

BOARD POLICIES

Advertising/Signage:

1. Inappropriate advertising or incorrect signage (e.g. Dentists/Denturists names not displayed appropriately) will result in the following course of action to assist licensees' in becoming compliant with Board rules:
 - I. A letter, from the Board, will be written to the licensee to bring the matter to their attention.
 - II. A second letter, from the Board, will be written to the licensee asking the licensee to come in to speak with the Board.
 - III. A Board generated complaint will be issued against the licensee (6/27/08)

Auxiliary Staff:

1. It is never inappropriate to give oxygen; all auxiliaries are CPR qualified (02/08/08)

Board Office:

1. Board to be given monthly list of all new licensees.
2. All mail not responded to, will be sent a 2nd notice certified & return receipt.
3. Board meeting material – All material to be streamlined so that all important hard copies are kept and anything else beyond 2 years old will be disposed of.
4. Board meeting materials-In order to be placed on the next available agenda, board meeting materials must be received at the staff office no later than 2 weeks prior to the meeting date. Materials received after that date will be placed on the next available agenda unless they are of an emergency nature or concern a licensure issue. 07/07/09
5. Duplicate licenses will only be issued, upon written request, when the original has been lost or destroyed. (addresses are not an issue)
6. Any irate person that requests to speak to a Board member is to be referred to the Board's counsel.
7. For any requests for personal information from the Board office, the individual must put the request in writing.
8. When Board staff receives a telephone report of a morbidity or mortality issue, staff will request a written report and make a record of the telephone call, so that it can be followed up in case a written report is not received.
9. Malpractice Reports – Anything over a \$20,000.00 settlement needs to be taken to the Board for them to see.
10. "Guidelines for Closing a Practice" – (8/1/03)
 - a. Notification in a local newspaper at least weekly starting 8 weeks prior to closure with specific times listed for patients to obtain copies of their records.
 - b. Written or oral notification of all patients of record to be documented in the charts.
 - c. Written notification of practice closure date to State Board
 - d. Notification to employees at least 8 weeks prior to closure.

Board Office continued:

11. When a licensee is invited in to meet with the Board to discuss an issue, a letter will be sent in follow-up concerning the outcome of that meeting. (10/15/04)
12. Licensees whose names will be submitted as NERB Consultant Members will be invited to the Board for an interview before the name(s) are submitted. (11/19/04)
13. ~~Board staff is advised to always obtain NERB scores on applicants for licensure, including those who are applying by endorsement who have taken the NERB. (6/24/05) Removed per 01/22/10 Board Meeting~~
14. Staff will obtain name change documentation for all new applicants for licensure in all licensure categories. (9/9/05)
15. Informed Consent -- On April 7, 2006, the Board adopted a General Policy Concerning Informed Consent, which includes a "Positional Statement, General Recommendations, Contents of the Consent, and Conclusion". The Policy will be available to anyone upon request and is attached as an addendum to this document.
16. Further Education for Board Staff – the Board may reimburse Employees who engage in further education that will enhance their job performance after first being reviewed by the Board, with any reimbursement and the amount thereof to be determined on a case-by-case basis. (11/03/06)
17. In the case of one-time emergency patients that never return for formal comprehensive care, are they considered "patients of record" of the practice by the Board? The Board agreed that no, the patients would not be considered patients of record. (8/3/07)
18. A.) For patients that are terminated from the practice due to non-payment of account and/or being sent to a collection agency, is the practice required to send the formal termination letter and offer them 30-days of emergency care as is standard for termination for other reasons? The Board agreed yes, the practice should follow the regular standards for dismissing a patient.

B.) If so, is it proper to make an "emergency" appointment available, contingent upon the settling of the delinquent account prior to seeing the patient? No, although the practice can require that the requested emergency visit be paid in full at the time of service. (8/3/07)
19. Board Member Policy – If a Board meeting extends beyond 8:00 p.m. and traveling is greater than 50 miles and/or there is inclement weather, the Board will reimburse the member for overnight stay, up to but not to exceed \$150.00. (9/21/07)
20. Board meeting agendas will be made available to individuals who have requested it, on the Friday before the Board meeting date. If an individual wishes to request a copy of an item on the agenda, this request must be made in writing to the Board office by noon the Wednesday prior to the Board meeting date. Upon appropriate request, Board staff will determine whether the information requested is of public nature. If the information can be released, the request will be honored no later than the morning of the Board meeting date. (10/16/09)

Continuing Education:

1. Any Continuing Education requests that come in to the Board office will be e-mailed to a member of the Board and to a dental hygiene member of the Board and Subcommittee to be determined by the MBDE and the DH Subcommittee for them to review and determine approval. If they do not agree, the request will then go to the Board or the Sub-Committee for their review and recommendation to the full Board. (6/27/03; 5/13/05; and 11/21/08)
2. Dentists and hygienists, who do ~~didactic~~ or clinical teaching in a dental professional program or volunteer their services at either of the two Maine dental hygiene schools, can receive category I credit for clinical supervision, on the basis of one credit for each hour. The maximum allowable per biennium would be ~~ten hours for dentists and 5 hours for hygienists~~, or one-fourth of the total requirements per biennium. To further clarify, dentists and hygienists who do didactic teaching can receive category II credit. (revised 03/19/10)
3. When conducting an audit, the Board will accept the following as proof of continuing education credits: certificates, notes with hours, cancelled checks, airfare, hotel lodging, agenda or schedule of the course, witnesses of attendance (people who sat near them), course ID #'s and codes and listing of attendees by the sponsoring agency.
4. Repetition of the same continuing education course during the same licensing period is unacceptable for continuing education.
5. Grand rounds are not accepted for continuing education credit.
6. Table clinics are accepted for category I credit if clinically related and category II credit if not. (4/8/05)
7. Licensee's who are applying for licensure in another state, and are required to take a clinical examination, cannot apply CE credits for license renewal. (4/7/06)
8. CPR re-certification if provided through the American Red Cross or the American Heart Association can be taken on-line, but only if the skills evaluation is successfully completed in the classroom setting.
9. You need to have BLS (CPR) to take ACLS so ACLS includes CPR and can be used in place of CPR certification.
10. The Board stated that when a licensee is exempt from continuing education for the initial licensure year, the ½ amount of credits that they need do not have to be earned during the license renewal year (i.e. if a dental license was granted in 2006, the dentist must show proof of 20 CEU's, these credits do not have to be earned during 2007). In addition, a residency course would qualify for 20 hours of CE credits for dentists. The taking of a Board Certification Examination, does not qualify for CE credits. A hygienist who completes a local anesthesia course can claim 1 credit per hour. (9/21/2007) Also, a hygienist can claim 1 credit per hour on the nitrous oxide course, not to exceed 10 CEU's.
11. A semester long course for an individual, who has completed post-graduate training within a related dental or medical degree program, can claim 1/2 of a full years credits. (i.e. 7.5 for hygienists; 10 for dentists; and 5 denturists)
12. Dental Hygienists who are attending the EFDA program through York County Community College can claim all credit hours (240 hours). (10/15/2008)

BOARD POLICY FOR CONTINUING EDUCATION

When granted a dental, dental hygiene or denturist license in the first year of the biennial reregistration, the licensee shall complete half of the required continuing education hours according to Chapter 13: Continuing Dental Education, but must maintain CPR certification.

When granted a dental, dental hygiene or denturist license in the second year of the biennial reregistration the licensee is not required to fulfill the continuing education hours according to Chapter 13: Continuing Dental Education, but must maintain CPR. (02/02/07)

Dentists:

1. “This is in regards to the limit on the amount the ASPIRE program will pay as it related to the issue of a dentist of record”. The Board determined that: a provider can build a treatment plan advising the patient up front what can be done for the amount that the ASPIRE program will cover. The provider will then have no further obligation to that patient.
2. Definition of Dentistry – The Board recognizes the American Dental Association’s definition of dentistry, with particular reference to its definition of maxillofacial and oral surgery, “dentistry is being able to diagnose, treat, prescribe or operate for a disease, pain, deformity, deficiency, injury or physical condition of the teeth or jaws or adjacent structures” as consistent with the Dental Practice Act and the Board’s statutes. Otherwise the statute would have to be changed.
3. Provisional anesthesia permits are granted for new applicants pending inspection by anesthesia team. Applications are reviewed by Board President or Board Designee first.
4. **Amalgam Brochure** – failure to comply, either by providing patients with a brochure to take home, or by laminating it and having them read it in the office before providing the services, or failing to display the poster, would be an informed consent issue and would constitute unprofessional conduct. (1/24/03)
5. The administration of Botox is accepted but limited to only those oral and maxillofacial surgeons that are qualified to do so. (1/16/04) (Revised from oral surgeons to oral and maxillofacial surgeons 09/15/09)
6. The use of cosmetic products such as dermal fillers will be limited to properly trained oral & maxillofacial surgeons for use in and around the oral and maxillofacial area. (9/15/06)
7. When the Anesthesia Committee has inspected a dentist’s primary office, including the staff, and it has passed, they only need to do a walkthrough in a satellite office to make sure all the materials are there. (2/27/04)
8. A dental practice or a dental clinic should have at least 60% coverage, (ie. three days out of five), by the dentist.
9. Only a dentist can take virtual impressions by a cadcam procedure. (8/12/05)
10. If you dispense narcotics and/or anti-anxiety drugs, the practice must have appropriate protocols of how to manage the supplies, conducting inventory of the supplies and storage of the supplies. (9/21/07)
11. The Maine Board of Dental Examiners has delegated, and continues to delegate, to Board Staff the review of initial applications and licensure of same when the applicant is a recent graduate unless a ‘yes’ response is given or other issue exists that bears review by the Board before licensure may occur. (07/07/09)

Denturists:

1. Qualifications for Denturist licensure – Graduates from a school with equivalent requirements to George Brown as of their curriculum in 1996. Applicants who graduated prior to 1996 must successfully complete the George Brown upgrade program and/or pass their examination. (see attached list of schools and years accepted)
2. IDEC Distance Learning Program from George Brown College is accepted as equivalent to their regular program for denturist licensure. All other licensure requirements must be met. (1/16/04)
3. Denturist examinations will be conducted yearly by George Brown College. (4/8/05)
4. If all other requirements are met, new denturist graduates do not need to sit for an interview with the Board and their application does not need to be reviewed by the Board. (1/24/03)
5. Board staff will obtain certification directly from George Brown with a school seal as well as a follow-up call to George Brown to confirm. (12/16/03)
6. *New* – All licensed denturists must have a valid, signed certificate of oral condition from a licensed dentist, prior to commencing clinical procedures related to the fabrication of a removable partial denture. (9/18/09)
7. Canadian Denturist Schools accredited by the Canadian Denturist Association are accepted by the Board, but only if the applicant graduated when the school was accredited. (6/28/02)

Although Maine does accept the educations provided by NAIT, George Brown and Eduard Mont-Petit we only have one licensing exam and it is provided by GBC on our behalf. This was set up in 1997 and the first testing was completed in 1998. Each year since then there has been a Maine licensing exam in conjunction with Montana, IDEC and the Royal College of Surgeons in England. This was done to keep costs down and was feasible because all of these jurisdictions recognize the same protocol for examination. Therefore, it doesn't matter which of the recognized programs or schools a student attended they must complete the Maine Denturist Licensing exam which is contracted to GBC. The only other exception is license by endorsement and a candidate must have been licensed in another jurisdiction for three years prior to being eligible for this type of license. You can contact the College directly at 1-416-415-5000 ext 4792.

Accredited Denturist Schools

George Brown College – (1996 – Renewal)

Toronto, Ontario (before 1996 the George Brown upgrade is required)

College Edouard-Montepetit – (1996 – Renewal)

Longueuil, Quebec

Northern Alberta Institute of Technology – (1996 – Renewal)

Edmonton, Alberta

Nova Scotia Community College – 1998 to 2002 are acceptable (status expired 6/30/02)

Dartmouth, Nova Scotia

As of April 4, 2006 (per Canadian Denturist Association)

Vancouver Community College – Accredited 2005

Northern Alberta Institute of Technology – Accredited 1999/ Re-Accredited 2005

George Brown College – Accredited 1999 / Review Scheduled for 2006

College Edouard Mont-Petit – Accredited 1999 / Review Scheduled for 2006

Disciplinary Information:

1. It will be Board policy to recover all costs when a complaint is resolved by Consent Agreement and, in some instances, for informal conferences that do not result in a Consent Agreement. (8/1/03)
2. Courses for consent agreement compliance will be accepted on a case-by-case basis to be approved by the Board or the Board's complaint officer. (11/03/06)
3. When a licensee enters into a Consent Agreement and the licensee is required to send in any type of reporting requirement(s), those reports will be reviewed by the Complaint Officer for the case. If the Complaint Officer is no longer on the Board, the current Complaint Officer will review the information. (2/17/06)
4. Although not considered formal discipline, copies of all letters of guidance will be kept for a period of five years. (8/12/05)

Hygienists:

(IPDH-Independent Practice Dental Hygienists)

1. School transcripts will be accepted in lieu of the IPDH-1 form (Education Requirements page) as long as they are an original, official transcript, signed by the Dean or Secretary of the school bearing the school seal, and received directly from the school (no photocopies and not included with your application). (06/27/08)
2. An IPDH can work for, or be employed by a non-profit organization providing independent practice dental hygiene services. (11/21/08)
3. An IPDH can hold Public Health Supervision (PHS) Status; they must submit a notification form, have a supervising dentist, be assigned a project number and submit reports in the same manner as an RDH. (10/10/08)
4. An IPDH can employ another IPDH, however, an IPDH may not employ an RDH. (10/10/08)
5. See Stand Alone Document for Information regarding Referral Networks and IPDH. (04/03/09)

Hygienists:

(RDH-Registered Dental Hygienists)

1. Air abrasion by dental hygienists is not acceptable in preparation for sealants. This does not disallow air polishing by dental hygienists.
2. Brush biopsies are not an allowable Hygiene procedure. (01/11/08)
3. Board staff requested clarification as to whether the use of lasers is an allowable procedure for a licensed dental hygienist. The Board agreed that a dental hygienist is able to use a laser **for delegable procedures**. (05/12/06)
4. Regarding Public Health Supervision -- Nontraditional hours or working outside the regular dental practice could be considered a non-traditional setting.
5. The final re-take of local anesthesia exam, use first exam again, but with questions in different order than first exam.

Hygienists continued:

(RDH-Registered Dental Hygienists)

6. If a hygienist has failed the local anesthesia exam three times, they must wait for a period of 3 months and then provide documented evidence of remediation through either a CODA approved dental hygiene program or continuing education credits amounting to 20 related to local anesthesia. They can then re-take the exam. (8/1/03)
7. Upon completion of an approved local anesthesia course, the hygienist has one year to take the Board examination. If it has been more than a year, the applicant would need to sit for an interview with the Board. (5/16/03)
8. The most senior hygiene member of the Board will be appointed by the Board President to serve on the Dental Hygiene Sub-Committee with the hygienist having the option to continue on the Sub-Committee. (10/14/05)
9. Hygienists (RDH/IPDH's) are not allowed to use lasers to perform bleaching as this is not within their scope of allowable duties. (6/27/08)
10. Hygienists may perform soft tissue curettage, using a laser, under the General Supervision of a Dentist. (6/27/08)
11. The Dental Hygiene Subcommittee has delegated, and continues to delegate, to Board Staff the review of initial applications and licensure of same when the applicant is a recent graduate unless a 'yes' response is given or other issue exists that bears review by the subcommittee before licensure may occur. (07/07/09)

Board Policy on IPDH Referral Networks

As recent legislation has created a new category of licensee – the Independent Practice Hygienist - the Board feels it is prudent and helpful to place some of its concerns and expectations about IPDH referrals into a policy position. Licensees are reminded that Board policy does not carry the enforcement capability of Board rules or the statute that regulates the practice of dentistry, hygiene, and denturism. Board policies are meant to be informative for licensees as to what the Board expects should occur in areas that are not clearly defined in rule or statute. As such, Board policies are often fluid documents that develop over time. When dealing with new privileges and expanded scopes of practice, the Board often feels the development of policies should precede changes in rules and/or statute.

The creation of the IPDH category is a major change in the way hygiene services can be delivered to the citizens of Maine. The Board of Dental Examiners wishes to express its strong feeling that independently practicing dental hygienists will be taking on a whole new level of patient responsibility. If the concept works as presented to the legislature, many Maine citizens who are currently receiving no dental care will be establishing a provider/patient relationship with their chosen IPDH. The Board hopes these will be ongoing relationships as the continuity of care is critical to achieving optimal oral health. As such, IPDH licensees will be the primary care providers for these patients. Many of these patients will have dental needs that are beyond the scope of practice for the IPDH. Recognizing conditions that may be detrimental to a patient's oral health has long been a function of the practicing dental hygienist. Traditionally these conditions have been brought to the attention of a supervising dentist whose responsibilities to the patient include appropriate diagnosis, treatment and/or referral. The result was that the patient's needs were clearly identified and options for treatment were available.

With the IPDH being the primary care provider, the Board expects that the independent practicing dental hygienist will have in place a referral network of dental professionals to handle conditions outside of their scope of practice. Such referral network should include restorative dentists, and specialists such as oral surgeons, periodontists, endodontists, orthodontists, and denturists. This expectation is no different than that of general dentists who, until now, have been the main primary dental care providers.

Referrals should be made in writing and clearly identify the condition that prompted the referral. The licensee accepting the referral is obligated to use his or her level of training to complete the diagnosis process. He or she will then treat for the referring condition and be responsible for only that portion of the patient's care they provide. If additional oral health conditions are identified, it is the responsibility of the second provider to inform the patient, but not to treat the additional conditions unless an agreement between patient and the second provider is reached.

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.

The Board recommends that appropriate informed consent is obtained by the licensee accepting the referral clearly identifying the procedures that are being performed. Such consent may also clearly state that the referred patient will not be a "patient of record" of the licensee accepting referral, but will be returned to the referring entity once treatment is complete.

The Board has high expectations the IPDH licensees will create this referral network. It is in the best interest of the patient and will go a long way to ensuring that IPDH in Maine will be successful and beneficial.

Informed Consent

Positional Statement

The Board of Dental Examiners and the malpractice insurance carriers look at the process of informed consent from completely separate viewpoints. The insurance industry is concerned with developing defensible positions should an insured face litigation. The Board of Dental Examiners is concerned that Maine citizens are appropriately educated and informed about dental treatment being offered so that they may make an informed choice on issues that directly affect them or their family members. This position of the Board is not intended to address the legal standard of informed consent.

In general terms, consent represents a form of approval or permission, and it consists of two basic types:

1. 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. Expressed consent is a more formal type of permission founded on words, either oral or written, and it applies to more invasive procedures. The so-called written informed consent is an expressed consent in written form which includes the signature of (at least) both the health care professional and the patient (or the patient's legal guardian). The written informed consent is particularly beneficial to the health care provider if questions concerning treatment should develop.

The Board recognizes that both the implied and the expressed consent have their place in the practice of dentistry.

General Recommendations

It's fair to say that malpractice insurance carriers would like their insured to secure the most comprehensive expressed consent as possible before embarking on a specific treatment plan. Often this advice is most appropriate and helpful for both the health care provider and the patient. Nevertheless, the Board understands that it is not always practical and often not necessary to treat all patient-directed activities the same.

For the dental specialist performing a particular related procedure, the written informed consent is considered the "standard of care". Specific specialty procedures are often of a more complex nature and harbor very particular, possible complications. Both the nature of the procedure and the potential complications associated with that procedure should be understood by the patient prior to embarking on treatment. It would be expected that the prosthodontist, endodontist, oral and maxillofacial surgeons, orthodontists, and periodontist have their patients properly informed and sign a written informed consent. In addition, it would be expected that the informed consent be procedure specific.

The nature of general dentistry, and much of pediatric dentistry, excludes the need for expressed consent for some procedures. Procedures which seem adequately covered by the implied consent include: (in addition to consultations, diagnoses, and examinations noted above) administration of fluoride, oral hygiene, placement of sealants, and basic restorative procedures. However, these treatment plans which involve more advanced treatment, i.e. those procedures included within the specialties but performed by the general dentist or pediatric dentist, should be covered with an expressed consent in the form of a written informed consent. This includes periodontal, endodontic, orthodontic, prosthetic, and oral and maxillofacial procedures. It should be noted that general dentists are held to the same standard of care as their specialist colleagues.

Contents of the Consent

If a particular procedure requires a consent which is expressed (oral and charted or written and signed), it should contain specific elements which make it complete. The following should be included and well documented either within the chart or on a separate consent form:

1. the complete diagnosis
2. the recommended treatment plan and/or procedure(s)
3. all realistic treatment options
4. common and/or significant possible complications

Although the implied consent, per se, need not be documented within the chart, it is wise and prudent to consider incorporating within the chart discussions which the professional had with the patient prior to treatment. This may include any or all of the above. For example, in light of Maine's amalgam information law, it would be most appropriate to document instruction concerning amalgam restoration and possible alternatives.

Conclusion

The need for the Board to establish this position on informed consent arises from the significant changes that have occurred in dentistry in the last decade. More and more general dentists are offering more and more involved care to patients. The Board recognizes that with proper training and education this provides the public with additional sources of advanced care needed to achieve and maintain oral health. At the same time it becomes necessary to ensure that the public is well informed of its options and possible complications arising from such procedures and treatment plans. As a result, the Board expects 10.5

implied consent or expressed consent prior to patient treatment for all patients utilizing the guidelines outlined above.

Licensing:

1. Radiology licensure – The Board voted to accept in lieu of the DANB exam for radiology licensure, official transcripts from any dental, dental hygiene, or dental assisting CODA approved program, demonstrating successful completion and submitting the syllabus of the radiology courses, which would include passing a final exam.
2. The 8 1/2" x 3 5/8" renewal license (biennial registration card) issued to a licensee must be displayed at the place of employment. (08/15/2008)
3. Each licensee may possess only one current biennial registration card, therefore, licensees who work in multiple practices should display the original license at their primary place of practice and may photocopy and display the photocopy at the other locations. (08/15/2008)
4. A “program seal” is sufficient for licensure for hygienists at University College of Bangor if a school seal is not available, for school transcripts.
5. Licensees who are reactivating their licenses and who have been practicing in another state or states, letters of good standing should be received from those states.
6. Canadian Dentists – 3 years or more of practice qualifies in lieu of NERB for licensure. However, the candidate must have successfully completed another regional or state exam. (2/28/03)
7. The Canadian National Boards are equivalent to the American Nationals.
8. The licensee has to have an interview before the Board to convert a license from “Inactive” to “Active”. (Must also complete an application, but not all the accompanying material)
9. The Board will waive an interview for reinstatement of a license if application is made within the two-year period following lapse or withdrawal of license. Board Staff and the current Board President will review the applicant’s reinstatement paperwork. If there is any issue such as a “yes” response, it may be taken to the Board for further review. All reinstatement applicants will be required to sit for an interview with the Board and/or Subcommittee when it has been two years or more. (12/14/07) (modified 07/07/09)
10. No refunds for initial applications.
11. A refresher course and/or skills assessment, at the Board’s discretion, is required when the licensee has been inactive or out of practice for 5 years. (1/13/06)
12. Staff will begin to conduct criminal background checks on all applicants for licensure. The applicant will be charged the fee(s) and it will be so noted on the application form or cover letter sent to the applicant. The appropriate fee(s) will be assessed after the application is received, but the application process will not be held up while waiting for the response to the background check, which can take months. An exception to that might be when the applicant him/herself provides a “yes” response to the corresponding question on the application form and, from the explanation the matter appears to be of a serious nature. In that situation, the application may be held up while waiting for the response. If a negative response is received after licensure has been granted, the Board has the option of issuing its own complaint against the licensee. (8/1/03) **Reinstated as of 10/14/05. Applicants will need to provide a list of the last 10 states where they have resided and submit background checks for those states. The contact information for obtaining background checks will be provided to them with their applications.**

Licensing continued:

13. “Yes” Responses – All “yes” responses will be reviewed by the Board’s Executive Secretary. The Executive Secretary will determine any that need further review by the Board President; the Board President will in turn make a determination as to whether the matter needs to be reviewed by the full Board. (2/16/07)
14. Residency programs do count towards years of active clinical practice. (1/14/05)
15. Temporary Permit – We need a request from a charitable or social organization; proof of dental degree directly from the school; and, a letter from the candidate why they need the permit and when they plan to take the examination.
16. When making a request to NERB for an applicant to complete only certain sections of their exam, it must be noted in the applicant’s cover letter that they must request the same on their NERB application. However, the Board must also send a letter to NERB on behalf of that applicant.
17. A copy of someone’s NERB Certificate is not acceptable in lieu of the actual scores. (8/12/05)
18. Radiographers and Denturists have the option of holding an inactive license. (5/13/05)
19. Under Board approved Externship Programs, for any temporary permits, including those that require renewal, Board staff will have the authority upon review by the Board President of the appropriate documentation to issue the permit and/or extend the permit. Board staff will include copies of documentation, i.e. letters sent to the entity, in the “Correspondence” tab for the following meeting of the full Board. (2/16/07)
20. Impaired practitioners – At renewal time, any licensee who is known to have a problem with alcohol or drug abuse, will not be issued the renewal unless a contract is signed with the Committee on Physician Health outlining an agreement for monitoring their recovery and the licensee is in full compliance with this agreement.
21. Renewal applications for licensees who have not practiced for five years but have been renewing their licenses in active status and submitting their continuing education credits do not need to come before the Board. (1/24/03)
22. **Renewals** – If there is an open complaint during renewal time, the renewal application will be pended by Board staff. If pended, a letter will be sent to the licensee informing them that until the final outcome of the complaint, the licensee is able to practice under their current license pursuant to Title 5; Chapter 375 § 10002. (2/16/07) A second letter will be generated as a courtesy letter with no indication of an open complaint, so that the licensee is able to provide this copy to others. (12/14/07)

Patient Dismissal from a Dental Practice

Although the practice of dentistry attempts, flourishes, and requires a healthy relationship between the patient and the practicing dentist/hygienist/denturist, this is not always achievable. Various circumstances, including but not limited to, patient cooperation, financial delinquency, and interpersonal interactions, can preclude amicable interactions. As a result, it may be necessary from time to time, in the best interest of both the patient and the dental professional, to part ways. Although all patients are not by definition patients of record, those that are patients of record and have not lived up to the policies set by the practice may be dismissed from the practice without a formal written reason.

Proper dismissal requires a notice of such be sent to the patient and/or patient's family (if applicable) by certified return/receipt mail. Although formal termination is effective as of the date of the letter, the practitioner must offer the patient (patient's family) a 30 day emergency care period from the date of formal termination. The date of final termination, identifying the end of the 30 day emergency grace period, must also be clearly indicated in the termination letter.

As in all other patient transfers, the terminating practitioner must offer and supply copies of the dismissed patient's dental records upon request by the dismissed patient, whether or not the patient has met his/her financial obligations. Offering to supply the patient's records should be clearly noted, as well, within the termination letter. When a practitioner has dismissed a patient from the practice, a nominal fee for supplying the copied records may be charged to the patient, but the cost of copying and supplying records may not be contingent on receipt of payment. Failure to send or supply copies of requested dental records is considered a breach of Maine's Dental Practice Act.

Board of Dental Examiners
September, 2007

Record Keeping Guidelines

One of the primary functions of the Maine Board of Dental Examiners (the Board) is to thoroughly evaluate and make decisions on complaints submitted to the Board. In order to objectively and forthrightly deliberate the issues involved, the Board relies in part, but to a great extent, on the records submitted by licensees of the Board. These records are of significant value to the health care provider, patient, and authorized third party payer(s) in the identification and delivery of appropriate and quality health care. Moreover, the overall dental record is an important component of caregiver defense when legal issues arise in the medical/dental arena. This document (Record Keeping Guidelines) is intended as a set of guidelines only; it is not brought forth, or to be construed, as a standard of care.

General Information

When it comes to documentation, particularly in the area of record keeping, it is perhaps unfortunate but true that “if it’s not documented, it didn’t occur”; that’s the mind-set of the legal world. Thus it becomes imperative that the dental caregiver identify and record all pertinent information in the patient’s chart. The dental record should be contemporary, chronological, accurate, and legible. Admissions to the chart need not be limited to the dentist of record but may include entries by hygienist, assistant, and front office personnel. All entries should be dated and include the initials or names of those making the report and, when appropriate, countersigned by the dentist responsible for care.

There are no standards or particular guidelines that serve all dental procedures or dental personnel. Patients who are evaluated and treated for a specific problem (such as an emergency, a second opinion or an isolated consultation) may not constitute “a patient of record” in comprehensive dental terms (i.e. dental home). As such, these patients may correctly be seen for limited dental care and need not have the type of examine, diagnosis and treatment plan expected by the dental care provider who commits to general, comprehensive care. Nevertheless, problem oriented care is expected to include all information necessary for complete and thorough treatment of the specific problem. In addition, the patient or patient’s guardian should be informed of the limited nature of the dental evaluation and treatment and be advised to seek comprehensive care when indicated.

The Dental Record

As previously noted, various members of the dental team may have access to and record in the dental chart. This begins as early as the first phone call or first visit to the dental office when the patient (through the receptionist) identifies basic personal information (i.e. name, DOB, telephone number, address, referral, chief complaint and perhaps significant medical history). This initiates the permanent dental record. In addition to this basic information, the patient’s record should include the following information:

Medical History

The medical history should be pertinent to any possible dental treatment. Many dental offices include within the medical history a standardized list of questions and/or medical conditions for the patient to complete or identify prior to initial consultation with the healthcare provider. Completion of this form does not relinquish the dentist’s/hygienist’s responsibility to further question the patient in order to clarify or identify the extent of the patient’s medical condition. The medical history should specifically include a list of all allergies and current medications. The past medical history needs to be complete with past and current diagnoses as well as previous surgical procedures/hospitalizations. The patient’s family physician should be recorded in the case of medical consultation or emergency. At times, it may be prudent to have a formal letter or note from the attending physician concerning the patient’s diagnoses and/or potential issues to address with treatment (such as the need for prophylactic antibiotics).

Patients with follow-up visits should have the chart reviewed and updated for possible changes and/or additions to the medical history.

Dental History

In addition to the medical history, a thorough dental history needs to be part of the chart. For those acting as the “dental home” for the patient, this should be complete and up-to-date. For those consulting for or treating an isolated problem (such as endodontics or oral surgery), the dental history should comprehensively address the dental history related to the specific problem at hand. Of importance to all practitioners, but often neglected, is the history surrounding oral hygiene and habits, orofacial trauma, and temporomandibular dysfunction (TMD).

Patient Examination

A natural follow-up to the medical/dental histories is the patient’s clinical examination. If there is a recorded or stated chief complaint, the initial exam may be limited to this concern. However, the dental caregiver would be remiss if a general (albeit limited), orofacial exam were deferred. This is an excellent opportunity to identify other dental issues of significance.

For those practitioners providing a dental home for a patient, this exam should be complete with charting of dental caries, current restorations, and periodontal status. Soft and hard tissue evaluation, including TMD assessment, as well as radiographic examination, are all important issues leading to a complete dental examination.

Of particular importance to proper dental treatment and overall health of the patient is the identification and recording of the patient's current blood pressure and pulse. Every patient (when possible) should have the blood pressure and pulse taken and recorded, both initially and before the administration of drugs (i.e. local anesthetics, oral sedatives, etc.) that can possibly affect the patient's vital signs. The dental professional has the unusual opportunity to identify those patients who have potentially life limiting problems (such as hypertension and cardiac arrhythmias) that have previously gone undiagnosed.

Correspondence and Laboratory Documents

Any correspondence(s) (such as consults) and/or laboratory report(s) or authorization(s) concerning the patient to be or in the midst of treatment represent a vital part of the dental chart. These correspondences or laboratory documents can be filed elsewhere but should be noted on the chart in a chronological and contemporaneous manner.

Treatment plan and Informed Consent

Following the history and physical examination, the diagnosis or diagnoses should be clearly established and a prioritized treatment plan developed; both should be recorded. At this point, the dentist is obligated to inform the patient of the diagnosis and explain to the patient the need and/or benefits of treatment. Treatment options should be stated and recorded as well. When defining the treatment or treatment options, the risks and expected results (without guarantees) should be clearly stated and recorded. Depending on the situation to be addressed, every patient should have an implied or written informed consent completed. (The Board has previously produced guidelines for *Informed Consent* which can be obtained "on-line" or through the Board's office.) Both the treatment plan and the informed consent are essential parts of the overall dental record.

Progress Notes

Progress notes are a key element to a complete and up-to-date dental record. Each patient visit should be dated and recorded chronologically and contemporaneously. Although the progress note represents the record of ongoing treatment (by the dental home), the form of the progress note can also be used by the dental practitioner who is evaluating and treating the patient for limited care (i.e. consults, isolated endodontic or oral surgical treatment, etc.). A simple mnemonic which helps to make this note complete is the **SOAP** note or entry:

"S" stands for "subjective information", that information related to the dental practitioner by the patient which clearly states how the patient is feeling dentally. Positive, as well as negative, statements and/or *symptoms* elicited from the patient should be recorded here. This is the ideal place to identify the patient's chief complaint; it is also the appropriate location to record the patient's pleasure with dental treatment. Any change in the patient's medical history can be noted here (as well as in the area designated as past medical history).

"O" represents the "objective findings" noted by the dental professional, medically referred to as the *signs*. Recording the signs completely and objectively assists the dental professional in decision making as well as helps to support the dentist/hygienist medical legally if untoward events should develop.

"A" indicates the "assessment" of the dental (or medical) situation made by the dentist. Here the diagnosis or, if the diagnosis is unknown, a differential diagnosis is clearly stated.

At some point, the treatment offered (Tx) needs to be recorded in the dental record. This is as good a place as any to record the treatment performed. Within this entry the treatment carried out, the type of materials used, and all drugs administered (including the type and amount of local anesthetic) are noted.

"P" refers to the "plan" for future treatment or follow-up care. Any change or deviation from the treatment plan should be noted here as well. For those offering limited care, this entry may simply represent no further need for follow-up visits unless a problem should develop.

Patient Dismissal

If a patient is dismissed from the dental practice, an appropriate letter of dismissal should be sent to the patient and retained within the dental chart. The suggested contents of the dismissal letter has been broached by the Board and can be obtained through the Board office.

If the patient should request the dental records to be sent to another dentist, upon receipt of a signed, written request by the patient, a copy of the records and a duplication of the x-rays should be sent in a timely manner for a reasonable charge. Original records and x-rays are the property of the dentist (who made the records and/or took the x-rays) and they should be retained by the dentist of record.

Conclusion

Record keeping is an important and vital part of overall dental treatment; it aids in the protection of both the patient and the dental professional. This set of guidelines represents only a brief overview on the topic; it is neither meant to be all inclusive nor meant to establish a standard of care. More in-depth information concerning record keeping can be found through various publications and educational lecture presentations.