standardized database must be developed. BigMouth is an oral health database[66] populated from dental schools in the United States. It was developed from partially de-identified EDR/EHR data, including medical history, dental history, clinical findings, planned and received procedures. Radiographic images will be added in the future.

With this kind of effort, the shared data and images can be analyzed for quality management in clinical care and for research purposes, such as training and validating AI/AuI models.

Diagnosis, Treatment Planning, and Risk Assessment Based on EDR/EHR

Clinical diagnosis and treatment plans are the most important decisions that clinicians have to make based on available history, clinical findings and radiographic images. Sometimes, improper decisions might be made because of ignoring or misinterpreting information. A variety of data and images in the EDR system can be integrated to establish a knowledge network to facilitate clinical decision-making. All information can be comprehensively organized and analyzed by AI/AuI, then the reports can be provided to help clinicians make clinical decisions.

Several caries[67] and periodontal risk assessment tools[68-71] are available to assess the progression risk of caries and periodontal diseases. Similar to diagnosis and treatment planning, multiple medical, personal, and clinical characteristics have to be assessed to identify and stratify clinically distinct risk profiles. With the assistance of the EDR system, parameters included in the risk assessment models can be immediately analyzed to assign the risk profile to each patient. AI/AuI can analyze large clinical data sets and images over time to improve the clinical relevance of these identified risk factors and provide more personalized risk assessments for individuals.[72, 73]

Scanning Use

With the advance of digital dentistry, it is now common to scan teeth and tissues to replace traditional impressions. Digital scanning can reduce patient discomforts and improve clinical efficiency compared to traditional impressions. According to an American Dental Association Clinical Evaluators Panel survey in 2021, approximately half of dentists are using intraoral scanning in their practice.[74] AI/AuI is able to help the clinician identify potential errors on the scanned images, allowing them to correct possible mistakes.[72] AI/AuI can also identify anatomic structures on the scanned images to facilitate digital workflow for treatment planning and prosthetic, orthodontic and surgical device fabrication.[76- 77] In the future, facial scanning will be more widely used to plan treatment and evaluate outcomes with the assistance of AI/AuI. [78-80]

Limitations

Generally, teledentistry, EDR, and scanned images improve clinical efficiency and efficacy, but some clinicians with limited technical experience and knowledge may not be able to efficiently use these devices or software.[81, 82] In addition, some clinicians may feel AI/AuI is not more accurate than or comparable with clinicians in interpreting images and clinical information.

Quality of imagery is a major concern, as AI/AuI is based on specific data imagery. If imagery is taken by patients in their homes, the images of the extraoral and intraoral structures may be of poor quality, allowing for false-positive and false-negative results, which could be a hindrance to the dentist. It is because of this that doctors must understand the limitations of these AI/AuI systems and always know that they have the final say in the diagnosis.

In summary, the applications of AI/AuI in imaging in teledentistry, EDR and scanning are promising. Using AI/AuI technologies can improve clinical performance, efficiency and efficacy, but more studies and regulations are required to ensure its validity and reliability.

4 How Might AI/AuI Related to Dental Imaging Impact Workflow and Patient Benefits Now and Into the Future?

Workflow

Algorithms can be used to prepare, process and present digital images, including radiographs, impressions, occlusal/functional/facial analysis, periodontal charting, wear patterns and airway data to best support the provider as the final clinical decision maker. Treatment options using data and algorithmic analysis can be presented with the support of evidence-based decision making. Several examples have already been highlighted in previous sections.

Future

The use of AI/AuI can help support the creation of a real time, integrative, learning (oral systemic) healthcare system. It can provide predictive analytics based upon data collection that includes different levels of imaging and real time adaptive population health, leading to precision oral medicine. However, nonbiased algorithmic interpretation remains a challenge in all of healthcare, not just dentistry. Much still needs to be done in this area.

The generalized impact of AI/AuI could be abundant and widespread. It may lead to enhanced and timely payments for providers and an overall reduction in healthcare burden and cost for payors. A prevention model allows for identification, monitoring and early intervention. Subsequently, this can lead to a reduction of emergency room visits and costly procedures while allowing for improvement of systemic health.

Oral healthcare providers have the opportunity to be at the forefront of preventive care and offer insight into integrative health and wellness. AI/AuI algorithms will allow for digitally driven data analysis of our patient population, offering an expanded spectrum of care. This will be based upon current and past medical history, comparison of digital radiographs and impression files over time and other patient specific data. This may bring about improved outcomes based upon prevention and early intervention. AI/AuI will help aggregate and analyze a wide range of data focused upon enhanced diagnosis, treatment options, material selection, outcomes and monitoring directly benefiting patient care.

Patient Benefits

Benefits must be easily identified by patients. AI/AuI provides calibration between providers and patients. One example is creating uniformity between caries assessment scores impacting and influencing interpretation and communication between clinician and patient. Additionally, many of the firms offering AI/AuI imaging products advance the idea that it can improve patient understanding through better visualization. This may also lead to greater patient trust in the diagnostic process.

If properly and safely adopted, AI/AuI can lead to many efficiencies that should be clearly demonstrated as benefits to our patients.

5 AI/AuI in Dental Imaging and the Non-Clinical Dental Environment

An Augmented Intelligence system in dentistry is an Artificial Intelligence system designed to aid in the application of human expertise to dental-related tasks. Successful use of such AI/AuI systems results in the important tasks of dental payors, providers and clearinghouses being performed in more comprehensive, accurate and timely ways. Non-clinical uses are primarily carried out by third-party users such as payors and dental clearing houses.

The AI capabilities discussed below have been categorized as existing, commercially available capabilities, or capabilities that are in development and expected to be available in the next 3- 5 years.

Payor: Claim Processing

Currently, the primary use of AI/AuI systems is in the payor claim review process. AI can be used to validate the type and content of attachments submitted with claims and to screen radiographic images to determine whether proposed or completed treatments meet payor clinical guidelines.

Claims submitted by dental offices to payors may contain attachments. The type and content of attachments may vary based on individual payor claim submission requirements. When a claim is received by a payor, or prepared through a clearinghouse, a series of checks are performed to determine if the claim should be accepted, rejected, or returned for additional information. Part of this validation is to identify the type and content of each attachment.

Currently available products can utilize AI/AuI systems to determine whether an attachment is a radiographic image, a periodontal chart, photographs, copies of patient treatment records, or other types of correspondence. These AI/AuI products can perform the validation of submitted attachments to identify whether the required documents have been submitted, and whether the contents of the attachments include all necessary information.[83-86]

Dental offices are often required by payors to submit radiographs for select procedures. These images may be reviewed by the payor dental consultant staff. A claim may include a single radiograph or multiple radiographs (e.g., a full-mouth series).

Currently available AI/AuI products provide the ability to identify the type of radiograph, identify each tooth within a radiograph, and identify anatomic structures, existing restorations and pathologies.[87-89] AI/AuI can then detect whether the appropriate teeth and anatomic structures are present in the submitted image. If the correct information is not present in the radiograph, the claim may be returned to the dental office with a request for the correct radiographic image.

Most payors, as part of their claim review process, route a selection of claims to dental consultants for review to determine whether the service met the payor's clinical guidelines. The logistics and manpower required for such a review are such that, typically, only a small percentage of claims submitted undergo review by a dental consultant. AI/AuI systems provide the ability to perform an

automated review of every radiographic image and associated attachments submitted with claims, not just a small subset.

Currently available AI/AuI products can make the review process more efficient by screening all radiographs submitted to identify those services that radiographically do not appear to meet the payor's clinical guidelines or are otherwise clinically inappropriate. The claims for those services are sent to a dental consultant for review. Claims that meet payor guidelines can complete the adjudication cycle without manual intervention. This type of prioritization of the review process significantly increases the effectiveness of the human reviewers as well as the efficiency of the overall review process.[90, 91]

Payment Integrity

Payors have an obligation as well as financial incentive to ensure appropriate use of premium dollars. This includes identifying and investigating potential acts of fraud, waste and abuse, which can include: (1) performing unnecessary services; (2) submitting a claim for a different service than was provided; (3) misrepresenting the clinical circumstance to justify payment; (4) falsifying documentation to justify payment; or (5) waiving co-payments.[83, 86]

As noted above, AI/AuI processing of radiographs, can accurately identify and segment teeth and their associated anatomy, existing restorations, and various pathologies in dental imagery. Additionally, computer vision provides the ability to create specialized representations of images, akin to a fingerprint, that can be compared to estimate the degree of similarity.[86]

These representations allow AI/AuI to compare submitted radiographs to those submitted previously in conjunction with other claims. And, importantly, using these digital fingerprints, similar images can be detected even when the images have been altered by cropping, resizing, contrast adjustment or other image manipulation techniques.[92] AI/AuI has the current capability to route any suspicious claims that have been submitted cross-patient, or under otherwise anomalous circumstances, to a dental consultant for appropriate investigation.

Payors may perform post-payment audits of claims, which may include reviews of treatment records, and associated images. An important capability now in development uses AI/AuI computer vision during post-payment reviews/audits to examine post-operative x-rays to determine if services were completed as billed and whether outcomes were within accepted practice standards.

Quality Assurance

Payors are subject to regulatory and contractual requirements to ensure consistent application of payor clinical guidelines by its professional review (dental consultant) staff.[93] A unique capability in development is the use of AI/AuI computer vision to monitor staff performance by comparing dental consultant decision making to their peers and to gold-standard AI/AuI models of performance. This can help identify training and retraining needs and help ensure consistent application of payer dental policy by its consultant staff.

Dental Practice

Claims prepared by dental offices and submitted to payors may contain attachments. The types and content of the attachments may vary based on individual payor claim submission requirements. A new capability now in development performs AI/AuI validation of claim packages at the dental office, prior to submission. Here, AI/AuI identifies whether all required documents have been included, and whether the contents of the attachments include all necessary information. Key to this comprehensive capability are AI/AuI subsystems that identify each tooth within a radiograph, the associated anatomic structures, and any existing restorations and pathologies.

Given this, AI/AuI can then determine whether the radiographic content appropriately supports the claim, or remedial steps are required before submission. The net effect of applying this capability within a dental practice is to streamline the claim adjudication process and shorten the revenue cycle.[93]

6 AI/AuI in Imaging and the Regulatory Environment

Perhaps one of the most important features to recognize about the use of AI/AuI in providing dental care is that it is *strictly a supplement to the clinician*. Dentists have the responsibility for diagnosis, prevention, care and treatment of oral diseases and conditions, under authority of state licensing agencies. Within their scope of practice, dentists use a variety of images, subjective and objective information and tools. AI/AuI provides a new tool to assist the dentist and dental team.

In addition to streamlining many routine front office and back office processes, new AI/AuI tools are emerging for the detection and monitoring of common oral diseases. Analyses of images from a variety of common dental devices is often used. These may include cameras, two-dimensional and three-dimensional radiographs, caries detection devices, and intraoral scanners. Longitudinal assessments, which can provide a glimpse into change over time, are now possible with AI/AuI, which, along with predictive data analytics, hold promise for improvements in individual, as well as population-based oral health outcomes.

The Global Regulatory Framework

There are several regulatory guideposts for future approvals, including privacy, consent for data use, equity, interoperability, transparency, validation and usability, according to the World Health Organization (WHO).[94]

In assessing AI/AuI, the practitioner must balance benefit and risks. While AI/AuI is an important and exciting decision support tool, responsibility for use, and benefits/risks for particular use, ultimately are dependent upon the decision authority of the dental professional using AI/AuI.

A global voluntary group, the International Medical Device Regulators Forum (IMDRF), provides guidance on medical device regulation. IMDRF develops internationally agreed upon guidance for medical devices. The Software as a Medical Device (SaMD) Working Group (WG) of the IMDRF supports specific guidance on innovation and timely access to safe and effective SaMD, globally. It is important to note that the recommendations of this group are strictly advisory.

The U.S. Regulatory Landscape (Jan 2022)

Food and Drug Administration (FDA) – According to the FDA, SaMD should include a validated clinical association between the outputs of the SaMD and the particular clinical conditions, as well as the data that is used for decision support with validated, private and secure technical and clinical data. This would exclude software within devices or used to run devices.

Table 2 – Clinical Evaluation Process

Clinical Evaluation		
Valid Clinical Association	Analytical Validation	Clinical Validation
Is there a valid clinical association between your SaMD output and your SaMD's targeted clinical condition?	Does your SaMD correctly process input data to generate accurate, reliable, and precise output data?	Does use of your SaMD's accurate, reliable, and precise output data achieve your intended purpose in your target population in the context of clinical care?

(Reference Diagram: <https://www.fda.gov/media/100714/download>)

FDA provides pre-market authorization of AI SaMD. Categorized by risk, FDA classifies use as Class I, Class II, and Class III, with Class I as the lowest risk.

FDA assesses patient safety, efficacy, use cases and risks (performance driven by use case/risk), and specifications. For example, the same tool used in the back office vs chair-side have different risk profiles, different safety and different performance measures. If a tool detects caries in the back office (for quality control), this is very different from a tool that detects caries chair-side (to aid diagnosis). The first use case has a low risk profile, while the second has a higher standard for risk and performance.[95]

Class I devices are perceived to be low or no risk. These may be exempt from FDA premarket notification (510k) and or current Good Manufacturing Practices (cGMP). Class II devices and Class III devices are subject to defined labeling, manufacturing and other requirements.

Additionally, the FDA has conducted workshops related to transparency in AI enabled medical devices and has created a list of principles for Good AI and Machine Learning practices. These can be found in Appendix 2.

7 Conclusion

This paper identifies many areas where AI/AuI have the potential for influencing the field of dentistry now and in the not too distant future. Dentistry is already beginning to see many changes including image analysis for caries and bone loss, robotic implant placement, and the many uses already implemented in prosthetic design and product construction. Many of the contributors to this paper would go further and suggest it will actually transform how dental care is delivered.

Appendix 1 Imaging and Algorithms

AI/AuI in Imaging – Algorithms and Key Questions

AI/AuI for dental image analysis is progressing rapidly. By understanding key principles of machine learning training and validation, and by asking key questions about intended use and system performance, clinicians can ensure the best patient care while reaping the benefits of an advancing technology.

AI/AuI Algorithms – The Classification Problem

Every day we are required to place a variety of situations into categories or classifications. Is the bread untoasted, under-toasted, just right, or burnt? By recognizing certain visual patterns associated with different levels of toastedness, we can classify a particular example into one of these categories. Of course, there are many kinds of patterns to notice, and many kinds of classifications to make. Is one's outfit suitable for sleep, exercise, play, or work? Is my child listless due to lack of sleep, dehydration, hunger, or emotional issues?

Because computer programs have proved capable of recognizing many kinds of patterns, they are also capable of handling a variety of classifications. By successfully recognizing features of chess positions, such a program is now the best chess player in the world. By successfully recognizing facial features, such programs now aid law enforcement in identifying suspects. And by recognizing features of the road, automobiles now warn drivers who drift out of their lane. Diagnosis can be viewed as such a recognition/classification problem. As a result, AI/AuI is well established in medicine, and has made some progress in dentistry.

The term Artificial Intelligence (AI) is often used for all these systems, but a distinction should be made. In the chess case, the system is acting independently. But in the latter cases the system acts only as an aid to the decision-maker. The term Augmented Intelligence (AuI) is often used to describe these latter cases.

Systems with Human Encoded Algorithms

One typically thinks of a computerized system as following the instructions of human programmers. So, of course one would expect that programmers could describe how the system arrives at a conclusion. For a system doing classification, one would expect programmers could describe how the system arrives at its classification findings. The terms AI/AuI have been applied to a variety of classification systems for which this is true.

One class of such systems encodes human expert knowledge into explicit rules. Called "Expert Systems," they rely on human expert knowledge. Such systems can stand alone within computers, or can be embedded into hardware systems that conduct measurements, e.g. heart monitors.

It is not always possible to reduce human expert knowledge into a set of rules. One approach for such a situation are K-Nearest Neighbor (KNN) systems. For each new sample to be classified, such a system tallies the various known samples that are most like the new one. The finding most prevalent in this tally is the finding suggested by the system.

Another approach is to reduce sets of known data to probabilities. For instance: The probability that a triangular shape is a lesion; the probability that a radiolucency is a lesion; and the probability that a particular position on the tooth has a lesion. Using Bayes Theorem, a Naïve Bayesian Classifier will mathematically combine those probabilities into a single probability, which it then uses to suggest a finding.

Systems with Machine Derived Algorithms

Humans are extremely good at recognizing human faces. But which of us can explain how we do it? And if we cannot explain our own process, a system designer must find a way to build a system without encoding any rules.

A revolution in AI/AuI began when developers began creating successful pattern recognition systems for which they could not provide a description of how the system did its classification. Most such systems are based on artificial neural networks (ANN). And although mathematics can provide an explanation of how these networks learn, and results can be measured for success, it is typically not possible to determine what patterns the network might be recognizing, or how the network uses those patterns to provide a finding.

Neural Network Learning

To the extent ANN's express intelligence, the intelligence is encoded in the details of each neuron's activation process and in the weight given to each neuron's activated output to later-layer neurons. Neural network training is a process of adjusting connection weights. Each input sample is tagged with a desired result and contributes to this training.

An intriguing aspect of machine learning is its ability to discover features in sample input. However, it is usually immensely difficult to determine what those features are. For example, one would not expect to be able to say, "The network discovered triangles in the input data, and those triangles are an important feature." This is part of a key issue with neural networks: It was the network's training process, rather than a designer that set the network weights; and it is generally not possible to know why network weights are as they are.

If training is fundamental to the performance of the network, then the training dataset of samples is also fundamental. In dental imaging, the training set is typically a collection of dental images, such as intraoral radiographs. The samples in the dataset will provide examples of the kinds of findings the network is to detect. For instance, the sample radiographs might have a variety of already-labeled class II lesions. It is then hoped the resulting network detects those lesions as effectively as the humans who originally identified them.

Human identification of findings in a dataset is called Data Labeling, Annotating or Tagging. Training to match the tagging is called Supervised Learning, which is the most common form of training for neural networks in dentistry. Since the point of such training is to mimic the behavior of the taggers, the network generally cannot improve on the taggers' expertise. Therefore, with supervised learning, one should not expect the network to detect findings the taggers could not. It is, however, possible that the network's consistency might improve upon the consistency of a tagger: Humans can tire or become distracted; neural networks do not.

A training dataset must have an adequate number and variety of samples, but generally, an increased quantity does not substitute for a lack of variety. If additional samples do not offer new views of intended findings, then the system has nothing to learn from them. A system should be expected to perform less well if its training set is less well tagged, even if the training set is larger.

System Validation

When a clinician's diagnostic ability is being evaluated, the evaluator can confirm that the clinician understands the diagnostic task, make sure that the clinician understands the features of the test case and question the clinician about the reasoning being used. In general, none of these are possible in evaluating a neural network. Though the network may report a test case as having a recognizable feature, it has no understanding of the diagnostic meaning of that feature. Though the network may encode features unnoticed by humans, we generally have no way to know what those features are or what they mean to the network's processing. And though a network may report a suggested finding, there is no practical way to question the network as to how it arrived at its conclusion. This makes objective validation of a neural network all the more important. The Code of Federal Regulations (21 CFR 820) defines design validation as "...establishing by objective evidence that device specifications conform with user needs and intended use(s)." But what is the "intended use" of a machine learning system?

In managing the introduction of self-driving systems in cars, much attention is given as to whether a human driver must be present, whether the human must have hands on the wheel and whether the human or the system is being relied on for safe driving. These are issues of intended use. Is the driving system, like previous ones that warn of lane drift, merely an aid to the driver? Or is the system the responsible actor? Similarly, the provider of a machine learning system in dentistry should be clear and specific about the tasks included in the system's intended use; and should be clear and specific about where diagnostic responsibility lies. If human drivers are still responsible for driving safely, they must stay awake in the driver's seat, with their hands at the wheel. And if human clinicians are still responsible for diagnosis, they must be sure to treat a machine learning system merely as an instrument in their armamentarium.

Of course, a machine learning system is a complex and sophisticated instrument. So how will the clinician have confidence in what the system reports? Against what standard will the system be evaluated?

For a system to be validated, there must be a reference standard to which it's held. For a human clinician, that standard may be the opinion of teachers or of a review board. But for a software system, validation is typically achieved through testing against a Validation Dataset of test cases, which operates as a gold standard. And because the system cannot be interrogated as to its methods, the only way to evaluate the system is by its effectiveness at those test cases. Therefore, one's confidence in the system should be limited by one's confidence in the Validation Dataset.

It is therefore critical, for each validation test case, that the expected findings be correct; that the Ground Truth for each case be well established. It would be ideal to have, for each test image, conclusive determination of the disease status of the imaged area. Depending on the task for which the model is being developed, absolute "gold standard" measures such as histologic examination of Micro-CT is sometimes not feasible or practical. Post-treatment notes about cases may record actual findings, but they may be difficult to obtain. And, of course, not every accurate finding may

involve treatment, and not every case requiring treatment may have had treatment and associated notes. Analysis by oral and maxillofacial radiologists is generally highly regarded, but their participation in tagging may be difficult to obtain. In practice, most validation image sets are tagged by dental clinicians, tagging which is easier to obtain but has less specificity.

The validation dataset must be sequestered from the system's training processes. Such sequestration is the only way to validate that the system's learning has been generalized beyond the specific samples encountered during training.

The Validation Dataset's scope must be adequate:

- To test for the various findings the system will be expected to detect, including findings of no disease.
- To test the system's ability to analyze images of poor quality, such as those with cone cuts or under-exposure.
- To test the system's performance among subpopulations, including patients of various age, gender and ethnicity.
- To test the system's reaction to novel images, such as images with electronic noise, images flipped from left to right, images of atypical restorations, or images that are not radiographs at all.

Ideally, all machine learning systems would be validated against the same validation dataset, allowing a direct comparison between systems. However, once the dataset became public, designers could train their networks to provide correct findings for just that data, ignoring the very large variety of real-world cases. It would be like allowing students to study from the test's answer book.

System Performance

As for many medical devices, a machine learning system's performance cannot be expressed as pass or fail. It is more useful to rate the system's performance for each of its claims. For example, how well does the system identify tooth numbers? How well does it identify a widened PDL space? How often will the system over-diagnose a lesion? How often will it under-diagnosis pulp involvement?

The needs of the user may be relevant to the questions to be asked.

- If the intended use of the system is to motivate an irreversible treatment, then the system's specificity may be most relevant: Is the rate of false positives very low?
- If the intended use for the system is radiographic screening, or clinician education, then the system's sensitivity may be most relevant: Is the rate of false negatives very low?
- If the intended use of the system is triage, then the system's accuracy (sometimes called test efficiency) may be most relevant: Is the overall percentage of correct findings high?

Machine learning systems can be sensitive to such considerations. Many can be tuned to minimize false positives, to minimize false negatives, or to achieve some combination which the designer considers optimal. In this way, a system can be tuned to meet goals related to maximizing patient care, to clinical productivity, or to business goals. Some designers even allow the user to make such adjustments, adapting the system for the task at hand.

Current Challenges for Machine Learning Systems

Establishment of Ground Truth – Most validation datasets rely on general clinicians to tag images, yet there is no consensus for credentials expected of taggers, for tagging procedures, or for required demographic information. Such consensus might improve comparability between machine learning systems.

Validation Scope and Quality – There is insufficient transparency in the quality and scope of the validation datasets currently being used. Research published in *Academic Radiology* (September, 2021) stated:

“Just 9/118 reviewed AI/ML algorithms had a validation dataset sizes[sic] of over 1000 patients.”

“Presently, there is a lack of transparency and adequate evaluation datasets for most FDA-regulated AI/ML algorithms. The public facing FDA summaries lack information and/or data which could help estimate generalizability and robustness of several algorithms across imaging examinations performed in different geography, patient age, gender, race, socioeconomic status, equipment, acquisition, and reconstruction parameters.”

Therefore, machine learning in dentistry would benefit from having a standard for the content of validation datasets, the processes by which samples are collected and the mechanisms for establishing ground truth. System designers, regulators, and users could then have appropriate confidence in the validated systems.

Responsibility – As long as clinicians are responsible for diagnosis and treatment planning, they must guard against becoming over-reliant on machine learning systems. For example:

- For a system intended merely to identify tooth numbers and automatically mount radiographs, false findings may not be significant.
- For a system intended to discover lesions, and having low false positives but high false negatives, the clinician might have high confidence in the identified lesions, but must still scan the entirety of each radiograph lest a finding be missed.
- For a system intended to discover lesions, and having high false positives but low false negatives, the clinician might have high confidence that all lesions have been identified, but must guard against the system over-diagnosing lesions.

On the validation of a machine learning system:

1. What tasks are claimed as part of the system’s intended use?
2. How was it established that the validation dataset had enough images for each classification task claimed as part of its intended use?
3. How was it established that the validation dataset had sufficient variety in gender, age and ethnicity? And how was it established that there were enough images for each subpopulation?
4. Was the validation dataset sequestered from the training and testing processes?

On the clinical use of a machine learning system:

1. Is the system or the clinician responsible for diagnosis and treatment planning?

2. Are the system's findings compatible with the clinician's own?
3. Does the system report levels of confidence in its results?
4. Will the system fail catastrophically if novel input is encountered?

On the performance of a machine learning system:

1. If the system's intended use includes treatment planning, what rate of false positives should be expected?
2. If the system's intended use includes radiographic screening, what rate of false negatives should be expected?
3. To accommodate specific intended uses, can thresholds be configured to adjust these rates?

By understanding the principles underlying these questions, and pressing system providers to answer them, individual clinicians can help guide an advancing technology toward both better patient care and higher efficiencies.

Appendix 2

FDA's Ten Principles as "Good AI/Machine Learning Practices" [96]

1. The total product life cycle uses multidisciplinary expertise.
2. The model design is implemented with good software engineering and security practices.
3. Participants and data sets represent the intended patient population.
4. Training data sets are independent of test sets.
5. Selected reference data sets are based upon best available methods.
6. Model design is tailored to the available data and reflects intended device use.
7. Focus is placed on the performance of the human-AI team.
8. Testing demonstrates device performance during clinically relevant conditions.
9. Users are provided clear, essential information.
10. Deployed models are monitored for performance, and retraining risks are managed.

On October 14, 2021, a virtual public workshop was held by the FDA, "Transparency of Artificial Intelligence/Machine Learning-enabled Medical Devices (AI/ML) (FDA-2019-N-1185)," to discuss transparency of AI/ML enabled medical devices to patients, caregivers, and providers.[97]

Optimal labeling for users and essential information for certain stakeholders to build trust in these devices was discussed. The American College of Surgeons provided a comprehensive response to the FDA, outlining key parameters for transparency, including that they are clinically sound, integrated easily into workflow, cost, testing and validation, real time performance monitoring, post-market surveillance and special considerations for images and labeling.[98]

There is concern and effort being made to minimize racial and ethnic bias. The Agency for Healthcare Research and Quality (AHRQ) released a request for information about developing AI algorithms on this topic.[99]

Also in 2021, the Federal Trade Commission (FTC) issued an advisory to companies to not implement any AI tools which might result in bias and/or discrimination. AI companies are advised to periodically inventory, review and adjust algorithms to mitigate bias or discrimination and to communicate change in algorithms to users. Users should periodically monitor purchased products for any changes.[100]

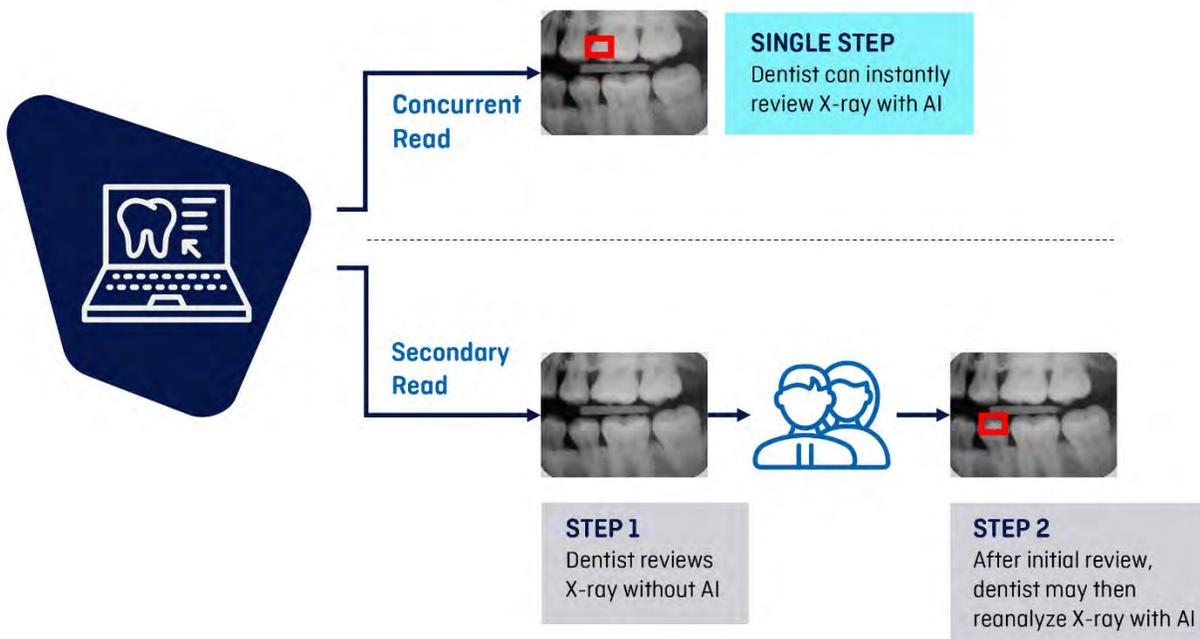


Figure A.1 – Two Methodologies used in Imaging AI

Federal Legislation that May Impact AI/AuI in Imaging

The 21st Century Cures Act Final Rule on Interoperability & Information Blocking (Cures Act) provides important information sharing requirements for exchanging information between health systems with Electronic Health Records. Under the Cures Act, patients would have immediate access to any imaging or tests used and this could include AI assessments of images.

Future Regulatory Considerations

Medical device labeling is any information associated with a device targeted to the patient or lay caregiver. It is intended to help assure that the device is used safely and effectively. Two general categories of information may be included in medical device patient labeling: (1) risk/benefit information; and (2) instructions for use (how to guide for the device). The label should provide information on intended user, intended population, indication for use, etc. Use the labeling to understand the following: 1) what is the device's intended use case; 2) understand when to use the device; 3) what population was the device tested on when selecting among similar devices; 4) understand how to operate and interpret the device outputs; 5) follow the manufacturer's directions carefully in using the device, such as understanding the basis for warnings, precautions, and contraindications.[101-103]

A simple label for all AI/AuI devices, as well as a more detailed labeling of AI/AuI devices, will be an important tool for proper use and assessment of risk. Labeling information about the AI/AuI products and services used within the dental setting should be clear to the dental practitioner.

Blueprint for Artificial Intelligence

In September 2022, the “Blueprint for an AI Bill Of Rights” was released in all sectors, including healthcare. The White House Office of Science and Technology Policy identified five principles to guide the design, use, and deployment of artificial intelligence to protect the American public. The Blueprint reinforces concepts to use technologies in ways that reinforce America's highest values.

Reference: <https://www.whitehouse.gov/ostp/ai-bill-of-rights/>

Considerations for Future Regulatory Action and Guidelines

As this field unfolds, consideration might given to these evolving technical requirements as adapted from WHO:[94]

- Clinical decisions are reserved for dental professionals.
- Standards for validity, safety, accuracy, and effectiveness occur within well-defined use cases.
- Transparency about how products are designed and function before they're used is provided by AI/AuI developers.
- Dental offices that rely on AI/AuI should ensure they are used under appropriate conditions by trained personnel.
- The best AI products promote equality and inclusiveness, and data sources for demographics are provided.

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Trends in Dentists' Income, Revenue, and Hours Worked

Update based on the ADA Health Policy Institute's
2025 Survey of Dental Practice and other sources

 **HPI** Health Policy Institute

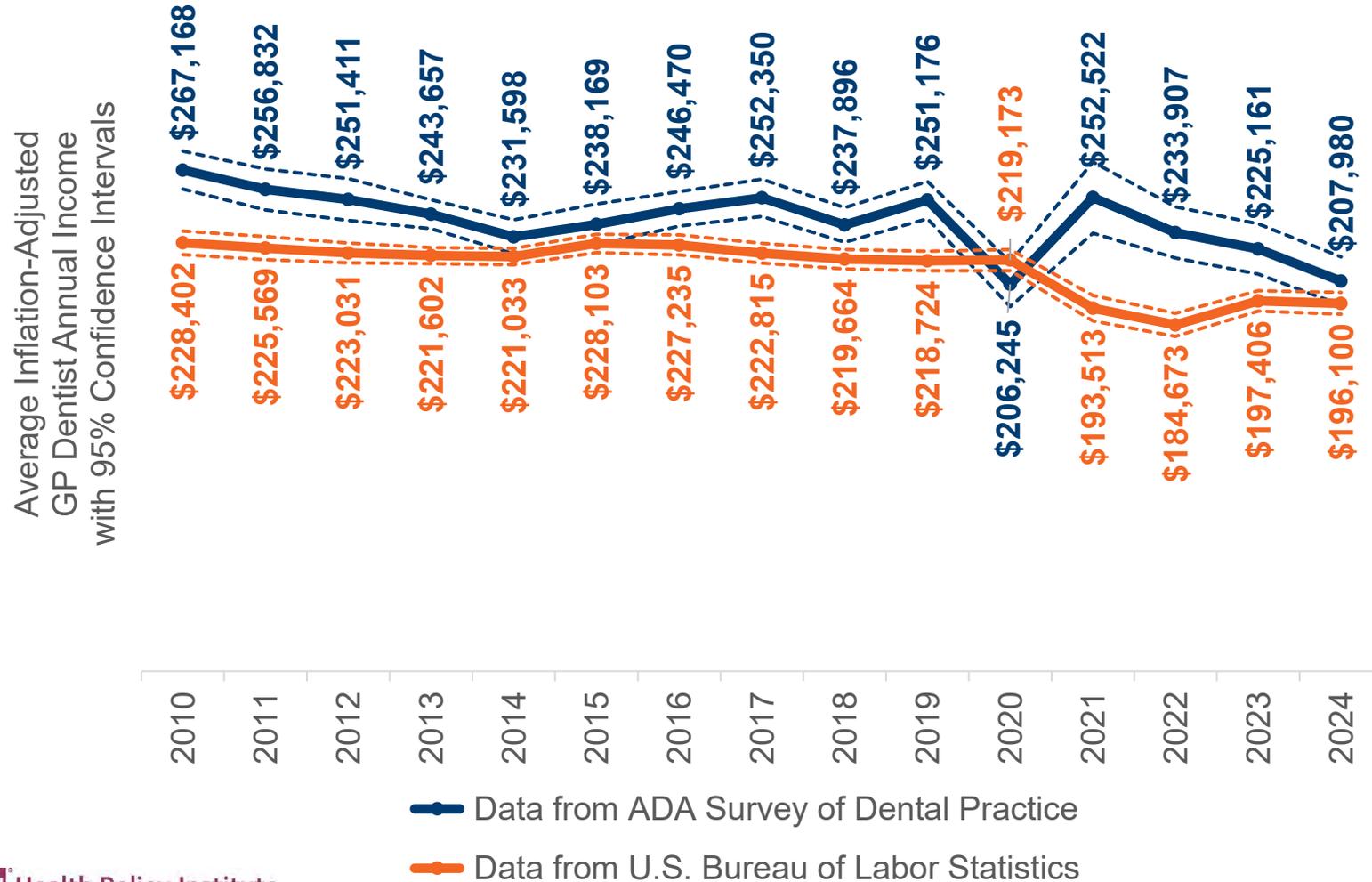
ADA American Dental Association®

Overall Takeaways

- General practitioner (GP) dentists' incomes have decreased in recent years due to growing practice expenses and decreasing revenue. According to HPI survey data, the average net income of GP dentists was \$207,980 in 2024.
- The gender income gap has narrowed over time, though male dentists, on average, still have higher incomes than female dentists. The income gap between owner and employee/associate dentists is shrinking over time as well.
- GP dentists are working slightly more hours each week due to extra time spent on non-clinical duties.
- The gender gap in hours worked has also narrowed considerably among GP dentists. Female dentists, on average, worked 2% fewer hours than their male counterparts in 2024, a much smaller gap than a decade earlier.
- Owner dentists work an average 5 hours more per week than employee/associate dentists. The difference in hours may be partly attributable to financial pressures stemming from decreasing revenue.

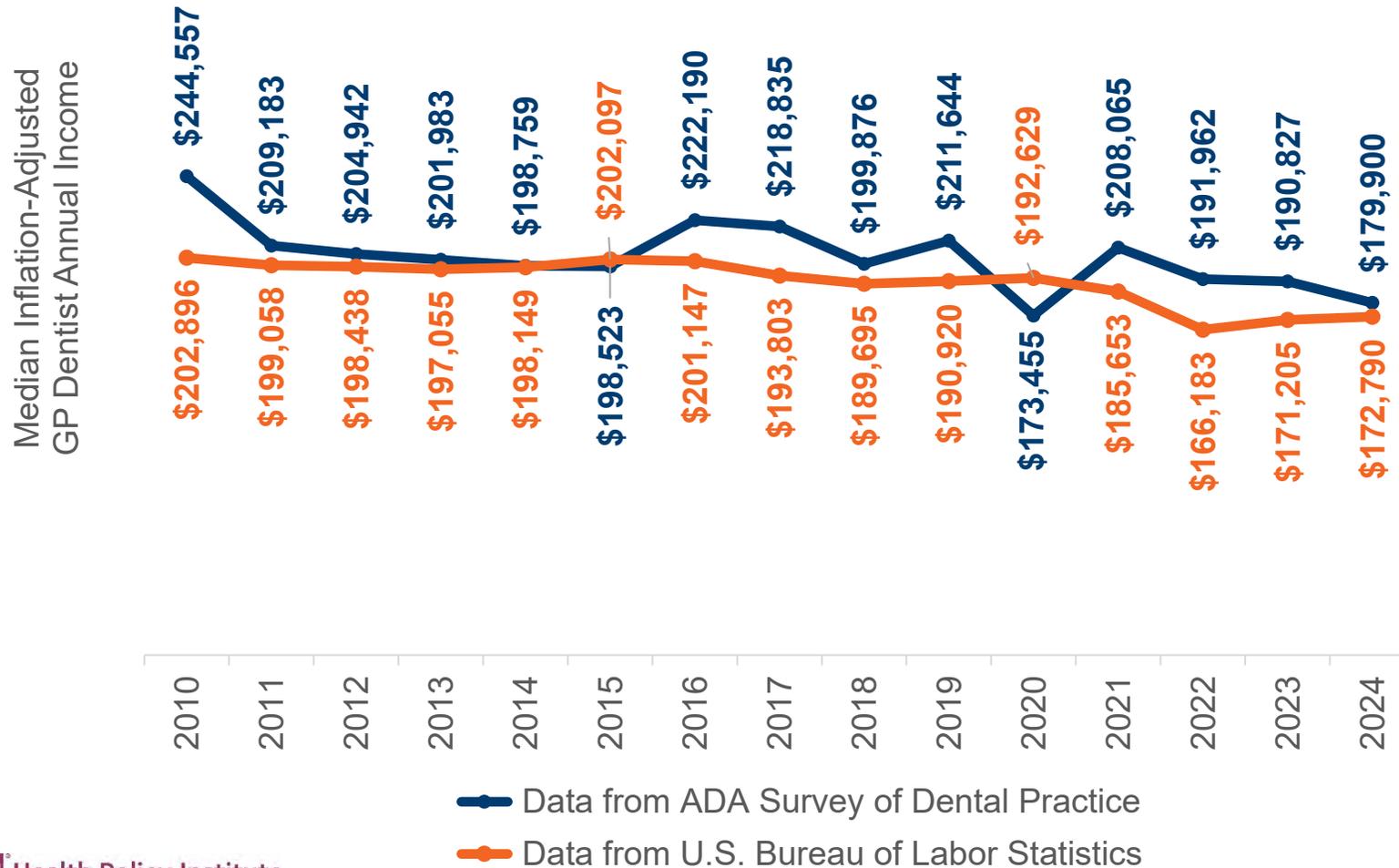
Dentists' Income and Revenue

GP Dentists' Average Net Income Declining



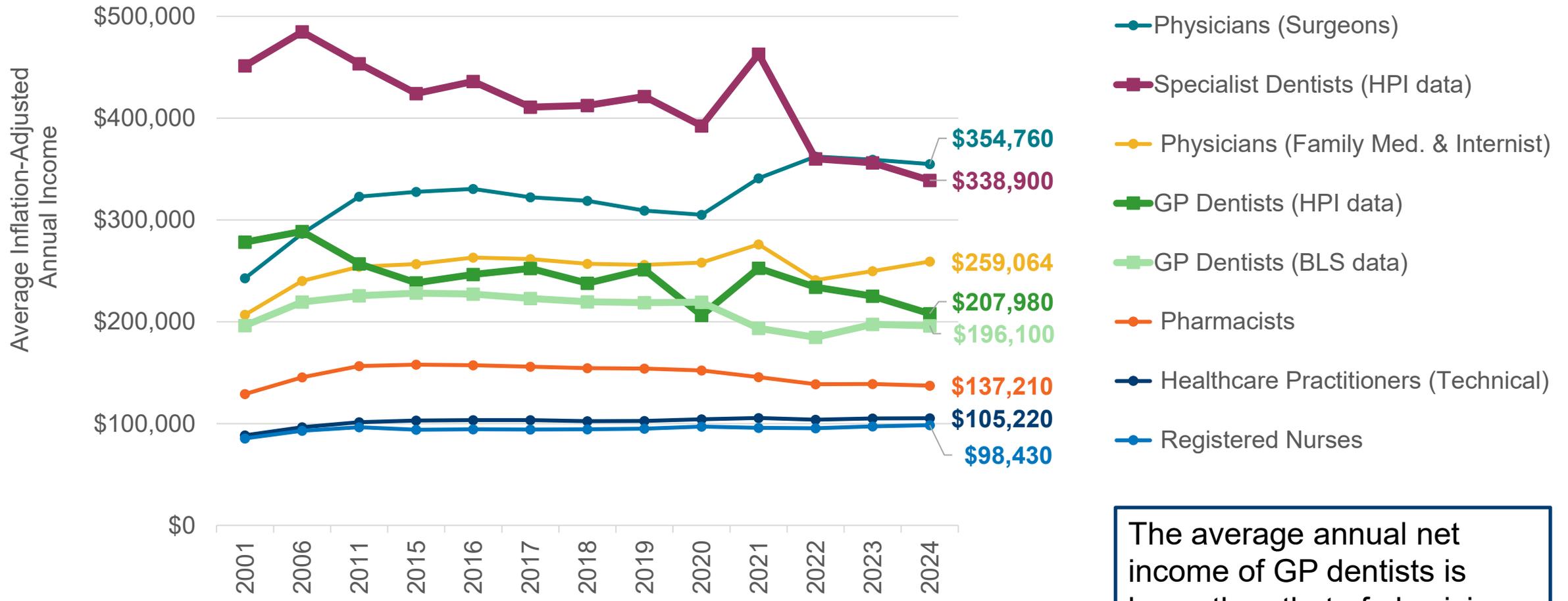
- Data from both the ADA and the U.S. Bureau of Labor Statistics show a decline in average inflation-adjusted income for GP dentists over 14 years.
- Average income for GPs five years after graduation was \$166,676 in 2022.

GP Dentists' Median Net Income Declining



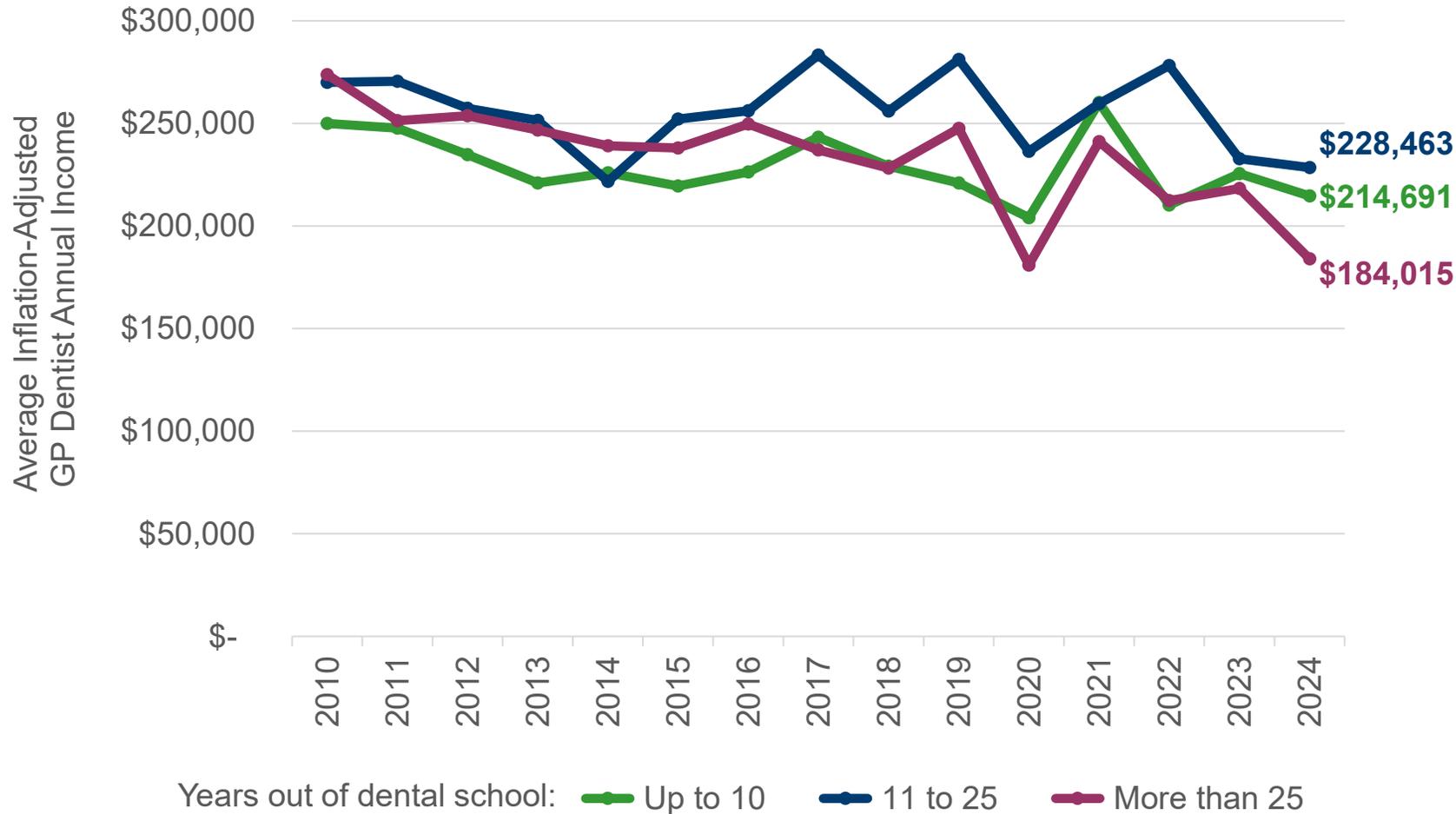
- GP dentist inflation-adjusted median net income has also decreased over 14 years.
- The median is the middle value; half of GP dentist incomes are higher, and half are lower.

Incomes of Dentists and Other Health Professionals



The average annual net income of GP dentists is lower than that of physicians.

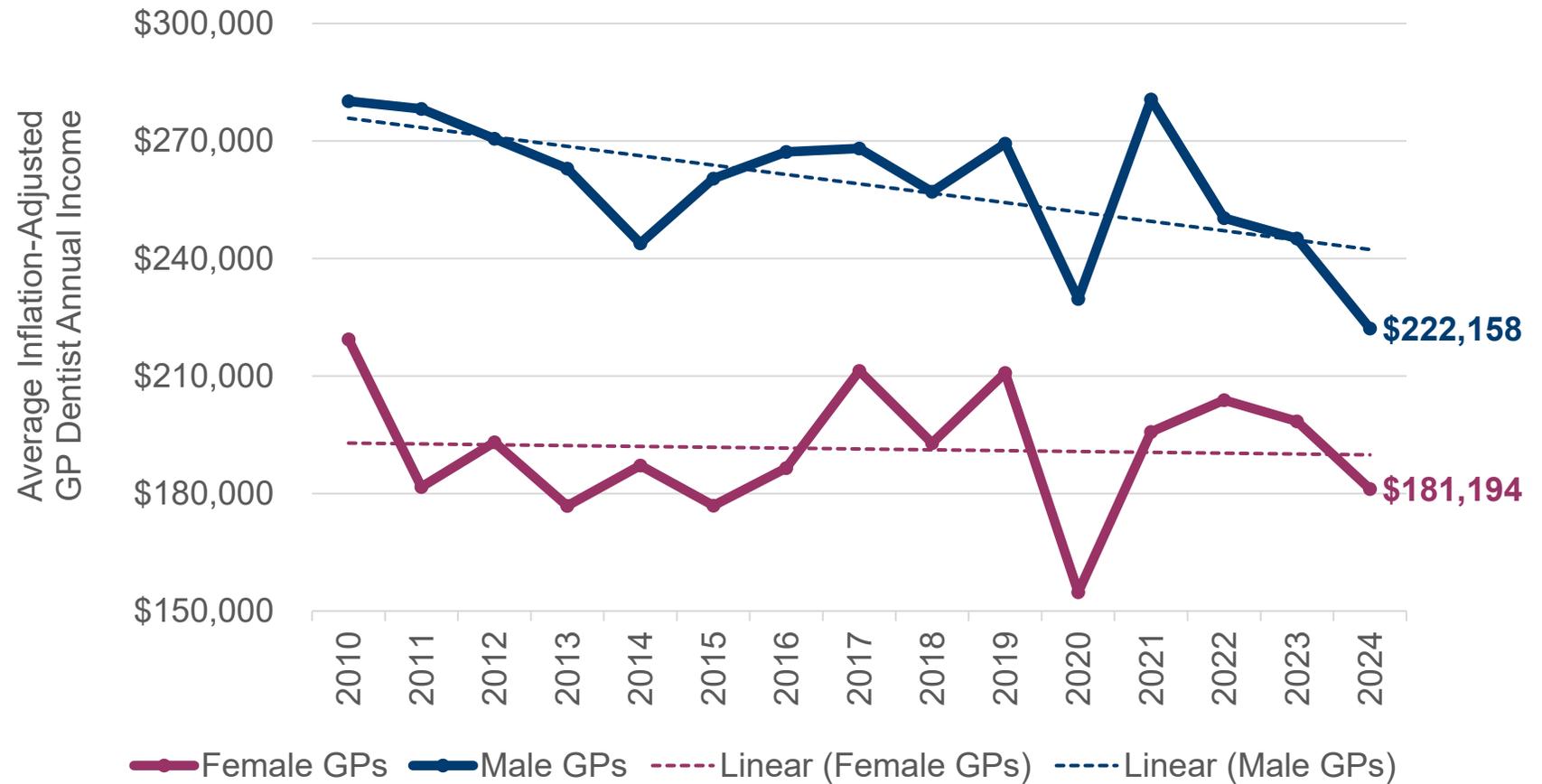
GP Dentists' Income Trends Similar by Career Stage



- A drop in GP dentist net income was seen for all career stages between 2023 and 2024.
- In recent years, GP dentists 11 to 25 years out of dental school had higher incomes than those with more or fewer years of experience.

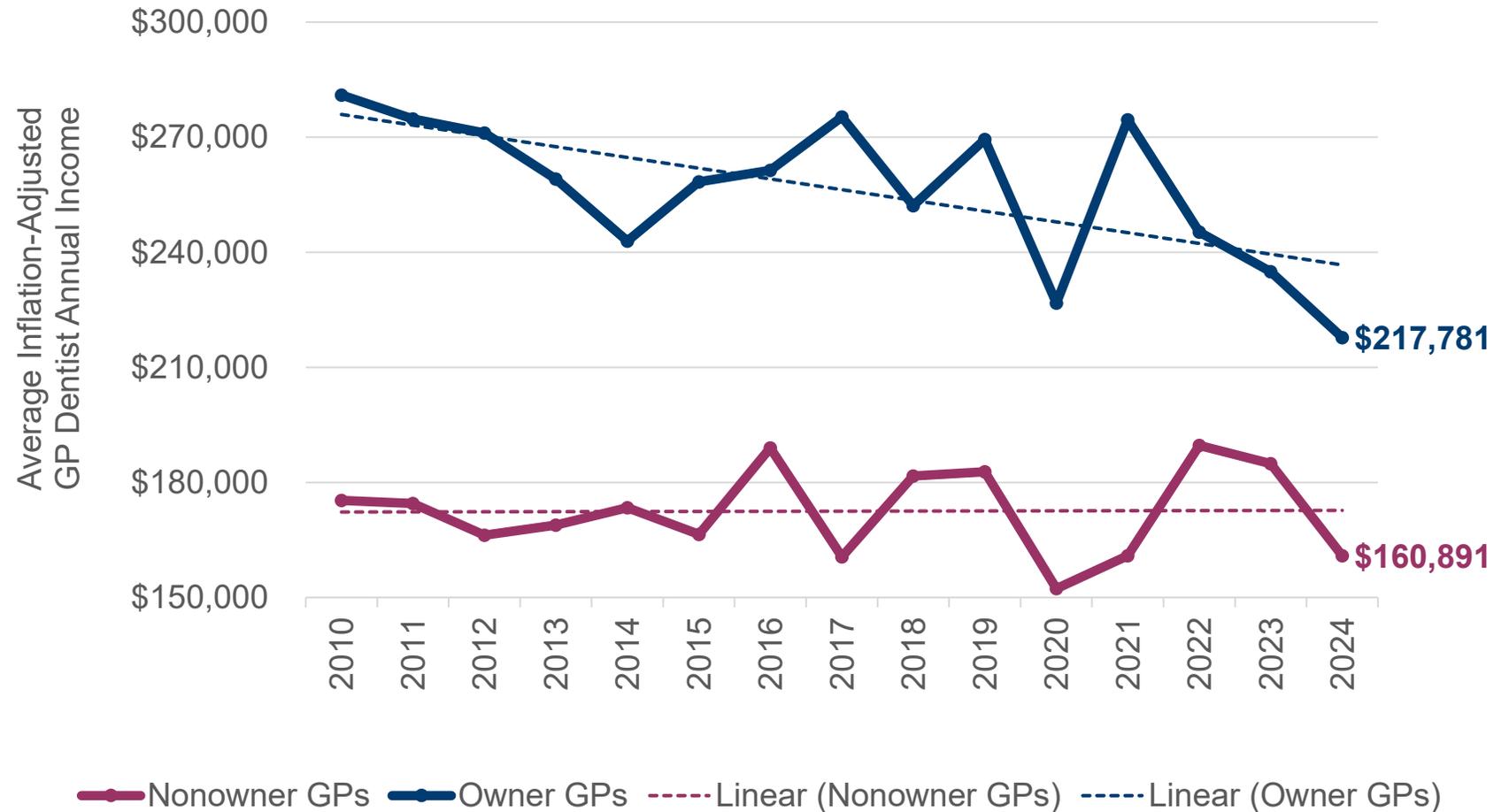
Gender Income Gap Among GP Dentists Narrows

- The gender gap in GP dentist incomes is narrowing.
- Comparing the 5-year period 2010-2014 to 2020-2024, inflation-adjusted incomes fell by \$23,000 for male GPs. The comparable decrease was only \$3,000 for female GPs.

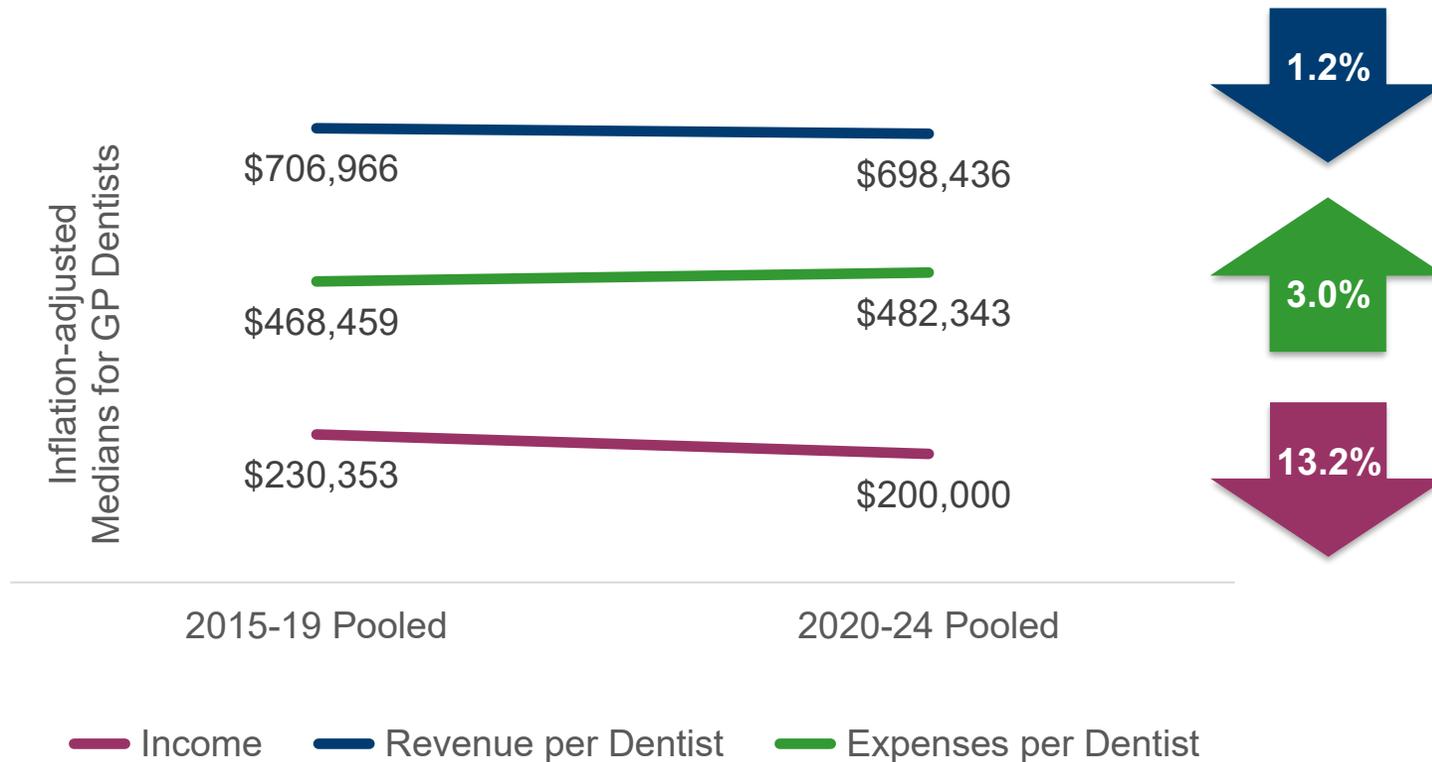


GP Owner/Nonowner Income Gap Narrows

- The income gap between owner and nonowner GP dentists is shrinking over time.
- Comparing the 5-year period 2010-2014 with 2020-2024, inflation-adjusted incomes fell by \$26,000 for owner GPs. The comparable decrease was only \$2,000 for nonowner GPs.

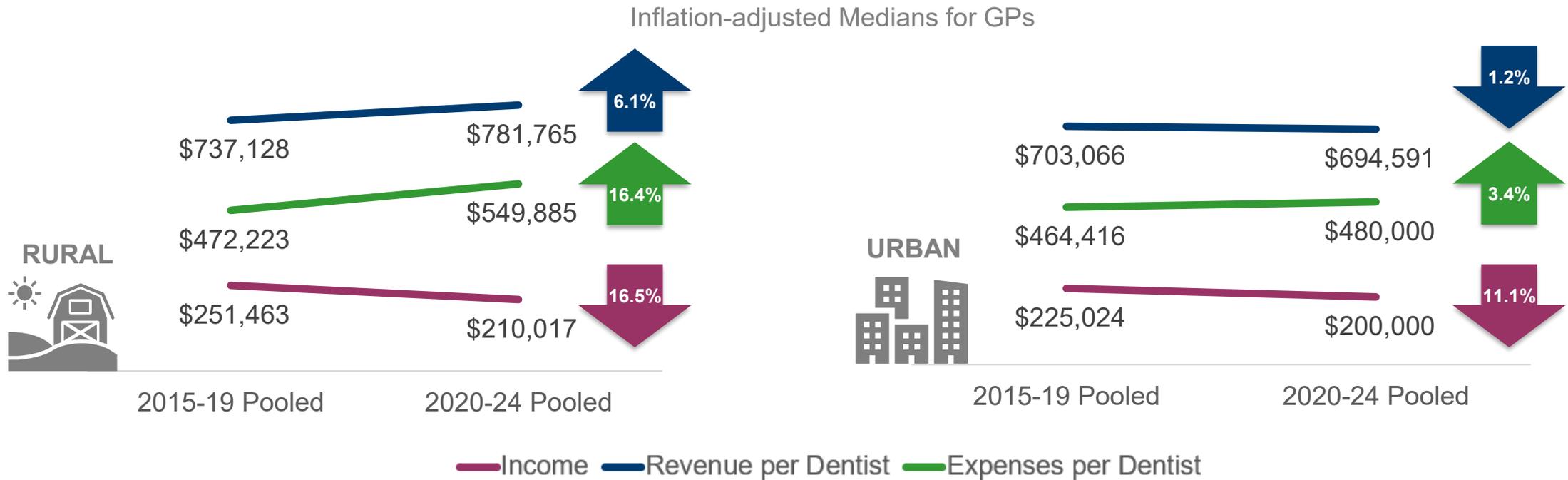


Expenses Rising, Revenue Down Slightly



- Expenses per dentist are rising while revenue per dentist is down slightly.
- Rising expenses and decreasing revenue are driving the downward trend in GP dentist net incomes.

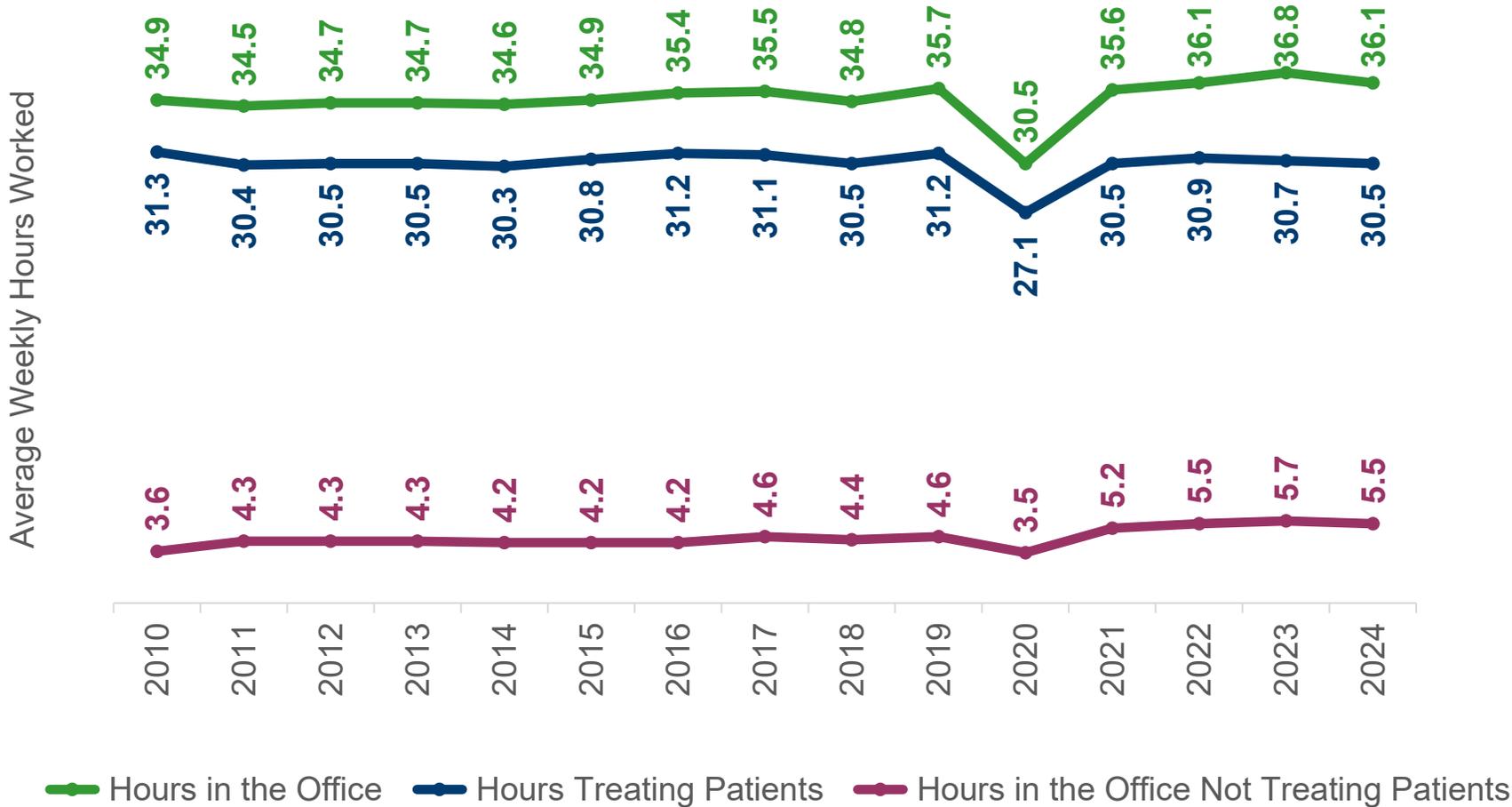
Revenue Per Dentist Higher in Rural Areas



- On average, dental practices in rural areas experienced a 6.1% increase in revenue per dentist between combined periods of 2015-19 and 2020-24, while urban practices saw a 1.2% decrease.
- Both rural and urban dentists saw a decrease in median annual income, though the decrease was more for rural dentists compared to urban dentists..

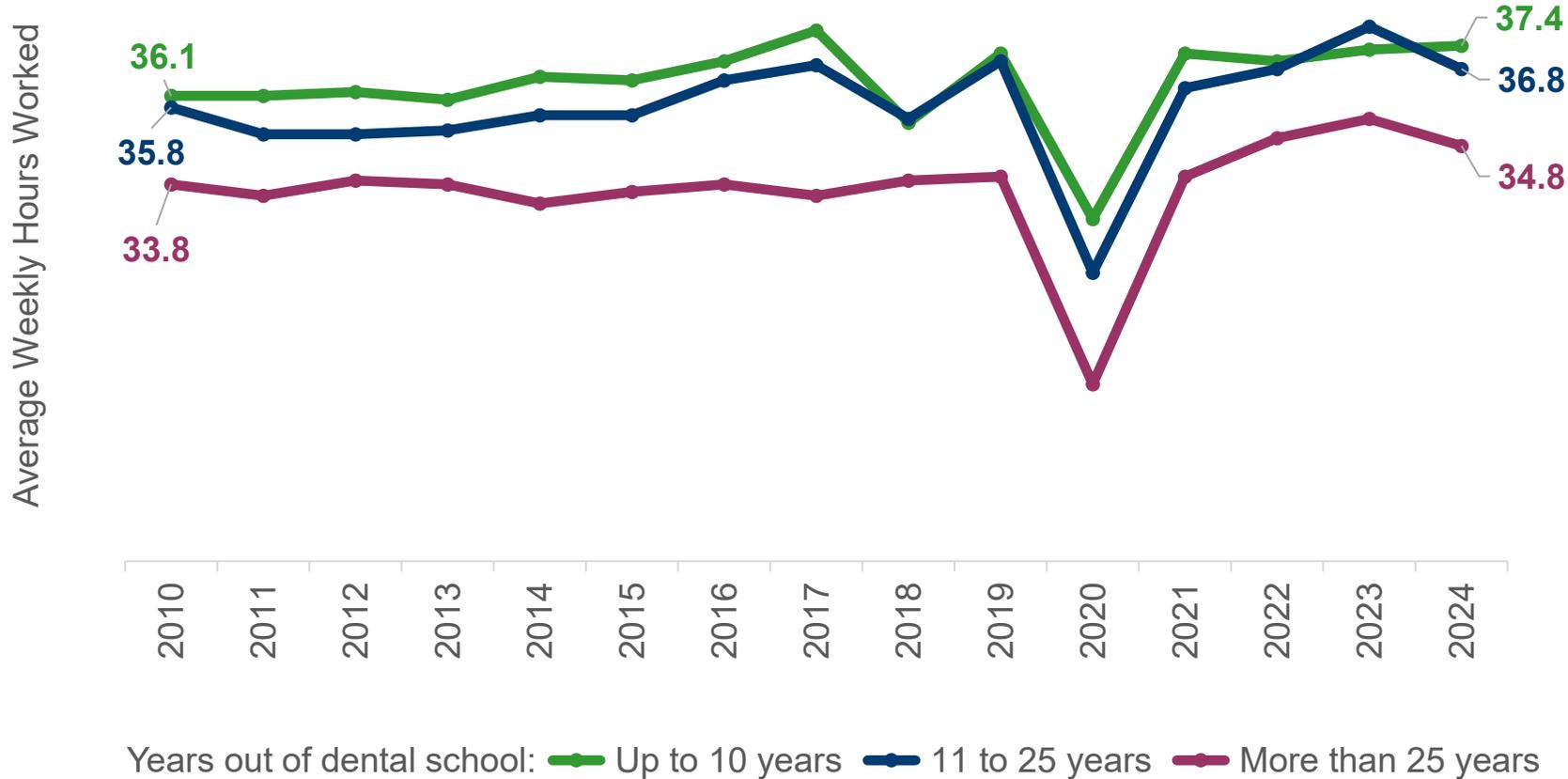
Dentists' Hours Worked

Dentists Spending More Time on Non-Clinical Hours



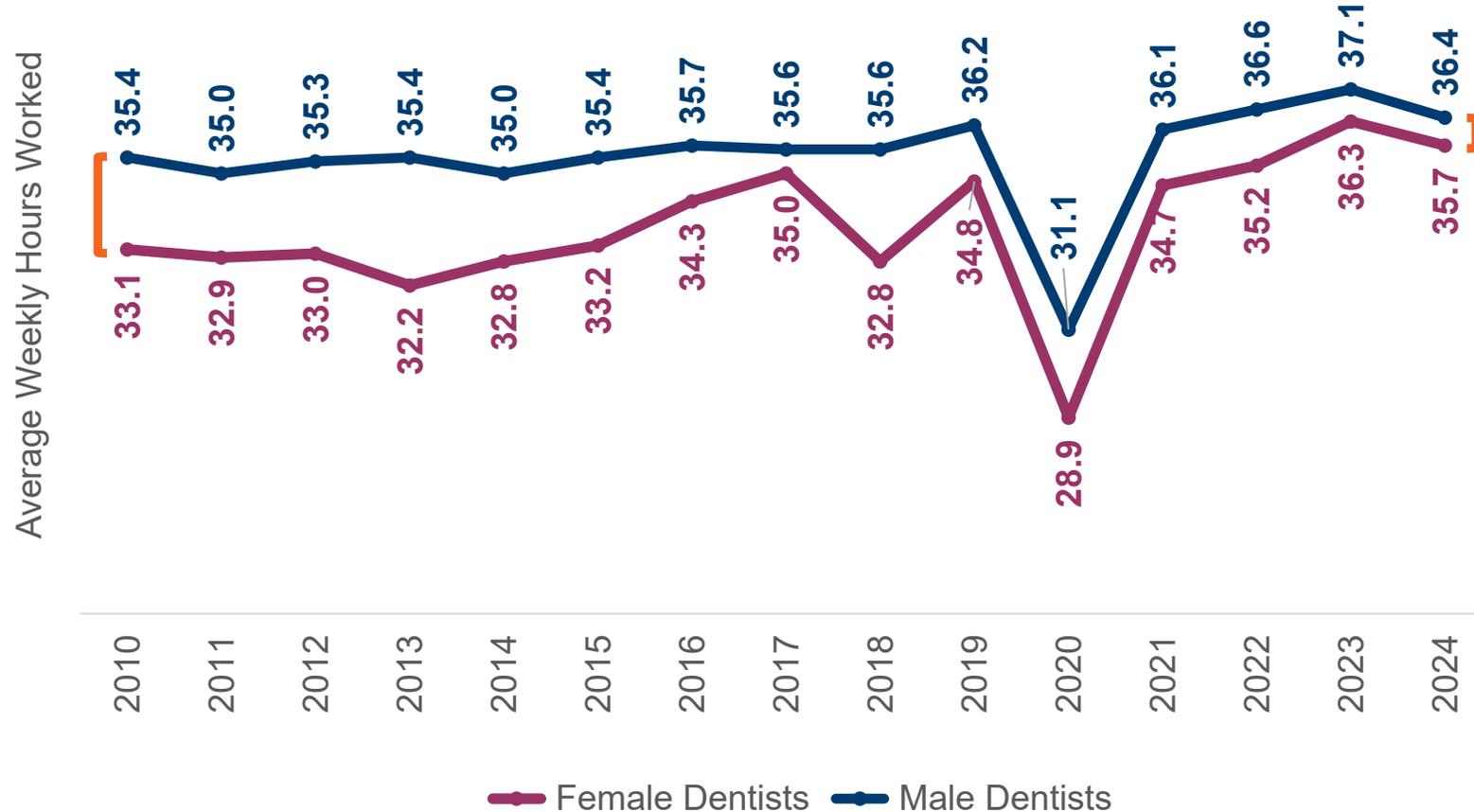
- From 2010 through 2019, dentists averaged 35 hours per week in the office.
- In comparison, from 2021 through 2024, the average hours worked was 36.2, an increase of 1.2 hours. The increase is entirely due to additional office time not treating patients.

Newer Dentists Work the Most Hours



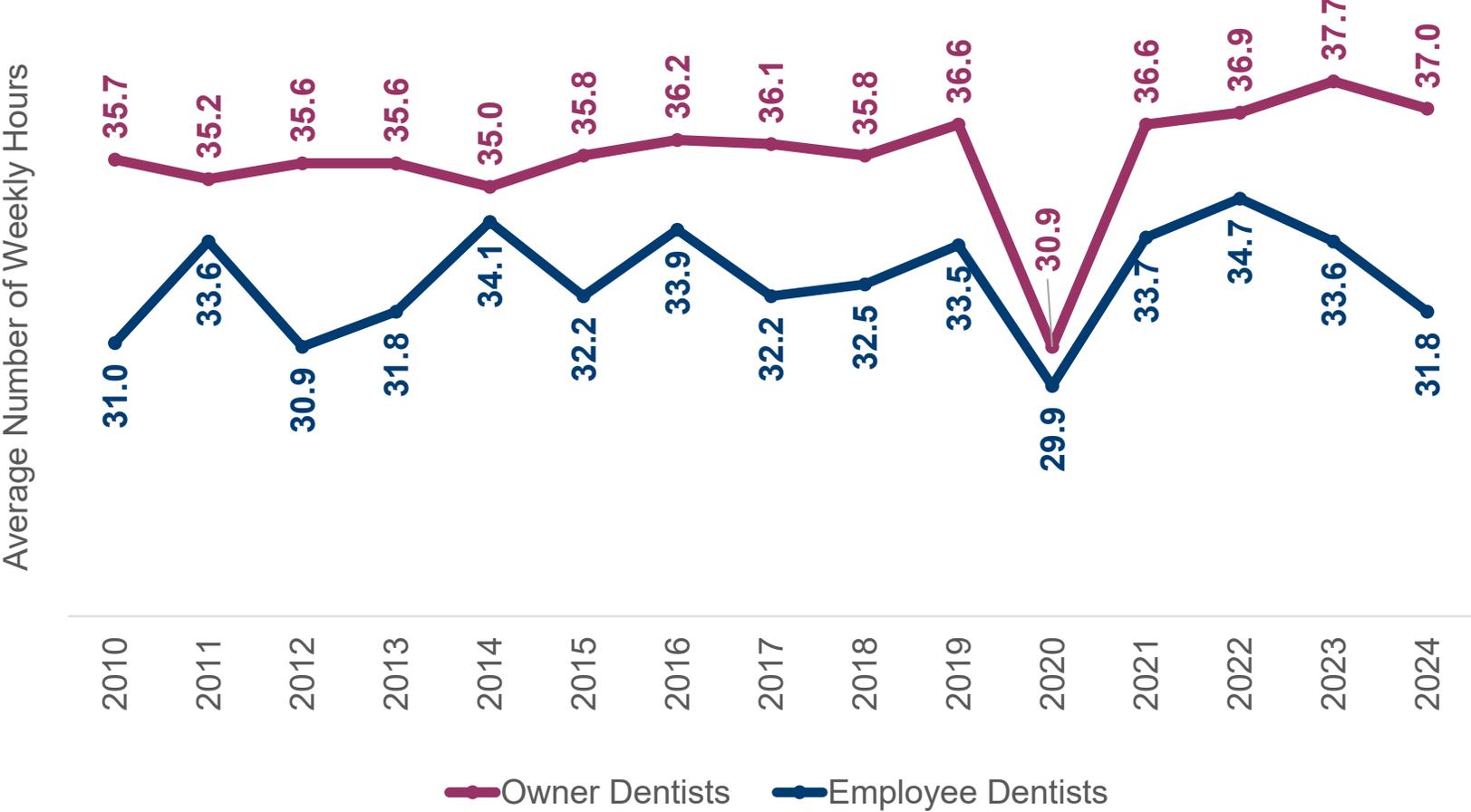
- All dentists, regardless of career stage, are working slightly more hours in 2024 than in 2010.
- More experienced dentists tend to work fewer hours per week compared to less experienced dentists.

Gender Gap in Hours Worked Has Narrowed



- The dentist gender **gap** in weekly hours worked has decreased from 140 minutes (2010) to 42 minutes (2024).
- Female dentists worked 98% as many hours per week as male dentists in 2024 compared to 94% in 2010.

Owner Dentists Work More Hours



In 2024, employee (or associate) dentists, on average, worked 5.2 fewer hours per week than owner dentists.

Data Sources and Methods

Data Sources and Methods

Dentists Surveyed	Bureau of Labor Statistics (BLS)	HPI Survey of Dental Practice (SDP)
Private practice owners (incorporated)	Yes	Yes
Private practice owners (unincorporated)	No	Yes
Private practice nonowners	Yes	Yes
Dentists in non-private practice settings (education, government, hospitals)	Yes	No

Items Included in Income Calculation	Bureau of Labor Statistics (BLS)	HPI Survey of Dental Practice (SDP)
Salary, commission, production bonuses	Yes	Yes
End-year bonuses, non-production bonuses	No	Yes
Payments made to a retirement plan	No	Yes

BLS and SDP income trends differ because of differences in the data collection method. These tables illustrate the differences.

Data Sources and Methods

Slides 4-6

Sources: ADA Health Policy Institute Survey of Dental Practice.

U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment and Wage Statistics (OEWS). Available at <https://www.bls.gov/oes/tables.htm>, accessed April 3, 2025.

U.S. Department of Labor, Bureau of Labor Statistics, Consumer Price Index. Available at <https://www.bls.gov/cpi/data.htm>, accessed April 3, 2025.

U.S. Department of Education, College Scorecard. Available at <https://collegescorecard.ed.gov/data>, accessed June 24, 2024.

Notes: Survey of Dental Practice results are weighted to compensate for oversampling and nonresponse bias. Dollar amounts are adjusted for inflation using the All-Item Consumer Price Index. All values are in constant 2024 dollars. Survey of Dental Practice methods available at https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpidata_sdpi_2024.xlsx.

The “Physicians (Family Medicine and Internist)” category is a combination of the "Family Medicine Physicians" and "General Internal Medicine Physicians" categories weighted by their job counts.

Data Sources and Methods

Slides 4-6 (continued)

Notes: For “Average income for GPs 5 years after graduation,” earnings are reported for those individuals who received federal financial aid. In this analysis, about 68% of dental school graduates received federal financial aid and, therefore, are included in the sample. Earnings were measured in 2020 and 2021 and inflation-adjusted to 2022 dollars. The earnings measurement represents the sum of wages and deferred compensation from all non-duplicate W-2 forms and positive self-employment earnings from IRS Form 1040 Schedules SE (Self-Employment Tax) for each dentist measured. National average annual earnings are the average of the institutions' median earnings, weighted by the number of graduates per institution. College Scorecard methods available at <https://collegescorecard.ed.gov/assets/FieldOfStudyDataDocumentation.pdf>. Accessed June 24, 2024.

Data Sources and Methods

Slides 7-10, 13-16

Source: ADA Health Policy Institute Survey of Dental Practice.

Notes: Survey of Dental Practice results are weighted to compensate for oversampling and nonresponse bias. Dollar amounts are adjusted for inflation using the All-Item Consumer Price Index. All values are in constant 2024 dollars. Survey of Dental Practice methods available at https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpidata_sdpi_2024.xlsx.

Slide 11

Sources: ADA Health Policy Institute annual *Survey of Dental Practice*; Health Resources & Services Administration, Federal Office of Rural Health Policy (FORHP) Data Files, available from <https://www.hrsa.gov/rural-health/about-us/what-is-rural/data-files>.

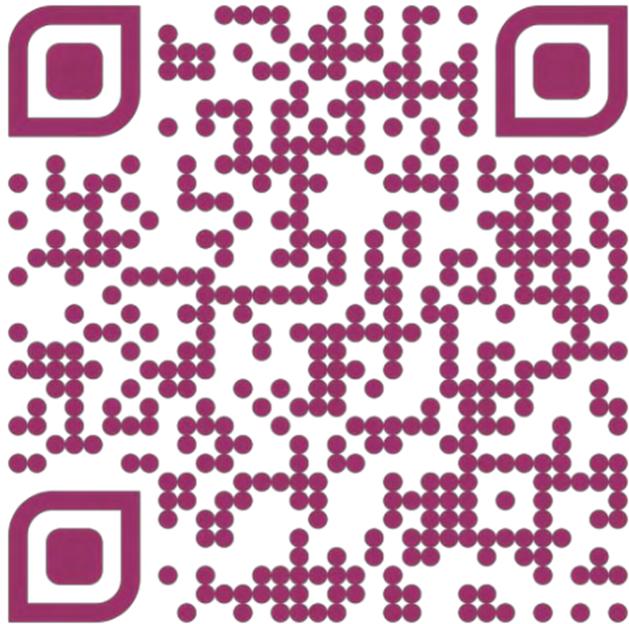
Notes: Survey of Dental Practice results are weighted to compensate for oversampling and nonresponse bias. Dollar amounts are adjusted for inflation using the All-Item Consumer Price Index. All values are in constant 2024 dollars.

Suggested Reference

Suggested Reference

American Dental Association. Trends in Dentists' Income, Revenue and Hours Worked. Health Policy Institute. November 2025. Available from: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/trends_in_dentists_income_revenue_hours_worked.pdf.

Thank you!



[ADA.org/HPI](https://ada.org/HPI)

hpi@ada.org

Haley Robinson

EDUCATION

Oregon State University

Bachelor of Science; Human Development and Family Sciences

WORK EXPERIENCE

Oregon Board of Dentistry

Interim Executive Director

November 2025 – Present

- Serve as the Board's chief operations officer, overseeing daily administration, office management, and all personnel functions, including recruitment, onboarding, development, and performance evaluation.
- Develop and manage the agency budget, ensuring fiscal accuracy, internal controls, and compliance with legislatively adopted expenditure levels.
- Establish administrative policies and direct procurement, facilities, equipment, and resource management to support agency operations.
- Act as the Board's administrative agent, preparing agendas and materials; ensuring public notice and legal compliance for all Board and committee meetings; and overseeing minutes and public records.
- Serve as spokesperson when delegated and act as primary liaison among the Board, committees, staff, and stakeholders, lead orientation for new Board members and support policy development.
- Ensure all rulemaking processes comply with Oregon law and facilitate strong public participation.
- Build and maintain collaborative relationships with state and federal agencies, professional associations, educational institutions, and national examination and regulatory bodies; represent the Board in regional and national organizations.
- Oversee review and approval of licensure and renewal applications; manage administration of specialty and jurisprudence examinations; and supervise certification processes for expanded-function dental assistants and anesthesia permits.

Operations Manager

April 2020 – November 2025

- Supervise and coordinate the work of staff, assigning, distributing and changing workflow as required to meet deadlines. Establishes work and vacation schedules and authorizes overtime. Develops and implements new or revised work procedures to improve workflow.
- Interpret and execute the provisions of the Dental Practice Act and rules of the Board and other regulations which determine the safe and legal practice of dentistry and dental hygiene in Oregon. Develops and recommend modification of the Dental Practice Act and rules of the Board.
- Manage Board administration and responsible for key personnel processes including recruitment, orientation, staff development and performance evaluations.
- Lead preparation of Board and committee agendas and materials, ensuring all meetings are properly noticed, compliant with administrative requirements, and accessible to the public. Oversee the accurate preparation of minutes and the lawful maintenance of public records. Direct the multi-disciplinary licensing/investigations database implementation project, ensuring project activities follow established management methodologies and comply with all relevant laws, regulations, and internal policies. Deliver ongoing reporting on progress and outcomes. Lead the development and oversight of agency website content in full compliance with state and federal law, ensuring information is timely, accurate, and user-centered to effectively serve the public and licensee community.

Haley Robinson

- Provide educational and outreach presentations about licensing, administration, investigations, and current factors impacting the dental community to dental institutions, professional organizations, dental conferences and dental, dental hygiene, and dental assisting programs.
- Ensure all rulemaking proceedings are conducted in full compliance with Oregon law while promoting meaningful public participation. Serve as the agency's Rules Coordinator. Build and maintain strong, collaborative relationships with community partners, consumers, and public interest groups. Coordinate public engagements—including presentations, events, and outreach activities—to increase awareness of agency programs and services.

Investigator/Diversion Coordinator

June 2018 – April 2020

- Conducted investigations into potential violations of criminal, civil, and administrative law, developing and implementing effective investigative methodologies. Collected and preserved evidence, issued subpoenas, and carried out fact-finding in accordance with rules of evidence.
- Managed the Board's confidential diversion program as the Diversion Coordinator, working independently to support licensees with substance use disorders, mental health conditions, or dual diagnoses.
- Monitored approximately 20 Health Professionals' Services Program (HPSP) participants to ensure compliance with program terms and conditions.
- Collaborated with treatment providers to assess progress, tracked required documentation—including treatment reports, triplicate prescriptions, and drug screening results and prepared detailed reports of potential violations for Board review.
- Maintained highly detailed and confidential case files for all investigations and diversion participants, upholding strict confidentiality standards and safeguarding evidence.

Investigator

June 2017 - June 2018

- Assessed incoming complaints by determining jurisdiction, identifying applicable statutes and administrative rules, designing an investigative plan, and initiating contact with complainants, respondents, and other relevant parties.
- Collected and analyzed all necessary evidence, including patient dental and insurance records; conducted interviews with complainants, respondents, and subsequent treating providers; and consulted independent dental experts on complex clinical issues. Evaluated testimony and documentation to determine potential violations of the Dental Practice Act or Board rules.
- Prepared comprehensive investigative reports and recommended disciplinary actions consistent with Board policy and established precedent.

Office Specialist

June 2016 - June 2017

- Supported the daily administrative and operational functions of the Oregon Board of Dentistry.
- Managed the agency's records retention program and responded to public records requests in accordance with state requirements.
- Prepared accurate Board meeting minutes using digital recording and transcription software.
- Assisted the Executive Director in developing the agency's biennial budget.
- Drafted, edited, and produced the Oregon Board of Dentistry newsletter.

Haley Robinson

Accomplishments

- Ambassador of Public Service for “Operational Excellence” 2024
- Ambassador of Public Service for “true Ambassador of Public Service and who has persevered in the face of adversity and exemplified resilience in service to Oregon” 2021
- Earned Accounts Receivable Honor Roll Award 2020-2025
- Earned Gold Star Certificate from State Controller’s Office 2020-2025
- Testified to the Legislature on HB 5512 (OBD budget bill) 2025

Certifications and Training

- Secretary of State Rules Coordinator 2020-Present
- Certified Investigator, Council on Licensure, Enforcement and Regulation May 2019
- Local Agency Security Officer (LASO), Oregon State Police Criminal Justice Information Services 2020-Present
- Law Enforcement Data Service Representative, Oregon State Police Criminal Justice Information Services 2018-Present
- Ethics Certification, National Institute of Health April 2015
- Nurturing Parenting Facilitator Certificate, Family Development Resources, Inc March 2015

LICENSE RATIFICATION

RATIFICATION OF LICENSES

As authorized by the Board, licenses to practice dentistry, dental therapy and dental hygiene were issued to applicants who fulfilled all routine licensure requirements. It is recommended the Board ratify the issuance of the following licenses. Complete application files will be available for review during the Board meeting.

DENTAL HYGIENISTS

H9160	Ware, Ashlee V	2025-12-03
H9161	Yang, Christine Shing	2025-12-05
H9162	Villicana, Marilyn	2025-12-05
H9163	Hansen, Sage Romney	2025-12-09
H9164	Lewis, Rochelle	2025-12-15
H9165	Ferdinand, Dana Renee	2025-12-16
H9166	Gallegos, Daryan	2025-12-23
H9167	Porharandy, Arghawan	2025-12-30
H9168	Bryant, Robert Alexander	2025-12-30
H9169	Gonzalez, Irma Guadalupe	2026-01-06
H9170	Flores Crisostomo, Magdalena	2026-01-06
H9171	Valdez Ortega, Joana	2026-01-06
H9172	Dunbar, Alanna	2026-01-09
H9173	Jones, Sheba N	2026-01-12
H9174	Valastro, Marissa Lynn	2026-01-14
H9175	Mayea, Libby	2026-01-20
H9176	Rollolazo, Dean Joseph Ramos	2026-01-20
H9177	Davis, Kristin	2026-01-22
H9178	Nguyen, Hamy Thi	2026-02-02
H9179	MULLINS, JESSICA LEE	2026-02-04
H9180	Ibbetson, Carrie Lynn	2026-02-09
H9181	Oakes, Amber	2026-02-12
H9182	Sauser, Marianna	2026-02-19
H9183	Loeffler, Skye Azurine	2026-02-19

DENTISTS

D12287	Alomran, Omar	2025-12-03	DMD
D12288	Kadamani, Mohamad Walid	2025-12-03	DDS
D12289	Akhavan, Parham	2025-12-08	DDS
D12290	Garcia, Jarlath	2025-12-09	DMD
D12291	Call, Carl	2025-12-15	DMD
D12292	Swallow, John Taylor	2026-01-06	DDS
D12293	Kim, Kyurim	2026-01-12	DMD
D12294	Kernig, Mikelle Louella	2026-01-13	DDS
D12295	Dolan, Jennifer	2026-01-14	DDS
D12296	Dharia, Karan Rakesh	2026-01-14	

D12297	Chen, Zixin	2026-01-20	DDS
D12298	Moricz, Claudia	2026-01-20	DDS
D12299	Nelson, Kirby Martin	2026-01-23	DDS
D12300	Perciaccante, Vincent James	2026-01-23	DDS
D12301	Mohammednur, Abubeker	2026-01-28	DMD
D12302	Jil-Agopian, Ara Garabet	2026-01-28	DDS
D12303	Rossa, Zuzanna	2026-02-11	DMD
D12304	Goyal, Nikita	2026-02-11	DDS

**LICENSE, PERMIT
&
CERTIFICATION**

Request for reinstatement of an expired license – Tyler Andrew Fix, D.M.D.

The Board has received a request for the reinstatement of an expired license. OAR 818-021-0085 requires that before a license that has been expired may be reinstated, the applicant must complete several steps. One of the requirements for reinstatement is that the applicant “passes any other qualifying examination as may be determined necessary by the Board after assessing the applicant’s professional background and credentials.”

Tyler Andrew Fix, D.M.D. (D10648) held a license to practice dentistry in Oregon that expired on March 31, 2023. Since Dr. Fix’s dental license expired, Dr. Fix has held an active license in Arizona, which was initially issued in January 2023. Dr. Fix would now like to reinstate his Oregon dental license so he can resume practicing dentistry in Oregon. Dr. Fix has submitted a License and Permit Reinstatement Application, fees, proof of continuing education for the renewal cycles during which his license was expired, passed the Board’s Jurisprudence Examination, and has submitted a background check. No disciplinary actions have been taken against Dr. Fix in any of the states in which he was licensed. Board staff submitted an inquiry to the National Practitioners Data Bank and the Healthcare Integrity Data Bank and no negative information regarding Dr. Fix has been filed by any other entity in either of these data banks.

Pursuant to OAR 818-021-0085, the Board needs to determine if it is necessary for Dr. Fix to take any further examination and whether to reinstate Dr. Fix’s dental license.

Relevant Rules:

818-021-0085 – Renewal or Reinstatement of Expired License

Any person whose license to practice as a dentist or dental hygienist has expired, may apply for reinstatement under the following circumstances:

- (1) If the license has been expired 30 days or less, the applicant shall:
 - (a) Pay a penalty fee of \$50;
 - (b) Pay the biennial renewal fee; and
 - (c) Submit a completed renewal application and certification of having completed the Board's continuing education requirements.
- (2) If the license has been expired more than 30 days but less than 60 days, the applicant shall:
 - (a) Pay a penalty fee of \$100;
 - (b) Pay the biennial renewal fee; and
 - (c) Submit a completed renewal application and certification of having completed the continuing education requirements.
- (3) If the license has been expired more than 60 days, but less than one year, the applicant shall:
 - (a) Pay a penalty fee of \$150;
 - (b) Pay a fee equal to the renewal fees that would have been due during the period the license was expired;
 - (c) Pay a reinstatement fee of \$500; and
 - (d) Submit a completed application for reinstatement provided by the Board, including certification of having completed continuing education credits as required by the Board during the period the license was expired. The Board may request evidence of satisfactory completion of continuing education

courses.

- (4) If the license has been expired for more than one year but less than four years, the applicant shall:
 - (a) Pay a penalty fee of \$250;
 - (b) Pay a fee of equal to the renewal fees that would have been due during the period the license was expired;
 - (c) Pay a reinstatement fee of \$500;
 - (d) Pass the Board's Jurisprudence Examination;
 - (e) Pass any other qualifying examination as may be determined necessary by the Board after assessing the applicant's professional background and credentials;
 - (f) Submit evidence of good standing from all states in which the applicant is currently licensed; and
 - (g) Submit a completed application for reinstatement provided by the Board including certification of having completed continuing education credits as required by the Board during the period the license was expired. The Board may request evidence of satisfactory completion of continuing education courses.
- (5) If a dentist or dental hygienist fails to renew or reinstate his or her license within four years from expiration, the dentist or dental hygienist must apply for licensure under the current statute and rules of the Board.

**OREGON BOARD OF DENTISTRY
LICENSE AND PERMIT REINSTATEMENT APPLICATION**

**Return to: Oregon Board of Dentistry
Unit 23
PO Box 4395
Portland, OR 97208-4395**

RECEIVED
DEC 17 2025

Oregon Board
of Dentistry

2104 \$722.00
1290 \$750.00
1706 \$100.00
1707 \$8.00

Name TYLER ANDREW FIX
License # D10648

Licensure Fees: \$822.00
Penalty Fee: \$250.00
Reinstatement: \$500.00
OWHI Survey Fee: \$8.00
Total: \$1580.00



Please list the address to which you prefer your mail to be sent. At least one address must be a physical street address.

Primary Business Address *Tyler A Fix DMD PLLC
PO Box 45083
Phoenix AZ 85064* Home Address *Tyler A Fix DMD
1635 E Mclellan Blvd
Phoenix AZ 85016*

Phone: 602-363-3731

Email Address: tylerfix1989@gmail.com

**NOTE: ALSO COMPLETE AND SIGN ON THE REVERSE
INCOMPLETE FORMS WILL BE RETURNED**

Request for reinstatement of an expired license – Dena M Schimel, R.D.H.

The Board has received a request for the reinstatement of an expired license. OAR 818-021-0085 requires that before a license that has been expired may be reinstated, the applicant must complete a number of steps. One of the requirements for reinstatement is that the applicant “passes any other qualifying examination as may be determined necessary by the Board after assessing the applicant’s professional background and credentials.”

Dena M Schimel (H3582) held a license to practice dental hygiene in Oregon that expired on September 30, 2022. Since Ms. Schimel’s dental hygiene license expired, she has not held any other licenses. Ms. Schimel would now like to reinstate her Oregon dental hygiene license so she can resume practicing in Oregon. Ms. Schimel has submitted a License and Permit Reinstatement Application, fees, proof of continuing education for the renewal cycle(s) during which her license was expired, passed the Board’s Jurisprudence Examination, and has submitted a background check. No other licensing agencies report any adverse action taken against Ms. Schimel. Board staff submitted an inquiry to the National Practitioners Data Bank and the Healthcare Integrity Data Bank and no negative information regarding Ms. Schimel has been filed by any other entity in either of these data banks.

Pursuant to OAR 818-021-0085, the Board needs to determine if it is necessary for Ms. Schimel to take any further examination and whether to reinstate Ms. Schimel’s dental hygiene license.

Relevant Rules:

818-021-0085 – Renewal or Reinstatement of Expired License

Any person whose license to practice as a dentist or dental hygienist has expired, may apply for reinstatement under the following circumstances:

- (1) If the license has been expired 30 days or less, the applicant shall:
 - (a) Pay a penalty fee of \$50;
 - (b) Pay the biennial renewal fee; and
 - (c) Submit a completed renewal application and certification of having completed the Board's continuing education requirements.
- (2) If the license has been expired more than 30 days but less than 60 days, the applicant shall:
 - (a) Pay a penalty fee of \$100;
 - (b) Pay the biennial renewal fee; and
 - (c) Submit a completed renewal application and certification of having completed the continuing education requirements.
- (3) If the license has been expired more than 60 days, but less than one year, the applicant shall:
 - (a) Pay a penalty fee of \$150;
 - (b) Pay a fee equal to the renewal fees that would have been due during the period the license was expired;
 - (c) Pay a reinstatement fee of \$500; and
 - (d) Submit a completed application for reinstatement provided by the Board, including certification of having completed continuing education credits as required by the Board during the period the license was expired. The Board may request evidence of satisfactory completion of continuing education courses.

- (4) If the license has been expired for more than one year but less than four years, the applicant shall:
- (a) Pay a penalty fee of \$250;
 - (b) Pay a fee of equal to the renewal fees that would have been due during the period the license was expired;
 - (c) Pay a reinstatement fee of \$500;
 - (d) Pass the Board's Jurisprudence Examination;
 - (e) Pass any other qualifying examination as may be determined necessary by the Board after assessing the applicant's professional background and credentials;
 - (f) Submit evidence of good standing from all states in which the applicant is currently licensed; and
 - (g) Submit a completed application for reinstatement provided by the Board including certification of having completed continuing education credits as required by the Board during the period the license was expired. The Board may request evidence of satisfactory completion of continuing education courses.
- (5) If a dentist or dental hygienist fails to renew or reinstate his or her license within four years from expiration, the dentist or dental hygienist must apply for licensure under the current statute and rules of the Board.

NOV 21 2025

**OREGON BOARD OF DENTISTRY
LICENSE AND PERMIT REINSTATEMENT APPLICATION**

Code
↓

Oregon Board
of Dentistry

**Return to: Oregon Board of Dentistry
Unit 23
PO Box 4395
Portland, OR 97208-4395**

2105 \$477.00
1290 \$750.00
1707 \$8.00

Name DENA M SCHIMEL
License # H3582

Licensure Fees: \$477.00
Penalty Fee: \$250.00
Reinstatement: \$500.00
OWHI Survey Fee: \$8.00
Total: \$1235.00



Please list the address to which you prefer your mail to be sent. At least one address must be a physical street address.

Primary
Business Address

Home
Address 1414 C st.
Hood River, OR 97301

Phone: 503-502-6133

Email Address: brnschimel1@gmail.com

**NOTE: ALSO COMPLETE AND SIGN ON THE REVERSE
INCOMPLETE FORMS WILL BE RETURNED**

*on
last page*

STRATEGIC PLANNING

Strategic Planning Retreat Inputs & Agenda

Oregon Board of Dentistry

The PEAK Fleet

February 17, 2026

Review / Revisit Prior Strategic Plan



Oregon Board of Dentistry Strategic Plan 2022-2025

Mission: *To promote quality oral health care and protect all communities in the State of Oregon by equitably and ethically regulating dental professionals.*

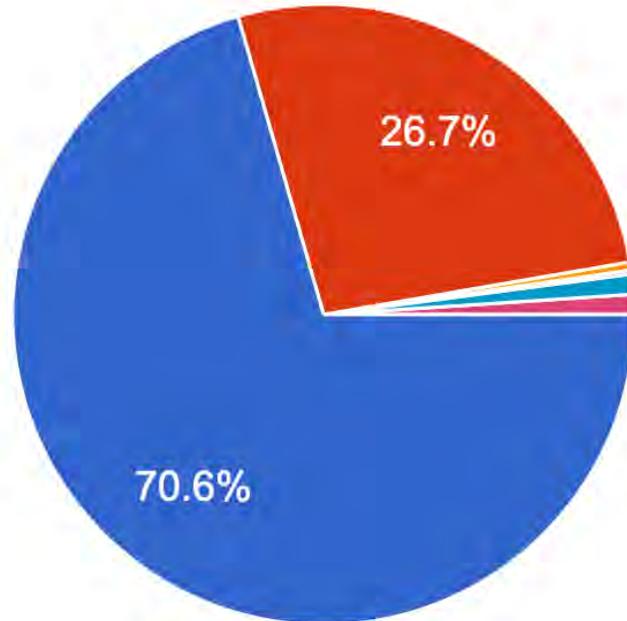
MISSION-CRITICAL PRIORITIES				
A. Licensure Evolution	B. Dentistry Practice Accountability	C. Community Interaction & Equity	D. Workplace Environment	E. Technology and Processes
GOALS				
<ul style="list-style-type: none"> Develop and implement rules based on legislation changes Successfully implement Dental Therapy license 	<ul style="list-style-type: none"> Ensure licensees dictate clinical care provided to patients (in contrast to corporate non-licensees driving care decisions) Increase OBD visibility into practice ownership models OBD jurisdiction over Dental practices in Oregon, regardless of ownership and business operating model Correlate patient care to level of competency required by practitioners (DT, DMD, DDS, DH); hold entities accountable to the level of licenses within their practice 	<ul style="list-style-type: none"> Communicate and market to reach the all communities within Oregon Increase ease of access to OBD services Ensure equity exists in investigation outcomes Increase OBD licensee, patient, and community understanding of OBD roles, responsibilities, and services 	<ul style="list-style-type: none"> Establish succession plan for Board members, continuing to represent many viewpoints and experiences in Board composition Increase workplace flexibility through a hybrid workplace guideline Increase workplace satisfaction and career development conversations 	<ul style="list-style-type: none"> Improve efficiency and resource utilization through on-line records keeping Increase ability to complete analytics related to licensees and investigations Improve investigation case management with archived files
ACTION ITEMS				
<ul style="list-style-type: none"> Develop and implement rules in support of HB 2528 (2021) for newly created Dental Therapist license Develop and implement communication strategies with communities impacted by Dental Therapy license implementation Engage interested parties to learn more and gather feedback about implementing Dental Therapy Practice in Oregon 	<ul style="list-style-type: none"> Implement changes to Licensee Renewal form to capture multiple office/group affiliation Gather dental practice ownership and training information Receive OHSU updated curriculum and include in Board Book Analyze complaints by ownership types Evaluate options for strengthening statute related to accountability, ownership, and standards of care Potential for proposed legislative changes 	<ul style="list-style-type: none"> Align Diversity, Equity, and Inclusion plans to guidance provided by the State of Oregon Racial Justice Council Enable OBD to take complaints in complainant's first language Include diversity analysis when developing Marketing or Communications materials; consider diversity in visual representations Create analysis of prior investigations, findings, and actions across licensee demographics to frame equity-related data Additional prioritized actions taken from recommendations and resources provided by State Racial Justice Council 	<ul style="list-style-type: none"> Develop succession plans for Board positions coming open and establish effective process for ongoing timely replacement Establish consistent expectation setting process Develop and implement hybrid workplace guidelines Implement standard performance evaluations and feedback process Evaluate overall workload and staff workload balance, consider adjustment for upcoming fiscal cycles 	<ul style="list-style-type: none"> Complete digitization and modernization process for Board Books Complete implementation of InLumon system Build working digital database of licensee records Pilot data analysis capabilities Create digital archive of investigation files

Member Survey Summary

479 Survey Participants as of Feb 11. 2026

Which best describes your relationship to the Oregon Board of Dentistry?

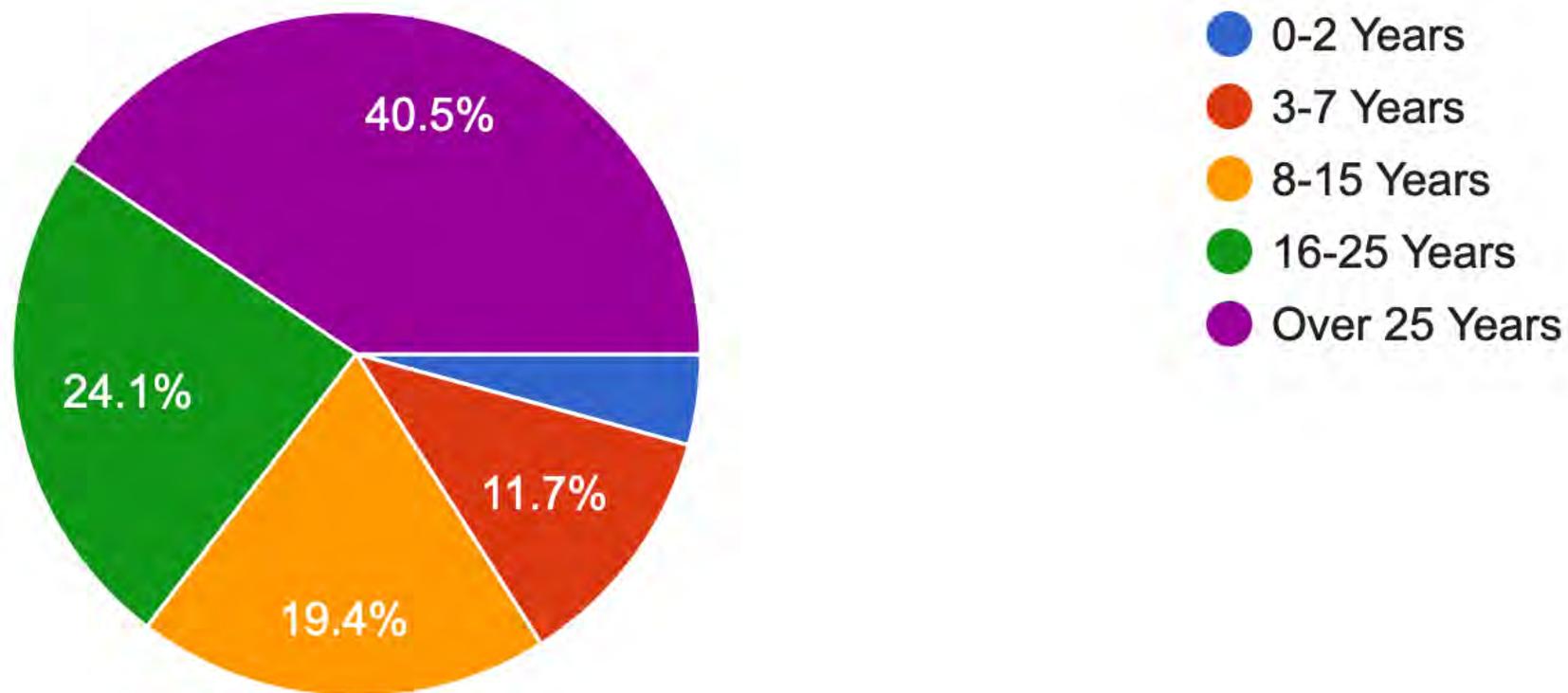
479 responses



- Dentist
- Registered Dental Hygienist
- Registered Dental Hygienist & Dental Therapist (dual license)
- Dental Therapist (single license)
- Dental Assistant
- Consumer/Member of the Public
- None of the above (please specify)

How many years have you practiced in Oregon?

469 responses

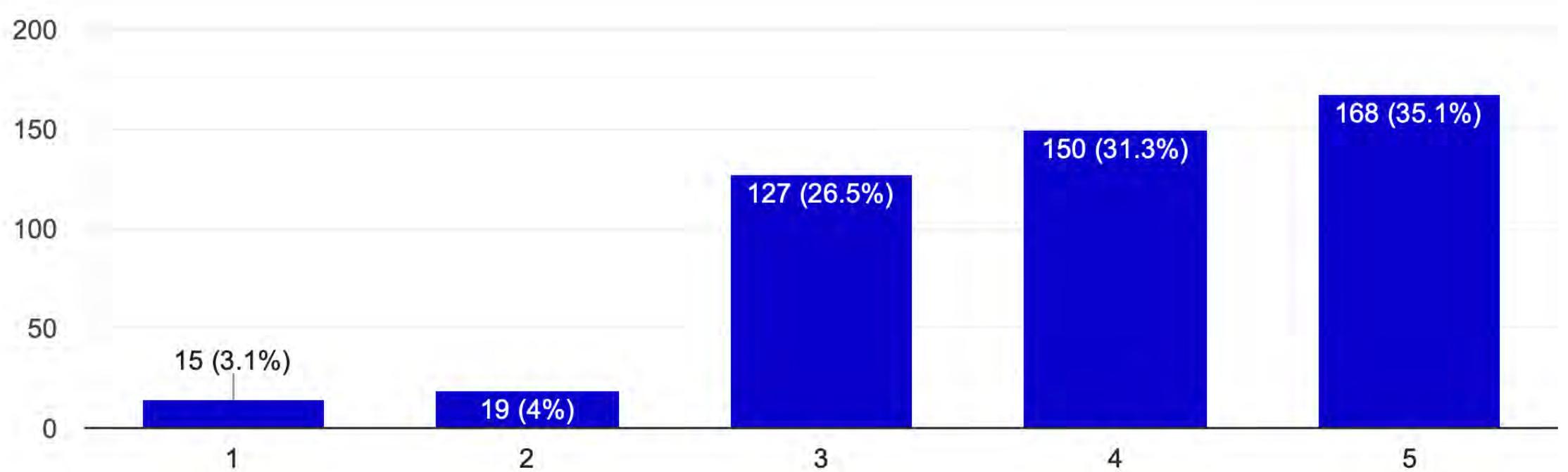


What is your primary practice setting?

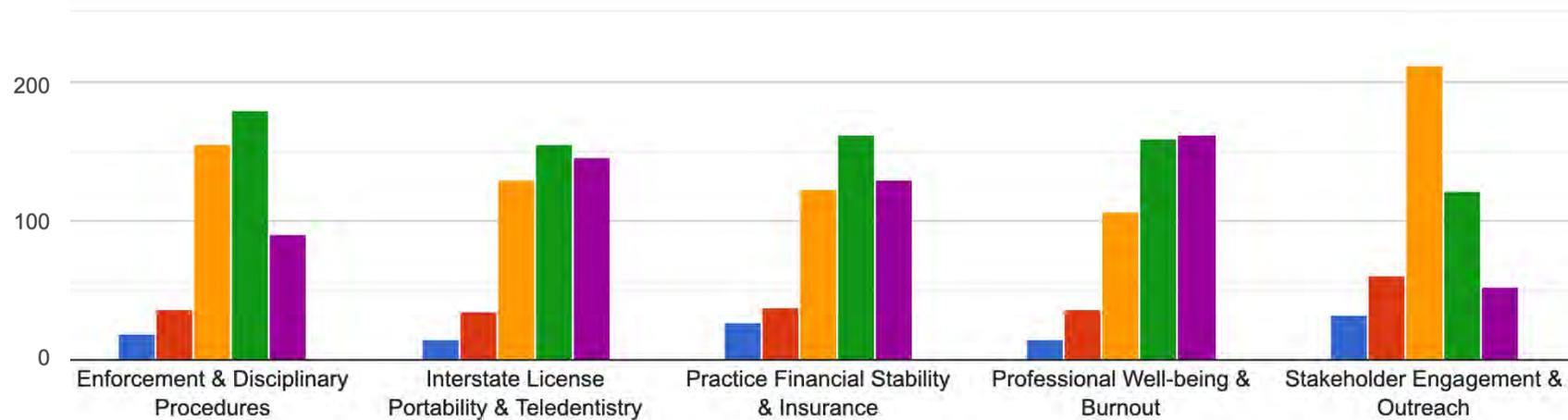
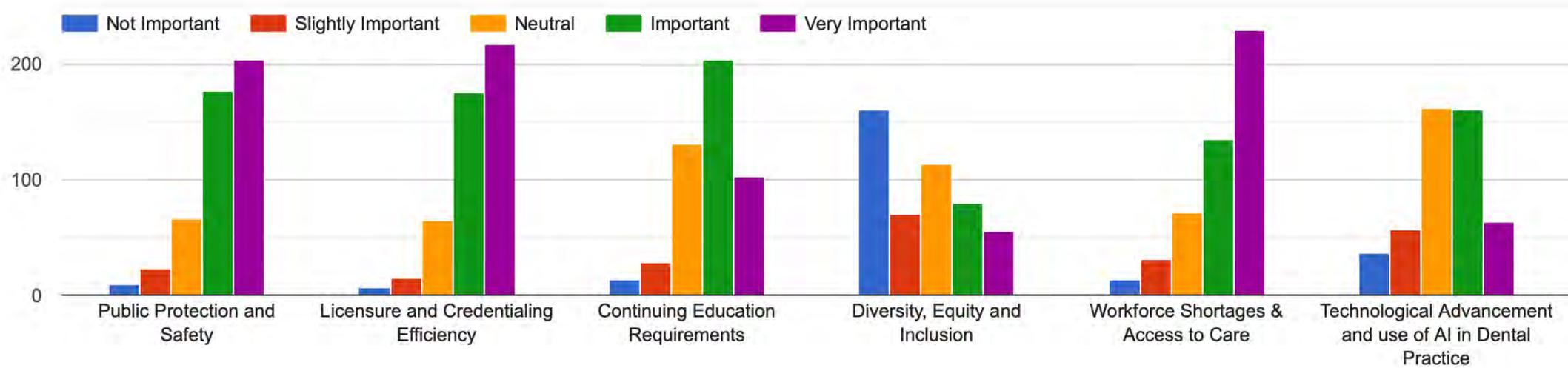
Private practice	74.3%
Community Health Center	6.1%
Academic/Education	5.0%
Group Practice	5.8%
Government/ Military	2.3%
DSO	0.6%
Tribal-related practice	1.0%
Retired or Not Practicing	2.3%
Other	2.5%

How satisfied are you with current communication and transparency from the Oregon Board of Dentistry?

479 responses

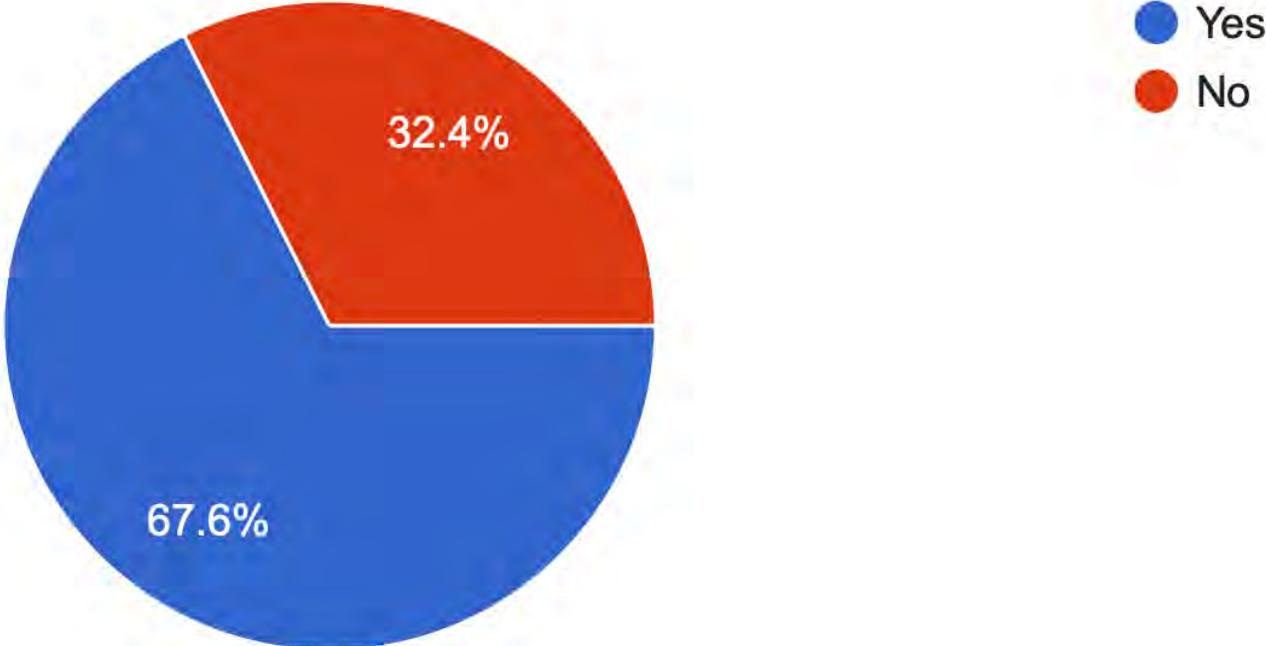


Please rate how important each of the following areas is for the Board to prioritize in the next 3-5 years. (1=Not Important; 5=Very Important)



Do you feel your voice is adequately represented by the Oregon Board of Dentistry?

479 responses



Voice Adequately Represented – Analysis of Comments

Responses: 134 (28.0%)

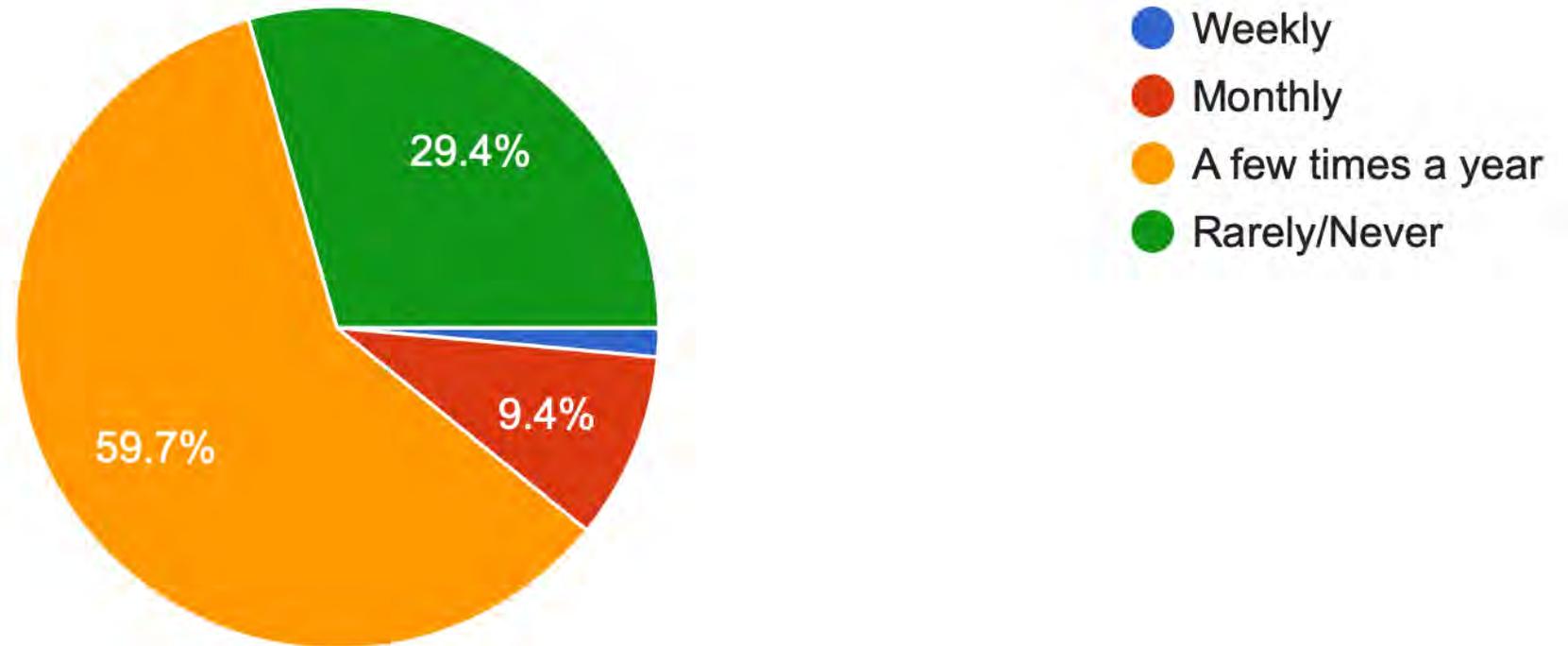
This question had the lowest response rate, with 72% of respondents choosing not to answer. This may indicate that many licensees feel neutral about representation or have not engaged deeply with Board activities. Among those who did respond, answers were diverse and ranged from strong satisfaction to significant concerns.

Top Representation Concerns:

- 1) Hygienist representation
- 2) Private practice dentists
- 3) Rural practice representation

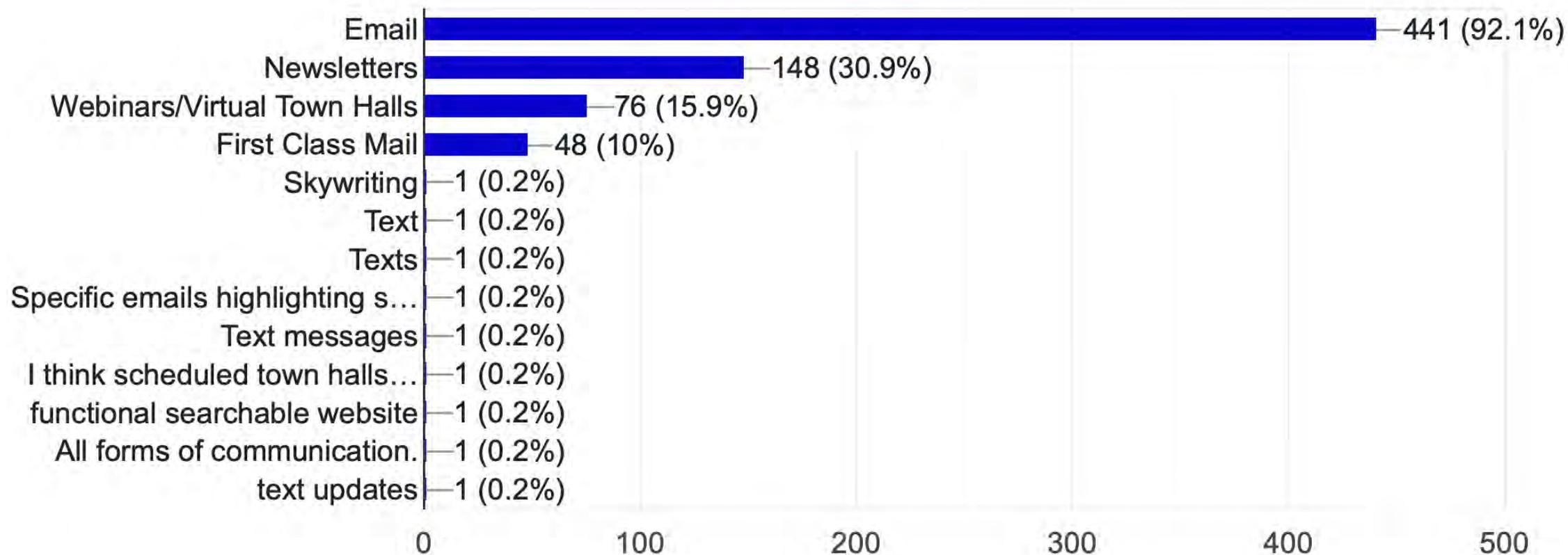
How often do you consult the OBD website or communications for updates?

479 responses



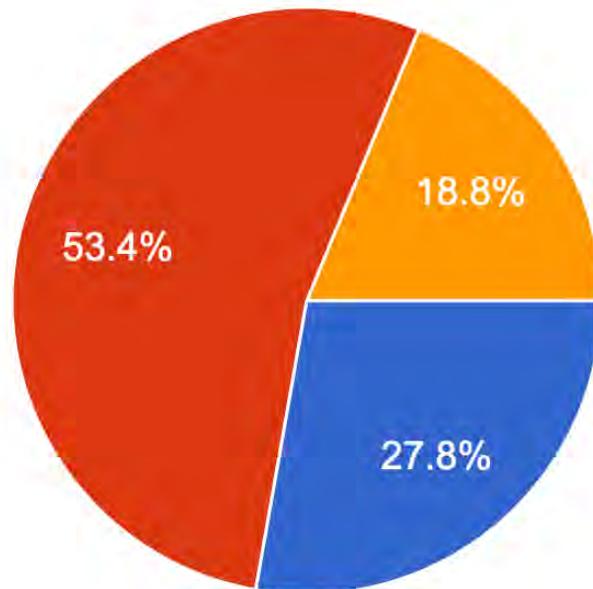
Which of the following communication channels would you prefer from the Oregon Board of Dentistry? (Select all that apply)

479 responses



Would you be willing to participate in future focus groups, advisory panels, or additional surveys to inform the Board's strategic planning?

479 responses



- No
- Maybe
- Yes (if yes, please email information@obd.oregon.gov expressing your interest)

Most Critical Issues over the Next 3-5 Years

Responses: 472 (98.7%)

Thematic Analysis

Theme	Mentions	Percentage
Education/Training	303	64.2%
Workforce/Staffing	185	39.2%
Access to Care	93	19.7%
Public Protection/Safety	88	18.6%
Insurance/Reimbursement	73	15.5%
Scope of Practice	63	13.3%

Changes or Improvements Desired

Responses: 423 (88.5%)

Top Themes

Theme	Mentions	Percentage
Education/Training	110	26.0%
Regulation/Rules	57	13.5%
Communication/Transparency	38	9.0%

Specific Suggestions

Respondents offered numerous specific suggestions for improvement, including:

- Streamline continuing education requirements and reduce redundant CE topics
- Improve communication about rule changes and Board decisions
- Make Board meeting minutes and agendas more accessible to licensees
- Increase transparency in complaint investigation processes
- Simplify license renewal process and improve online portal functionality
- Provide more regular updates to licensees about Board activities
- Address workforce shortage issues through regulatory flexibility where appropriate
- Balance public protection with support for dental professionals

Additional Background & Prep Info for Strategy Retreat

Topics raised by Board/Staff Members

- Technology & Processes
 - AI
 - Additional InLumon Functionality to support efficiency
 - HIPPA compliance improvement for investigations
- Registered Dental Hygienists Administering Botox
- Continuing Education
- Dental Compact
- Review/Update Board Protocols
- Substance Abuse/Mental Health CE Requirement
- Improving access to care for low-income patients
- Ongoing Board Funding Concerns
- Affordability of Dentistry for practices + community
- Maintaining Dental standards

Potential / Proposed Strategic Themes

Workplace environment / engaged workforce + board

- Succession Planning & Future Org planning – Board and Staff
- Training & Development – AI, etc.

Processes & Technology

- Streamline & Automate processes including leveraging InLumon further
- AI integration / guidelines / processes
- Improved HIPPA compliant solutions for investigations
- Communication to Member Community

Future of Dental Regulation / Oversight

- Dental Compact options
- Group Dentistry accountability
- Dental Assisting accountability
- Impacts / Risks to Sustainability of practice & board with lowered membership #s

Support of Emerging /Existing Dental Practice challenges

- Rising Costs of Dental Practices
- Mental Health & Substance Abuse challenges and support

Access to Care / Community Concerns

Agenda – Friday, Day 1

Date: February 27, 2026					
Start	End	Duration	Topic	Owner/Presenter	Objective/Outcomes
1:00 PM	1:10 PM	0:10:00	Objectives and Goals for 2-day workshop	Jen Coyne / Haley Robinson	Set stage for the flow of information, key activities and logistics
1:10 PM	1:50 PM	0:40:00	Opening Exercises: Core Values Exercise + Mission Alignment	Jen Coyne	Build framework for the workshop discussion
1:50 PM	2:40 PM	0:50:00	Situational Assessment	Jen Coyne	Review inputs to strategic planning process: Survey, Staff Input, Research, SWOT analysis
2:40 PM	3:00 PM	0:20:00	Preview Strategic Themes, Discuss potential initiatives. Introduce Prioritization and Execution Criteria	Jen Coyne / Sarah Brown	Review the 5 Strategic Initiative areas and the two pass, prioritized weighting system
3:00 PM	3:05 PM	0:05:00	COMMENTS AND WRAP UP	Jen Coyne	

Agenda – Saturday, Day 2

Date: February 28, 2026					
Start	End	Duration	Topic	Owner/Presenter	Objective/Outcome
8:30 AM	9:00 AM	0:30:00	Arrive, refreshment, get settled	All	
9:00 AM	9:15 AM	0:15:00	Warm up for the day	Jen Coyne	Team focused collaboration exercise
9:15 AM	9:20 AM	0:05:00	Board Retreat Goals / Desired Outcomes	Jen Coyne / Sarah Brown	Review activities, time table and end goals
9:20 AM	10:30 AM	1:10:00	Walk the Room - Themes & Initiatives	Jen Coyne	Review Strategic Themes. Progressively build goals for each theme
10:30 AM	10:45 AM	0:15:00	BREAK	All	
10:45 AM	11:05 AM	0:20:00	Review Prioritization Criteria	Sarah Brown	Discuss the weighting of prioritization criteria
11:05 AM	12:15 PM	1:10:00	Apply prioritization criteria to frame success for each initiative and goal.	Jen Coyne / Theresa Treistad	Break into groups, use prioritization in 1-10 scale to score each goal. Take turns sharing recommendations with the full group.
12:15 PM	1:00 PM	0:45:00	LUNCH (All); Jen: Compile, Stack Rank	All, Jen Coyne	Completion of all initiative level goals into a merged stack rank.
1:00 PM	1:30 PM	0:30:00	Board Building Activity	Sarah Brown	Using your individual superpowers for Board service
1:30 PM	2:15 PM	0:45:00	Organizational Strengths, Capacity, Apply Execution criteria to identify gaps	Jen Coyne / Haley	Apply Organizational Strengths and Opportunities via a facilitated discussion. What effort and resources are needed to achieve? Use Execution criteria to identify gaps
2:15 PM	2:45 PM	0:30:00	Alignment on Impact and Effort	Sarah Brown	Create understanding of items most important to tackle
2:45 PM	3:15 PM	0:30:00	Apply Goals and Actions to the Roadmap	Jen Coyne / Sarah Brown	Initial Strategic Roadmap Based on Effort Required
3:15 PM	3:30 PM	0:15:00	Wrap up & Final comments	Haley Robinson / Jen Coyne	

OBD 2026-2029 Possible Strategic Plan Priorities

Bullet 2: Simplify Dental Assistant Rules and eliminate pathways and rules (cut the red tape)

Oregon has one of the most organized pathway ladders for a dental assisting career out of all of the states. To eliminate these pathways would create more confusion than there already is. Oregon dental assistants are proud to have a career advancement ladder. This allows a dentist and dental assistant to decide what is best for the practice and the dental patients they serve.

1. A person can be trained on the job to do all basic dental assisting duties that assist a dentist without any additional approved training courses required. It is the responsibility of the dentist to provide training and manage the trainee. Example: assisting all chairside procedures; seating patients, reviewing health history, setting up instruments and materials, preparing materials, passing instruments, suctioning, cleaning and disinfecting treatment rooms, sterilization, etc.
2. CODA accredited and non-accredited programs are available in most Oregon community colleges, private institutions and dental practices. Oregon has removed barriers for those who are unable to attend a dental assisting program. It is not required to attend a program to obtain any or all of the certificates offered in Oregon.
3. Oregon requires a dental assistant to complete an approved radiological proficiency course and pass the DANB Radiation Health and Safety exam to expose patients to radiographs. These courses are included in dental assisting programs or are taught by individually approved dentists, hygienists and dental assistants throughout the state. A dental assistant can choose to take an online DALE Foundation RHS course that does not require in-person attendance. A candidate must take and pass the DANB RHS exam and demonstrate proficiency to a dentist or dental hygienist who signs a form endorsing the dental assistants' abilities. Once receiving a DANB RHS Certificate, the dental assistant is then qualified to expose radiographs.
4. If a dental assistant wants to become an expanded function dental assistant, they must hold the RHS certificate. If they have not graduated from a CODA program, Oregon requires dental assistants to pass the written DANB EFDA/ICE exam and complete a skills check-off list endorsed by a licensed dentist to become an EFDA.
5. An EFDA can take the following OBD approved courses to expand their careers and support patient care:
Pit and Fissure Sealants, Denture Reline, Cord Packing, Restorative, Local Anesthetic

6. Specialty dental practices have specific requirements for additional expanded functions; EFODA, EFPDA, Anesthesia, etc. These are written clearly in the DPA.

In my opinion the problem is not the pathways that have been established by the OBD but the fact that the dental community is not well-educated on how to follow the pathways.

I would suggest **not** dismantling the Oregon dental assistant career/certification pathways but to educate and promote the processes to the dental community and the public.

Oregon dental assistant pathways fit easily into the DANB sponsored Professional Dental Assisting Model that would help to provide a dental assistant education/certification standardization for all states.

If it is indeed the responsibility of the OBD to protect dental patients I believe we should also be the body that educates the public on the requirements that we have created and endorse.

OBD continues to work with DANB to better serve the dental assistant who is training and studying to pass the written exams. The DALE Foundation offers online courses and practice tests to assist a dental assistant if they are not enrolled in a dental assisting program.

Providing DPA education to the dental community and the public should be a top priority...not just for the dental assistant pathways but for dentist and dental hygienist requirements as well. It is important that OBD is recognized for the hard work it takes to ensure the safest, best dental care possible is provided for Oregon citizens.

I would appreciate the opportunity to work on such a plan.

Thank you.

Ginny Jorgensen,