2. The handheld dental x-ray system shall only be used in conjunction with "F-speed" film, Phosphor Storage Plates (PSP), or digital image receptors to further minimize patient and operator radiation exposure.

3. The handheld dental x-ray system shall be secured in a safe location that prevents unauthorized use, as required pursuant to N.J.A.C. 7:28-2.4.

4. The registrant shall ensure that all authorized operators have been properly trained by reading the manufacturer's user manual and shall document all training. The registrant shall maintain all training records in the facility file and make such records immediately available upon the request of the Department.

5. The handheld dental x-ray systems shall be certified by the U.S. Food and Drug Administration (FDA) and bear a certification label/tag, a warning label, and an identification (ID) label/tag on the unit's housing. All labels/tags shall be in the English language and permanently affixed or inscribed on each product so that they are legible and readily accessible when the x-ray unit is fully assembled for use. The CERTIFICATION LABEL shall include one of the following or similar statement: "This product complies with 21 CFR 1020.30 - 1020.31" or "This product complies with 21 CFR Subchapter J."

6. A 510(k) (premarket notification) letter from the FDA is required at least 90 days before marketing unless the device is exempt from 510(k) requirements. Documentation shall be made immediately available upon the request of the Department.

7. A warning label shall be on the x-ray panel of the unit and state these exact words: "This x-ray unit may be dangerous to patient and operator unless safe exposure factors, operating instructions and maintenance schedules are observed."

8. Aside from use in emergency situations, a handheld dental x-ray system shall not be used in areas where there may be unintended exposure of other individuals (for example, occupied waiting rooms and corridors.) Exposures shall be made only when the area adjacent to the clinical area is free of all individuals not directly involved in the imaging procedure.

7:28-16.9 (No change in text.)

7:28-16.10 Radiation safety surveys

(a) No person shall operate or permit the operation of x-ray equipment used for dental radiography unless the installation meets the following requirements:

1.-2. (No change.)

3. The minimum requirements for the information to be included in the radiation safety survey report are as follows:

i. The name of the registrant of the installation as it appears on the registration form, address, telephone number, and room location of the unit;

ii.-vii. (No change.)

viii. Records of the measurement of radiation exposure with a suitable phantom in the average patient position. Measurements shall be taken at the operator's position and at all nearby locations that are normally occupied. For each measurement, the kVp, mA, exposure time, instrument reading, and correction made to the instrument reading (such as energy response, calibration, etc.) shall be recorded;

ix. Exposure rates at each measured location shall be converted into Coulombs/kilogram/week or mR/week. Records shall include all assumptions of workload, use and occupancy factors used in the calculations; and

x. A picture of the generator serial plate showing the model number, generator serial number, and control panel serial number.

Recodify existing N.J.A.C. 7:28-16.9 and 16.10 as 16.11 and 16.12 (No change in text.)

HUMAN SERVICES

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Psychiatric Adult Acute Partial Hospital and Partial Hospital Services
Provider Participation and Beneficiary Eligibility
Adopted Amendments: N.J.A.C. 10:52A-1.2, 2.1, 3.1, 3.2, 4.5, 4.11, and 4.12

Proposed: November 4, 2024, at 56 N.J.R. 2122(a).
Adopted: September 22, 2025, by Sarah Adelman, Commissioner, Department of Human Services.
Filed: September 22, 2025, as R.2025 d.121, **without change**.

Authority: N.J.S.A. 30:4D-1 et seq., and 30:4J-8 et seq.

Effective Date: October 20, 2025.
Expiration Date: July 29, 2028.

Summary of Public Comments and Agency Responses:

Comments were received from Roger Borichewski, MSW, LCSW, Vice President, Quality and Risk Management, CPC Integrated Health, and Christine Stearns, Chief Government Relations Officer, New Jersey Hospital Association (NJHA).

1. COMMENT: N.J.A.C. 10:52A-3.1(d). A commenter suggested that the list of professionals allowed to provide referrals and justifications for acute partial hospitalization (APH) services be expanded to include clinicians holding the following licenses: licensed clinical social worker (LCSW), licensed professional counselor (LPC), psychiatric-mental health advanced practice nurse, or psychiatric-mental health nurse practitioner/doctor of nursing practice (NP/DNP). The commenter maintains that this expansion of the list would allow New Jersey to better leverage its behavioral healthcare workforce to improve continuity of care and wait times for individuals in need of higher levels of intervention.

RESPONSE: The Department of Human Services (Department) will not be making any changes to this rulemaking upon adoption. N.J.A.C. 10:52A-3.1(d) requires that all beneficiaries be referred by screening centers or as a step down from an inpatient hospital stay to receive APH services. These referrals are done by treatment teams, not individual providers. The beneficiary's treating psychiatrist or advanced practice nurse (APN) must justify the acute clinical need for the services, and the referring treatment team must provide a certification containing the clinical evidence necessary to support the referral, including documentation of the beneficiary's specific condition. With regard to the specific professionals the commenter listed, a psychiatric-mental health advanced practice nurse or psychiatric-mental health nurse practitioner/doctor of nursing practice would be able to provide the justification and licensed clinical social workers and licensed professional counselors, practicing within their scope of practice, would be eligible to be members of the beneficiary's treatment teams.

2. COMMENT: N.J.A.C. 10:52A-4.4. A commenter suggested that New Jersey's partial hospital (PH) services allow for hourly or case rate billing to address the need for a more flexible and client-centered approach to payment structures. The commenter stated that hourly billing would enable providers to offer services in a more tailored way.

RESPONSE: Payment structures for APH/PH services were beyond the scope of the rulemaking published at 56 N.J.R. 2122(a). If the Department decides to change the payment structure for these services, a separate proposed rulemaking will be published in accordance with N.J.A.C. 1:30-5.

3. COMMENT: N.J.A.C. 10:52A-4.4. A commenter suggested that implementing a case rate system, similar to New Jersey's Certified Community Behavioral Health Clinics (CCBHC) Demonstration prospective payment system, could further improve service delivery of partial hospital services by helping providers offer comprehensive, wrap-around services that are currently not covered by the existing payment structure, such as case management and care coordination, and improve outcomes for individuals receiving PH services.

RESPONSE: Payment structures for APH/PH services were beyond the scope of the rulemaking published at 56 N.J.R. 2122(a). If the Department decides to change the payment structure for these services, a separate proposed rulemaking will be published in accordance with N.J.A.C. 1:30-5.

Federal Standards Statement

42 U.S.C. § 1396d(a) requires a state Title XIX program to provide inpatient and outpatient hospital services to most eligibility groups. Inpatient and outpatient hospital services are optional services for the medically needy population; however, New Jersey has elected to provide these services to medically needy beneficiaries. Federal regulations at 42 CFR 440.2, 440.10, and 440.20 provide definitions of inpatient hospital services and outpatient hospital services.

Title XXI of the Social Security Act allows states to establish a children's health insurance program for targeted low-income children. New Jersey elected this option through implementation of the NJ FamilyCare Children's Program. 42 U.S.C. § 1397cc, provides broad coverage guidelines for the program. Section 2110 of the Act, 42 U.S.C. § 1397jj, defines hospital services for the children's health insurance program.

The Department has reviewed the applicable Federal statute, rules, and regulations and has concluded that the adopted amendments do not exceed Federal standards. Therefore, a Federal standards analysis is not required.

Full text of the adoption follows:

SUBCHAPTER 1. GENERAL PROVISIONS

10:52A-1.2 Definitions

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

. . .

"Community mental health associate" means a community mental health associate as defined by the Addiction Professional Certification Board, Inc., located at 180A Tices Lane, Suite 205, East Brunswick, NJ 08816. The website of the Addiction Professional Certification Board, Inc., is https://certbd.org/.

. . .

"DMHAS" means the Division of Mental Health and Addiction Services within the New Jersey Department of Human Services.

"DSM-IV-TR" means the Diagnostic and Statistical Manual of Mental Disorders, incorporated herein by reference, as amended and supplemented, published by American Psychiatric Publishing, Inc., 800 Maine Avenue, SW, Suite 900, Washington, DC 20024. The website of the American Psychiatric Publishing, Inc., is https://www.appi.org/.

. . .

"National Plan and Provider Enumerations System" (NPPES) means the system that assigns NPIs, maintains and updates information about health care providers with NPIs, and disseminates the NPI Registry and NPPES Downloadable File. The NPI Registry is an online query system that allows users to search for a health care provider's information.

"National Provider Identifier" (NPI) means a unique 10-digit identification number issued to health care providers by the Centers for Medicare and Medicaid Services (CMS).

. . .

"Taxonomy code" means a code that describes the provider or organization's type, classification, and the area of specialization.

"Type 2 NPI" means a code that describes an organizational provider in the NPPES system.

. . .

SUBCHAPTER 2. ENROLLING AS A PROVIDER

10:52A-2.1 Authority to provide services

(a) Each program site location, as described at N.J.A.C. 10:52-1.3, at which APH or PH services are provided and which has been approved to be a Medicaid/NJ FamilyCare provider by the Division's Office of Reimbursement Services shall provide services and be reimbursed for those services pursuant to N.J.A.C. 10:49 and 10:52 and this chapter.

(b) Each program site location, as described at N.J.A.C. 10:52-1.3, at which APH or PH services are provided, shall be approved to be a Medicaid/NJ FamilyCare provider by the Division's Office of Reimbursement Services and, additionally, shall either be licensed by the Commissioner of the Department of Human Services as a mental health program and have a purchase of services contract with the Division of Mental Health and Addiction Services, or be licensed by the Commissioner of the Department of Health as a health care facility.

(c) In order to participate in the New Jersey Medicaid/NJ FamilyCare Program, an APH/PH services provider shall:

1. Have a valid NPI number obtained from the NPPES.

2. Have a valid taxonomy code for APH/PH services obtained from the NPPES.

3. Remain a provider in good standing by successfully completing provider revalidation when requested by DMAHS.

SUBCHAPTER 3. BENEFICIARY ELIGIBILITY REQUIREMENTS

10:52A-3.1 Eligibility for APH services

(a)-(b) (No change.)

(c) In order to be eligible for APH services, a beneficiary shall:

1. At the time of referral or as a result of psychiatric evaluation provided or arranged for, have at least one of the following primary DSM-IV-TR diagnoses on Axis I:

i.-vi. (No change.)

vii. A covered psychiatric disorder diagnosis consistent with codes, Axis I-V of the Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR, as amended and supplemented, including some 301.XX Axis II codes if the personality disorder is considered in the severe range and the beneficiary is at high risk of psychiatric hospitalization; and

2. Have disordered thinking or mood, bizarre behavior, or psychomotor agitation or retardation to a degree that interferes with activities of daily living or abilities to fulfill family, student, or work roles to such an extent that a structured intensive treatment program is needed and cannot adequately be addressed at a less restrictive level of care; the beneficiary also has a need for prescribed psychotropic medications or has a need for assistance with medication adherence.

(d) In order to be eligible for APH services, a beneficiary may be referred by the local designated screening center or psychiatric emergency service as a diversion from hospitalization; by an inpatient psychiatric facility post discharge as a step-down treatment; or if a psychiatrist or APN clearly justifies acute clinical need. Additionally, for a beneficiary to receive APH services, the beneficiary must receive, from the referring treatment team, a certification containing the clinical evidence necessary to support the referral, documenting the required specific conditions set forth at (c)1 and 2 above.

(e) In the case of a beneficiary who has previously been admitted to an APH program, in order to be eligible for APH services, the beneficiary shall be readmitted to an APH program only through a referral from the local designated screening center or psychiatric emergency service as a diversion from hospitalization or by an inpatient psychiatric facility if the treating psychiatrist or APN clearly justifies acute clinical need. Additionally, for a beneficiary to receive APH services, the beneficiary must receive, from the referring treatment team, a certification containing the clinical evidence necessary to support the referral, documenting the required specific conditions set forth at (c)1 and 2 above.

10:52A-3.2 Eligibility for PH services

(a)-(b) (No change.)

(c) In order to be eligible for PH services, a beneficiary shall at the time of referral:

1. Have a primary diagnosis as set forth at N.J.A.C. 10:52A-3.1(c)1; and

2. Have impaired functioning, which necessitates learning critical skills in order to achieve valued community roles and community integration in at least one of the following domains on a continuing, intermittent basis for at least one year or have recently decompensated to a significantly impaired status:

i.-v. (No change.)

vi. Ability to acquire or maintain safe, affordable housing when at risk of requiring a more restrictive living situation.

(d) In order to be eligible for PH services, a beneficiary shall be referred by the APH or be significantly impaired, such that a need for PH

exists, and receive from the interdisciplinary treatment team certification containing the clinical evidence to justify the necessity for a beneficiary to receive PH services, documenting the beneficiary's specific conditions set forth at (c)1 and 2 above.

SUBCHAPTER 4. PROGRAM REQUIREMENTS

10:52A-4.5 Prior authorization for APH services

(a) (No change.)

(b) When requesting prior authorization, Forms FD-07 and FD-07A, "Request for Authorization of Mental Health Services and/or Mental Health Rehabilitation Services" and "Request for Prior Authorization: Supplemental Information" shall be completed and forwarded to the Medical Assistance Customer Center (MACC) that serves the county in which the services are rendered. (The forms may be obtained through the website www.njmmis.com or by contacting Gainwell Technologies Provider Services at 1-800-776-6334.) The "Brief Clinical History" and "Present Clinical Status" sections of the FD-07A "Request for Prior Authorization: Supplemental Information" form are particularly important and shall provide sufficient medical information to justify and support the proposed treatment request. A request for additional information may be made at the discretion of the Medicaid/NJ FamilyCare reviewer if the reviewer believes that insufficient medical information has been provided for the Division to make a determination. Failure to comply with such a request may result in a result in a reduction or denial of requested services.

(c)-(d) (No change.)

10:52A-4.11 Documentation requirements for APH and PH

(a)-(d) (No change.)

(e) Each provider shall make all records available for review by the Department or an authorized representative of the Department.

10:52A-4.12 Discharge planning for APH and PH

(a)-(b) (No change.)

Recodify existing (d)-(f) as (c)-(e) (No change in text.)

LAW AND PUBLIC SAFETY

(a)

DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF MEDICAL EXAMINERS
Sexual Misconduct Prevention
Adopted Amendment: N.J.A.C. 13:35-6.23

Proposed: April 15, 2024, at 56 N.J.R. 544(a).
Notice of Substantial Changes Upon Adoption: May 5, 2025, at 57 N.J.R. 900(a).
Adopted: August 13, 2025, by State Board of Medical Examiners, S. Chetan Shah, M.D., President.
Filed: September 22, 2025, as R.2025 d.120, with **substantial changes** to proposal after additional notice and comment period pursuant to N.J.S.A. 52:14B-4.1.

Authority: N.J.S.A. 45:9-2.

Effective Date: October 20, 2025.
Expiration Date: January 8, 2032.

Take notice that the State Board of Medical Examiners (Board) proposed amendments to rules related to observers at N.J.A.C. 13:35-6.23 on April 15, 2024, at 56 N.J.R. 544(a), to prevent sexual misconduct. The notice of proposal was issued in response to Administrative Executive Directive No. 2021-3 (2021), which set forth a comprehensive agenda for tackling sexual misconduct in the licensed professions.

Comments on the original notice of proposed amendments were received from Lawrence Downs, CEO, Medical Society of New Jersey; Laurie A. Clark, Legislative Counsel, the New Jersey Association of Osteopathic Physicians and Surgeons, the New Jersey Society of Interventional Pain Physicians, New Jersey Section of ACOG, and New Jersey Podiatric Medical Society; Patricia Kelmar, Senior Director, Health Care Campaigns, and Doug O'Malley, Senior Advisor, New Jersey Public Interest Research Group (NJPIRG); John D. Fanburg, Brach Eichler, LLC, for New Jersey State Society of Anesthesiologists; Lisa McGiffert, President/Co-founder and Carol Cronin, Chair, Medical Board Roundtable, Patient Safety Action Network; and Azza AbuDagga, M.H.A., Ph.D., Health Services Researcher, Public Citizen.

The Board published a Notice of Substantial Changes Upon Adoption on May 5, 2025, at 57 N.J.R. 900(a). The public comment period closed on July 4, 2025. The Board received three comments on the notice of proposed substantial changes upon adoption to proposed amendments from: Khayriyyah Chandler, DO; Lawrence Downs, CEO, Medical Society of New Jersey; and Donald P. Talenti, MD, MAHP.

1. Comments Received During Initial Comment Period Giving Rise to Substantial Changes in Proposal Upon Adoption

1. COMMENT: Every commenter addressed the credentials and training of observers. Three commenters stated that observers should be trained individuals, but that no license or certification should be required due to the financial burden and staffing challenges associated with the observer being a licensee or a certified medical assistant (CMA). One commenter expressed difficulty finding and retaining staff even without the additional requirement of the observer being a licensee or CMA and suggested a new category of registered assistants. Two commenters stated that the requirement that observers be licensees or CMAs would be especially burdensome on small practices. One commenter stated that it would disproportionately affect practices running on margins, which tend to serve vulnerable populations, leading to decreased access to essential care. These commenters all supported required training for observers, in lieu of a requirement for the observer to be a licensee or CMA. One commenter suggested a two-hour training course on proper technique and conduct in the performance of sensitive examinations. Another commenter suggested the Board make an online observer training course available at no cost.

Three other commenters supported the requirement of medical training or licensure for observers. These commenters also stated that observers should be trained, even if they are licensees or CMAs. Two commenters stated that observers should be required to take the same training course that physicians are required to take pursuant to N.J.A.C. 13:35-6.15(e). Another commenter stated that the observers should have training that addresses what constitutes an appropriate exam for the type of exam being observed, when an intimate exam is medically indicated, how to intervene when they witness misconduct, reporting obligations, and protection from retribution and retaliation. Another commenter stated that without mandatory training for observers, "their presence will just offer an 'illusion of safety.'" This commenter also stated that the rules should stipulate that the observer not have past criminal, disciplinary, or malpractice history.

RESPONSE: The Board believes that observers must be medically trained and empowered to report misconduct to be effective. The Board proposed to use a license or certification as a mechanism to ensure observers have training and that a board or certifying agency has authority over the observer. Having reviewed the public comments summarized above, the Board recognizes that this approach would be burdensome on small practices due to staffing challenges and the financial impact of dedicating a licensee or CMA to observation. The Board remains committed to ensuring that observers are trained. Accordingly, the Board is removing the proposed requirement that the observer be a licensee or a CMA and is replacing it with the requirements at new N.J.A.C. 13:35-6.23(a)1. This paragraph requires the licensee to utilize an observer who has provided the licensee with documentation of completion of two hours of observer training and an affirmation that the licensee has not been subject to discipline or civil or criminal liability for failure to report misconduct or been convicted of a crime that would disqualify the observer from obtaining a license pursuant to N.J.S.A. 45:1-15.9. The Board believes that this training requirement will reduce the burden on licensees, especially small practices, while ensuring observers are adequately trained. This requirement will go into effect 180 days after the effective of the proposed new rule to ensure observers have time to complete the required training.