**02 DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION**

**313 MAINE BOARD OF DENTAL PRACTICE**

**Chapter 12: PRACTICE REQUIREMENTS**

**Summary:** This chapter sets forth the practice requirements as noted for individuals licensed under the *Maine Dental Practice Act*. Failure to adhere to the practice requirements may result in disciplinary action taken pursuant to 32 M.R.S. §18325 and 10 M.R.S. §8003(5).

1. **GENERAL PRACTICE REQUIREMENTS**

The following practice responsibilities apply to individuals licensed as indicated below:

1. **INFECTION CONTROL**
   1. All licensees shall utilize the CDC Guidelines for Infection Control in Dental Health-Care Settings, 2003.
   2. A licensee who is providing general supervision or direct supervision must ensure the supervised individual’s training and/or certification is completed to comply with the CDC Guidelines noted in Section I (A)(1).
2. **RADIATION PROTECTION; DENTAL RADIOGRAPHS; PATIENT SELECTION**
   1. A licensee who is providing dental services utilizing radiological equipment is required to operate and maintain such equipment in compliance with Maine’s Radiation Control Program, as provided for in the *Radiation Protection Act*, 22 M.R.S. §§ 671-690.
   2. A licensee who is authorized to practice dental radiography or use ionizing radiation for diagnostic purposes is required to place on or over a patient’s body radiation barriers, such as protective aprons and thyroid shields, prior to exposing that patient to ionizing radiation.
   3. A licensee shall utilize the ADA/FDA publication “Dental Radiographic Examinations: Recommendations for Patient Selection and Limiting Radiation Exposure” (as revised in 2012) when selecting patients for dental radiographic examinations and utilizing ionizing radiation.
3. **LOCAL, STATE, AND FEDERAL HEALTH AND SAFETY REGULATIONS**
4. All licensees shall comply with the following:
5. Premises shall be kept clean, orderly and free of accumulated rubbish and similar substances;
6. Premises shall be kept free of all insects and vermin by utilizing proper control and eradication methods;
7. Piped water supply shall conform with local, state and federal regulations. Use of other water sources shall comply with the CDC Guidelines for Infection Control in Dental Health-Care Settings, 2003;
8. All structures shall be in compliance with local and state building codes;
9. Sanitary conditions shall be maintained at all times for patients and employees, including immediately available toilet facilities. *See* 29 C.F.R. § 1910.141(c); and
10. Operations shall be in compliance with OSHA Standards applicable to dental practices related to bloodborne pathogens, hazard communication, ionizing radiation, and exit routes and emergency planning. *See* 29 C.F.R. §§ 1910.35-1910.39, 1910.1030, 1910.1096, 1910.1200.
11. **EMERGENCY PROTOCOL**

1. All licensees shall comply with the following:
   1. Adopt and follow a written protocol for managing medical or dental emergencies;
   2. Maintain a current emergency drug kit appropriate to scope of practice;
   3. Maintain communication equipment that ensures rapid access to emergency responders and others as necessary;
   4. Provide training, if responsible for hiring and/or supervising staff, to ensure that staff are trained upon employment/supervision, and at least annually thereafter, to implement the emergency protocols; and
   5. Maintain accessibility to an automated external defibrillator device.
2. **DENTAL ADVERSE OCCURENCE REPORT**
3. All licensees shall report the following adverse conditions to the Board:
   1. Death of a patient within 48 hours after the administration of a dental practice procedure. Such reporting shall be made within 72 hours of the death.
   2. Activation of an emergency response of a patient or emergent transport of a patient to another facility. Such reporting shall be made within 72 hours of obtaining knowledge of the emergency.
4. Information to be included in the adverse report:
   1. Date and time of occurrence;
   2. Name of patient;
   3. Dental practice procedure involved, if any;
   4. Type and dosage of nitrous oxide analgesia, local anesthesia, sedation, and/or general anesthesia used in the procedure; and
   5. Description of the occurrence.
5. In the event the licensee does not have knowledge or cannot reasonably be expected to have knowledge, but subsequently obtains actual knowledge of an adverse occurrence, then such licensee shall report to the Board the earlier of 72 hours after obtaining knowledge of a patient death, or 30 days after obtaining knowledge of the permanent organic brain dysfunction or hospitalization of a patient related to a dental procedure.
6. **CONTROLLED SUBSTANCES; INVENTORY CONTROL**
   1. Dentists who are authorized to dispense, administer, and prescribe any controlled substances shall do so in accordance with 32 M.R.S. §18308, Board Rules, Chapter 21, and the provisions of the *Comprehensive Drug Abuse Prevention and Control Act of 1970*, 21 U.S.C. §§ 801-971.
   2. Dentists authorized to prescribe, administer and dispense controlled substances shall adopt protocols to maintain inventories and records of controlled substances in accordance with state and federal laws and regulations. Protocols shall be reviewed at least annually and updated as needed. Licensees who hold permits issued by the United States Department of Justice, Drug Enforcement Administration shall adhere to the practitioner requirements as outlined in the “Practitioner’s Manual – An Informational Outline of the Controlled Substances Act” (2006 Edition), published by the Drug Enforcement Administration, Office of Diversion Control.
7. **PATIENT RECORDS**: Commensurate with a licensee’s scope of practice, patient records shall include, but are not limited to, dental charts, photographs, patient histories, examination and test results, diagnoses, treatment plans, progress notes, anesthesia charts, prescriptions, radiographs, patient consents, and billing records.
   * 1. **Confidentiality of Patient Records**. All patient records shall be maintained in a manner that ensures confidentiality and access for patients and authorized practitioners who may wish to obtain a copy of patient records as required by the state and federal requirements. *See* 22 M.R.S. § 1711-C; 45 C.F.R. §§ 164.500-164.534 (privacy rule of the *Health Insurance Portability and Accountability Act*, or “HIPAA”).
     2. **Record Retention Requirement**. A dentist, denturist, dental hygienist who is practicing with an independent practice dental hygiene authority, public health dental hygiene authority, or dental therapy authority (including a provisional authority) shall maintain a patient's original dental record and original radiographs for a minimum of seven (7) years from the date of the last patient treatment.

Licensees who do not have legal authority or ownership over patient records in the delivery of their services shall, at a minimum, maintain access to such records to comply with this subsection.

* + 1. **Availability of Dental Records**
       1. The licensee shall provide upon written request by a patient or another specifically authorized person, a copy of the patient’s dental record. A copy of the patient record, including radiographs, shall be provided within a reasonable amount of time not to exceed 21 days from the receipt of the request. The licensee may charge a reasonable fee for the expense of providing a patient’s record, not to exceed the cost of either labor and/or materials incurred in the copying of the patient record and radiographs. The licensee shall not require payment for services rendered as a condition of providing a copy of the patient record.
       2. Electronic patient records shall be unalterable and producible in paper form upon request.

1. **CONTENT OF PATIENT RECORDS**: All licensees shall comply as set forth below:
   * 1. The patient record shall be a complete record of all patient contact, including, but not limited to, a general description of the patient’s medical and dental history and status at the time of examination, diagnoses, patient education, treatment plan, referral for specialty treatment, medications administered and prescribed, pre- and post-treatment instructions, and information conveyed to the patient.
     2. Patient records shall be legible and clear in meaning to a subsequent examining or treating dentist, the patient, dental auxiliaries or other authorized persons.
     3. At a minimum, a patient's record shall include:
        1. **Patient Information** 
           1. Name, address and date of birth of the patient;
           2. If the patient is not of the age of majority, the name of the parent or legal representative; and
           3. Patient's telephone numbers(s) and electronic mail addresses, except if the patient declines to provide this information.
        2. **Medical and Dental History Form**. The patient's medical history and dental history shall include, but not be limited to:
           1. A review of past and present illnesses, diseases and disabilities;
           2. Systemic disease(s);
           3. Current prescription and non-prescription medications as well as any known drug allergies;
           4. Documentation of consultation with the patient's medical physician(s) as appropriate;
           5. Date of the patient's last dental visit and frequency of dental visits; and
           6. At each patient visit, the licensee shall inquire and document in the patient record any changes in the patient's medical history, including but not limited to, changes in medications.
        3. **Record of Examination**. Each patient record shall include documentation of the results of a comprehensive examination of the following areas:
           1. Head and neck;
           2. Radiographic images as necessary and appropriate to facilitate a comprehensive diagnosis of the patient. Radiographs shall be clearly identified with the patient name, and date the radiographic exposure was taken;
           3. Intra-oral and extra-oral soft tissue examination, including charting of existing restorations and current status of patient's hard and soft tissue;
           4. Comprehensive periodontal screening;
           5. Oral cancer screening;
           6. Examination of the teeth;
           7. Duration of edentulousness, and any previous or existing removable prosthesis;
           8. Results of any other examination performed as necessary and appropriate to facilitate comprehensive diagnoses of the patient's dental status;
           9. Findings which are within or outside of normal limits; and
           10. Baseline blood pressure at initial consultation visit, and as clinically necessary thereafter.
2. **Diagnoses**. The patient record shall include written diagnoses of the patient's current dental status based on the evaluation of the patient's medical and dental history, examination, and radiographic findings.
3. **Treatment Plan**. The patient record shall include a written treatment plan describing in detail the proposed treatment. The proposed treatment plan, including alternatives to treatment, and information regarding estimated fees must be reviewed with the patient prior to the commencement of treatment. The treatment plan shall also include referrals to other providers as necessary. If there is no treatment plan this must be explained and documented in the patient record.
4. **Informed Consent**. There are two categories of informed consent: implied consent and express consent.
   * + - 1. **Implied Consent**. Implied consent is a presumed type of permission based on the patient’s conduct and it applies primarily to non-invasive procedures such as consultations, examinations, and diagnoses.
         2. **Express Consent**. Express consent is a more formal type of permission founded on words, either oral or written, and it applies to more invasive procedures. Written informed consent is an express consent which includes the signature of (at least) both the licensee and the patient (or the patient’s legal guardian).
5. **Progress Notes**. The patient record shall include written documentation of the treatment provided by the dentist and/or dental auxiliary, including but not limited to:
   * + - 1. Administration of medicines and medicaments including the type, amount, and route of administration;
         2. A statement of services provided including patient reaction, if any, during the treatment visit, procedures performed, and diagnoses;
         3. A description of the pre- and post-treatment instructions including, if applicable, plans for subsequent treatment;
         4. Documentation of any referral for specialty treatment, including the name of the specialist the patient is referred to; and
         5. A dated written or electronic signature by the dentist or dental auxiliary who treated the patient.

(h) **Patient Financial Payment/Record**. The patient's financial record shall include, but not be limited to, the name of the patient's dental insurer, documentation of fees for treatment and payment schedule, and claims submitted to third parties.

1. **PATIENT DISMISSAL**: Dentists, denturists, dental hygienists who are practicing with an independent practice dental hygiene authority, a public health hygiene authority, or a dental therapist authority (including provisional) shall comply as set forth below:
2. A written notice of dismissal shall be sent to the patient and/or patient’s guardian by certified return/receipt mail. The dismissal is effective as of the date of the letter. However, the licensee must offer the patient a 30-day emergency care period from the date of the dismissal notice. The date identifying the end of the 30-day emergency care period must also be clearly indicated in the dismissal notice; and
3. The licensee shall offer and supply copies of the dismissed patient’s dental records upon request by the dismissed patient and/or patient’s guardian, regardless of the patient meeting his/her financial obligation. Offering to supply the patient’s records should be clearly noted, as well, within the termination letter. Supplying records may not be contingent on receipt of payment.
4. **PRACTICE SALE AND CLOSURE NOTIFICATIONS; WAIVER**
5. Licensees who either sell or close a practice shall provide to the Board in writing within 10 days from the date of sale or closure the following documentation:
6. **Practice sale**. If the practice sale includes the transfer of patient records, then contact information including the name, address, phone number of the new owner and/or individual responsible for the patient records shall be submitted to the Board.
7. **Practice closure**. If the practice closure includes the transfer of patient records, then contact information including the name, address, phone number of the individual responsible for the patient records shall be submitted to the Board.
8. **Practice closure**. Submit documentation of the communication tools used such as newspaper ads, social media accounts, email notifications, or letters notifying patients at least 30 days in advance of the closure. The notification shall list specific times for patients to obtain copies of their records.
9. **Board waiver**. The Board retains the authority to waive the requirements where immediate sale and/or closure is a result of sudden illness, incapacity, death, or other cause as determined by the Board.

**II**. **SPECIFIC PRACTICE REQUIREMENTS – ADMINISTRATION OF NITROUS OXIDE ANALGESIA**

1. **DENTAL HYGIENIST RESPONSIBILITIES**
   1. **Limitations**. A dental hygienist who is not authorized to administer nitrous oxide analgesia from the Board may, during nitrous oxide analgesia administration by the dentist, observe the gauges and advise the dentist of any changes in gauge indices or readings but shall not in any way or under any circumstances adjust, manipulate, or control the nitrous oxide apparatus or equipment.
   2. **Authorization**. A dental hygienist issued a permit or authority to administer nitrous oxide analgesia may administer nitrous oxide analgesia utilizing induction via titration and not to exceed 50% concentration under the direct supervision of a dentist.
2. **DENTIST RESPONSIBILITIES**
   1. A dentist who is providing the direct supervision of the administration of nitrous oxide analgesia must:
      1. Decide which patient will receive nitrous oxide analgesia and document this decision by note or prescription in the patient dental record;
      2. Note in the patient dental record the condition of the patient’s recovery prior to the patient’s discharge; and
      3. Utilize engineering controls and maintenance procedures to ensure safety of inhalation equipment.
   2. A dentist who is supervising the delivery of nitrous oxide analgesia or providing the delivery of nitrous oxide analgesia to a patient is responsible to ensure that any nitrous oxide delivery system within the dental practice adheres to the hazard controls recommendations of nitrous oxide during anesthetic administration as established by the following publications of the U.S. Department of Health and Human Services (“DHHS”), CDC, National Institute for Occupational Safety and Health (NIOSH):

(a) DHHS (NIOSH) Publication No. 94-100, “Controlling Exposures to Nitrous Oxide During Anesthetic Administration”;

* + - 1. DHHS (NIOSH) Publication No. 94-118, “NIOSH Warns: Nitrous Oxide Continues to Threaten Health Care Workers”; and

(c) DHHS (NIOSH) Publication No. 96-107, “Control of Nitrous Oxide in Dental Operatories.”

Copies of the foregoing publications may be obtained on line at [www.cdc.gov/niosh/pubs.html](http://www.cdc.gov/niosh/pubs.html), by calling 1-800-356-4674, or by writing to the physical address at:

NIOSH

4676 Columbia Parkway, Mail Slot C-13

Cincinnati, OH 45226

**III**. **SPECIFIC REQUIREMENTS FOR THE USE OF CERTAIN MATERIALS, LASER AND DIGITAL EQUIPMENT**

1. Use and placement of temporary restorations. A licensee shall use temporary restorative material that is not harmful to the tooth, and preferably be fluoride releasing. A licensee shall use the protocols attached to this Chapter as Figure 1 and Figure 2 when placing a temporary restoration with or without the use of a dental radiograph.
2. Use of silver diamine fluoride. A licensee who applies silver diamine fluoride shall obtain written informed consent from the patient (or the patient’s legal guardian). The informed consent will identify the risks, benefits, contraindicators and alternatives to the treatment of silver diamine fluoride.
3. Use of mercury or mercury amalgam. A licensee who uses mercury or mercury amalgam in any dental procedure shall obtain written informed consent from the patient (or the patient’s legal guardian). The informed consent will identify the risks, benefits, contraindicators, and alternatives to the use of mercury or mercury amalgam in dental procedures.
4. Use of lasers and digital equipment devices. A licensee may delegate the use of lasers and digital equipment when both the supervising licensee and the individual subject to the supervision obtain proper training on the use of the device. The use of the device is subject to the limitations of the licensee’s scope of practice, including the limitations of the licensee’s ability to delegate the procedure.

**IV**. **SPECIFIC PRACTICE REQUIREMENTS – INDEPENDENT PRACTICE DENTAL HYGIENE AUTHORITY**

1. Prior to an initial patient visit, an independent practice dental hygienist shall obtain from the patient or the parent or guardian of a minor patient written acknowledgment of the patient's or parent's or guardian's understanding that the independent practice dental hygienist is not a dentist and that the service to be rendered does not constitute restorative care or treatment.
2. An independent practice dental hygienist shall provide to a patient or the parent or guardian of a minor patient a written plan for referral to a dentist for any necessary dental care. The referral plan must identify all conditions that should be called to the attention of the dentist.
3. An independent practice dental hygienist exposing radiographs must have a written agreement with a licensed dentist that provides that the licensed dentist will be available to interpret all dental radiographs within 21 days from the date the radiograph is taken and that the dentist will sign a radiographic review and findings form.

**V**. **SPECIFIC PRACTICE REQUIREMENTS – REFERAL NETWORK**

1. A licensee who provides patient care shall have in place a referral network to handle patient conditions outside of their scope of practice, training, or level of expertise.
2. Referrals shall be made in writing and clearly identify the condition(s) that prompted the referral. The licensee accepting the referral is obligated to use his or her level of training to complete the assessment, diagnosing, and treatment planning for referred patients.
3. Once referred treatment is completed, ethical standards require that the patient is returned to the referring licensee. Patients, however, retain the right to choose their dental provider as long as such provider is willing and able to accept them in their practice.
4. A denturist must immediately refer to a licensed dentist or physician any abnormality or disease process that requires medical or dental treatment observed during oral inspection. In such a case, the denturist shall take no further action to manufacture or place a denture if it may impact the successful outcome of the treatment until the patient has been examined by a dentist or physician. If the examination reveals the need for tissue modification or opposing natural tooth modification in order to assure proper fit of a full denture, the denturist shall refer the patient to a dentist and assure that the modification has been completed before taking an impression for the completion of the denture.

**VI. SPECIFIC PRACTICE REQUIREMENTS – AFTER HOUR PATIENT CARE**

1. A licensee shall make reasonable efforts to establish a network of providers to offer both emergency and non-emergency dental care to a patient after hours.

**VII**. **SPECIFIC PRACTICE REQUIREMENTS – DEVIATION OF PRACTICE STANDARDS**

1. A licensee may deviate from the standards outlined in this Chapter, if the deviation is shown to be reasonable, is based upon physiological conditions or requirements, or responds to specific requests of the individual patient. The reason(s) for any deviation from the standards must be documented in the patient’s records at the time the deviation is made.

**X**. **PRINCIPLES OF ETHICS AND CODES OF PROFESSIONAL CONDUCT**

1. Dentists shall comply with the American Dental Association Principles of Ethics and Code of Professional Conduct, as amended, February 2018.
2. Dental hygienists shall comply with the American Dental Hygienists’ Association Code of Ethics as published in its Bylaws and Code of Ethics, adopted June 13, 2016.
3. Denturists shall comply with the National Denturist Association’s Code of Conduct, Appendix A, as published in its By-Laws dated September 19, 2015.

STATUTORY AUTHORITY:

32 M.R.S. §§ 18324, 18325, 18371, 18372, 18373, 18374, 18374, 18375, 18376, 18377, 18378, 18393

EFFECTIVE DATE

April 5, 2020 – filing 2020-085

**Placement of Temporary Restorations – Dental Radiograph Available**

**Figure 1.**

**Lesion/Fracture Present**

**No Radiographic Exposure or Substantial Root Remaining (Deciduous)**

**Radiograph to Determine the Extent of Pathology or Degree of Root Resorption (Deciduous)**

**Radiographic Pulpal Exposure or Periapical P Periapical Pathology Present**

**Symptomatic**

**Asymptomatic and Presenting Appropriately for Temporary Restoration**

**Refer for Immediate Dental Appointment**

**Do Not Refer**

**Irreversible Pulpitis**

**Reversible Pulpitis**

**Pain Not Relieved When Stimulus Removed**

**Restore and Follow Up Within -30- Days**

**Unprovoked Pain**

**Stimulus Needed to Provoke Pain**

**Pain Waking From Sleep**

**Pain Goes Away When Stimulus is Removed**

**Steady Pain Requiring Medication**

**No History of Toothache Lasting Longer Than Stimulus**

**Stimulus**

**Presence of Fistula or Gingival Swelling**

**Facial Swelling**

**No Interruption of Sleep Patterns**

**Positive Pain on Percussion**

**No Unprovoked Pain**

**No Temporary Restoration - Refer for Treatment or Extraction**

**Place Temporary Restoration and Follow Up Within 30 Days**

**Placement of Temporary Restorations – Dental Radiograph Not Available**

**Figure 2.**

**Lesion/Fracture Present**

**No Radiographs Available**

**Determination of**

**Irreversible Pulpitis**

**(Based Solely on Symptoms)**

**Reversible Pulpitis**

**(Based Solely on Symptoms)**

**No Pulpitis**

**Asymptomatic and Presenting Appropriately for Temporary Restoration**

**(Based Solely on Symptoms)**

**Pain Not Relieved When Stimulus Removed**

**Stimulus Needed to Provoke Pain**

**Unprovoked Pain**

**Steady Pain Requiring Medication**

**Pain Goes Away When Stimulus is Removed**

**Pain Waking From Sleep**

**No History of Toothache Lasting Longer Than Stimulus**

**Presence of Fistula or Gingival Swelling**

**Facial Swelling**

**Positive Pain on Percussion**

**No Interruption of Sleep Patterns**

**No Unprovoked Pain**

**Do Not Place Temporary Restoration - Refer for Treatment or Extraction**

**Place Temporary Restoration and Refer for Restoration**

**Place Temporary Restoration and Refer for Restoration**