Office of Professional Licensure Review

UTAH DEPARTMENT OF COMMERCE

Interim Committee Presentation

Minor Surgical, Med Spa & Wellness Review

September 16th, 2026

MSMW issues addressed

Minor Surgical Procedures	• Scope of practice for APRNs and PAs impacted by Utah Supreme Court decision • Lack of clarity regarding the types of procedures APRNs and PAs may perform
Medical Spas	• Expansion in the types of services offered in medical spas • Unclear regulation regarding who can do what • Concerns regarding a lack of oversight from medical directors • Instances of patient harm related to non-pharmacist compounding in medical spas
Ketamine Clinics	• Growth in off-label use of ketamine for mental health indications • Ketamine treatments have medical and psychological risks that are unaddressed by current regulations

Stakeholder engagement

OPLR held **nine** in-depth policy discussions with a **technical working group**

Name	Profession	Affiliation	Education
Shelbi Brooke	Physician Assistant	The Plastics Clinic & Spa	Rocky Mountain University
Kevin Byrne	Physician (Psychiatry)	University of Utah; Huntsman Mental Health Institute	Boston University
Rich Cox	Pharmacist	Intermountain Healthcare	University of Utah
Shawn Kinross	Certified Registered Nurse Anesthetist	Intermountain Healthcare	Southern Connecticut State University
Eric Millican	Physician (Dermatology)	University of Utah	Washington University
Christine Platt	Advanced Practice Nurse Practitioner	Brigham Young University Parkinson Dermatology	Brigham Young University University of Arizona
Mallory Stahl	Master Esthetician	Elle Esthetics	Skin Science Institute

OPLR also held **six vetting sessions** to get feedback on proposals from a wide range of stakeholders, including individuals from:

- The Utah Medical Association
- The Utah Academy of Physician Assistants
- Utah Nurse Practitioners
- Utah Association of Nurse Anesthetists
- Utah Action Coalition for Health
- The University of Utah Health
- Intermountain Health
- DOPL Board Members
- APRN and PA education programs

These meetings also included individual practitioners involved in these spaces.

Recommendation overview

Minor Surgical Procedures	Medical Spas	Ketamine Clinics
• Define **'surgical procedure'** • Define **'minor surgical procedure'** as a subset of 'surgical procedure' – APRNs and PAs may perform independently • Define **'minor cosmetic medical procedure'** as a subset of 'minor surgical procedure' – can be delegated to an RN, LPN, or master esthetician	• Define **'medical spa'** • Define **'responsible cosmetic medical practitioner'** and **'qualified cosmetic practitioner'** • Allow a responsible cosmetic medical practitioner to **delegate** a minor cosmetic medical procedure, cosmetic injection, or wellness injection to a qualified cosmetic practitioner **under supervision** • Outline the **responsibilities** of the delegating responsible cosmetic medical practitioner	• Define **'psychiatric ketamine clinic'** • Define **'responsible medical practitioner'** and require one **on-site** at all times • Define the **responsibilities** of a responsible medical practitioner • Limit the prescription of **at-home ketamine** to patients **seen by a provider** and who have **received monitored treatments** in the past

Definition of 'surgical procedure'

Surgical Procedures

- Physicians may perform independently
- APRNs and PAs may assist *(see next slide for those APPs may perform independently)*

A **'surgical procedure'** means a medical intervention that involves the incision, excision, puncture, implantation, repair, destruction, or structural alteration of living tissue, an organ, or a body part.

Surgical procedure **does not include** the following:

- Puncture of tissue for the introduction or withdrawal of a substance at the intradermal, subcutaneous, intramuscular or intravascular level;
- Dry needling as defined in 58-24b-102(3);
- The practice of acupuncture as defined in 58-72-102(5);
- Microneedling that does not exceed a penetration depth of 1.5 millimeters and does not include energy-based frequency or the infusion of substances;
- Body piercing as defined in 26B-7-401(7)(a), ear piercing as defined in 26B-7-401(10), permanent cosmetics as defined in 26B-7-401(17), and tattooing;
- The practice of electrolysis.

'Implantation' means the placement of a medical device into a body cavity, natural orifice, or surgically created opening which is intended to remain in the body after the completion of the procedure.

Implantation **does not include**:

- The placement of a tube or catheter into a natural orifice for airway management, feeding, drainage, or decompression
- The replacement, exchange, or removal of a tube or catheter in an established tract.

Examples: Coronary artery bypass, appendectomy, amputation, liposuction, rhinoplasty, craniotomy

Definition of 'minor surgical procedure'

Surgical Procedures

Minor Surgical Procedures

- Physicians, APRNs, and PAs may perform independently

A **'minor surgical procedure'** means a surgical procedure that:

- In accordance with generally accepted professional standards, is ordinarily performed under minimal **sedation** as defined in Section 58-1-510(1)(e), local anesthesia, topical anesthesia, or without anesthesia; AND
- Presents a low **risk** of death, permanent or severe disability, or permanent or severe unintentional loss of bodily function; AND
- Does not, in the ordinary course, require post-operative **hospitalization** or intensive **monitoring**.

Examples: Incision and drainage, laceration repair, removal of a foreign body from skin tissue, IUD insertion

Definition of 'minor cosmetic medical procedure'

Surgical Procedures

Minor Surgical Procedures

Minor Cosmetic Medical Procedures

- Physicians, APRNS, and PAs may perform independently
- RNs, LPNs, and master estheticians may perform under supervision

A **'minor cosmetic medical procedure'** is a minor surgical procedure that:

- Is performed to **enhance or alter an individual's appearance** and not to promote the proper function of the body or prevent or treat illness or disease; AND
- In accordance with generally accepted professional standards, is ordinarily performed under **topical anesthesia or without anesthesia**; AND
- Does not destroy or alter tissue **below the subcutaneous layer**; AND
- **Does not involve** the incision, excision, vaporization, or implantation of tissue, an organ, or a body part

Examples: Intense pulsed light treatments, cryolipolysis, laser hair removal, medium-depth chemical peels, RF skin tightening

Surgical procedure scope of practice matrix

All licensees will be limited to performing procedures for which they have documented training.

	MDs/DOs	APRNs	PAs	RNs	LPNs	Master Estheticians	Medical Assistant
Surgical Procedure	May independently perform	May assist with	May assist with	No	No	No	No
Minor Surgical Procedure	May independently perform	May independently perform	May independently perform	No	No	No	No
Minor Cosmetic Medical Procedure	May independently perform May act as a "responsible cosmetic medical practitioner"	May independently perform May act as a "responsible cosmetic medical practitioner"	May independently perform May act as a "responsible cosmetic medical practitioner"	May perform under **general** supervision*	May perform under **direct** supervision*	May perform under **general** supervision*	No

Each profession still has a separate legal scope that contains services besides these types of procedures.
* OPLR recommends setting a baseline supervision level for all minor cosmetic medical procedures while allowing DOPL in rule, with collaboration from boards, to raise the level of supervision for certain higher-risk procedures.

Surgical assisting for APRNs and PAs

Allow APRNs and PAs to
assist with non-minor surgical procedures.

This would mean performing appropriate aspects of the procedure under the delegation and supervision of a physician.

The physician would be required to participate in all critical portions of the procedure and must be immediately available to provide care during the entire procedure.

Medical spa definition

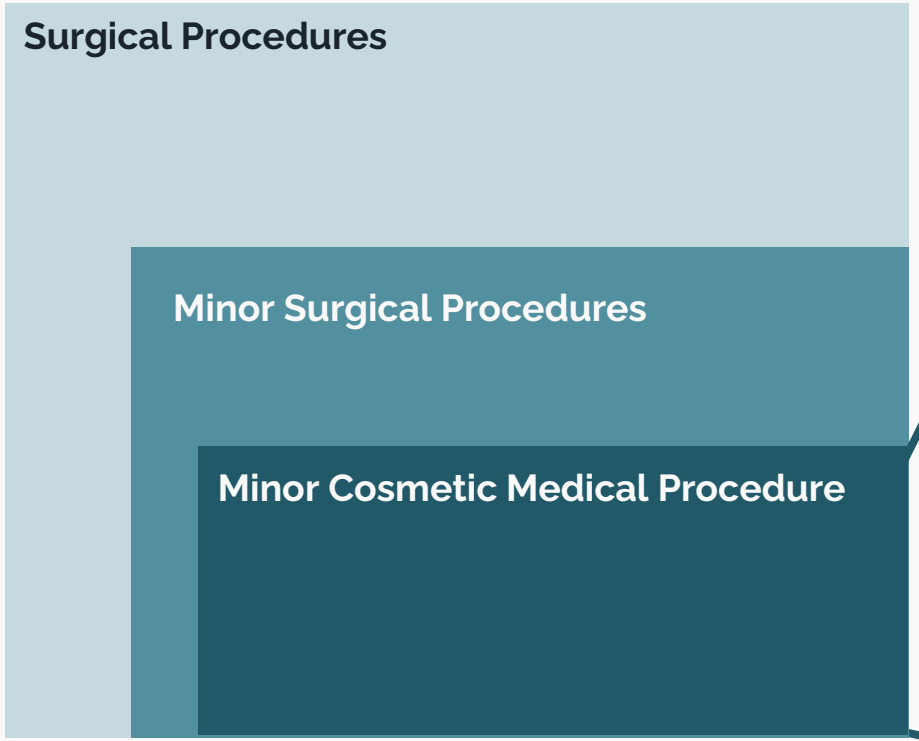
OPLR recommends that the state define a medical spa as:

A facility that offers:

- **Minor cosmetic medical procedures**
- **Cosmetic injections**
- **Wellness injections**

Any facility required to be licensed by DHHS would be exempt from this definition.

‘Minor cosmetic medical procedure’ definition



A **‘minor cosmetic medical procedure’** is a minor surgical procedure that:

- Is performed to enhance or alter an individual’s appearance and not to promote the proper function of the body or prevent or treat illness or disease; AND
- In accordance with generally accepted professional standards, is ordinarily performed under topical anesthesia or without anesthesia; AND
- Does not destroy or alter tissue below the subcutaneous layer; AND
- Does not involve the incision, excision, vaporization, or implantation of tissue, an organ, or a body part

Injection definitions

Cosmetic Injections*

A procedure in which a medication or substance, including a neurotoxin or filler, is injected for cosmetic purposes.

Wellness Injections**

A procedure:

a) In which fluids, nutrients, medications, minerals, vitamins, hormones, peptides, biological products, or blood or a blood derivative are injected directly into a patient's body by an intradermal, subcutaneous, intravenous, or intramuscular route; and

b) Which is sought by a patient to alleviate symptoms of temporary discomfort or improve temporary wellness.

* Based on the definition of 'cosmetic medical procedure' found in Utah's Medical Practice Act (see UCA 58-67-102(11)).

** Based, in part, on Texas' definition of 'elective intravenous therapy.'

Med spa delegation and supervision framework

A cosmetic minor cosmetic medical procedure, cosmetic injection, or wellness injection must be:
a) Performed by a **responsible cosmetic medical practitioner**; or
b) Performed by a **qualified cosmetic practitioner** under the **delegation** and **supervision** of a responsible medical practitioner

	Examples	Responsible Cosmetic Medical Practitioner	Qualified Cosmetic Practitioner (Min. Required Supervision)*	Evaluation Required*	Individual Treatment Plan Required**	Other Responsibilities of Medical Practitioner
Minor Cosmetic Medical Procedure	Laser treatments, non-invasive body contouring	Must: 1. Be licensed as a physician, APRN, or PA (with independent practice authority); and 2. Have education and training in the procedures they will delegate	RN (General) Master Esthetician (General) LPN (Direct)	Yes	Yes	
Cosmetic Injection	Botox, filler, filler removal, liquid lipo		RN (General)	Yes	Yes	Ensure any compounding is done according to state law (see next page)
Wellness Injection	IV hydration, peptides, hormone replacement		RN (Indirect)	Yes	Yes	

* The legislature could give DOPL authority to heighten the required level of supervision for specific procedures if evidence of harm
** To match current policy, OPLR recommends allowing the evaluation for only hair removal procedures to be delegated to an RN or master esthetician.

Compounding authority

OPLR recommends that the state be explicit about who can compound drugs and under what conditions.

In a DHHS-licensed facility or a DOPL-licensed pharmacy, the following may compound:

- **Pharmacists** and **pharmacy techs**
- **Physicians**
- **APRNs** and **PAs**, limited to *immediate use compounding*,
- Any **individual authorized to administer a medication**, limited to *immediate use compounding* and **under the direction** of pharmacist, physician, APRN or PA

In all other settings, the following may compound:

- **Pharmacists** and **pharmacy techs**
- **Physicians**
- **APRNs** and **PAs**, limited to *immediate use compounding*,

Immediate Use Compounding

Term used in U.S. Pharmacopeia for compounding in which:

- Three or fewer unique products are mixed; and
- The drug will be administered to a patient within 4 hours of the start of preparation.

Anyone engaged in compounding would be required to follow professional standards adopted by the Division (likely U.S. Pharmacopeia standards).

Ketamine regulation should address associated risks

Risks associated with ketamine:

Short-term risks

- **Airway Emergencies** – very rare at sub-anesthetic doses but also very serious
- **Blood Pressure Issues** – more common but usually not serious, contraindication
- **Negative Psychological Experiences** – more common than airway, but less serious
- **Safety Issues After Discharge** – related to the dissociative effects

Long-term risks

- **Abuse and Dependency** – possible but not as common as some other drugs
- **Urinary Tract and Cognition Issues** – possible with long-term, recreational use

Ketamine regulation should address associated risks

Risk	Policy Proposal
Airway Emergencies	• Require a qualified 'responsible medical practitioner' to be on-site at all times • Require monitoring at all times • Limit at-home prescriptions
Blood Pressure	
Negative Psychological Experiences	• Require someone on site qualified to respond to psychological emergencies • Limit at-home prescriptions
Safety Issues After Discharge	• Task the 'responsible medical practitioner' with establishing safe protocols for discharge • Limit at-home prescriptions
Abuse and Dependency	• Require a diagnosis/indication, mental health treatment, and valid order for treatments • Limit at-home prescriptions
Urinary Tract and Cognition Issues	

Define a psychiatric ketamine clinic

Define a ketamine clinic and require a responsible medical practitioner to be on-site:

"Psychiatric ketamine clinic" means a facility that offers ketamine treatments for mental health disorders.

- DHHS-licensed facilities would be exempt

Require the owner of a psychiatric ketamine clinic to either:

- Qualify as a responsible medical practitioner; or
- Employ at least one responsible medical practitioner.

Require a qualified responsible medial practitioner must be on-site whenever ketamine treatments are being administered.

Establish qualifications and responsibilities of a responsible medical practitioner

Qualifications of a responsible medical practitioner:

To qualify as a responsible medical practitioner in a psychiatric ketamine clinic, and individual must:

- Be **actively licensed** in the state as a:
  - Physician
  - APRN
  - PA (who has completed their collaborative practice period)
  - CRNA?
- Have **4,000 hours of clinical experience** in a residency or post-licensure clinical practice; and
- Be **trained to perform the responsibilities** outlined.

Responsibilities of a responsible medical practitioner:

A responsible medical practitioner in a psychiatric ketamine clinic is responsible for ensuring that each individual receiving treatment:

- has a **mental health diagnosis or indication**, as determined by someone legally authorized to diagnose, for which there is evidence that ketamine may be efficacious;
- is receiving **ongoing mental health treatment** from an individual licensed to provide such treatment;
- has a **valid order to receive ketamine treatments**, given by someone legally authorized to prescribe the treatment;
- receives **dosing** that is in accordance with **professional standards** adopted by the division in collaboration with relevant boards
- is **monitored continuously** throughout the treatment by someone trained to respond to **medical needs** and someone trained to respond to **psychological needs**
- is **discharged** from the facility only after:
  - the individual's **vitals have returned** to pre-procedure levels; and
  - the individual has been assessed by the medical director as **medically and psychologically stable**.

Limit the prescription of ketamine for at-home use

A prescriber may only prescribe ketamine treatments for at-home use under the following conditions:

- The prescriber has evaluated the patient **in person during the previous year**
- The patient has received at least **two ketamine treatments monitored** by a healthcare practitioner in person which **did not result in serious side effects**.

A prescriber may prescribe a maximum of **three-months supply at a time**.

To renew the prescription for another three months, the prescriber must **meet with the patient in-person or via telehealth**, though the requirement that they have met with the patient in-person in the last year would still apply.

Outstanding issues to be addressed

Minor Surgical

- Tweak the language in 'surgical' to ensure liposuction and incision/drainage are included
- Address a few procedures falling in minor that shouldn't, a few procedures not falling in minor that should
- Develop a provision to allow NPs and PAs to perform a procedure in an emergency

Medical Spas

- Establish supervision levels above the base-level for any higher risk procedures

Ketamine Clinics

- Determine the role of a CRNA given extensive training on the medical side but legal complexities

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UTAH DEPARTMENT OF COMMERCE

Business & Labor Committee Presentation

OPLR Healthcare Licensure Review (Year 2)

August 19th, 2026

Today's discussion

- **OPLR healthcare review recommendations summary**
- Deeper dives (based on committee interest)
- Next steps and timing

Summary of OPLR's Recommendations (1/2)

Deregulation

Occupation	Recommendation
Physician (MD & DO)	• **Remove defunct "fifth pathway"** for IMGs; align **6,000-hour physician endorsement to one-year** DOPL universal endorsement standard
Naturopathic Physician	• **Remove:** residency requirement, limits on naturopathic manipulation, and unnecessary insurance clauses
Dentist & Hygienist	• Align **6,000-hour dentist and 2,000-hour hygienist endorsement to one-year** DOPL universal endorsement standard (AR)*
Optometrist	• **Expand scope** with specified training and supervision to include **YAG and SLT**, plus certain **minor surgical procedures**
Rad Tech	• **Remove RPT X-Ray scope restrictions** so long as RPTs are trained and supervised • **Expand scope of RA and broaden supervision** to increase value of role
Dietitian	• **Reject licensure**, maintain voluntary certification • **Allow similar qualifications (CNS)** to obtain a combined, not separate, certification
Medical Language Interpreter	• **Remove** the current **voluntary certification**

* AR = Additional, or secondary, recommendation
Source: OPLR analysis

Summary of OPLR's Recommendations (2/2)

	Occupation	Recommendation
Neutral	**Medication Aide Certified**	• **Deregulatory:** Remove license requirement in SNFs (contingent on next…) • **Up-regulatory:** Transition to DHHS-approved, industry-run standard training across both SNF and ALF settings
	Health Facility Administrator	• **Deregulatory:** Lower length of required preceptorship based on degree earned • **Neutral:** Add DHHS member to DOPL Advisory Board
Up-Regulation	**Chiropractor**	• **Grant DOPL citation authority** for unprofessional conduct • **Add patient protections** (e.g., written consent for sensitive procedures, draping standard, chaperoning); consider mandatory ethics CE
None	**Pharmacist & Technician**	
	Podiatric Physician	
	Genetic Counselor	
	Anesthesiology Assistant	

Source: OPLR analysis

Today's discussion

- OPLR healthcare review recommendations summary
- **Deeper dives (based on committee interest)**
  - **Physician**
  - **Chiropractor**
  - **Optometrist**
  - **Naturopathic Physician**
  - **Rad Tech**
  - **Dietitian**
- Next steps and timing

Physician overview

Issues identified from review

- Primary care & rural access issues
- Significant training cost/length
- Opportunity for residency capacity planning via RHTP grants

Main review recommendations

- Remove defunct "fifth pathway" for IMGs
- Align **6,000-hour physician endorsement to one-year** DOPL universal endorsement standard

Additional recommendations

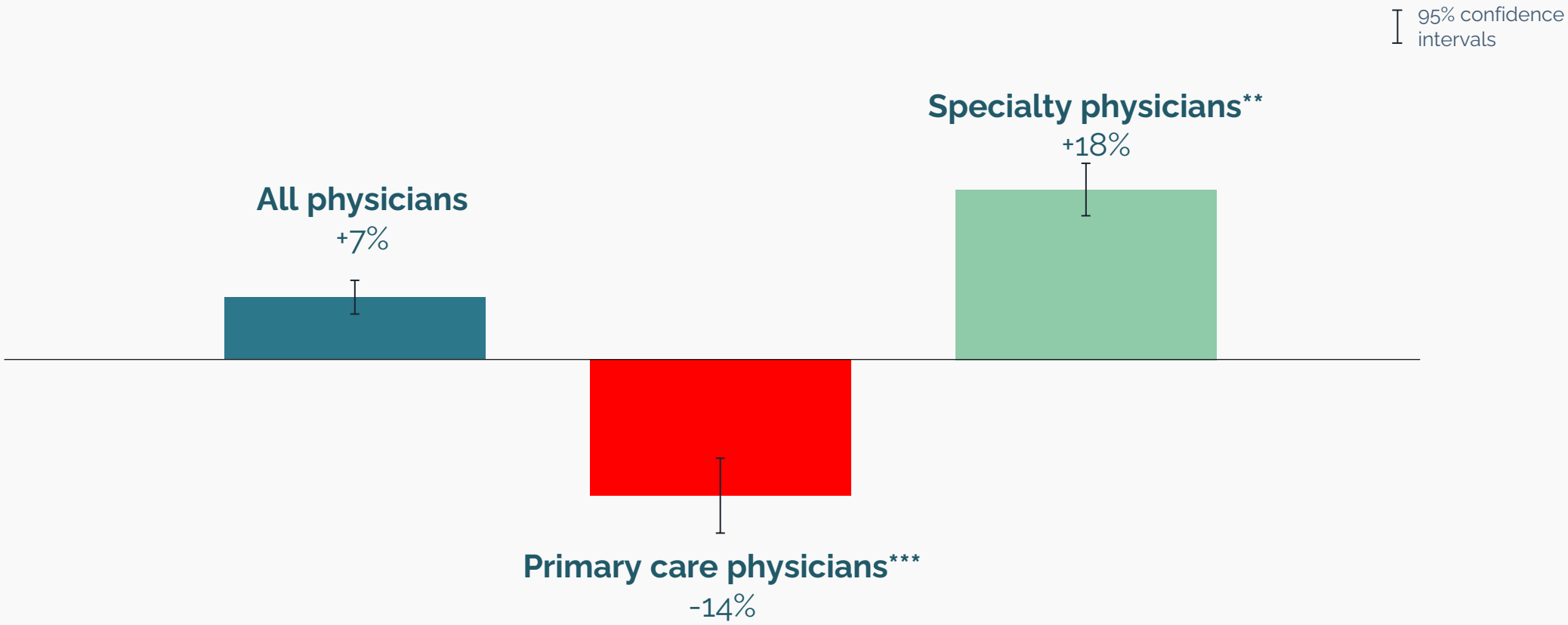
- Bolster existing state efforts to address physician access in primary care

Other potential or future considerations

- Expansion of IMG pathways
- Adequacy of physician training on use of AI

Growth in physician ratios in Utah is driven by specialties, not primary care

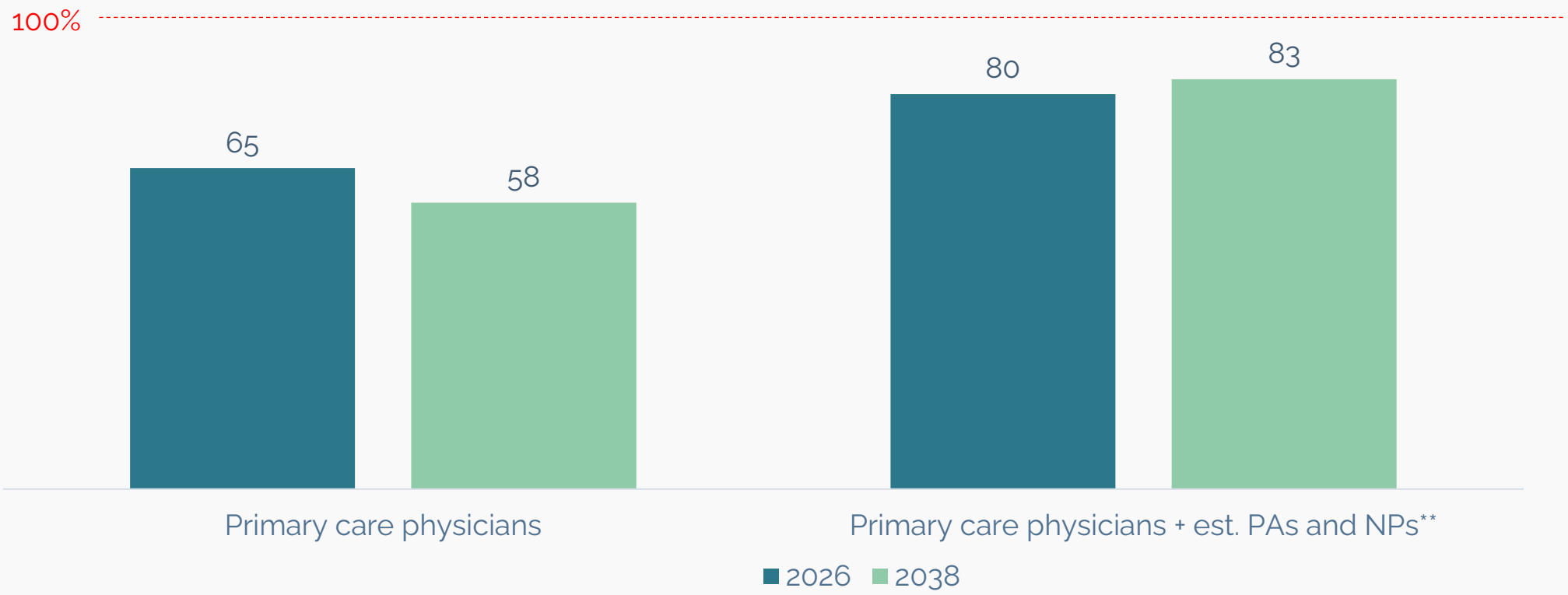
Percent change in number of physician FTEs per 10,000 people in Utah (2020–24)*



* FTE counts weighted by age and gender (to follow UMEC 2020 methodology)
** Specialty physicians include pediatric subspecialists. OPLR analysis reveals a high level of growth in this category between 2020 and 2024.
*** Primary care physicians include: family medicine, general internal medicine, general OBGYN, general pediatrics, and primary care
Source: 2020 UMEC Physician Report and OPLR analysis of 2024 MD and DO physician license renewal survey; OPLR analysis

Growth of PAs and NPs partially addresses Utah's primary care physician shortage

Estimated adequacy, *combining primary care physicians and estimated primary care PAs and NPs**
Percent



*Primary care includes family medicine, geriatrics, general internal medicine, and pediatrics.
**OPLR applied an estimated percent of NPs and PAs working in primary care specialties from responses to DOPL licensee renewal surveys
Source: U.S. Health Resources & Services Administration (HRSA); DOPL renewal surveys 2024, OPLR analysis

Utah's physician licensing regulations are similar to other states

	Utah	Other U.S. states
Residency Requirement[1]	*US-educated*: 1 year* *IMG*: 2 years	*US-educated:* 1-2 years *IMG:* 2-3 years
Continuing Education[2]	20 per year**	Average: 25 hours per year Median: 20 hours per year** Range: 0-50 hours per year
Physician-Specific Endorsement[3]	Licensed in another state Have practiced at least 6,000 hours in the last 5 years Meet all UT licensure requirements*** No disciplinary action Records review/practice history	*Examples* • AZ, CO: require **one year** of practice • HI: requires **two years** of practice • FL: requires **three years** of practice • CA: requires **four years** of practice
Universal Endorsement[4]	• Similar scope: one year of experience • Similar entry requirements: none • Determined competent: one year of experience	

1. "State Specific Requirements for Initial Medical Licensure," FSMB
2. "Continuing Medical Education," FSMB
3. UCA 58-67-302(2) & OPLR policy scan using Westlaw AI
4. UCA 58-1-302

* In UT, the residency requirement is one year only if the individual is enrolled in a UT-based residency (UCA 58-1-302(1)(e)(ii)).
** Hours are presented on an annual yearly basis even if states require hours over a multi-year period.

There are multiple initiatives on physician access; an intentional, coordinated state approach is important

Examples of current initiatives

Pre-Medical School

- Utah AHEC Scholars program
- "Grow our own" initiative (with RHTP funding)

Medical School

- U of U evaluating ways to accelerate medical curriculum
- U of U MD program in St George for rural primary care (10 students per year)
- BYU MD program (initial cohort of 60 students)
- Financial incentives supporting 20–50 preceptors (with RHTP funding)

Medical Residency

- 10-year GME strategic plan (with RHTP funding) to increase residencies/rural capacity
- Limited state-funding of state residencies (e.g., $1.5m subsidize 24 residency positions serving high-priority populations or areas + $1.2m towards 4 positions in family medicine)

Post Residency

- Limited state-funding for physician loan repayment for rural practice ($80k over two years with possibly extensions for approx. 8 – 15 physician)

Examples from other states

- Goal of 100+ increase in residency positions (IA)
- 10-year plan to increase residency capacity (ID)
- Min. 50% retention of residents for continued state funding (WI)

Source: OPLR interviews

Clear international medical graduate (IMG) pathways are being pursued; others are limited

	Options*	Considerations
1 Bypass U.S. or Canadian residency requirement • ***Creates two standards*** • ***May not be eligible for board certification***	**a** Allow specified non-U.S. or Canadian residencies	• **Little precedent** in the U.S. (ME and OK allow U.K. Royal College) • **Vetting** non-US residencies would be a challenge for DOPL
	b Codify DOPL/ITAC 'limited supervised training permit' pathway in statute	• **DOPL/ITAC (under UCA 58-1-302) has flexibility** to develop an experience-based licensure pathway and test employer demand
	c Codify in statute accredited fellowship as a stand-in for residency	• **Adopted by DOPL in rule** • **May not address primary care** if fellowships are specialized • ~30% of fellowship matches are IMGs but there is **limited data about this group** (e.g., % who completed a U.S. residency) • **Other states may allow** this, especially via implication
2 Require U.S. residency	**a** Expand time-limited Associate Physician license to IMGs wanting to match into residency	• **Almost no uptake for this license currently** (e.g. billing is a barrier) • **Match rate of IMGs is lower** (58-68% vs ~93% for initial match out of medical school, data on later match rates not available) • **Experience of other states is mixed** (e.g., lack of supervision, unclear evidence of how many are working)

* Implies ECFMG (Educational Commission for Foreign Medical Graduates) certification as one requirement

Source: OPLR policy scan, National Resident Matching Program data, 2018 and 2026 studies of Physician Assistant programs, interviews

Chiropractic Physician overview

Issues identified from review

- Relatively high rate of sexual misconduct complaints
- Reimbursement and education ROI challenges

Main review recommendations

- **Grant DOPL citation authority** for unprofessional conduct
- **Add patient protections** (e.g., written consent for sensitive procedures, draping standard, chaperoning); consider mandatory ethics CE

Additional recommendations

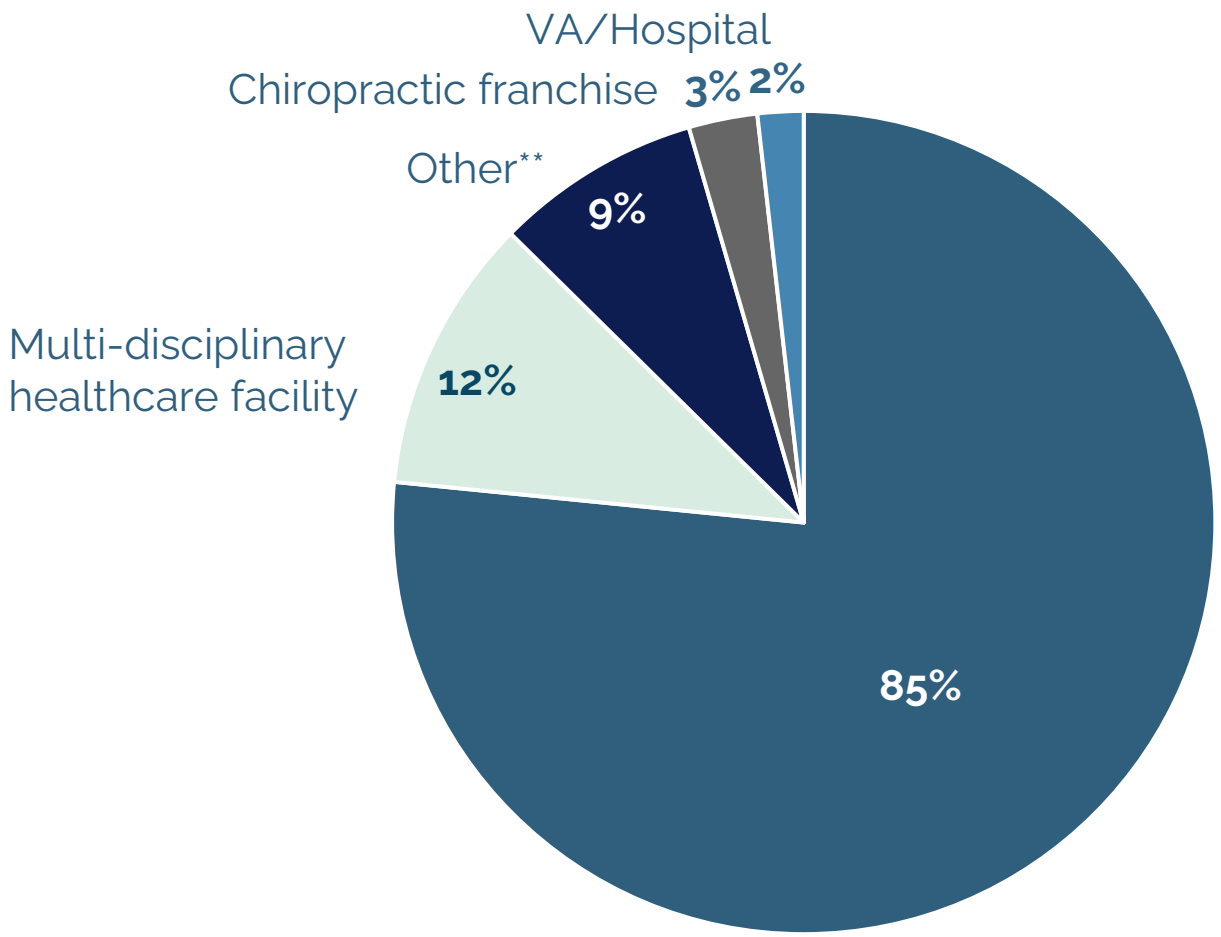
- None

Other potential or future considerations

- Scope and training requirements for expanded injection therapy into joints

Chiropractic physicians primarily work in independent clinics

Distribution of chiropractor work settings, United States*



Private, out-patient clinic

- 58% in solo practice
- 42% in multi-DC offices

* Numbers do not add to 100% due to chiropractors working across settings
** "Other" includes academic and concierge settings
Source: National Board of Chiropractic Examiners (2025) Practice Analysis of Chiropractic

Chiropractic physicians have a disproportionate rate of sexual misconduct complaints

DOPL substantiated complaints 2017-22

License	Total complaint rate	Sexual misconduct rate	% of complaints listed as sexual misconduct*	Number of licensees
Chiropractic Physician	**5.1**	**0.80**	**10/64 (16%)**	**1,257**
Massage Therapist	1.7	0.37	36/168 (21%)	9,789
Physician (MD/DO)	2.0	0.07	12/365 (3%)	18,458
Physical Therapist	0.7	0.03	1/23 (4.3%)	3,449
Nurse Practitioner**	2.5	0.03	2/150 (1.3%)	6,047

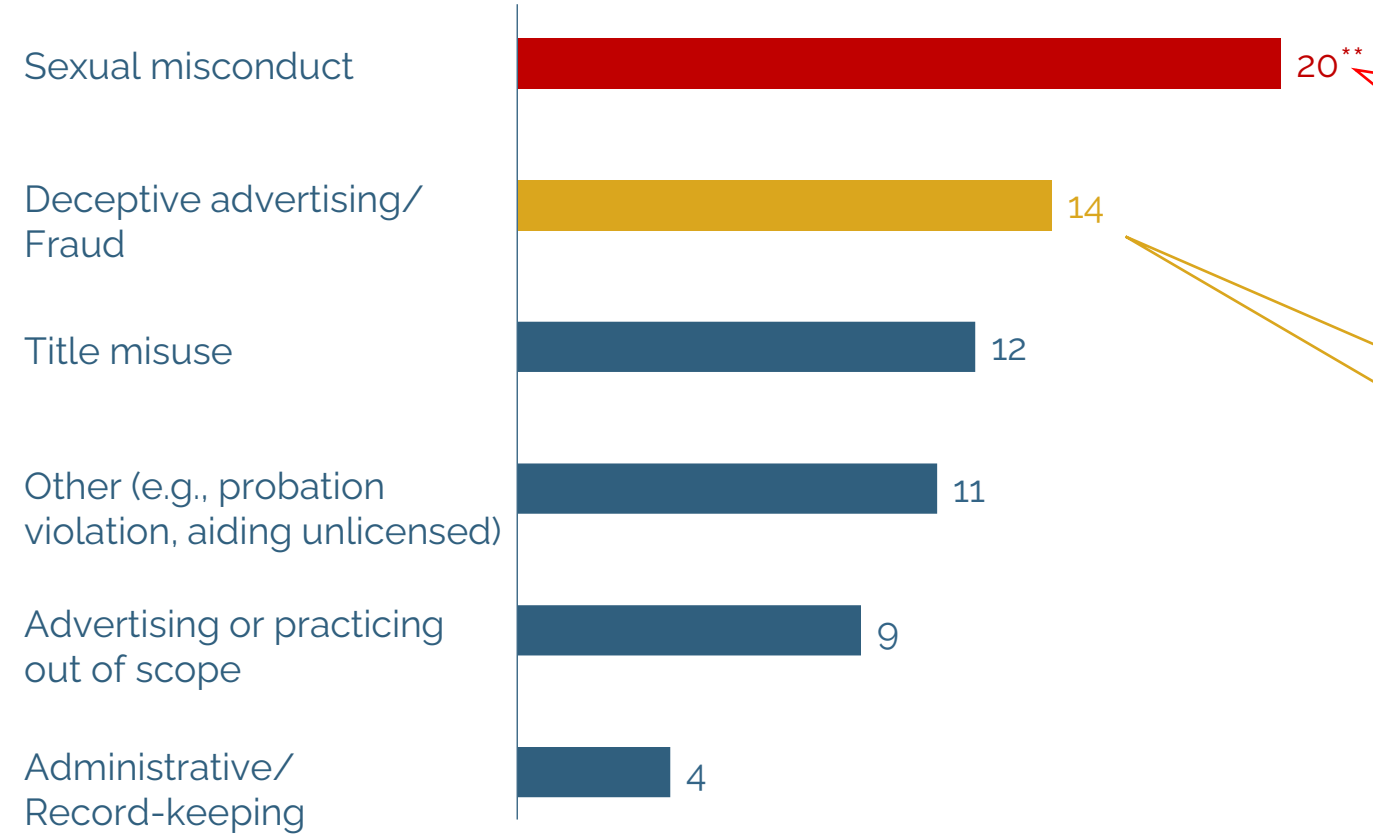
2017-2024 rates are slightly worse:

- Higher complaint rate: **5.35**
- Higher sexual misconduct rate: **1.0**
- Sexual misconduct is a greater share of complaints: **14/73 (19%)**

*Data reflect standard DOPL categories for comparison with other professions. OPLR's review of chiropractic complaints found a higher number related to sexual misconduct beyond DOPL's standard categorization (20 of 73 complaints reviewed 2017-24).
**Includes APRN, CNM, and CRNA licenses
Source: DOPL license data; DOPL complaint data; OPLR analysis

Sexual misconduct is a major theme in substantiated complaints

Chiropractic Physician DOPL substantiated complaints by type 2017-24*
Number



OPLR observations

20 distinct licensees
- **75% non-consensual**
- 6 cases of sexual battery/assault against multiple patients
- 4 led to criminal convictions & prison time
- 5 involved inappropriate comments rather than touching
- 1-2 may have been accidental

- 5 cases of insurance fraud (2 of which were less severe)
- 4 cases of defrauding/deceiving vulnerable adults
- 3 relatively minor cases likely not resulting in harm

* 73 total complaints, but OPLR analysis (and visual) includes only 70 complaints
** OPLR recategorized some complaints as 2/6 "other criminal conduct" and 4/22 "ethical standards" complaints related solely to sexual misconduct
Source: DOPL complaint data; OPLR analysis

Utah has one of the broadest scopes of practice for chiropractic physicians

Example states:	**ID, NM, OR**	**Utah**	**WA, FL, HI**
Example scope:	Examine and diagnose human conditions and treat via application of chiropractic methods	Examine, diagnose and treat any human illness or condition within defined scope of chiropractic care	Spine alignment, joint disfunction, musculoskeletal disorders
Example allowances:*	• Minor surgery • Obstetrics • Limited prescribing	• Acupuncture • Injection therapy • Administration of physical agents (heat, etc.) • Image ordering	• Spinal adjustments and manipulations • Diagnostic X-rays • Therapeutic exercise
Example restrictions:*	• Operative surgery • X-rays for therapeutic purposes	• Incisive surgery • Setting displaced bone fractures • Prescribing (excl. certain topical agents) • Obstetrics	• Use of needles • Massage • Treating specific disorders (e.g., tuberculosis, malaria, syphilis)

* Not every example state will allow and/or restrict all examples provided. For example, Idaho does not allow chiropractors to practice obstetrics, while Oregon does

Source: OPLR policy scan of 21 states

Optometry overview

Issues identified from review

- Need to optimize access
- Scope may be misaligned with training

Main review recommendations

- **Expand scope** with specified training and supervision to include **YAG and SLT**, plus certain **minor surgical procedures**

Additional recommendations

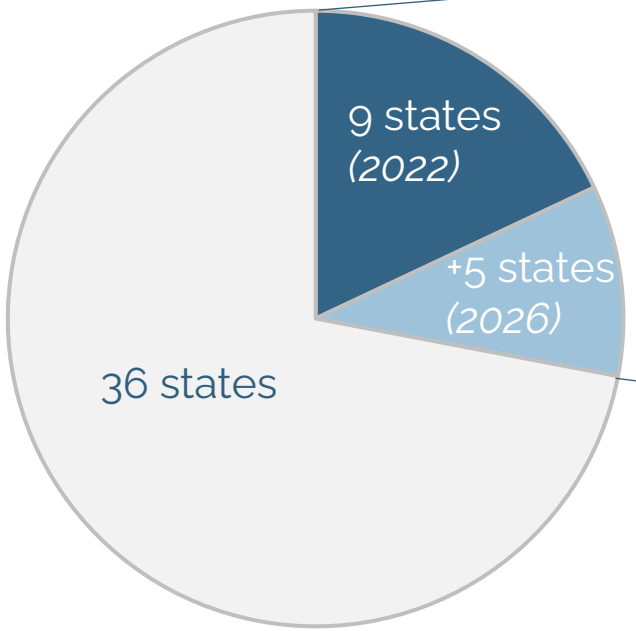
- None

Other potential or future considerations

- None

Fourteen states allow optometrists to perform some laser procedures

States allowing laser procedures by optometrists*



YAG, SLT & LPI**	10 states
YAG & SLT only	3 states
YAG only	1 state

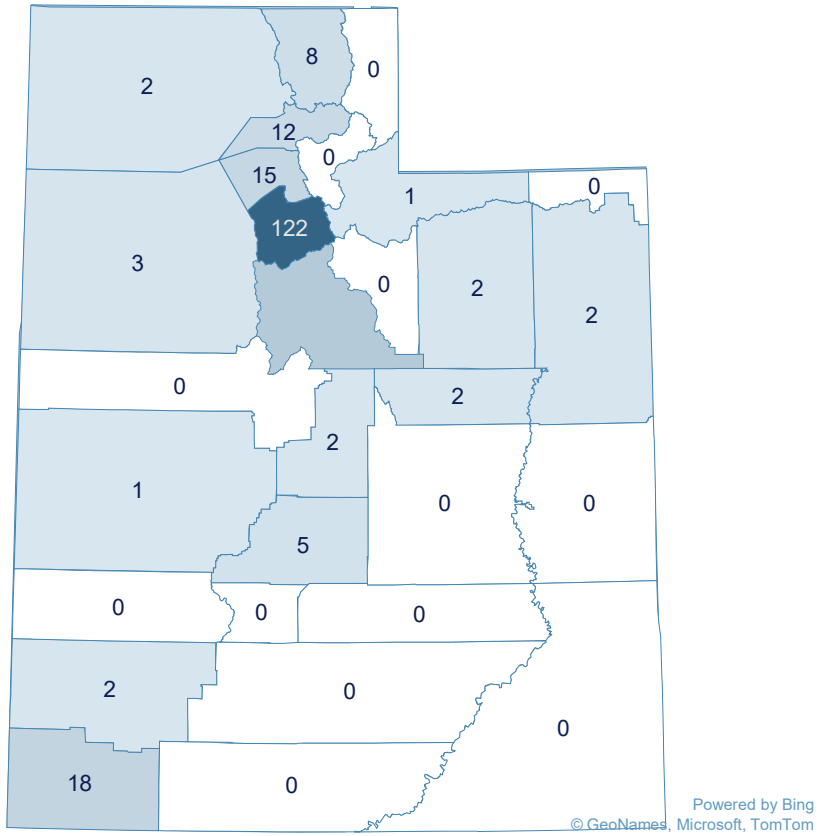
States typically require:

- **Recent graduation** (i.e., since 2020) from an accredited program **where procedures were taught**
- Completion of a training course with **demonstration of proficiency** (e.g., # of 'live-eyes' under supervision)

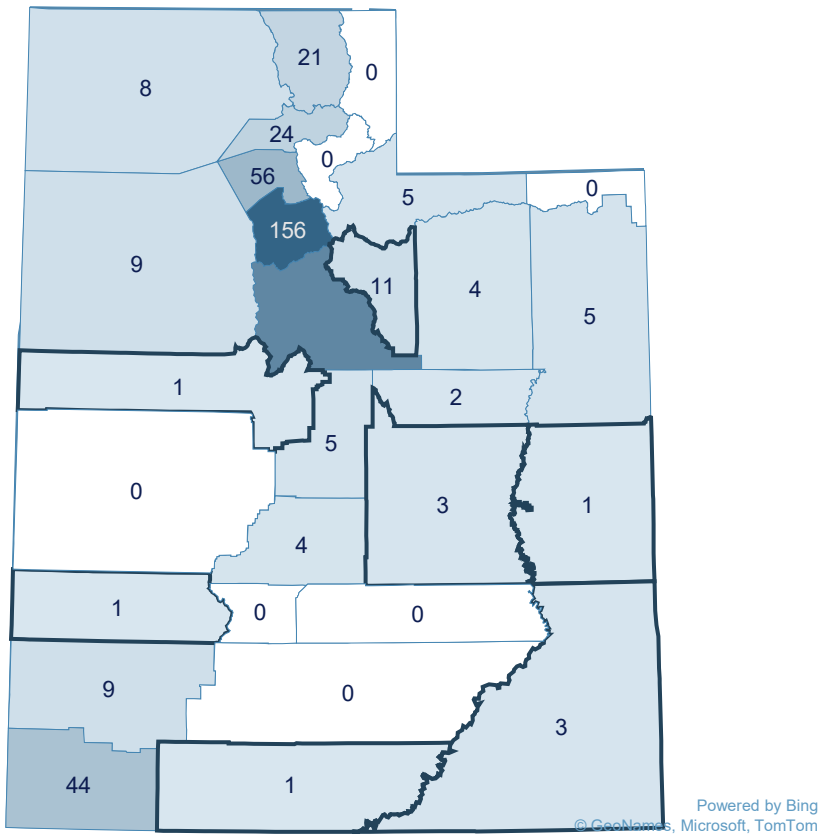
* Excludes Wisconsin and Indiana because OPLR was unable to verify laser procedure scope within those states' statutes
** This analysis focuses on YAG, SLT and LPI procedures. Somes states include other procedures, such as ALT and PRK, but the number is hard to determine as the procedures may not be mentioned explicitly in statute
Source: OPLR policy scan

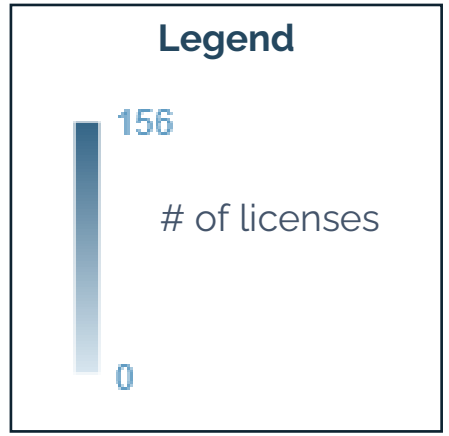
Counties lacking ophthalmologists still maintain an optometrist presence

Number of Ophthalmology Physicians



Number of Optometrist Licenses





Source: OPLR analysis of 2026 DOPL licensing data (optometry) and CMS 'doctors and clinicians national file' (ophthalmologists)

Studies on optometrist-performed YAG and SLT are not definitive, but lean towards safety

3 reported negative outcomes over two studies

- A 2023 OPLR review found **one** negative patient outcome out of ~200,000 optometrist performed laser surgeries
- A 2025 report found optometrists have performed **over 145,000 laser procedures,** with 2 negative outcomes

1 of 11 states saw increased malpractice payments

Of the 11 states that allow optometrists to perform laser surgeries, only one state saw a statistically significant (*p=0.049*) post-expansion increase in optometrist malpractice payments

Data has **important limitations**

One principal study performed by investigator with **possible economic interest** in scope expansion; some studies are from U.K. and **not easily generalizable to the U.S**; Complaint data is limited, as it is **self-reported** and adverse outcomes do not always end in litigation

Source: Duszak et al., *Optometry and vision Science* (2026); Lighthizer et al., *Clinical and Experimental Optometry* (2025)
**Discrepancy in performed surgery count explained by differences in time period and data collection methods

Naturopathic Physician overview

Issues identified from review

- Very small profession relative to its primary care focus
- Higher barriers to practice vs. other states (e.g., residency)

Main review recommendations

- **Remove:** residency requirement, limits on naturopathic manipulation, and unnecessary insurance clauses

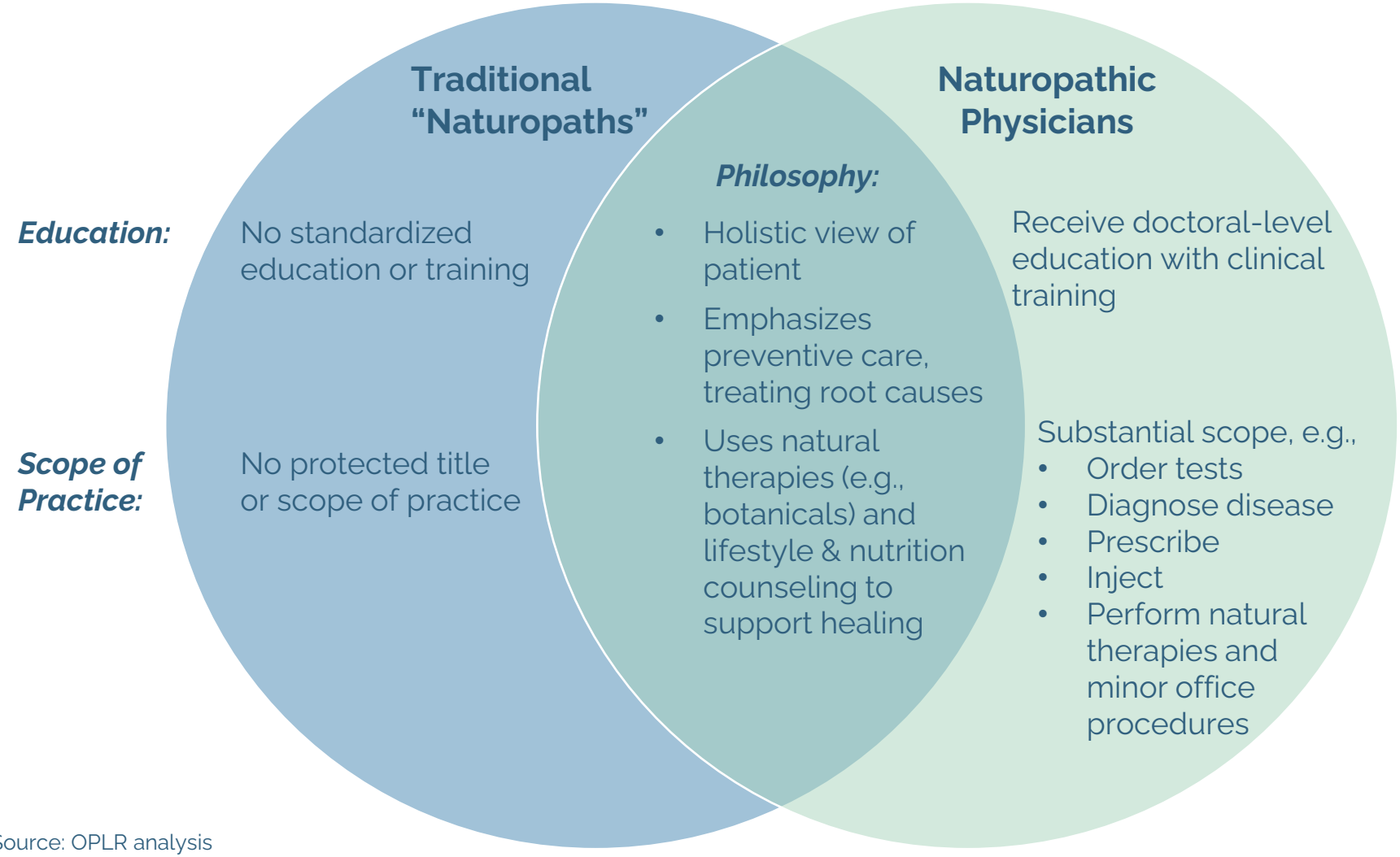
Additional recommendations

- None

Other potential or future considerations

- Prescribing authority for additional legend drugs (not controlled substances)
- Oversight of prescribing authority limitations within DOPL

Naturopathic physicians share a similar philosophy with traditional "naturopaths" but are distinct



Source: OPLR analysis

Naturopathic physicians share similarities with other providers but focus on primary care

Areas where NDs differ most

		Naturopathic Physician	Nurse Practitioner	Physician Assistant	Medical Doctor (MD/DO)
Education	**Prerequisites**	Undergraduate degree*	Undergraduate degree, active RN license, RN experience*	Undergraduate degree, 250-2000 hours clinical patient care	Undergraduate degree, MCAT
	Program Length	4+ years	2-3 years	2-3 years	4+ years
	Clinical Hours	1,200 hours; 450 patient encounters	750 hours	1600-2000 hours	3,000 hour clerkship & 3+ year residency
Scope in Utah	**Diagnosing & Treating**	Independent authority for all illness, disease	Independent authority for all illness, disease	Independent authority for all illness, disease *after* 8,500 hour CPA	Independent authority for all illness, disease
	Prescriptive Authority	Most legend drugs, testosterone is only CS	Unrestricted	Unrestricted *after* 8,500 hour CPA	Unrestricted
	Surgery	Minor office procedures only	Minor surgical procedures only	Assist MD/DO or minor surgical procedures	Yes
Practice	**Treatment Focus**	Nearly 100% primary care	Majority specialize; 25-35% primary care	Majority specialize; 25-35% primary care	Majority specialize; 25-35% primary care
	Acute Settings	Rarely if ever	Often	Often	Often

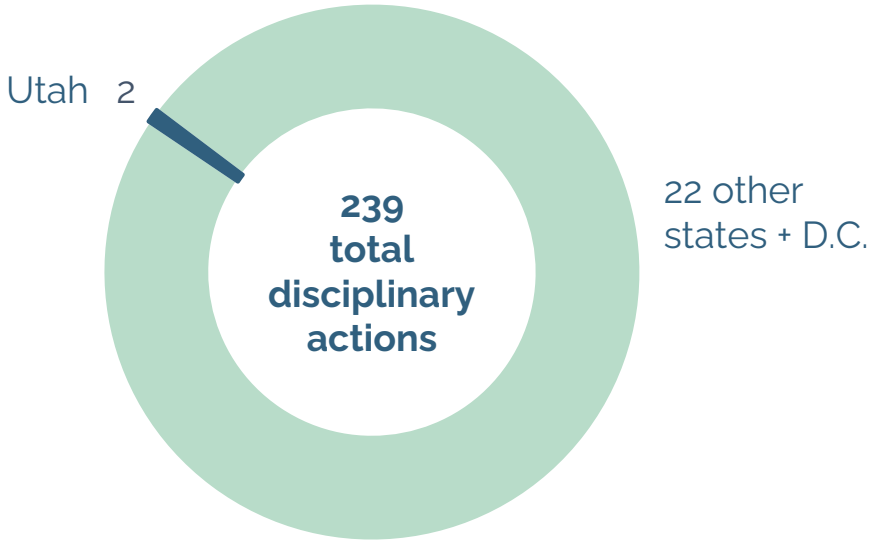
* A few schools may not enforce this requirement

Source: Association of Accredited Naturopathic Medical Colleges 2020 Graduate Success and Compensation Study; OPLR analysis of ND/MD/DO/PA/NP education requirements; MD/DO/PA/NP DOPL Renewal Surveys

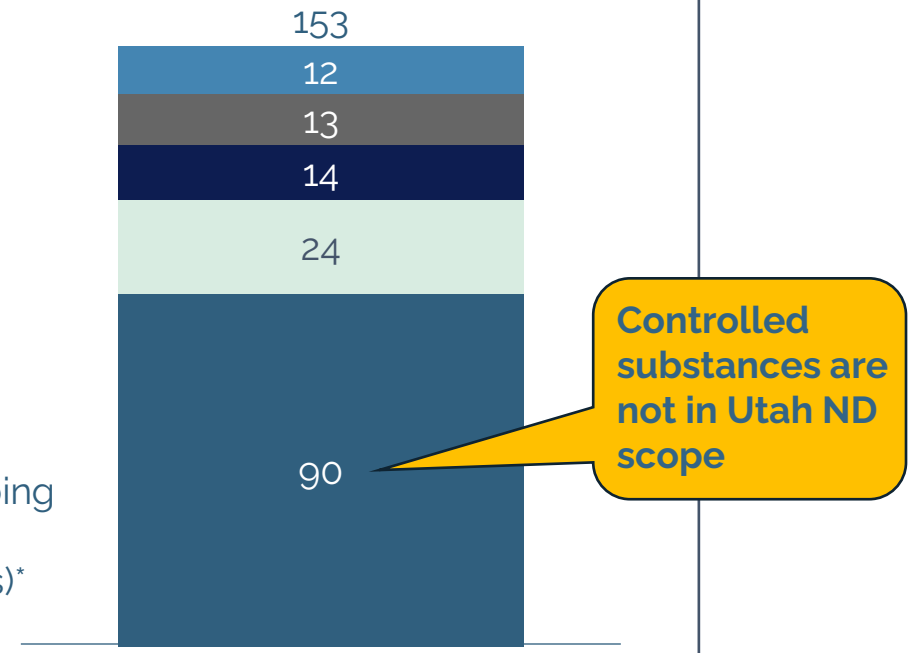
Naturopathic physicians receive few disciplinary actions and almost none in Utah

Nationwide disciplinary actions since 2010

Number of actions against practitioners

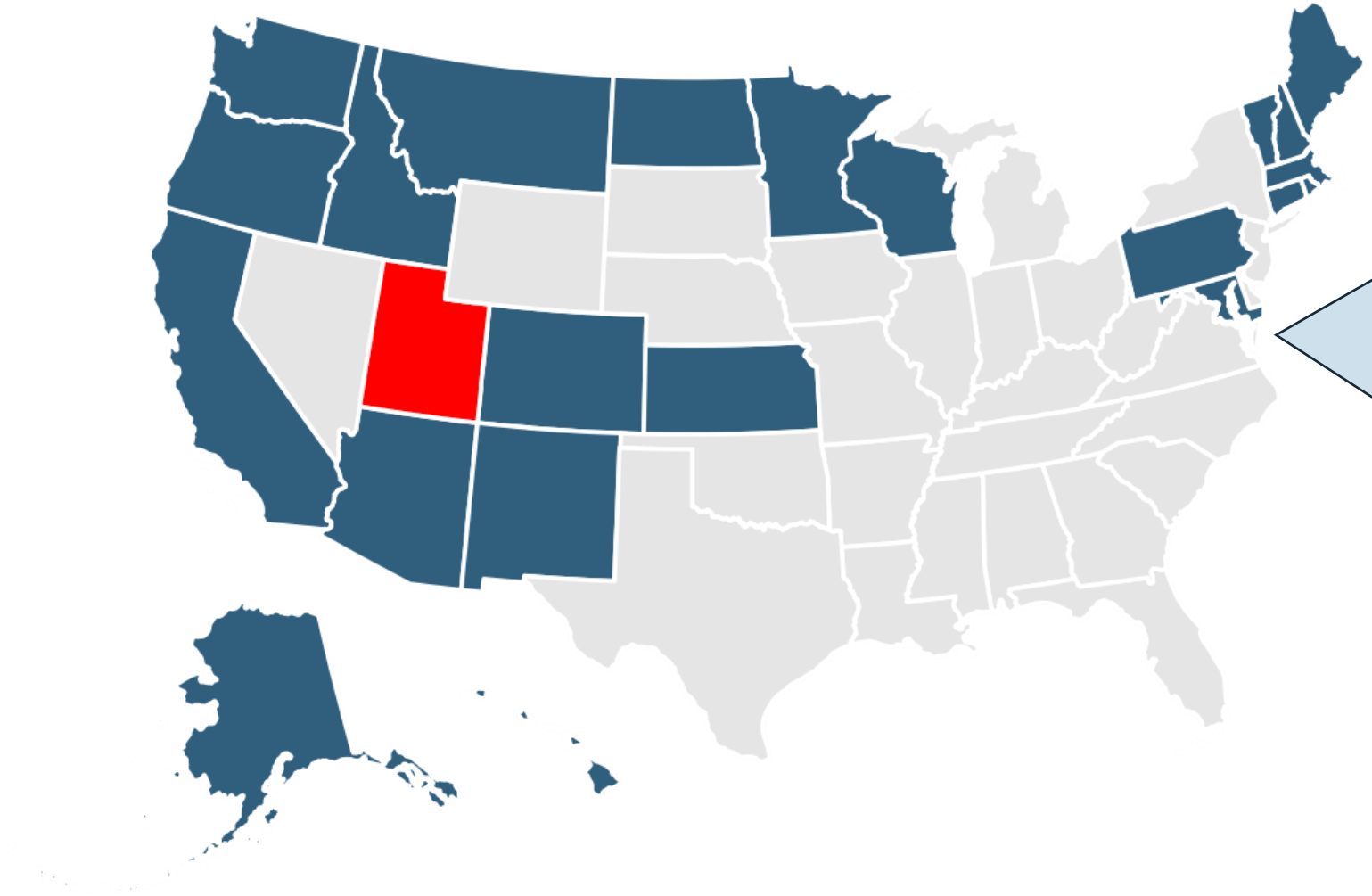


Number of actions in the 5 most common categories



* Utah NDs may prescribe testosterone, but these complaints centered around pain relievers not hormones
Source: Federation of Naturopathic Medicine Regulatory Authorities

Only Utah requires naturopathic physicians to complete a residency



Considerations for removing Utah residency requirement:

- Almost half of licensees entered by endorsement, potentially without completing a residency
- Few in-state opportunities
- Does not guarantee practice in high-risk treatments
- NDs elsewhere appear to practice competently without this requirement
- **Counter-argument:** state should require residency hours for all providers with certain scope

Source: American Association of Naturopathic Physicians, OPLR analysis of state licensing statutes and rules

Rad Tech overview

Issues identified from review

- Narrow scope limits utilization of limited Rad Techs (RPT)
- Low workforce participation for Rad Techs (RT)
- Low uptake of advanced license (RA)

Main review recommendations

- Remove **RPT X-Ray scope restrictions** so long as RPTs are trained and supervised
- **Expand scope of RA and broaden supervision** to increase value of role

Additional recommendations

- None

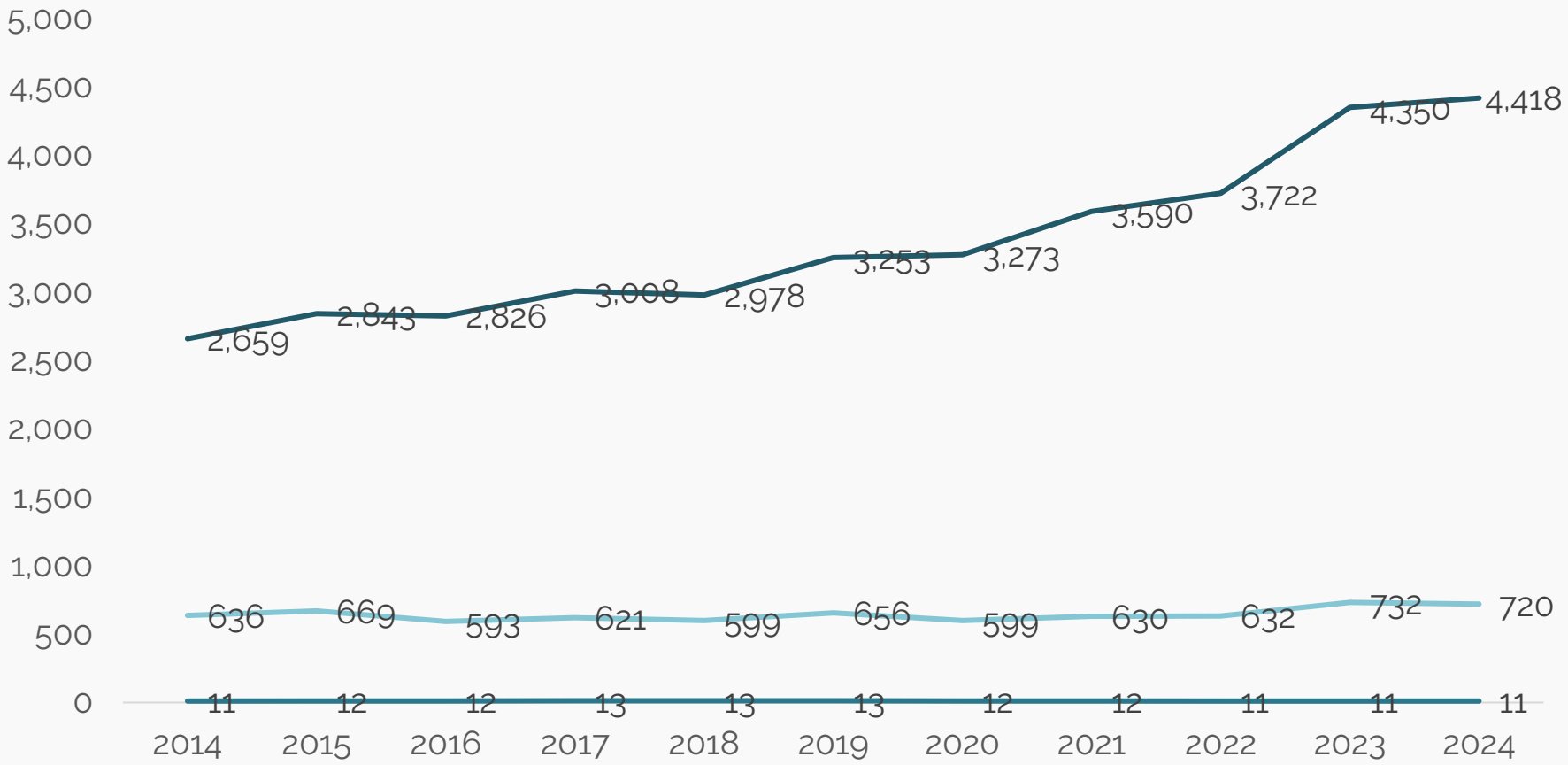
Other potential or future considerations

- None (**Talent Ready Utah** is evaluating concurrent enrollment and competency pathway to obtain RT credential)

RT licenses in Utah have increased substantially but RPT and RA licenses have not

Growth in active radiologic technology licenses, 2014-24*

Number



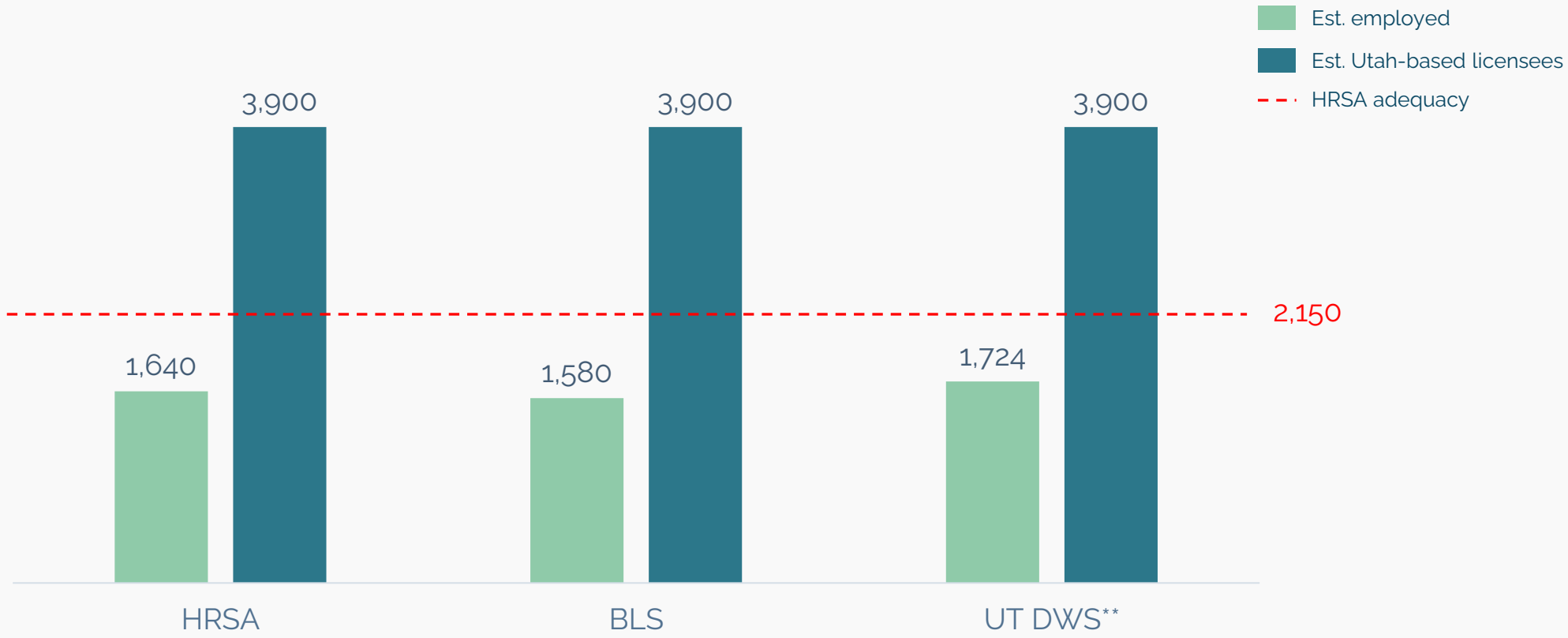
	CAGR
Radiologic Technologist (RT)	5.2%
Radiology Practical Technician (RPT)	1.3%
Radiologist Assistant (RA)	0.0%

* Majority of licensees use a UT address for their licensing record, suggesting this is a highly local workforce

Source: DOPL licensee data; OPLR analysis

RT employment estimates are much lower than licensure, suggesting participation is an issue

Comparison of employment vs licensure for Radiologic Technologists and Technicians, 2024*
Number



* HRSA estimates full-time equivalent (FTE) workers, BLS and DWS estimates include full-time and part-time workers
** DWS data is presented as "current", year unknown
Source: HRSA: Health Resources and Services Administration (HRSA) Workforce Projections; U.S. Bureau of Labor Statistics (BLS): Occupational Employment and Wage Statistics; UT DWS: Utah Department of Workforce Services; DOPL licensee data; OPLR analysis

Expanding RPT scope creates more flexibility and potential capacity in providing x-ray services

RPT role: Perform X-ray imaging only; do not order, interpret or diagnose

Current law

Scope: Defined by passage of each AART exam and that exam content

Includes: *Only* radiological positions and projections as specified by the ARRT Limited Scope Exam*

Training: Set by employer

Supervision: Under a radiologist or radiology practitioner

OPLR Recommendations

Scope: Additional views can be performed with completion of one AART exam, with employer training and supervision

Includes: *All* radiologic positions and projections in areas of the chest, extremities, skull/sinuses, spine, podiatric**

Training: No change

Supervision: No change

ARRT = American Registry of Radiologic Technologists
*Areas include the chest, extremities, skull/sinuses, spine, podiatric
**Expands positions and projections related to pelvis, hip, ribs, and sternum that were previously unclear

Dietitian overview

Issues identified from review

- Potential for harm generally moderate and/or reversible
- Access appears sufficient
- Dietitians can be reimbursed under current model
- States are including other providers (e.g., CNS credential)
- Breadth of nutrition field cautions against restrictive policy

Main review recommendations

- **Reject licensure**, maintain voluntary certification
- **Allow similar qualifications (CNS)** to obtain a combined, not separate, certification

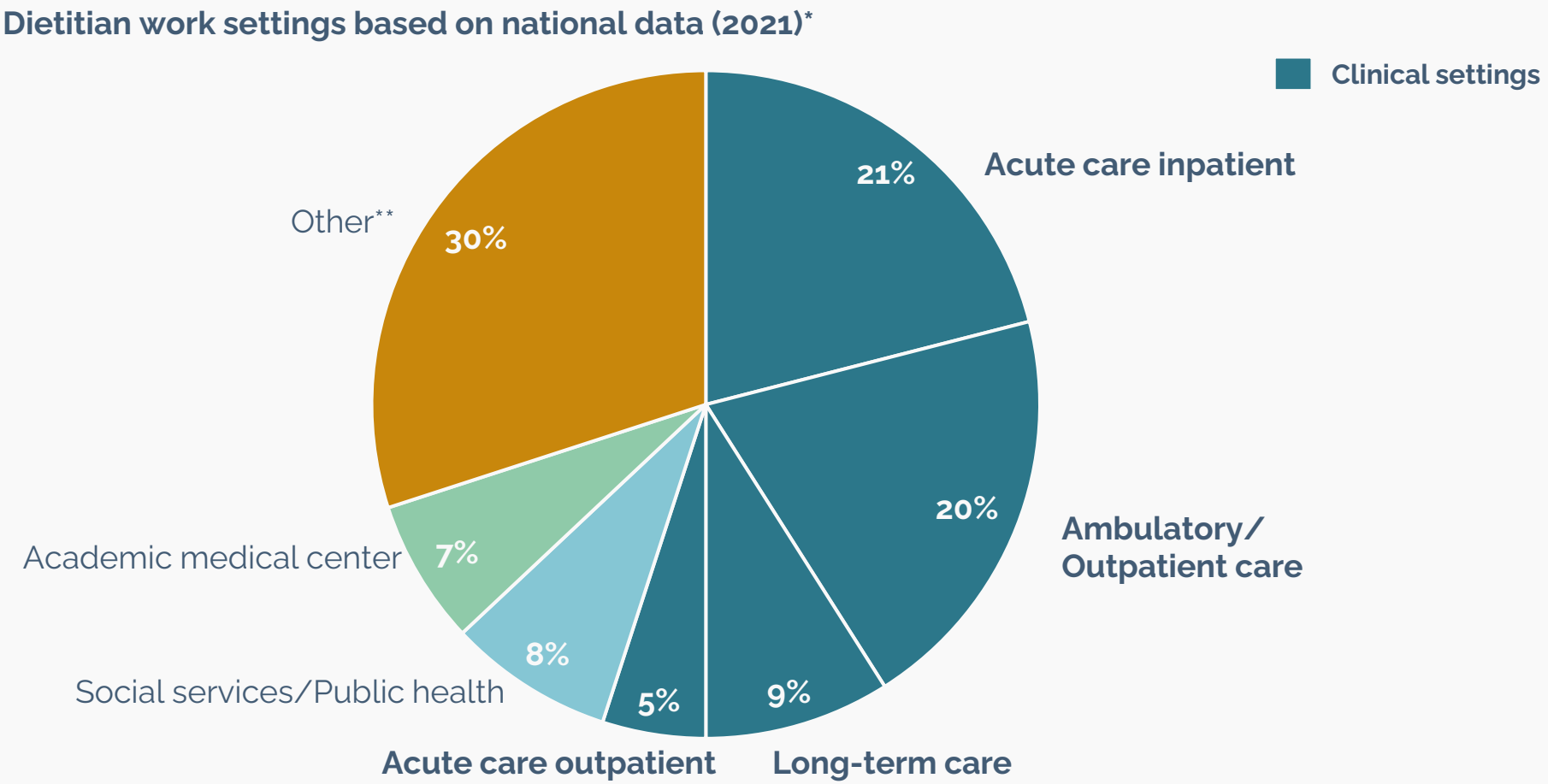
Additional recommendations

- None

Other potential or future considerations

- None

Most dietitians work in clinical and generally supervised settings



* Across all settings, 8% report being self employed
** Other includes school nutrition and other settings not disclosed; none of which accounted for >=4% of respondents
Source: Academy of Nutrition and Dietetics, Compensation and Benefits Survey (2021)

Potential for harm and observed level of harm from dietitians is low

Potential for harm

- In non-acute cases, harm is often **moderate and reversible** (e.g., nutrient deficiencies from an overly restrictive plan)
- Incompetent **MNT** (e.g., incorrect refeeding or care of acute patients) **can lead to downstream effects,** delaying correct treatment in time for time-sensitive conditions such as diabetes or eating disorders

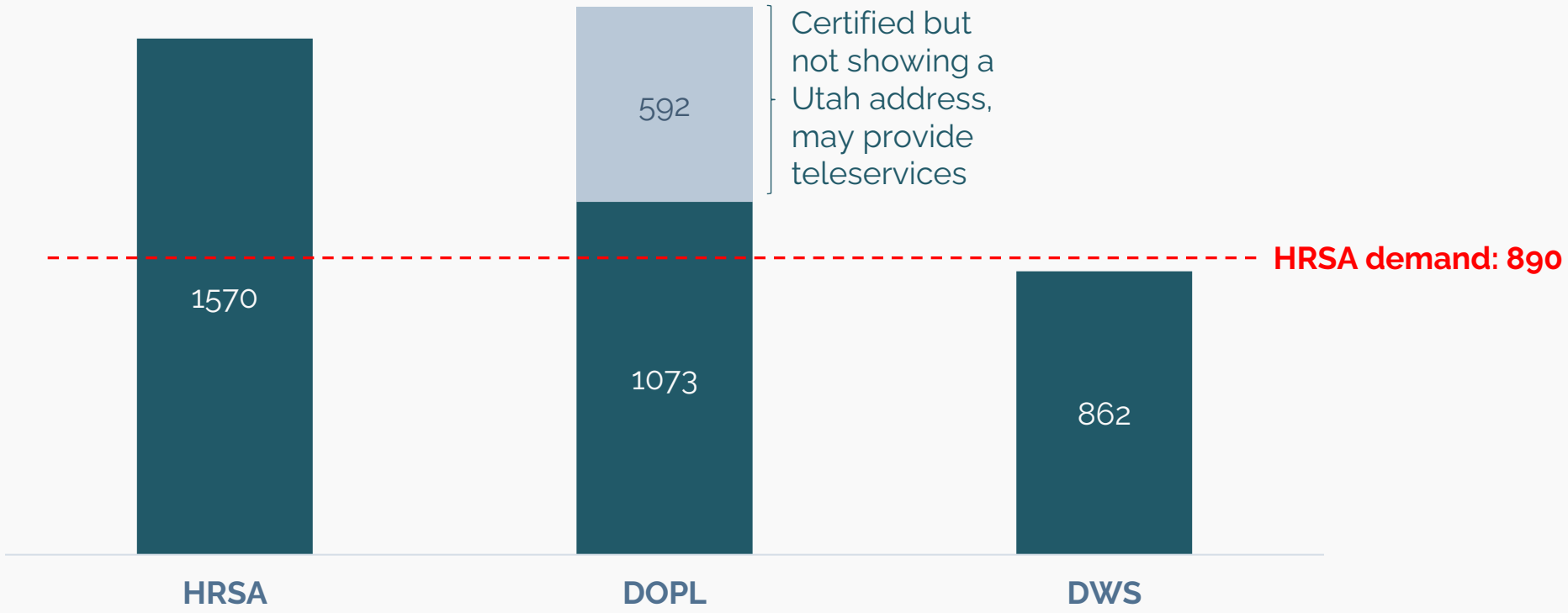
Actual level of harm

- DOPL substantiated complaint rate of **0.4 per 100 practitioners** 2017–22
- Of the 9 dietitian-related complaints from 2017 through 2024**, only one involved a practicing dietitian** (an expired certification, with no evidence of harm)

Source: DOPL license data; DOPL complaint data; OPLR analysis

A variety of sources suggests Utah has a sufficient number of dietitians

Estimates of the supply of dietitians in Utah, 2026
Number



* HRSA estimates full-time equivalent (FTE) workers, Utah DOPL estimate is based on certified dietitians as of January 2026, Utah DWS estimates include full-time and part-time workers
Source: HRSA: Health Resources and Services Administration (HRSA) Workforce Projections; UT DWS: Utah Department of Workforce Services; DOPL licensee data; OPLR analysis

Other states regulate CNS as well as RD

Overview of U.S. state regulation of dietetics and nutrition

			Reimbursable for insurance	
	No regulation	*Title protection only*	*Certification**	*License***
Registered Dietitian (RD)	1 state	3 states	16 states (including Utah)	30 states
Certified Nutrition Specialist (CNS)	31 states (including Utah)	None	6 states	12 states

* Certification = entry requirements
** License = entry requirements and some varied protections for scope of practice
NOTE: in healthcare, unlike most other industries, absence of state regulation may prevent participation in the market, and state regulation allows participation because of insurance/payer requirements
Source: OPLR policy scan, ANA (2025) CNS MNT Laws

Registered dietitians and certified nutrition specialists share many aspects of education

	Registered Dietitian (RDN)*	Certified Nutrition Specialist (CNS)*
Education	• ACEND accredited **master's degree** in dietetics • Requires competence in broad set of practices and settings	• **MS** or Doctoral degree in nutrition or related field** OR doctoral degree in clinical healthcare • 36 credit hours of relevant coursework, 12 must be in graduate nutrition science
Clinical Experience	• **1,000** hours (700 in formal settings) • Formalized, ACEND-accredited in pre-vetted sites (incl. clinical, community, and food service management settings)	• **1,000** hours of personalized nutrition assessment, intervention, and evaluation • Self-directed and supervised by a BCNS-approved supervisor (CNS, RD, DCN, must be licensed)
Exam	• **3 hours, 125 questions** on: dietetic principles, nutrition care, management of food programs, foodservice systems	• **4 hours, 200 questions** on: clinical intervention and monitoring, MNT, principles of nutrition, nutrition assessment, nutritional biochemistry, public health
Emphasis	• Broad set of nutrition and dietetics roles, including acute and industry settings	• Personalized nutrition therapy, largely in non-clinical settings (*unless already a licensed provider*)
Payor status	• Reimbursed in Utah due to certification	• Not currently reimbursed in Utah

* Both credentials are accredited by the NCCA and recognized by the U.S. Department of Labor as advanced nutrition credentials
**Includes public health, health science, biochemistry, nursing, PA, dietetics
Source: OPLR Analysis, ANA, Academy of Nutrition and Dietetics

Today's discussion

- OPLR healthcare review recommendations summary

- Deeper dives (based on committee interest)
  - Physician
  - Chiropractor
  - Naturopathic Physician
  - Optometrist
  - Rad Tech
  - Dietitian

- **Next steps and timing**