# RULES OF

**TENNESSEE BOARD OF DENTISTRY**

665 Mainstream Drive

Nashville, TN 37243

|  |  |
| --- | --- |
| ***Chapters*** | ***Title*** |
| 0460-01 | ………………………………………….…………..………………………………….General Rules |
| 0460-02 | …..…………………………………………………….Rules Governing the Practice of Dentistry |
| 0460-03 | …….……………………..…………….…….Rules Governing the Practice of Dental Hygienists |
| 0460-04 | …..……………………………………………Rules Governing the Practice of Dental Assistants |
| 0460-05 | ….................................................General Rules Governing Schools, Programs and Courses for Dentists, Dental Hygienists, and Registered Dental Assistants |
| 0460-06  through 0460-14 | ……………….……………………………………………………………………….……..Repealed |

# ADMINISTRATIVE HISTORY

Original Chapters 0460-01 through 0460-05 were certified on June 7, 1974, under Chapter 491 of the Public Acts of 1974 as rules in effect when Chapter 491 became effective. The Administrative History following each rule gives the date on which the rule was certified, or the date on which the rule was filed and its effective date, if promulgated after March 11, 1974. The Administrative History after each rule also shows the dates of any amendments or repeals.

Amendment to rules 0460-01-.11 and 0460-02-.11 filed February 5, 1975; effective March 7, 1975.

Original chapter 0460-07 filed November 22, 1978; effective January 8, 1979.

Chapter 0460-07 filed January 22, 1979; effective May 1, 1979.

Repeal of rules 0460-01-1-.01 through 0460-01-01-.04 and 0460-02-01-.01 through 0460-02-01-.03 and

new rules filed August 26, 1980; effective December 1, 1980.

Repeal of rules 0460-01-01-.05 through 0460-01-01-.20, 0460-02-01-.04 through 0460-02-01-.17, 0460-

04-01-.01 through 0460-04-01-.03, 0460-04-01-.13 and 0460-04-01-.14 filed August 26, 1980; effective

December 1, 1980.

Amendment to rules 0460-04-01-.04 through 0460-04-01-.12, 0460-05-01-.01 through 0460-05-01-.09,

0460-06-01-.01, 0460-04-01-.03, 0460-04-01-.13 and 0460-04-01-.14 filed August 26, 1980; effective

December 1, 1980.

Amendment to chapters 0460-09 through 0460-13 filed August 26, 1980; effective December 1, 1980.

Amendment to rule 0460-01-01-.03 filed December 2, 1980; effective March 31, 1981.

Amendments to rules 0460-01-01-.02, 0460-01-01-.03, 0460-01-01-.04, 0460-02-01-.01, 0460-02-01-.02,

0460-04-01-.05, 0460-06-01-.01, 0460-10-01-.02 and 0460-11-01-.01 filed October 13, 1983; effective

November 14, 1983.

Amendment to rule 0460-07-.02 by Public Chapter 969, effective July 1, 1984.

Amendments to rules 0460-01-01-.01, 0460-02-01-.03, 0460-06-01-.01 and 0460-06-01-.02 and repeal of

chapter 0460-11 and new chapter 0460-11 filed September 13, 1985; effective October 13, 1985.

Amendments to rules 0460-01-01-.01, 0460-01-01-.02, 0460-01-01-.04, 0460-02-01-.01, 0460-02-01-.02,

0460-05-01-.07, 0460-05-01-.08 and 0460-10-01-.02 filed September 24, 1987; effective November 8,

1987.

New rules 0460-07-.01 through 0460-07-.07 filed September 24, 1987; effective November 8, 1987.

Amendment to rules 0460-01-01-.02, 0460-02-01-.01 and 0460-02-01-.02 filed June 8, 1989; effective

July 23, 1989.

Amendment to rules 0460-01-01-.03 and 0460-02-01-.03 filed September 21, 1989; effective November

5, 1989.

Amendment to rule 0460-6-01-.01 filed November 9, 1989; effective December 24, 1989.

New rule 0460-09-.04 and amendment to rules 0460-01-01-.02 and 0460-02-01-.01 filed November 30,

1989; effective January 14, 1990.

Original rule 0460-09-01-.05 and original chapter 0460-14-01 filed January 29, 1990; effective March 15,

1990.

Repeal and new rules 0460-06-.01 and 0460-06-.02; original rules 0460-06-.03 through 0460-06-.06 filed

February 28, 1991; effective April 14, 1991.

Amendments to rules 0460-01-01-.03, 0460-02-01-.01 through 0460-02-01-.03, 0460-06-01-.01 and

0460-09-01-.04 filed April 30, 1991; effective June 14, 1991.

Original rule 0460-06-01-.07 and amendment to rule 0460-09-.01 filed May 7, 1991; effective June 21,

1991.

Repeal of and new chapters 0460-01, 0460-02, 0460-03, new rules 0460-04-.04 through 0460-04-.12,

0460-05-.01 through 0460-05-.09, 0460-06-.01 through 0460-06-.03, 0460-06-.05 through 0460-06-.07,

0460-07-.01 through 0460-07-.07, and repeal of Chapter 0460-09 through 0460-014 filed December 11,

1991; effective January 25, 1992.

Amendment to rule 0460-02-.11 filed June 20, 1994; effective September 3, 1994.

Amendment to rules 0460-01-.05, 0460-02-.11, 0460-03-.02, 0460-04-.01 and 0460-04-.02 filed June 29,

1994; effective September 12, 1994.

Amendment to rule 0460-01-.02, 0460-01-.04, 0460-01-.05, 0460-03-.02, 0460-03-.02, 0460-03-.07,

0460-04-.02 and 0460-04-.04 filed December 5, 1994; effective February 18, 1995.

Amendment to rule 0460-04-.04 filed October 17, 1995; effective December 31, 1995.

Amendment to rules 0460-01-.01, 0460-01-.06, 0460-02-.08, 0460-03-.07 and 0460-04-.06; repeal of

chapter 0460-05-01 and rule 0460-06-01-.04 filed February 12, 1996; effective April 27, 1996.

Amendment to rules 0460-01-.02 through 0460-01-.05, 0460-02-.05, 0460-02-.09, 0460-03-.03, 0460-03-

.08, 0460-04-.03, 0460-04-.04 and 0460-04-.07 filed March 20, 1996; effective June 3, 1996.

Amendment to rules 0460-01-.03 through 0460-01-.06, 0460-02-.01 through 0460-02-.07, 0460-02-.10,

0460-02-.11, 0460-03-.01 through 0460-03-.06, 0460-03-.09, 0460-04-.02 through 0460-04-.04 and 0460-

04-.08 filed May 15, 1996; effective September 27, 1996.

Amendment to rule 0460-01-.02 filed September 26, 1996; effective December 10, 1996.

Amendment to rule 0460-01-.05 and 0460-04-.01 filed October 9, 1997; effective December 23, 1997.

New rule 0460-01-.08 and 0460-01-.09 filed September 4, 1998; effective November 18, 1998.

Amendment to rules 0460-01-.01, 0460-01-.06, 0460-02-.06, and 0460-02-.10 filed December 7, 1998;

effective February 20, 1999.

Amendment to rules 0460-01-.01, 0460-01-.02, 0460-01-.05, 0460-01-.07, 0460-02-.01, 0460-02-.03,

0460-02-.11, 0460-03-.01 through 0460-03-.03, 0460-04-.01, and 0460-04-.02 filed February 9, 2000;

effective April 24, 2000.

Original rule 0460-01-.17 and amendment to rule 0460-01-.06 filed February 15, 2000; effective April 30,

2000.

Amendments to rule 0460-04-.02 filed March 14, 2001; effective May 28, 2001.

New rule 0460-01-.07 and amendment to rules 0460-01-.03, 0460-01-.04, 0460-01-.06, 0460-02-.03,

0460-02-.06, 0460-02-.08, 0460-03-.01, 0460-03-.02, 0460-03-.03, 1460-03-.07, and 0460-04-.06 filed

April 10, 2001; effective June 24, 2001.

Amendment to rules 0460-02-.05 and 0460-03-.05 filed August 28, 2001; effective November 11, 2001.

Repeal and new rule 0460-01-.02 and amendment to rules 0460-01-.03, 0460-01-.05, 0460-02-.03, 0460-

02-.05, 0460-03-.02, 0460-03-.03, 0460-03-.05, 0460-04-.02, and 0460-04-.03 filed April 10, 2002;

effective June 24, 2002.

Amendment to rules 0460-01-.01, 0460-01-.02, 0460-01-.06, 0460-01-.10, 0460-02-.08, 0460-02-.09,

0460-03-.07, 0460-03-.08, 0460-04-.06, and 0460-04-.07 filed August 21, 2002; effective November 4,

2002.

Amendment to rules 0460-01-.01, 0460-02-.07, 0460-03-.06, and 0460-04-.05 filed February 18, 2003;

effective May 4, 2003.

Amendment to rule 0460-01-.02 filed March 17, 2003; effective July 29, 2003.

Amendment to rule 0460-01-.02, 0460-01-.05, 0460-01-.08, 0460-01-.09, 0460-01-.11, and 0460-01-.16

filed June 13, 2003; effective August 27, 2003.

Amendment to rules 0460-01-.05 and 0460-04-.04 filed June 18, 2003; effective September 1, 2003.

Amendment to rule 0460-01-.05 filed July 22, 2003; effective October 10, 2003.

Notice of Withdrawal to rule 0460-01-.05 of subparagraph (3)(c) filed and effective September 24, 2003. Amendment to rules 0460-01-.02, 0460-01-.05, 0460-02-.02 through 0460-02-.06, 0460-02-.08, 0460-03-

.04, 0460-03-.05, 0460-03-.07, and 0460-04-.06 filed August 18, 2003; effective November 1, 2003.

New rules 0460-05-.01 through 0460-05-.03, and 0460-04-.09 and amendment to rules 0460-01-.01,

0460-01-.02, 0460-03-.06, 0460-03-.09, 0460-04-.04, 0460-04-.05, and 0460-04-.08 filed September 17,

2003; effective December 1, 2003.

Original rule 0460-02-.12 and amendment to rules 0460-01-.02, 0460-01-.13, 0460-02-.01, 0460-02-.03,

0460-02-.05, and 0460-02-.11 filed October 20, 2003; effective January 3, 2004.

Amendment to rules 0460-01-.01 and 0460-02-.06 filed November 17, 2003; effective January 31, 2004.

Amendment to rules 0460-01-.12 and 0460-02-.11 filed May 28, 2004; effective August 11, 2004.

Amendment to rules 0460-01-.01, 0460-01-.02, 0460-01-.06, and 0460-02-.06 filed June 18, 2004;

effective September 1, 2004.

Amendment to rules 0460-01-.03, 0460-02-.06, and 0460-03-.02 filed July 21, 2004; effective October 4,

2004.

Amendment to rule 0460-01-.06 filed August 27, 2004; effective November 10, 2004.

Amendments to 0460-01-.01, 0460-01-.02, 0460-01-.05, 0460-01-.06 and 0460-02-.07 and new rule

0460-01-.18 filed December 28, 2004; effective March 13, 2005.

Amendments to rules 0460-01-.01, 0460-01-.05, 0460-03-.09, 0460-04-.08, 0460-05-.02 and 0460-05-

.03; and original rules 0460-03-.10 and 0460-04-.10 filed August 3, 2005; effective October 17, 2005.

Amendments to rules 0460-01-.01, 0460-01-.05, 0460-02-.01, and 0460-03-.02; and repeal and new rules

0460-01-.14 and 0460-01-.15 filed August 23, 2005; effective November 6, 2005.

Original rules 0460-02-.13 and 0460-03-.11; and amendments to rules 0460-01-.02, 0460-02-.01, 0460-

02-.06, and 0460-04-.03 filed December 16, 2005; effective March 1, 2006.

Amendments to rules 0460-02-.01, 0460-02-.02, 0460-02-.03, 0460-03-.01, 0460-03-.02, 0460-03-.03,

and 0460-04-.02 filed March 17, 2006; effective May 31, 2006.

Repeal of rule 0460-01-.09; repeal and new rule 0460-01-.08; and amendments to rules 0460-01-.03, 0460-01-.06, 0460-02-.05, and 0460-03-.05 filed April 5, 2006; effective June 19, 2006.

Amendments to rules 0460-01-.05, 0460-02-.03, 0460-02-.06, and 0460-02-.07 filed July 10, 2006;

effective September 23, 2006.

Amendments to rules 0460-01-.01, .02, .14; 0460-03-.09, .10, 0460-04-.01, .02, .04, .05, .08, .09, .10,

0460-05-.02, and .03; and original rules 0460-03-.12 and 0460-04-.11; and repeal of rule 0460-04-.03

filed October 12, 2007; effective December 26, 2007.

Amendments to rules 0460-01-.01, .03, .05, and .08; 0460-02-.07, .10, and .11; 0460-03-.09; 0460-04-.04

and .08; and 0460-05-.02 and .03 filed September 25, 2008; effective December 9, 2008.

Public necessity rule 0460-02-.14 filed June 25, 2009; effective through December 7, 2009.

Amendments to rules 0460-01-.04, .05 and .06, 0460-02-.13, 0460-03-.02 and .11, and 0460-04-.07 filed

August 4, 2009; effective November 2, 2009.

Public necessity rule 0460-02-14 filed June 25, 2009 expired; on December 8, 2009, the rule reverted to its prior status.

Emergency rule 0460-02-.14 filed December 21, 2009; effective through June 19, 2010.

Original rule 0460-02-.14 filed March 22, 2010; effective June 20, 2010.

Amendments to rules 0460-01-.05; 0460-02-.06, .07 and .11; 0460-03-.09; 0460-04-.04; and 0460-05-.03

filed October 22, 2010; effective January 20, 2011.

Amendments to rules 0460-01-.02, 0460-04-.04 and 0460-05-.03 filed December 20, 2011; effective

March 19, 2012.

Amendment to rule 0460-01-.02 filed April 17, 2013; effective July 16, 2013.

Amendments to rule 0460-01-.05 filed September 30, 2014; effective December 29, 2014.

Amendments to rules 0460-02-.01, .02, .03, .06, and .07 filed September 30, 2014; effective December

29, 2014.

Amendments to rules 0460-03-.01, .02, .03, .06, .10, and .12 filed September 30, 2014; effective

December 29, 2014.

Amendments to rules 0460-04-.02, .08, .10. and .11 filed September 30, 2014; effective December 29,

2014.

Amendments to rules 0460-02-.01, .02, .03, .06, and .07 filed September 30, 2014; effective December

29, 2014.

Amendments to rules 0460-05-.02 and .03 September 30, 2014; effective December 29, 2014.

Amendments to rule 0460-05-.03 filed January 31, 2017; effective May 1, 2017.

Amendments to rules 0460-02-.01, 0460-02-.02, 0460-02-.03, 0460-02-.05, 0460-02-.08, 0460-02-.09,

0460-03-.01, 0460-03-.02, 0460-03-.03, 0460-03-.05, 0460-03-.07, 0460-03-.08, 0640-04-.02, 0460-04-

.06, and 0460-04-.07 filed October 25, 2017; effective January 23, 2018.

# RULES OF

**TENNESSEE BOARD OF DENTISTRY**

**CHAPTER 0460-01 GENERAL RULES**

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**0460-01-.01 DEFINITIONS.** As used in Chapters 1 through 5 of Rule 0460, the following terms and acronyms shall have the following meanings ascribed to them:

1. Associated Structures - Any structures grouped by some common factor. Structures can be associated with the oral cavity and/or maxillofacial area by anatomic and/or functional factors (e.g., the oral cavity and maxillofacial area are associated with the major and minor muscles of mastication and all of their attachments; the oral cavity and maxillofacial area are associated with the oral pharynx, nasal pharynx and the airway including the trachea). All structures adjacent, attached, or contiguous with the oral cavity and/or maxillofacial area are associated structures (e.g., the oral cavity and maxillofacial area are associated with the head and neck, including the face and its components orbital, nasal, aural, etc.).
2. Board - The Tennessee Board of Dentistry.
3. Board Administrative Office - The office of the Director assigned to the Tennessee Board of Dentistry located at 665 Mainstream Drive, Nashville, TN 37243.
4. Certified Dental Assistant - A designation for an individual who has obtained certification from the Dental Assisting National Board, and with such designation, the individual may apply for registration to practice as a registered dental assistant in this State. All certified dental assistants must be registered by the State, pursuant to Rule 0460-04-.02, before they are eligible to practice as registered dental assistants in this State.
5. Continuing Education – Continuing education consists of dental educational activities designed to review existing concepts and techniques, to convey information beyond the basic dental education and to update knowledge on advances in scientific, clinical and non-clinical practice related subject matter, including evidence-based dentistry. The objective is to improve the knowledge, skills and ability of the individual to provide the highest quality of service to the public and the profession. All continuing dental education should strengthen the habits of critical inquiry and balanced judgment that denote the truly professional and scientific person and should make it possible for new knowledge to be incorporated into the practice of dentistry as it becomes available.
   1. Continuing dental education programs are designed for part-time enrollment and are usually of short duration, although longer programs with structured, sequential curricula

may also be included within this definition. Continuing dental education should be a part of a life long continuum of learning.

* 1. Continuing dental education programs for dentists do not lead to eligibility for ethical announcements or certification in a specialty recognized by the American Dental Association. Accredited advanced dental education programs will be accepted for continuing dental education pursuant to Rule 0460-01-.05 (3) (d) 2.

1. Coronal Polishing - The polishing of the enamel and restorations on the clinical crown of human teeth by utilizing a combination of a polishing agent and a slow speed handpiece, a prophy angle, a rubber cup, or any home care cleaning device.
2. Dental Public Health - That specialty branch of dentistry which deals with the science and art of preventing and controlling dental diseases and promoting dental health through organized community efforts. It is that form of dental practice which serves the community as a patient rather than the individual. It is concerned with the dental health education of the public, with applied dental research, and with the administration of group dental care programs as well as the prevention and control of dental diseases on a community basis.
3. Division - The Tennessee Department of Health, Division of Health Related Boards, from which the Board receives administrative support.
4. Endodontics - That specialty branch of dentistry which deals with the morphology, physiology and pathology of the human dental pulp and periradicular tissues. Its study and practice encompass the basic and clinical sciences including biology of the normal pulp, the etiology, diagnosis, prevention and treatment of diseases and injuries of the pulp and associated periradicular conditions.
5. Full-Time Employment – A minimum of one thousand and five hundred (1500) employed hours per year.
6. Licensed Dental Hygienist – An auxiliary employee of a licensed dentist(s) who has been issued a license to engage in clinical procedures primarily concerned with the performance of preventive dental service which does not constitute the practice of dentistry and is performed in accordance with the statutes and rules of the Board, under the direct and/or general supervision and full responsibility of a licensed dentist, pursuant to T.C.A. §§ 63-5-108 and 63-5-115.
7. Licensee - Any person who has been lawfully issued a license to practice dentistry or dental hygiene in Tennessee.
8. Mobile Dental Clinic – Any self-contained clinic or unit which may be moved, towed, transported or utilized on a permanent or temporary basis to an out-of-office location in which dentistry is practiced. The out-of-office location may include, but is not limited to, schools, nursing homes, or other institutions.
9. Oral and Maxillofacial Radiology – That specialty of dentistry and discipline of radiology concerned with the production and interpretation of images and data produced by all modalities of radiant energy that are used for the diagnosis and management of diseases, disorders and conditions of the oral and maxillofacial region.
10. Oral and Maxillofacial Surgery - That specialty branch of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial regions. Oral and Maxillofacial Surgery includes the treatment of the oral cavity and maxillofacial area or adjacent or associated structures and their impact on the human body

that includes the performance of the following areas of Oral and Maxillofacial Surgery, as described in the most recent version of the Parameters and Pathways: Clinical Practice Guidelines for Oral and Maxillofacial Surgery of the American Association of Oral and Maxillofacial Surgeons:

* 1. Patient assessment;
  2. Anesthesia in outpatient facilities, as provided in T.C.A. §§ 63-5-105 (6) and 63-5-108 (g);
  3. Dentoalveolar surgery;
  4. Oral and craniomaxillofacial implant surgery;
  5. Surgical correction of maxillofacial skeletal deformities;
  6. Cleft and craniofacial surgery;
  7. Trauma surgery;
  8. Temporomandibular joint surgery;
  9. Diagnosis and management of pathologic conditions;
  10. Reconstructive surgery including the harvesting of extra oral/distal tissues for grafting to the oral and maxillofacial region; and
  11. Cosmetic maxillofacial surgery.

1. Oral and Maxillofacial Pathology - Oral and Maxillofacial Pathology is the specialty of dentistry and discipline of pathology that deals with the nature, identification, and management of diseases affecting the oral and maxillofacial regions. It is a science that investigates the causes, processes, and effects of these diseases. The practice of Oral and Maxillofacial Pathology includes research and diagnosis of diseases using clinical, radiographic, microscopic, biochemical, or other examinations. Oral and Maxillofacial Pathology deals with the nature of the diseases affecting the oral cavity and maxillofacial area or adjacent or associated structures, through study of its causes, its processes and its effects, together with the associated alternations of oral structure and function. The practice of oral and maxillofacial pathology shall include development and application of this knowledge through the use of clinical, microscopic, radiographic, biochemical or other such laboratory examinations or procedures as may be required to establish a diagnosis and/or gain other information necessary to maintain the health of the patient, or to correct the result of structural or functional changes produced by alternations from the normal.
2. Orthodontics and Dentofacial Orthopedics - That specialty branch of dentistry concerned with the supervision, guidance, and correction of the growing, or mature dentofacial structures, including those conditions that require movement of teeth or correction of malrelationships and malformations of their related structures and the adjustment of relationships between and among teeth and facial bones by the application of forces and/or the stimulation and redirection of functional forces within the craniofacial complex. Major responsibilities of orthodontic and dentofacial orthopedic practice include the diagnosis, prevention, interception and treatment of all forms of malocclusions of the teeth and associated alterations in their surrounding structures; the design, application, and control of functional and corrective appliances, and the guidance of the dentitions and its supporting structures to attain and maintain optimal occlusal relations in physiologic and esthetic harmony among facial and cranial structures.
3. Pediatric Dentistry (Pedodontics) - That specialty branch of dentistry associated with the practice and teaching of comprehensive preventive and therapeutic oral health care of children from birth through adolescence. It shall be construed to include care for special patients beyond the age of adolescence who demonstrate mental, physical and/or emotional problems.
4. Periodontics - That specialty branch of dentistry which deals with the diagnosis and treatment of disease of the supporting and surrounding tissue of the teeth. The maintenance of the health of these structures and tissues, achieved through periodontal treatment procedures, is also considered to be a responsibility of a periodontist.
5. Practical Dental Assistant - An auxiliary employee of a licensed dentist(s) who performs supportive chairside procedures under the direct supervision and full responsibility of that licensed dentist or who is a dental assistant student in an educational institution accredited by the Commission on Dental Accreditation of the American Dental Association, as defined by Rule 0460-04-.01.
6. Prosthetic Function – Dental procedure involving any inlay, crown, bridge, partial denture, or complete denture that restores or replaces loss of tooth structure, teeth, or oral tissues.
7. Prosthodontics - That specialty branch of dentistry pertaining to the diagnosis, treatment planning, rehabilitation and maintenance of the oral function, comfort, appearance and health of patients with clinical conditions associated with missing or deficient teeth and/or maxillofacial tissues using biocompatible substitutes. The following constitute branches of Prosthodontics:
   1. Removable Prosthodontics is that branch of prosthodontics concerned with the replacement of teeth and contiguous structures for edentulous or partially edentulous patients by artificial substitutes that are removable from the mouth.
   2. Fixed Prosthodontics is that branch of prosthodontics concerned with the replacement and/or restoration of teeth by artificial substitutes that are not removable from the mouth.
   3. Maxillofacial Prosthetics is that branch of prosthodontics concerned with the restoration and/or replacement of stomatognathic and associated facial structures by artificial substitutes that may or may not be removable.
8. Registered Dental Assistant - An auxiliary employee of a licensed dentist(s) who has been issued a registration to practice intraoral dental assisting procedures in accordance with the statutes and rules of the Board, and is eligible to seek certification and training in advanced dental assisting areas, and who practices under the direct supervision and full responsibility of a licensed dentist.
9. Registrant - Any person who has been lawfully issued a registration from the Board to practice as dental assistants.
10. Restorative Function – Dental procedure involving the repairing, restoring, or reforming the shape, form, and function of part or all of a tooth.
11. Sealant Application - The application of an organic polymer to the enamel surfaces of teeth.
12. S.R.T.A. - The Southern Regional Testing Agency or its successor organization.
13. Specialist - A licensee who has satisfactorily completed the requirements as set forth in the Dental Practice Act and these rules to practice one of the specialties recognized by the Board.

***Authority:*** *T.C.A. §§4-5-202, 4-5-204, 63-5-101, 63-5-105, 63-5-107, 63-5-108, 63-5-111 through 63-5-*

*115, and 63-5-117.* ***Administrative History:*** *Original rule filed June 7, 1974. Repeal and new rule filed August 26, 1980; effective December 1, 1980. Amendment filed September 13, 1985; effective October*

*13, 1985. Amendment filed September 24, 1987; effective November 8, 1987. Amendment filed April 30,*

*1991; effective June 14, 1991. Repeal and new rule filed December 11, 1991; effective January 25,*

*1992. Amendment filed February 12, 1996; effective April 27, 1996. Amendment filed December 7,*

*1998; effective February 20, 1999. Amendment filed February 9, 2000; effective April 24, 2000.*

*Amendment filed August 21, 2002; effective November 4, 2002. Amendment filed February 18, 2003;*

*effective May 4, 2003. Amendment filed September 17, 2003; effective December 1, 2003. Amendment*

*filed November 17, 2003; effective January 31, 2004. Amendment filed June 18, 2004; effective*

*September 1, 2004. Amendment filed December 28, 2004; effective March 13, 2005. Amendments filed*

*August 3, 2005; effective October 17, 2005. Amendment filed August 23, 2005; effective November 6,*

*2005. Amendment filed October 12, 2007; effective December 26, 2007. Amendments filed September*

*25, 2008; effective December 9, 2008.*

**0460-01-.02 FEES.** The fees authorized by the Tennessee Dental Practice Act (T.C.A. §§ 63-5-101, et seq.) and other applicable statutes are established and assessed by the Board as non-refundable fees, as follows:

|  |  |  |
| --- | --- | --- |
| (1) | Dentists |  |
|  | (a) Licensure Application Fee - Payable each time an application for licensure is filed. This fee also applies to dual degree and criteria (reciprocity) licensure applicants. | $400.00 |
|  | (b) Limited and Educational Limited Licensure Fee - Payable each time an application for a limited or an educational limited license is filed. | $150.00 |
|  | (c) Criteria (Reciprocity) Licensure Fee - Payable each time an application for a criteria (reciprocity) license is filed. This fee is to be paid in addition to the licensure application fee. | $ 150.00 |
|  | (d) Specialty Certification Application Fee - Payable each time an application for a specialty certification is filed. | $150.00 |
|  | (e) Student Clinical Instructors Exemption Fee - Payable each time and for each individual named in the Application for Exemption submitted pursuant to Rule 0460-02-.04 (5). | $10.00 |
|  | (f) Permit Fees - (limited conscious sedation, comprehensive conscious sedation, deep sedation/general anesthesia) Payable each time an application for a new permit or a biennial renewal of a permit is filed. |  |
|  | 1. Initial Permit Fee | $300.00 |
|  | 2. Biennial Permit Renewal Fee | $100.00 |

(g) Licensure Renewal Fee – Payable biennially by all $250.00

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|  | licensees excluding Limited, Educational Limited and Inactive Pro Bono licenses. |  |
|  | (h) Limited and Educational Limited Licensure Renewal Fee - Payable biennially. | $ 50.00 |
|  | (i) State Regulatory Fee - Payable upon application for licensure and biennially thereafter by all licensees. | $ 10.00 |
|  | (j) Reinstatement Fee - Payable when a licensee fails to renew licensure timely and which is paid in addition to all current and past due licensure renewal fees. | $750.00 |
|  | (k) Duplicate License Fee - Payable when a licensee requests a replacement for a lost or destroyed “artistically designed” wall license or renewal certificate. | $ 30.00 |
|  | (l) Inactive Pro Bono Renewal Fee | $ 0.00 |
| (2) | Dental Hygienist |  |
|  | (a) Licensure Application Fee - Payable each time an application for licensure is filed. This fee also applies to criteria approval and educational licensure applications. | $115.00 |
|  | (b) Criteria Licensure Fee - Payable each time an application for criteria approval licensure (reciprocity) is filed. This fee is to be paid in addition to the licensure application fee. | $ 50.00 |
|  | (c) Educational Licensure Fee - Payable each time an application for an educational license is filed. This fee is to be paid in addition to the licensure application fee. | $ 50.00 |
|  | (d) Student Clinical Instructor Exemption Fee - Payable each time and for each individual named in the Application for Exemption submitted pursuant to Rule 0460-03-.04(5). | $ 10.00 |
|  | (e) Licensure Renewal Fee - Payable biennially by all licensees, including criteria approved and educational licensees. | $100.00 |
|  | (f) State Regulatory Fee - Payable upon application for licensure and biennially thereafter by all licensees. | $ 10.00 |
|  | (g) Reinstatement Fee - Payable when a licensee fails to renew licensure timely and which is paid in addition to all current and past due licensure renewal fees. | $200.00 |
|  | (h) Duplicate License Fee - Payable when a licensee requests a replacement for a lost or destroyed “artistically designed” wall license or renewal certificate. | $ 20.00 |
|  | (i) Examination Fee - Payable each time an application is filed to take a Board-approved examination as provided in rule 0460-03-.05 (1) (a) or the National Boards’ examination, and when the applicant has been instructed | $ 875.00 |

to submit this fee directly to the Board.

1. Dental Assistants
   1. Registration Application Fee - Payable each time an application for a registration to practice as a dental assistant is filed.

$ 30.00

* 1. Registration Renewal Fee - Payable biennially by all registrants.

$ 50.00

* 1. State Regulatory Fee - Payable upon application for registration and biennially thereafter by all registrants

$ 10.00

* 1. Reinstatement Fee - Payable when a registration is not timely renewed and which is paid in addition to all current and past due registration renewal fees.

$100.00

* 1. Duplicate Registration Fee - Payable when a registrant requests a replacement for a lost or destroyed “artistically designed” wall registration or renewal certificate.

$ 20.00

* 1. Coronal Polishing Certification Fee – To be paid to the Board’s Administrative Office.

$ 15.00

* 1. Sealant Application Certification Fee - To be paid to the Board’s Administrative Office.

$ 15.00

* 1. Radiology Certification Fee – To be paid to the Board’s Administrative Office

$ 15.00

* 1. Nitrous Oxide Monitoring Certification Fee – To be paid to the Board’s Administrative Office

$ 15.00

* 1. Expanded Restorative Functions Certification Fee – To be paid to the Board’s Administrative Office

$ 15.00

* 1. Expanded Prosthetic Functions Certification Fee – To be paid to the Board’s Administrative Office

$ 15.00

1. Fees may be paid in the following manner:
   1. All fees paid by money order, certified, personal, or corporate check must be submitted to the Board’s Administrative Office and made payable to the Tennessee Board of Dentistry.
   2. Fees may be paid by Division-approved credit cards or other Division-approved electronic methods.

***Authority:*** *T.C.A. §§ 4-3-1011, 4-5-202, 4-5-204, 63-1-103, 63-1-106, 63-1-107, 63-1-108, 63-5-105, 63-*

*5-105(7), 63-5-107, 63-5-107(c), 63-5-108, 63-5-110 through 63-5-115, 63-5-117, 63-5-118, 63-5-124*

*and 63-5-132.* ***Administrative History:*** *Original rule certified June 7, 1974. Repeal and new rule filed August 26, 1980; effective December 1, 1980. Amendment filed October 13, 1983; effective November*

*14, 1983. Amendment filed September 24, 1987; effective November 8, 1987. Amendment filed June 8,*

*1989; effective July 23, 1989. Amendment filed November 30, 1989; effective January 14, 1990. Repeal*

*and new rule filed December 11, 1991; effective January 25, 1992. Amendment filed December 5, 1994;*

*effective February 18, 1995. Amendment filed March 20, 1996; effective June 3, 1996. Amendment filed*

*September 26, 1996; effective December 10, 1996. Amendment filed February 9, 2000; effective April*

*24, 2000. Repeal and new rule filed April 10, 2002; effective June 24, 2002. Amendment filed August 21,*

*2002; effective November 4, 2002. Amendment filed March 17, 2003; effective July 29, 2003.*

*Amendment filed June 13, 2003; effective August 27, 2003. Amendment filed August 18, 2003; effective*

*November 1, 2003. Amendment filed September 17, 2003; effective December 1, 2003. Amendment*

*filed October 20, 2003; effective January 3, 2004. Amendment filed June 18, 2004; effective September*

*1, 2004. Amendment filed December 28, 2004; effective March 13, 2005. Amendment filed December*

*16, 2005; effective March 1, 2006. Amendments filed October 12, 2007; effective December 26, 2007.*

*Amendment filed December 20, 2011; effective March 19, 2012. Amendments filed April 17, 2013;*

*effective July 16, 2013.*

# 0460-01-.03 BOARD OFFICERS, CONSULTANTS, MEETINGS, DECLARATORY ORDERS, AND SCREENING PANELS.

1. The Board shall annually elect from its members the following officers:
   1. President - who shall preside at all Board meetings.
   2. Vice President - who shall preside at Board meetings in the absence of the President.
   3. Secretary-Treasurer - who along with the Board Administrator shall be responsible for correspondence from the Board.
2. Minutes of the Board meetings and all records, documents, applications, and correspondence will be maintained in the Board Administrative Office.
3. All requests, applications, notices, complaints, other communications and correspondence shall be directed to the Board Administrative Office. Any requests or inquiries requiring a Board decision or official Board action except documents relating to disciplinary actions, declaratory orders or hearing requests must be received fourteen (14) days prior to a scheduled Board meeting and will be retained in the Administrative Office and presented to the Board at the Board meeting. Such documents not timely received shall be set over to the next Board meeting.
4. The Board authorizes its designee, who shall be a Board designated licensed dentist employed by the Division, to act as the Board consultant and who is vested with the authority of the Board to do the following acts:
   1. Review and make determinations on licensure, registration, certification, permits, exemption, renewal, and reactivation of licensure or registration applications subject to the rules governing those respective applications.
   2. Serve as consultant to the Board to make determinations, subject to subsequent ratification by the full Board, of the following:
      1. Applications by out of state practitioners for permission to consult or operate in Tennessee pursuant to T.C.A. §63-5-109(4).
      2. Approve or reject special projects pursuant to T.C.A. §63-5-109(5) and T.C.A.

§63-5-109(12).

* + 1. Approve or reject agencies employing dental interns, externs or graduates of dental and dental hygiene schools pursuant to T.C.A. §63-5-109(9).
    2. Approve or reject research or development projects pursuant to T.C.A. §63-5- 109(10).
    3. Approve or reject protocols for delivery of services in health care facilities by dental hygienists pursuant to T.C.A. §63-5-115(d).
    4. Any other matter authorized by a majority vote of the Board.

1. In addition to the board consultant described in paragraph (4), consultants may be recruited from licensed dentists in Tennessee, who meet certain qualifications including, but not limited to those qualifications required for board membership, to act as rotational (part-time) consultants to the Division to decide the following:
   1. Whether and what type disciplinary actions should be instituted upon complaints received or investigations conducted by the Division.
   2. Whether and under what terms a complaint, case or disciplinary action might be settled or closed. Any matter proposed for settlement must be subsequently ratified by the full Board before it will become effective.
   3. Whether and under what terms a complaint might be closed with a letter of warning, letter of concern, or acknowledgement of closure.
2. The salary of the Secretary of the Board shall be set at $000.00 so long as the consultant authorized by paragraph (4) of this rule is designated. In the event that the Secretary acts as the Board consultant, the salary of the secretary shall be five hundred dollars ($500.00) each month.
3. Request for Certificates of Fitness (verifications) for licensees or registrants desiring to practice in another state must be made in writing to the Board Administrative Office.
4. Request for duplicate or replacement licenses or registrations must be made in writing on a form to be supplied by the Board and forwarded to the Board’s Administrative Office with the fee required in Rule 0460-01-.02.
5. Declaratory Orders. The Board adopts, as if fully set out herein, Rule 1200-10-1-.11 of the Division of Health Related Boards, as it may from time to time be amended, as its rule governing the declaratory order process. All declaratory order petitions involving statutes, rules or orders within the jurisdiction of the Board shall be addressed by the Board pursuant to the rule and not by the Division. Declaratory order petition forms can be obtained from the Board’s Administrative office.
6. Screening Panels - The Board adopts, as if fully set out herein, Rule 1200-10-1-.13, of the Division of Health Related Boards and as it may from time to time be amended, as its rule governing the screening panel process.
7. Stays and Reconsiderations – The Board authorizes the member who chaired the Board for a contested case to be the agency member to make the decisions authorized pursuant to rule 1360-4-1-.18 regarding petitions for reconsiderations and stays in that case.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 4-5-223, 4-5-224, 4-5-225, 63-1-106, 63-1-108, 63-1-118, 63-1-*

*132, 63-1-138, 63-5-105, 63-5-116 and 63-5-124.* ***Administrative History:*** *Original rule certified June 7,*

*1974. Repeal and new rule filed August 26, 1980; effective December 1, 1980. Amendment filed*

*December 2, 1980; effective March 31, 1981. Amendment filed October 13, 1983; effective November*

*14, 1983. Amendment filed September 21, 1989; effective November 5, 1989. Amendment filed April 30,*

*1991; effective June 14, 1991. Repeal and new rule filed December 11, 1991; effective January 25,*

*1992. Amendment filed March 20, 1996; effective June 3, 1996. Amendment filed May 15, 1996;*

*effective September 27, 1996. Amendment filed April 10, 2001; effective June 24, 2001. Amendment*

*filed April 10, 2002; effective June 24, 2002. Amendment filed July 21, 2004; effective October 4, 2004.*

*Amendment filed April 5, 2006; effective June 19, 2006. Amendment filed September 25, 2008; effective*

*December 9, 2008.*

# 0460-01-.04 APPLICATION REVIEW, APPROVAL, DENIAL, AND INTERVIEWS. Review and

decisions on applications cross referenced in Chapters 0460-02, 0460-03 and 0460-04, to this rule shall be governed by the following:

1. Completed applications received in the Board Administrative Office shall be submitted to a member of the Board or the Board consultant for review.
   1. An initial determination as to issuance or denial of the application shall be made after the application file is complete. Each member of the Board and the Board consultant is vested with the authority to make these initial determinations.
   2. Applicants, who by virtue of any criteria for licensure in the areas of mental, physical, moral or educational capabilities as contained in the application and review process which indicates derogatory information or a potential risk to the public health, safety and welfare, may be required to present themselves to the Board for an interview before final licensure may be granted. If sufficient cause exists, an applicant may be required to submit to a mental and/or physical examination.
2. The specific authorization applied for may be issued pursuant to the initial determination made by the Board member or consultant reviewing the application. However, such determination shall not become fully effective until such time as the full Board ratifies it.
3. If an application is incomplete when received by the Board Administrative Office or the reviewing Board member determines additional information is required from an applicant before an initial determination can be made, the Board Administrative Office shall notify the applicant of the information required. The applicant shall cause the requested information to be received by the Board Administrative Office on or before the sixtieth (60th) day after receipt of the notification.
   1. Such notifications shall be sent certified mail return receipt requested from the Board Administrative Office.
   2. If the requested information is not timely received, the application file shall be closed and the applicant notified. No further Board action will take place until a new application is received pursuant to the rules governing the applicable process, including another payment of all fees.
4. If a completed application is initially denied by the reviewing Board member or consultant, the applicant shall be informed of that initial decision and that final determination shall be made by the full Board at its next meeting. If the full Board ratifies the initial denial, the action shall become final and the following shall occur:
   1. A notification of the denial shall be sent by the Board Administrative Office by certified mail return receipt requested which shall contain all the specific statutory or rule authorities for the denial.
   2. The notification, when appropriate, shall also contain a statement of the applicant’s right to request a contested case hearing under the Tennessee Administrative

Procedures Act (T.C.A. §4-5-101 et seq.) to contest the denial and the procedure necessary to accomplish that action.

* + 1. An applicant has a right to a contested case hearing only if the licensure denial was based on subjective or discretionary criteria.
    2. An applicant may be granted a contested case hearing if licensure denial is based on an objective, clearly defined criteria only if after review and attempted resolution by the Board’s Administrative staff, the licensure application cannot be approved and the reasons for continued denial present a genuine issue of fact and/or law which is appropriate for appeal.

1. The initial determination procedures of this rule will not apply if the full Board reviews and makes final determination on any application during its meetings.
2. Any applicant who has successfully complied with all requirements of the rules governing the specific authorization applied for shall be entitled to its issuance with the following exceptions:
   1. Applicants who by virtue of any criteria in the area of mental, physical, moral or educational capabilities, as contained in the application and review process which indicates a potential risk to the public health, safety and welfare may, pursuant to

T.C.A. §63-5-111(a)(1), be required to present themselves to the Board or selected member(s) of the Board for oral examination before final approval may be granted. If sufficient cause, as determined by the full Board, exists an applicant may be required, pursuant to T.C.A. §63-5-124(b), to submit to a mental and/or physical examination.

* 1. The examinations which may be required by paragraph (6)(a) of this rule are considered part of the examinations as required prior to issuance of the authorization applied for pursuant to T.C.A. §63-5-111(a)(1).
  2. The issuance of the authorization applied for may be withheld or restricted for violation of the provisions of T.C.A. §63-5-124(a) and any rules promulgated pursuant thereto or failure to fully comply with all application requirements.

1. If the Board finds it has erred in the issuance of a license, the Board will give written notice by certified mail of its intent to revoke the license. The notice will allow the applicant the opportunity to meet the requirements for licensure within thirty (30) days from the date of receipt of the notification. If the applicant does not concur with the stated reason and the intent to revoke the license, the applicant shall have the right to proceed according to rule 0460-01-.04 (4) (b).

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-111, and 63-5-124.* ***Administrative History:*** *Original rule certified June 7, 1974. Repeal and new rule filed August 26, 1980; effective December 1, 1980. Amendment filed October 13, 1983; effective November 14, 1983. Repeal filed September 24,*

*1987; effective November 8, 1987. Repeal and new rule filed December 11, 1991; effective January 25,*

*1992. Amendment filed December 5, 1994; effective February 18, 1995. Amendment filed March 20,*

*1996; effective June 3, 1996. Amendment filed May 15, 1996; effective September 27, 1996.*

*Amendment filed April 10, 2001; effective June 24, 2001. Amendment filed August 4, 2009; effective*

*November 2, 2009.*

# 0460-01-.05 CONTINUING EDUCATION AND C.P.R.

1. Continuing Education - Hours Required
   1. Beginning January 1, 2003, each licensed dentist must successfully complete forty (40) hours of continuing education in courses approved by the Board during the two (2) calendar years (January 1st of an odd-numbered year through December 31st of the subsequent even-numbered year) that precede the licensure renewal year. At least two (2) hours of the forty (40) hour requirement shall pertain to chemical dependency education. Dentists who hold limited or comprehensive conscious sedation or deep sedation/general anesthesia permits must also obtain a minimum of four (4) hours of continuing education in the subject of anesthesia and/or sedation as required by rule 0460-02-.07(8)(c) as part of the required forty (40) hours of continuing education for dental licensure.
      1. Example – To renew a license that expires in 2008, a dentist will attest on the renewal application that he/she completed forty (40) hours of continuing education from January 1, 2005 to December 31, 2006.
      2. Example – To renew a license that expires in 2009, a dentist will attest on the renewal application that he/she completed forty (40) hours of continuing education from January 1, 2007 to December 31, 2008.
      3. Example – To renew a license that expires in 2010, a dentist will attest on the renewal application that he/she completed forty (40) hours of continuing education from January 1, 2007 to December 31, 2008.
   2. Beginning January 3, 2003, each licensed dental hygienist must successfully complete thirty (30) hours of continuing education in courses approved by the Board during the two (2) calendar years (January 1st of an odd-numbered year through December 31st of the subsequent even-numbered year) that precede the licensure renewal year. At least two (2) hours of the thirty (30) hour requirement shall pertain to chemical dependency education.
      1. Example – To renew a license that expires in 2008, a dental hygienist will attest on the renewal application that he/she completed thirty (30) hours of continuing education from January 1, 2005 to December 31, 2006.
      2. Example – To renew a license that expires in 2009, a dental hygienist will attest on the renewal application that he/she completed thirty (30) hours of continuing education from January 1, 2007 to December 31, 2008.
      3. Example – To renew a license that expires in 2010, a dental hygienist will attest on the renewal application that he/she completed thirty (30) hours of continuing education from January 1, 2007 to December 31, 2008.
   3. Beginning January 3, 2003, each registered dental assistant must successfully complete twenty-four (24) hours of continuing education in courses approved by the Board during the two (2) calendar years (January 1st of an odd-numbered year through December 31st of the subsequent even-numbered year) that precede the registration renewal year. At least two (2) hours of the twenty-four (24) hour requirement shall pertain to chemical dependency education.
      1. Example – To renew a registration that expires in 2008, a dental assistant will attest on the renewal application that he/she completed twenty-four (24) hours of continuing education from January 1, 2005 to December 31, 2006.
      2. Example – To renew a registration that expires in 2009, a dental assistant will attest on the renewal application that he/she completed twenty-four (24) hours of continuing education from January 1, 2007 to December 31, 2008.
      3. Example – To renew a registration that expires in 2010, a dental assistant will attest on the renewal application that he/she completed twenty-four (24) hours of continuing education from January 1, 2007 to December 31, 2008.
   4. New licensees and new registrants are exempt from the provisions of subparagraphs
2. (a), (1) (b), and (1) (c) during their initial two (2) calendar year (January 1 - December 31) cycle, starting with an odd-numbered year if it is the year of initial licensure or registration, or starting with the odd-numbered year if it precedes an even- numbered initial licensure or registration year.
3. Example – An individual whose new license or registration was granted in 2008 is exempt from the continuing education requirements for the period beginning January 1, 2007 and ending December 31, 2008.
4. Example – An individual whose new license or registration was granted in 2009 is exempt from the continuing education requirements for the period beginning January 1, 2009 and ending December 31, 2010.
5. Example – An individual whose new license or registration was granted in 2010 is exempt from the continuing education requirements for the period beginning January 1, 2009 and ending December 31, 2010.
   1. The Board approves courses for only the number of hours contained in the course. The approved hours of any individual course will not be counted more than once in a continuing education cycle toward the required hourly total regardless of the number of times the course is attended or completed by any individual licensee.
   2. Each practitioner is responsible to attend only courses approved by the Board under Rule 0460-01-.05(3)(d) if credit for continuing education is desired unless prior approval under Rules 0460-01-.05(3)(b) and (e) has been obtained.
   3. Notwithstanding the provisions of subparagraph (3) (d), all continuing education courses intended to meet the requirements of Rules 0460-02-.07 (6) (a) 1. (ii), 0460- 02-.07 (6) (a) 2. (ii), and 0460-02-.07 (8) (b) shall have prior approval by an Anesthesia Consultant as provided in Rule 0460-02-.07 (11).
6. Continuing Education. Proof of Compliance
   1. The due date for successful completion of the required continuing education hours is December 31st of the two (2) calendar years (January 1st of an odd-numbered year through December 31st of the subsequent even-numbered year) that precede the licensure or registration renewal year.
   2. Each dentist, dental hygienist, and registered dental assistant must, on their biennial renewal application, attest to attendance and successful completion of the required continuing education hours and that such hours were obtained during the calendar years of report.
   3. Each dentist, dental hygienist, and registered dental assistant must retain independent documentation of attendance and completion of all continuing education courses. This documentation must be retained for a period of three (3) years from the end of the calendar year in which the course is completed. This documentation must be produced for inspection and verification, if requested in writing by the Board during its verification process.
   4. Further, it is the responsibility of the practitioner to obtain documentation in the form of a certificate indicating the name of the practitioner attending such course, title of the course taken, date of the course, number of hours obtained for attending the course, and verification of the approved organization sponsoring the course.
   5. Any practitioner who, on their biennial renewal application, attests to attendance and successful completion of the required continuing education which in any way is not true will be subject to disciplinary action pursuant to T.C.A. §§ 63-5-124 (a) (1), (2), (3), (7) and (18).
7. Continuing Education Course Approval - Courses to be offered for credit toward the continuing education requirement must, unless otherwise provided, receive prior approval from the Board.
   1. Course approval procedure for course providers - Unless otherwise provided, all courses shall be offered within Tennessee.
      1. To obtain prior approval the course provider must have delivered to the Board’s Administrative Office at least thirty (30) days prior to a regularly scheduled meeting of the Board that precedes the course, documentation which includes all of the following items which must be resubmitted if changes are made after receipt of approval from the Board:
         1. course description or outline.
         2. names of all lecturers.
         3. brief resume of all lecturers.
         4. number of hours of educational credit requested.
         5. date of course.
         6. copies of materials to be utilized in the course.
         7. how verification of attendance is to be documented.
      2. Under no circumstances shall continuing education courses be approved if the materials required by subparts (3) (a) 1. (i) through (3) (a) 1. (vii) are not received at least thirty (30) days prior to a regularly scheduled meeting of the Board at which approval is sought that precedes the course.
      3. Notwithstanding the provisions of subparagraph (3) (a), any clinic, workshop, seminar or lecture at national, regional, state and local meetings of dentists, dental hygienists, and dental assistants will be recognized for continuing education credit by the Board if
         1. the course provider has complied with the provisions of parts (3) (a) 1. and (3) (a) 2.; or
         2. the course provider is exempt from needing prior approval as provided in subparagraph (3) (d).
      4. Notwithstanding the provisions of subparagraph (3) (a), out-of-state continuing education providers may seek course approval if they are a dental, dental

hygiene, or dental assisting regulatory agency or association from a state that borders Tennessee; and

* + - 1. the course provider has complied with the provisions of parts (3) (a) 1. and (3) (a) 2.; or
      2. the course provider is exempt from needing prior approval as provided in subparagraph (3) (d).
  1. Course approval procedure for individual licensees and registrants.
     1. Any licensee or registrant may seek approval to receive credit for successfully completing continuing education courses by complying with the provisions of subparagraph (3) (a).
     2. To retain course approval, the licensee or registrant must submit a course evaluation form, supplied by the Board, to the Board’s Administrative Office within thirty (30) days after successfully completing the course.
  2. Continuing Education courses may be presented in any of the following formats:
     1. Lecture.
     2. Audio or audiovisual - with successful completion of a written post experience examination to evaluate material retention if correspondence course.
     3. Correspondence - with successful completion of a written post experience examination to evaluate material retention.
     4. Any combination of the above.
  3. The following courses and/or activities need not receive prior approval and shall constitute Board approved continuing education:
     1. Courses sponsored or approved by any of the following organizations:
        1. American Dental Association or its Constituent or Component Societies.
        2. Academy of General Dentistry or a State Affiliate.
        3. American Dental Hygienists’ Association or its Constituent or Component Societies.
        4. Any National, Regional or State Academy or Association of any of the recognized specialty branches of dentistry listed in T.C.A. §63-5-112.
        5. National Dental Association or its Constituent or Component Societies.
        6. National Dental Hygiene Association.
        7. Capital City Dental Society.
        8. American Dental Assistants’ Association or its Constituent or Component Societies.
        9. Tennessee Dental Hygienists Academy of Advanced Study.
        10. Tennessee Department of Health and its affiliated Metropolitan Health Departments, those being the Chattanooga/Hamilton County Health Department, the Davidson County Health Department, the Jackson- Madison County Health Department, the Knox County Health Department, the Memphis and Shelby County Health Department, and the Sullivan County Health Department.
        11. Tennessee Emergency Management Agency (TEMA).
        12. Federal Emergency Management Agency (FEMA).
     2. Educational courses sponsored by an accredited school of dentistry, dental hygiene, or dental assisting. If such course is taken for or assigned quarter or semester credit hours, three (3) semester hours or equivalent quarter hours shall be equivalent to fifteen (15) continuing education hours. No credits will be counted for courses failed.
     3. Five (5) hours of continuing education credit shall be granted for attendance at a state, regional or national dental meeting. A maximum of ten (10) continuing education credits may be earned in this category during the continuing education cycle that precedes the licensure or registration renewal year. These hours are in addition to any continuing education courses attended at any of those meetings.
     4. Participation at examinations
        1. Four (4) hours of continuing education credit shall be awarded each time a licensee participates as an examiner for S.R.T.A.
        2. One (1) hour of continuing education credit shall be awarded each time a licensee participates as an examiner for the coronal polishing examination.
     5. Hour-for-hour of continuing education credit will be granted for courses in Advanced (ACLS) or Pediatric (PALS) Cardiac Life Support that are taught in accordance with the “Guidelines” of the American Heart Association or the American Red Cross or sponsored by the American Heart Association or the American Red Cross during the continuing education cycle that precedes the licensure or registration renewal year.
     6. Twenty (20) hours of continuing education credit will be awarded for authorship of publications relevant to the practice of dentistry (e.g., a book, a chapter of a book, or an article or paper published in a professional peer reviewed journal).
     7. Four (4) hours of continuing education credit shall be awarded, during each continuing education cycle that precedes the licensure or registration renewal year, to presenters for each hour of an initial presentation of a formal continuing education course that is a didactic and/or a participatory presentation to review or update knowledge of new or existing concepts and techniques. Hour-for-hour credit will be granted for repeat presentations. This category is limited to a maximum of twenty (20) hours continuing education credit during each continuing education cycle that precedes the licensure or registration renewal year.
  4. Individual Board members and the Board consultant are vested with the authority to approve continuing education courses submitted in compliance with this rule. All such approvals must be presented to the Board for ratification..

1. Cardio Pulmonary Resuscitation (CPR)
   1. Each dentist, dental hygienist, and dental assistant must attest, check a box, and/or enter signature when applying for biennial renewal of licensure or registration, which indicates current training in cardiopulmonary resuscitation (CPR) which is defined as successful completion of a BLS for Healthcare Providers, or CPR/AED for Professional Rescuers, or an equivalent course, which provides training for healthcare professionals in CPR and the use of an AED. The course must be conducted in person and include a skills examination on a manikin with a certified instructor.
   2. The hours necessary to obtain or maintain C.P.R. may be counted as continuing education hours.
   3. Each dentist, dental hygienist and registered dental assistant must retain independent documentation of CPR training for a period of three (3) years from the end of the calendar year in which the training is received. Such proof must be produced for inspection and verification, if requested in writing by the Board during its verification process.
   4. The following organizations are approved by the Board for CPR training:
      1. The American Red Cross
      2. The American Heart Association
      3. Programs offered in hospital settings
      4. Any organization which receives approval of specially designed CPR courses from the Board after its review.
2. Waiver of Continuing Education And/Or CPR Training
   1. The Board may grant a waiver of the need to attend and complete the required hours of continuing education and/or the required CPR training if it can be shown to the Board that the failure to comply was not attributable to or was beyond the physical capabilities of the person seeking the waiver.
   2. Waivers will be considered only on an individual basis and may be requested by submitting the following items to the Board Administrative Office:
      1. A written request for a waiver which specifies what requirement is sought to be waived and a written and signed explanation of the reasons for the request.
      2. Any documentation which supports the reason for the waiver requested or which is subsequently requested by the Board.
   3. A waiver approved by the Board is effective for only the two (2) calendar years (January 1st of an odd-numbered year through December 31st of the subsequent even-numbered year) that precede the licensure renewal year for which the waiver is sought unless otherwise specified in writing by the Board.
   4. A dentist may not perform dental procedures if C.P.R. training is waived unless another dentist, a dental hygienist or dental assistant currently trained in C.P.R. is present within the confines of the dental office.
   5. The Board Consultant is authorized to grant or deny requests for waivers subject to subsequent Board ratification.
3. Continuing Education for Reactivation of Retired License or Registration - The continuing education hours obtained as a prerequisite for reactivation of licensure or registration may not be counted toward the continuing education hours required to be obtained before the licensee’s or registrant’s next biennial renewal.
   1. Any dentist or dental hygienist who applies for reactivation of a license must comply with the following:
      1. If the license has been retired for less than two (2) years, the licensee must submit along with the reactivation request and application, proof or check a box/or enter signature on a Board form which indicates the attendance and completion of one half (½) the number of hours of approved dental-related continuing education required by subparagraphs (1) (a) and (1) (b) of this rule, all of which must have been earned in the twelve (12) months immediately preceding application for reactivation.
      2. If the license has been retired for a period of two (2) years or more, but less than five (5) years, the licensee must submit, along with the reactivation request and application, proof or check a box/or enter signature on a Board form which indicates the attendance and completion of twenty four (24) hours of Board- approved dental-related continuing education. The continuing education must include at least one (1) course which focuses on and serves as a clinical (in the mouth) refresher and must have been earned in the twelve (12) months immediately preceding application for reactivation. In addition, and at the sole discretion of the Board or its consultant, when information indicates a cause for concern about continued competency, the licensee may be required to contact one of the approved schools of dentistry/hygiene for an evaluation of current competency before reinstatement will be considered.
      3. All applicants who have been retired for a period of five (5) years or more must submit, along with the reactivation request and application, proof or check a box/or enter signature on a Board form which indicates the attendance and completion of twenty four (24) hours of Board approved dental-related continuing education. The continuing education must include at least one (1) course which focuses on and serves as a clinical (in the mouth) refresher and must have been earned in the twelve (12) months immediately preceding application for reactivation. In addition, the licensees shall be required to present themselves to one of the approved schools of dentistry/hygiene for an evaluation of current competency before reinstatement will be considered. Compliance with any educational recommendations of the evaluating school is required before reinstatement will be considered.
   2. Any registered dental assistant who applies for reactivation of a registration must comply with the following:
      1. If the registrant has been retired for less than two (2) years, the registrant must submit along with the reactivation request and application, proof or check a box/or enter signature on a Board form which indicates the attendance and completion of one-half (½) the number of hours of approved dental-related

continuing education required by subparagraph (1) (c) of this rule, all of which must have been earned in the twelve (12) months immediately preceding application for reactivation.

* + 1. If the registrant has been retired for a period of two (2) years or more, but less than five (5) years, the registrant must submit, along with the reactivation request and application, proof or check a box/or enter signature on a Board form which indicates the attendance and completion of twelve (12) hours of continuing education as provided in subparagraph (1) (c) of this rule and must have been earned in the twelve (12) months immediately preceding application for reactivation.
    2. All applicants who have been retired for a period of five (5) years or more must submit, along with the reactivation request and application, proof or check a box/or enter signature on a Board form which indicates the attendance and completion of twenty-four (24) hours of continuing education as provided in subparagraph (1) (c) of this rule and must have been earned in the twelve (12) months immediately preceding application for reactivation.
  1. The dentist, dental hygienist, or registered dental assistant who applies for reactivation of a license must also submit proof or check a box and/or enter signature on a Board form which indicates current training in CPR issued by a Board approved training organization. The hours required to obtain or maintain CPR training shall not constitute continuing education hours.
  2. The Board, upon receipt of a written request and explanation, may waive or condition any or all of the continuing education or CPR requirements for reactivation of a retired license in emergency situations.
  3. The Board Consultant is authorized to grant or deny requests for waivers subject to subsequent Board ratification.

1. Violations
   1. Any dentist, dental hygienist, or dental assistant who falsely attests to attendance and completion of the required hours of continuing education and/or the CPR training requirement may be subject to disciplinary action pursuant to T.C.A. §63-5-124(A)(1), (3), (7) and (18).
   2. Any dentist, dental hygienist, or dental assistant who fails to obtain the required continuing education hours and/or CPR training may be subject to disciplinary action pursuant to T.C.A. §63-5-124(a)(1) and (18).
   3. Education hours obtained as a result of compliance with the terms of a settlement or Board Orders in any disciplinary action shall not be counted toward the continuing education hours required to be obtained during the two (2) calendar years (January 1st of an odd-numbered year through December 31st of the subsequent even-numbered year) that precede the licensure or registration renewal year.
2. Continuing education - In order to retain a limited or comprehensive conscious sedation or deep sedation/general anesthesia permit, a dentist must:
   1. Maintain current certification in ACLS (a pediatric dentist may substitute PALS); or
   2. Certify attendance every two (2) years at a board approved course comparable to ACLS or PALS and devoted specifically to the prevention and management of emergencies associated with conscious sedation or deep sedation/general anesthesia.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-1-107, 63-5-105, 63-5-107, 63-5-107(c), 63-5-108, 63-5-112,*

* + 1. *, 63-5-115, 63-5-117, and 63-5-124.* ***Administrative History:*** *Original rule certified June 7,*

*1974. Repeal filed August 26, 1980; effective December 1, 1980. Repeal and new rule filed December*

*11, 1991; effective January 25, 1992. Amendment filed June 29, 1994; effective September 12, 1994.*

*Amendment filed December 5, 1994; effective February 18, 1995. Amendment filed March 20, 1996;*

*effective June 3, 1996. Amendment to rule filed October 9, 1997; effective December 23, 1997.*

*Amendment filed February 9, 2000; effective April 24, 2000. Amendment filed April 10, 2002; effective*

*June 24, 2002. Amendment filed June 13, 2003; effective August 27, 2003. Amendment filed June 18,*

*2003; effective September 1, 2003. Amendment filed July 22, 2003; effective October 10, 2003. Notice of Withdrawal to subparagraph (3)(c) filed and effective September 24, 2003. Amendment filed August 18, 2003; effective November 1, 2003. Amendment filed December 28, 2004; effective March 13, 2005.*

*Amendment filed August 3, 2005; effective October 17, 2005. Amendment filed August 23, 2005;*

*effective November 6, 2005. Amendment filed July 10, 2006; effective September 23, 2006.*

*Amendments filed September 25, 2008; effective December 9, 2008. Amendment filed August 4, 2009;*

*effective November 2, 2009. Amendment filed October 22, 2010; effective January 20, 2011.*

*Amendment filed September 30, 2014; effective December 29, 2014.*

# 0460-01-.06 DISCIPLINARY ACTIONS, CIVIL PENALTIES, PROCEDURES, ASSESSMENT OF COSTS, AND SUBPOENAS.

* + - 1. Upon a finding by the Board that a licensee or registrant has violated any provision of the Tennessee Dental Practice (T.C.A. §63-5-101 et seq.) or the rules promulgated pursuant thereto, the Board may impose any of the following actions separately or in any combination which is deemed appropriate to the offense:
         1. Private Censure - This is a written action issued for minor or near infractions. It is informal and advisory in nature and does not constitute a formal disciplinary action.
         2. Public Censure or Reprimand - This is a written action issued for one time and less severe violations. It is a formal disciplinary action.
         3. Probation - This is a formal disciplinary action which places a licensee or registrant on close scrutiny for a fixed period of time. This action may be combined with conditions which must be met before probation will be lifted and/or which restrict activities during the probationary period.
         4. Suspension - This is a formal disciplinary action which suspends a licensee’s or registrant’s right to practice for a fixed period of time. It contemplates the reentry into practice under the license or registration previously issued.
         5. Revocation for Cause. This is the most severe form of disciplinary action which removes an individual from the practice of the profession and terminates the registration or licensure previously issued. The Board, in its discretion, may allow reinstatement of a revoked registration or license upon conditions and after a period of time it deems appropriate. No petition for reinstatement and no new application for registration or licensure from a person whose license or registration was revoked shall be considered prior to the expiration of at least one year unless otherwise stated in the Board’s revocation order.
         6. Conditions - Any action deemed appropriate by the Board to be required of a disciplined licensee in any of the following circumstances:

During any period of probation and/or suspension; or

During any period of revocation, after which the licensee may petition for an order of compliance to reinstate the revoked license; or

As a prerequisite to the lifting of probation and/or suspension or as a prerequisite to the reinstatement of a revoked license; or

As a stand-alone requirement(s) in any disciplinary order.

* + - * 1. Civil penalty - A monetary disciplinary action assessed by the Board pursuant to paragraph (4) of this rule.
        2. When the Board suspends a license or registration, the person may not practice dentistry, dental hygiene or as a dental assistant during the period of suspension and is also prohibited from doing the following:

Direct chairside assistance to another dentist or dental hygienist in the dental treatment of any patient;

Appear before dental patients in a laboratory coat, clinic smock or other garment which is customarily worn by practitioners when treating patients;

Consultation with another practitioner concerning the treatment of the person’s patients in the presence of, or within hearing of, any patient or patients; provided, however, that he or she may discuss with a subsequent treating practitioner, out of the presence or hearing of any patient, the patient’s prior diagnosis or pre- existing treatment plan and such subsequent treating practitioner’s proposed treatment plan. However, the fact or substance of such discussion shall not be communicated or conveyed to a patient or patients personally, or by another treating practitioner who presents it to the patient, as that person’s judgment, such diagnosis, treatment plan or other professional determination;

Personal acceptance of payment for dental services directly from a patient in the reception area of the office.

* + - * 1. Once ordered, probation, suspension, revocation, assessment of a civil penalty, or any other condition of any type of disciplinary action may not be lifted unless and until the licensee or registrant petitions, pursuant to paragraph (2) of this rule, and appears before the Board after the period of initial probation, suspension, revocation, or other conditioning has run and all conditions placed on the probation, suspension, revocation, have been met, and after any civil penalties assessed have been paid.
      1. Order of Compliance - This procedure is a necessary adjunct to previously issued disciplinary orders and is available only when a petitioner has completely complied with the provisions of a previously issued disciplinary order, including an unlicensed or unregistered practice civil penalty order, and wishes or is required to obtain an order reflecting that compliance.
         1. The Board will entertain petitions for an Order of Compliance as a supplement to a previously issued order upon strict compliance with the procedures set forth in subparagraph (b) in only the following three (3) circumstances:

When the petitioner can prove compliance with all the terms of the previously issued order and is seeking to have an order issued reflecting that compliance; or

When the petitioner can prove compliance with all the terms of the previously issued order and is seeking to have an order issued lifting a previously ordered suspension or probation; or

When the petitioner can prove compliance with all the terms of the previously issued order and is seeking to have an order issued reinstating a license or registration previously revoked.

* + - * 1. Procedures

The petitioner shall submit a Petition for Order of Compliance, as contained in subparagraph (c) or as contained in a Board-approved petition form, to the Board’s Administrative Office that shall contain all of the following:

A copy of the previously issued order; and

A statement of which provision of subparagraph (a) the petitioner is relying upon as a basis for the requested order; and

A copy of all documents that prove compliance with all the terms or conditions of the previously issued order. If proof of compliance requires testimony of an individual(s), including that of the petitioner, the petitioner must submit signed statements from every individual the petitioner intends to rely upon attesting, under oath, to the compliance. The Board’s consultant and administrative staff, in their discretion, may require such signed statements to be notarized. No documentation or testimony other than that submitted will be considered in making an initial determination on, or a final order in response to, the petition.

The Board authorizes its consultant and administrative staff to make an initial determination on the petition and take one of the following actions:

Certify compliance and have the matter scheduled for presentation to the Board as an uncontested matter; or

Deny the petition, after consultation with legal staff, if compliance with all of the provisions of the previous order is not proven and notify the petitioner of what provisions remain to be fulfilled and/or what proof of compliance was either not sufficient or not submitted.

If the petition is presented to the Board the petitioner may not submit any additional documentation or testimony other than that contained in the petition as originally submitted.

If the Board finds that the petitioner has complied with all the terms of the previous order an Order of Compliance shall be issued.

If the petition is denied either initially by staff or after presentation to the Board and the petitioner believes compliance with the order has been sufficiently proven the petitioner may, as authorized by law, file a petition for a declaratory order pursuant to the provisions of T.C.A. § 4-5-223 and rule 1200-10-1-.11.

* + - * 1. Form Petition

Petition for Order of Compliance Board of Dentistry

Petitioner’s Name: Petitioner’s Mailing Address:

Petitioner’s E-Mail Address:

Telephone Number:

Attorney for Petitioner: Attorney’s Mailing Address:

Attorney’s E-Mail Address:

Telephone Number:

The petitioner respectfully represents, as substantiated by the attached documentation, that all provisions of the attached disciplinary order have been complied with and I am respectfully requesting: (circle one)

An order issued reflecting that compliance; or

An order issued reflecting that compliance and lifting a previously ordered suspension or probation; or

An order issued reflecting that compliance and reinstating a license or registration previously revoked.

Note – You must enclose all documents necessary to prove your request including a copy of the original order. If any of the proof you are relying upon to show compliance is the testimony of any individual, including yourself, you must enclose signed statements from every individual you intend to rely upon attesting, under oath, to the compliance. The Board’s consultant and administrative staff, in their discretion, may require such signed statements to be notarized. No documentation or testimony other than that submitted will be considered in making an initial determination on, or a final order in response to, this petition.

Respectfully submitted this the day of , 20

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Petitioner’s Signature

* + - 1. Order Modifications - This procedure is not intended to allow anyone under a previously issued disciplinary order, including an unlicensed or unregistered practice civil penalty order, to modify any findings of fact, conclusions of law, or the reasons for the decision contained in the order. It is also not intended to allow a petition for a lesser disciplinary action, or civil penalty other than the one(s) previously ordered. All such provisions of Board orders were subject to reconsideration and appeal under the provisions of the Uniform Administrative Procedures Act (T.C.A. §§ 4-5-301, et seq.). This procedure is not available as a substitute for reconsideration and/or appeal and is only available after all reconsideration and appeal rights have been either exhausted or not timely pursued. It is also not available for those who have accepted and been issued a reprimand.
         1. The Board will entertain petitions for modification of the disciplinary portion of previously issued orders upon strict compliance with the procedures set forth in

subparagraph (b) only when the petitioner can prove that compliance with any one or more of the conditions or terms of the discipline previously ordered is impossible. For purposes of this rule the term “impossible” does not mean that compliance is inconvenient or impractical for personal, financial, scheduling or other reasons.

* + - * 1. Procedures

The petitioner shall submit a written and signed Petition for Order Modification on the form contained in subparagraph (c) or on a Board-approved petition form to the Board’s Administrative Office that shall contain all of the following:

A copy of the previously issued order; and

A statement of why the petitioner believes it is impossible to comply with the order as issued; and

A copy of all documents that proves that compliance is impossible. If proof of impossibility of compliance requires testimony of an individual(s), including that of the petitioner, the petitioner must submit signed and notarized statements from every individual the petitioner intends to rely upon attesting, under oath, to the reasons why compliance is impossible. No documentation or testimony other than that submitted will be considered in making an initial determination on, or a final order in response to, the petition.

The Board authorizes its consultant and administrative staff to make an initial determination on the petition and take one of the following actions:

Certify impossibility of compliance and forward the petition to the Office of General Counsel for presentation to the Board as an uncontested matter; or

Deny the petition, after consultation with legal staff, if impossibility of compliance with the provisions of the previous order is not proven and notify the petitioner of what proof of impossibility of compliance was either not sufficient or not submitted.

If the petition is presented to the Board the petitioner may not submit any additional documentation or testimony other than that contained in the petition as originally submitted.

If the petition is granted a new order shall be issued reflecting the modifications authorized by the Board that it deemed appropriate and necessary in relation to the violations found in the previous order.

If the petition is denied either initially by staff or after presentation to the Board and the petitioner believes impossibility of compliance with the order has been sufficiently proven the petitioner may, as authorized by law, file a petition for a declaratory order pursuant to the provisions of T.C.A. § 4-5-223 and rule 1200- 10-01-.11.

* + - * 1. Form Petition

Petition for Order Modification Board of Dentistry

Petitioner’s Name: Petitioner’s Mailing Address:

Petitioner’s E-Mail Address:

Telephone Number:

Attorney for Petitioner: Attorney’s Mailing Address:

Attorney’s E-Mail Address:

Telephone Number:

The petitioner respectfully represents that for the following reasons, as substantiated by the attached documentation, the identified provisions of the attached disciplinary order are impossible for me to comply with:

Note – You must enclose all documents necessary to prove your request including a copy of the original order. If any of the proof you are relying upon to show impossibility is the testimony of any individual, including yourself, you must enclose signed and notarized statements from every individual you intend to rely upon attesting, under oath, to the reasons why compliance is impossible. No documentation or testimony other than that submitted will be considered in making an initial determination on, or a final order in response to, this petition.

Respectfully submitted this the day of , 20 .

Petitioner’s Signature

* + - 1. Civil Penalties
         1. Purpose

The purpose of this rule is to set out schedule designating the minimum and maximum civil penalties which may be assessed pursuant to T.C.A. §63-1-134. The Board may assess these civil penalties in lieu of, the civil penalties authorized by T.C.A. §63-5- 124(a) and T.C.A. §63-5-116.

* + - * 1. Schedule of Civil Penalties

A Type A Civil Penalty may be imposed whenever the Board finds a person who is required to be licensed, certified, permitted, or registered by the Board, guilty of a willful and knowing violation of the Dental Practice Act, or regulations promulgated pursuant thereto, to such an extent that there is, or is likely to be,

an imminent, substantial threat to the health, safety and welfare of an individual patient or the public. For purposes of this section, willfully and knowingly practicing dentistry, as a dental hygienist or as a dental assistant without a permit, license, certification or registration from the Board is one of the violations of the Dental Practice Act for which a Type A Civil Penalty is assessable.

A Type B Civil Penalty may be imposed whenever the Board finds the person required to be licensed, certified, permitted, or registered by the Board is guilty of a violation of the Dental Practice Act or regulations promulgated pursuant thereto in such manner as to impact directly on the care of patients or the public.

A Type C Civil Penalty maybe imposed whenever the Board finds the person required to be licensed, certified, permitted, or registered by the Board is guilty of a violation of the Dental Practice Act or regulations promulgated pursuant thereto, which are neither directly detrimental to the patients or public, nor directly impact their care, but have only an indirect relationship to patient care or the public.

* + - * 1. Amount of Civil Penalties.

Type A Civil Penalties shall be assessed in the amount of not less than $500 and not more than $1000.

Type B Civil Penalties may be assessed in the amount of not less than $100 and not more than $500.

Type C Civil Penalties may be assessed in the amount of not less than $50 and not more than $100.

* + - * 1. Procedures for Assessing Civil Penalties

The Division of Health Related Boards may initiate a civil penalty assessment by filing a Memorandum of Assessment of Civil Penalty. The Division shall state in the memorandum the facts and law upon which it relies in alleging a violation, the proposed amount of the civil penalty and the basis for such penalty. The Division may incorporate the Memorandum of Assessment of Civil Penalty with a Notice of Charges which may be issued attendant thereto.

Civil Penalties may also be initiated and assessed by the Board during consideration of any Notice of Charges. In addition, the Board may, upon good cause shown, assess a type and amount of civil penalty which was not recommended by the Division.

In assessing the civil penalties pursuant to these rules the Board may consider the following factors:

Whether the amount imposed will be a substantial economic deterrent to the violator;

The circumstances leading to the violation;

The severity of the violation and the risk of harm to the public;

The economic benefits gained by the violator as a result of non- compliance; and

The interest of the public.

All proceedings for the assessment of civil penalties shall be governed by the contested case provision of Title 4, Chapter 5, T.C.A.

* + - 1. All contested case hearings before the Board shall be conducted pursuant to the Uniform Rules of Procedures for Contested Case Hearings Before State Administrative Agencies, Rules 1360-04-01-.01 through 1360-04-01-.20.
      2. Assessment of costs in disciplinary proceedings shall be as set forth in T.C.A. §§ 63-1-144 and 63-5-124.
      3. Subpoenas
         1. Purpose - Although this rule applies to persons and entities other than dentists, it is the Board’s intent as to dentists that they be free to comprehensively treat and document treatment of their patients without fear that the treatment or its documentation will be unduly subjected to scrutiny outside the profession. Consequently, balancing that intent against the interest of the public and patients to be protected against substandard care and activities requires that persons seeking to subpoena such information and/or materials must comply with the substance and procedures of these rules.

It is the intent of the Board that the subpoena power outlined herein shall be strictly construed. Such power shall not be used by the Division or Board investigators to seek other incriminating evidence against dentists when the Division or Board does not have a complaint or basis to pursue such an investigation. Thus, unless the Division or its investigators have previously considered, discovered, or otherwise received a complaint from either the public or a governmental entity, no subpoena as contemplated herein shall issue.

* + - * 1. Definitions - As used in this chapter of rules the following words shall have the meanings ascribed to them:

Probable Cause

For Investigative Subpoenas - Shall mean that probable cause, as defined by case law at the time of request for subpoena issuance is made, exists that a violation of T.C.A. §§ 63-5-101, et seq., or rules promulgated pursuant thereto has occurred or is occurring and that it is more probable than not that the person(s), or item(s) to be subpoenaed possess or contain evidence which is more probable than not relevant to the conduct constituting the violation.

The utilization of the probable cause evidentiary burden in proceedings pursuant to this rule shall not in any way, nor should it be construed in any way, to establish a more restrictive burden of proof than the existing preponderance of the evidence in any civil disciplinary action which may involve the person(s) or item(s) that are the subject of the subpoena.

Presiding Officer - For investigative subpoenas shall mean any elected officer of the Board.

* + - * 1. Procedures

Investigative Subpoenas

Investigative Subpoenas are available only for issuance to the authorized representatives of the Tennessee Department of Health, its investigators and its legal staff.

An applicant for such a subpoena must either orally or in writing notify the Board’s Unit Director of the intention to seek issuance of a subpoena. That notification must include the following:

The time frame in which issuance is required so the matter can be timely scheduled; and

A particular description of the material or documents sought, which must relate directly to an ongoing investigation or contested case, and shall, in the instance of documentary materials, be limited to the records of the patient or patients whose complaint, complaints, or records are being considered by the Division or Board.

In no event shall such subpoena be broadly drafted to provide investigative access to dental records of other patients who are not referenced in a complaint received from an individual or governmental entity, or who have not otherwise sought relief, review, or Board consideration of a dentist’s conduct, act, or omission.

If the subpoena relates to the prescribing practices of a licensee, then it shall be directed solely to the records of the patient(s) who received the pharmaceutical agents and whom the Board of Pharmacy or issuing pharmacy(ies) has so identified as recipients; and

Whether the proceedings for the issuance are to be conducted by physical appearance or electronic means; and

The name and address of the person for whom the subpoena is being sought or who has possession of the items being subpoenaed.

The Board’s Unit Director shall cause to have the following done:

In as timely a manner as possible, arrange for an elected officer of the Board to preside and determine if issuing the subpoena should be recommended to the full Board; and

Establish a date, time and place for the proceedings to be conducted and notify the Presiding Officer, the applicant and the court reporter; and

Maintain a complete record of the proceedings including an audio tape in such a manner as to:

Preserve a verbatim record of the proceeding; and

Prevent the person presiding over the proceedings from being allowed to participate in any manner in any disciplinary action of any kind, formal or informal, which may result which involves either the person or the documents or records for which the subpoena was issued.

The Proceedings

The applicant shall do the following:

Provide for the attendance of all persons whose testimony is to be relied upon to establish probable cause; and

Produce and make part of the record copies of all documents to be utilized to establish probable cause; and

Obtain, complete and provide to the Presiding Officer a subpoena which specifies the following:

A. The name and address of the person for whom the subpoena is being sought or who has possession of the items being subpoenaed; and

B. The location of the materials, documents or reports for which production pursuant to the subpoena is sought, if that location is known; and

C. A brief, particular description of any materials, documents or items to be produced pursuant to the subpoena; and

D. The date, time and place for compliance with the subpoena.

Provide the Presiding Officer testimony and/or documentary evidence which in good faith the applicant believes is sufficient to establish that probable cause exists for issuance of the subpoena as well as sufficient proof that all other reasonably available alternative means of securing the materials, documents or items have been unsuccessful.

The Presiding Officer shall do the following:

Have been selected only after assuring the Board’s Unit Director that he or she has no prior knowledge of or any direct or indirect interest in or relationship with the person(s) being subpoenaed and/or the licensee who is the subject of the investigation; and

Commence the proceedings and swear all necessary witnesses; and

Hear and maintain the confidentiality of the evidence, if any, presented at the proceedings and present to the full Board only that evidence necessary for an informed decision; and

Control the manner and extent of inquiry during the proceedings and be allowed to question any witness who testifies; and

Determine, based solely on the evidence presented in the proceedings, whether probable cause exists and, if so, make such recommendation to the full Board; and

Not participate in any way in any other proceeding whether formal or informal which involves the matters, items or person(s) which are the subject of the subpoena. This does not preclude the presiding officer from presiding at further proceedings for consideration of issuance of subpoenas in the matter.

The Board shall do the following:

By a vote of two thirds (2/3) of the Board members, issue the subpoena for the person(s) or items specifically found to be relevant to the inquiry, or quash or modify an existing subpoena by a majority vote; and

Sign the subpoena as ordered to be issued, quashed or modified.

Post-Notice of Charges Subpoenas - If the subpoena is sought for a contested case hearing pursuant to Title 4, Chapter 5 of the Tennessee Code Annotated, the procedure in part (c) 1. of this paragraph shall not apply and all such post- notice of charges subpoenas should be obtained from the office of the Administrative Procedures Division of the Office of the Secretary of State pursuant to the Uniform Administrative Procedures Act and rules promulgated pursuant thereto.

* + - * 1. Subpoena Forms

All subpoenas shall be issued on forms approved by the Board.

The subpoena forms may be obtained by contacting the Board’s Administrative Office.

* + - * 1. Subpoena Service - Any method of service of subpoenas authorized by the Tennessee Rules of Civil Procedure or the rules of the Tennessee Department of State, Administrative Procedures Division may be utilized to serve subpoenas pursuant to this rule.

***Authority:*** *T.C.A. §§ 4-5-105, 4-5-202, 4-5-204, 4-5-217, 4-5-223, 4-5-224, 4-5-225, 63-1-122, 63-1-*

*134, 63-1-144, 63-5-105, 63-5-116, 63-5-124, 63-5-125, and 63-5-128.* ***Administrative History:***

*Original rule filed December 11, 1991; effective January 25, 1992. Amendment filed February 12, 1996;*

*effective April 27, 1996. Amendment filed May 15, 1996; effective September 27, 1996. Amendment*

*filed December 7, 1998; effective February 20, 1999. Amendment filed February 15, 2000; effective April*

*30, 2000. Amendment filed April 10, 2001; effective June 24, 2001. Amendment filed August 21, 2002;*

*effective November 4, 2002. Amendment filed June 18, 2004; effective September 1, 2004. Amendment*

*filed August 27, 2004; effective November 10, 2004. Amendment filed April 5, 2006; effective June 19,*

*2006. Amendment filed August 4, 2009; effective November 2, 2009.*

# 0460-01-.07 WORKING INTERVIEWS.

1. A dentist shall not conduct employment interviews with dentists, dental hygienists or dental assistants that include any patient care unless the dentist visually inspects and verifies the

dentist’s, dental hygienist’s or dental assistant’s current and unrestricted authorization to practice their profession in Tennessee.

1. A licensee’s failure to comply with the provisions of this rule shall constitute unprofessional conduct and subject the licensee to disciplinary action pursuant to Rule 0460-01-.06.
2. An applicant’s failure to comply with the provisions of this rule shall constitute unprofessional conduct and subject the applicant to licensure denial pursuant to Rule 0460-01-.04.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-104, 63-5-105, 63-5-107, and 63-5-116.* ***Administrative***

***History:*** *Original rule filed December 11, 1991; effective January 25, 1992. Amendment filed February 9, 2000; effective April 24, 2000. New rule filed April 10, 2001; effective June 24, 2001.*

# 0460-01-.08 DENTAL PROFESSIONAL CORPORATIONS AND DENTAL PROFESSIONAL LIMITED LIABILITY COMPANIES.

1. Dental Professional Corporations (D.P.C.) – Except as provided in this rule Dental Professional Corporations shall be governed by the provisions of Tennessee Code Annotated, Title 48, Chapter 101, Part 6.
   1. Filings – A D.P.C. need not file its Charter or its Annual Statement of Qualifications with the Board.
   2. Ownership of Stock – Only the following may form and own shares of stock in a foreign or domestic D.P.C. doing business in Tennessee:
      1. Dentists licensed pursuant to Tennessee Code Annotated Title 63, Chapter 5; and/or
      2. A foreign or domestic general partnership, D.P.C. or Dental Professional Limited Liability Company (D.P.L.L.C.) in which all partners, shareholders, members or holders of financial rights are dentists licensed pursuant to Tennessee Code Annotated Title 63, Chapter 5 to practice dentistry in Tennessee, or composed of entities which are directly or indirectly owned by such licensed dentists.
   3. Officers and Directors of Dental Professional Corporations -
      1. All, except the following officers, must be persons who are eligible to form or own shares of stock in a dental professional corporation as limited by T.C.A. § 48- 101-610 (d) and subparagraph (1) (b) of this rule:
         1. Secretary;
         2. Assistant Secretary;
         3. Treasurer; and
         4. Assistant Treasurer.
      2. With respect to members of the Board of Directors, only persons who are eligible to form or own shares of stock in a dental professional corporation as limited by

T.C.A. § 48-101-610 (d) and subparagraph (1) (b) of this rule shall be directors of a D.P.C.

* 1. Practice Limitations
     1. Engaging in, or allowing another dentist incorporator, shareholder, officer, or director, while acting on behalf of the D.P.C., to engage in, dental practice in any area of practice or specialty beyond that which is specifically set forth in the charter may be a violation of the unprofessional conduct enumerated in Rule 0460-01-.12 and/or Tennessee Code Annotated, Section 63-5-124 (a) (1).
     2. Nothing in these rules shall be construed as prohibiting any health care professional licensed pursuant to Tennessee Code Annotated, Title 63 from being an employee of or a contractor to a D.P.C.
     3. Nothing in these rules shall be construed as prohibiting a D.P.C. from electing to incorporate for the purposes of rendering professional services within two (2) or

more professions or for any lawful business authorized by the Tennessee Business Corporations Act so long as those purposes do not interfere with the exercise of independent dental judgment by the dentist incorporators, directors, officers, shareholders, employees or contractors of the D.P.C. who are practicing dentistry as defined by Tennessee Code Annotated, Section 63-5-108.

* + 1. Nothing in these rules shall be construed as prohibiting a dentist from owning shares of stock in any type of professional corporation other than a D.P.C. so long as such ownership interests do not interfere with the exercise of independent dental judgment by the dentist while practicing dentistry as defined by Tennessee Code Annotated, Section 63-5-108.

1. Dental Professional Limited Liability Companies (D.P.L.L.C.) - Except as provided in this rule Dental Professional Limited Liability Companies shall be governed by either the provisions of Tennessee Code Annotated, Title 48, Chapters 248 or 249.
   1. Filings - Articles filed with the Secretary of State shall be deemed to be filed with the Board and no Annual Statement of Qualifications need be filed with the Board.
   2. Membership - Only the following may be members or holders of financial rights of a foreign or domestic D.P.L.L.C. doing business in Tennessee:
      1. Dentists licensed pursuant to Tennessee Code Annotated Title 63, Chapter 5; and/or
      2. A foreign or domestic general partnership, D.P.C. or D.P.L.L.C. in which all partners, shareholders, members or holders of financial rights are either dentists licensed pursuant to Tennessee Code Annotated Title 63, Chapter 5 to practice dentistry in Tennessee or composed of entities which are directly or indirectly owned by such licensed dentists.
   3. Managers, Directors or Governors of a D.P.L.L.C.
      1. All, except the following managers, must be persons who are eligible to form or become members or holders of financial rights of a dental professional limited liability company as limited by T.C.A. § 48-248-401 (d) and subparagraph (2) (b) of this rule:
         1. Secretary
         2. Treasurer
      2. Only persons who are eligible to form or become members or holders of financial rights of a dental professional limited liability company as limited by T.C.A. § 48- 248-401 (d) and subparagraph (2) (b) of this rule shall be allowed to serve as a director, or serve on the Board of Governors of a D.P.L.L.C.
   4. Practice Limitations
      1. Engaging in, or allowing another dentist member or holder of financial rights, officer, manager, director, or governor, while acting on behalf of the D.P.L.L.C., to engage in, dental practice in any area of practice or specialty beyond that which is specifically set forth in the articles of organization may be a violation of the unprofessional conduct enumerated in Rule 0460-01-.12 and/or Tennessee Code Annotated, Section 63-5-124 (a) (1).
      2. Nothing in these rules shall be construed as prohibiting any health care professional licensed pursuant to Tennessee Code Annotated, Title 63 from being an employee of or a contractor to a D.P.L.L.C.
      3. Nothing in these rules shall be construed as prohibiting a D.P.L.L.C. from electing to form for the purposes of rendering professional services within two (2) or more professions or for any lawful business authorized by the Tennessee Limited Liability Company Act or the Tennessee Revised Limited Liability Company Act so long as those purposes do not interfere with the exercise of independent dental judgment by the dentist members or holders of financial rights, governors, officers, managers, employees or contractors of the D.P.L.L.C. who are practicing dentistry as defined by Tennessee Code Annotated, Section 63-5-108.
      4. Nothing in these rules shall be construed as prohibiting a dentist from being a member or holder of financial rights of any type of professional limited liability company other than a D.P.L.L.C. so long as such interests do not interfere with the exercise of independent dental judgment by the dentist while practicing dentistry as defined by Tennessee Code Annotated, Section 63-5-108.
      5. All D.P.L.L.C.s formed in Tennessee pursuant to Tennessee Code Annotated, Sections 48-248-104 or 48-249-1104 to provide services only in states other than Tennessee shall annually file with the Board a notarized statement that they are not providing services in Tennessee.
2. Dissolution - The procedure that the Board shall follow to notify the attorney general that a

D.P.C. or a D.P.L.L.C. has violated or is violating any provision of Title 48, Chapters 101, 248 and/or 249, shall be as follows but shall not terminate or interfere with the secretary of state’s authority regarding dissolution pursuant to Tennessee Code Annotated, Sections 48-101- 624, 48-248-409, or 48-249-1122.

1. Service of a written notice of violation by the Board on the registered agent of the

D.P.C. and/or D.P.L.L.C. or the secretary of state if a violation of the provisions of Tennessee Code Annotated, Title 48, Chapters 101, 248, and/or 249 occurs.

1. The notice of violation shall state with reasonable specificity the nature of the alleged violation(s).
2. The notice of violation shall state that the D.P.C. and/or D.P.L.L.C. must, within sixty

(60) days after service of the notice of violation, correct each alleged violation or show to the Board’s satisfaction that the alleged violation(s) did not occur.

1. The notice of violation shall state that, if the Board finds that the D.P.C. and/or

D.P.L.L.C. is in violation, the attorney general will be notified and judicial dissolution proceedings may be instituted pursuant to Tennessee Code Annotated, Title 48.

1. The notice of violation shall state that proceedings pursuant to this section shall not be conducted in accordance with the contested case provisions of the Uniform Administrative Procedures Act, compiled in Title 4, Chapter 5 but that the D.P.C. and/or D.P.L.L.C., through its agent(s), shall appear before the Board at the time, date, and place as set by the Board and show cause why the Board should not notify the attorney general and reporter that the organization is in violation of the Act or these rules. The Board shall enter an order that states with reasonable particularity the facts describing each violation and the statutory or rule reference of each violation. These proceedings shall constitute the conduct of administrative rather than disciplinary business.
2. If, after the proceeding the Board finds that a D.P.C. and/or D.P.L.L.C. did violate any provision of Title 48, Chapters 101, 248, and/or 249 or these rules, and failed to correct said violation or demonstrate to the Board’s satisfaction that the violation did not occur, the Board shall certify to the attorney general and reporter that it has met all requirements of Tennessee Code Annotated, Sections 48-101-624 (1)-(3), and/or 48- 248-409 (1)-(3) and/or 48-249-1122 (1)-(3).
3. Violation of this rule by any dentist individually or collectively while acting as a D.P.C. or as a

D.P.L.L.C. may subject the dentist(s) to disciplinary action pursuant to Tennessee Code Annotated, Sections 63-5-124 (a) (1).

1. The authority to own shares of stock or be members or holders of financial rights in a D.P.C. or a D.P.L.L.C. granted by statute or these rules to professionals not licensed in this state shall in no way be construed as authorizing the practice of any profession in this state by such unlicensed professionals.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 48-101-605, 48-101-608, 48-101-610, 48-101-618, 48-101-624,*

*48-101-628, 48-101-629, 48-101-630, 48-248-104, 48-248-202, 48-248-401, 48-248-404, 48-248-409,*

*48-248-501, 48-248-601, 48-248-602, 48-248-603, 48-249-101, et seq., 63-5-105, 63-5-107, 63-5-108,*

* + 1. *, 63-5-121, and 63-5-124.* ***Administrative History:*** *Original rule certified June 7, 1974. Repeal*

*filed August 26, 1980; effective December 1, 1980. New rule filed September 4, 1998; effective*

*November 18, 1998. Amendment filed June 13, 2003; effective August 27, 2003. Repeal and new rule*

*filed April 5, 2006; effective June 19, 2006. Amendment filed September 25, 2008; effective December 9,*

*2008.*

# 0460-01-.09 REPEALED.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, and 63-5-105.* ***Administrative History:*** *New rule filed September 4, 1998; effective November 18, 1998. Amendment filed June 13, 2003; effective August 27,*

*2003. Repeal filed April 5, 2006; effective June 19, 2006*

**0460-01-.10 CLINICAL TECHNIQUES-TEETH WHITENING.** All teeth whitening formulations, except those sold over-the-counter, shall be prescribed and dispensed by a licensed dentist. Licensed dental hygienists or registered dental assistants are authorized to apply teeth whitening formulations, but only under the direct supervision of a licensed dentist.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-108, and 63-5-115.* ***Administrative History:***

*Original rule certified June 7, 1974. Repeal filed August 26, 1980; effective December 1, 1980. New rule*

*filed August 21, 2002; effective November 4, 2002.*

# 0460-01-.11 INFECTION CONTROL.

* + - 1. The dentist shall ensure that at least one (1) of the following sterilization procedures is utilized daily for instruments and equipment:
         1. Steam autoclave
         2. Dry-heat
         3. Chemical vapor
         4. Disinfectant/chemical sterilant. U.S. Environmental Protection Agency (EPA) approved disinfectant shall be used in dilution amounts and specified time periods.
         5. Any procedure listed in MMWR, Vol 41, No. RR8, pp. 1-12, May 28, 1993 or successor publications.
      2. The following instruments, unless disposable, shall be sterilized between patients, after removal of debris, by one (1) of the above methods provided in paragraph (1):
         1. Low speed handpiece contra angles, prophy angles and nose cone sleeves
         2. High speed handpieces and surgical handpieces
         3. Hand and orthodontic instruments
         4. Burs and bur changers, including contaminated laboratory burs and diamond abrasives
         5. Endodontic instruments
         6. Air-water syringe tips
         7. High volume evacuator tips
         8. Sonic or ultrasonic scalers and tips
         9. Surgical instruments
         10. Electro-surgery tips
         11. Metal impression trays
         12. Intra-oral radiographic equipment that can withstand heat sterilization
      3. All heat sterilizing devices must be tested for proper function by means of a biological monitoring system that indicates microorganism kill. The biological monitoring system used must include a control to verify proper microbial incubation. In the event of a positive biological spore test, the dentist must take immediate action to ensure that heat sterilization is being accomplished. Immediate action is defined as following manufacturer guidelines and performing a second (2nd) biological spore test. In the event a second (2nd) positive biological spore test occurs, the device must be removed from service until repaired. Proof of such repair must be maintained with the testing documentation.
      4. Documentation must be maintained on all heat sterilizing devices in a log reflecting dates and person(s) conducting the testing, or by retaining copies of reports from an independent testing entity. The documentation shall be maintained for a period of at least two (2) years, and shall be maintained in the dental office and be made immediately available upon request by an authorized agent of the Tennessee Department of Health.
      5. Environmental surfaces that are contaminated by blood or saliva must be properly cleaned prior to disinfecting.
      6. Disinfection must be accomplished with an appropriate disinfectant that is registered with the EPA and used in accordance with the manufacturer’s instructions or with bleach used in a dilution ratio of one (1) to ten (10) or one hundred (100) [1:10 or 1:100]. The disinfection process must be followed between each patient in the absence of a barrier.
      7. Barrier such as impervious backed paper, aluminum foil or plastic wrap must be used to cover surfaces or items that may be contaminated by blood or saliva and that are difficult or impossible to disinfect. The barrier must be removed, discarded, and then replaced between patients.
      8. All single use or disposable items, labeled as such, used to treat a patient must be discarded and not reused.
      9. Items such as impressions contaminated with blood or saliva must be thoroughly rinsed, disinfected, placed in, and transported to the dental laboratory in an appropriate case containment device that is properly sealed and labeled “Biohazard”, or labeled with the universal symbol for hazardous materials, or placed in a red container.
      10. Oral prosthetic appliances received from a dental laboratory must be washed with soap or a detergent and water, rinsed well, appropriately disinfected, and rinsed well again before the prosthetic appliance is placed in the patient’s mouth.
      11. Surgical or examination gloves, surgical masks, and eye protection with eye shields shall be worn by all dentists, dental hygienists and dental assistants while performing, or assisting in the performance of, any intra-oral dental procedure on a patient in which contact with blood and/or saliva is imminent in accordance with CDC recommendations. Surgical or examination gloves must be changed between patients. Gloves are never to be washed and reused. Surgical or examination gloves that are punctured or torn must be removed and replaced immediately with new gloves following rewashing of the practitioner’s hands with soap and water.
      12. All dentists, dental hygienists, and dental assistants shall follow hand hygiene guidelines in accordance with current CDC recommendations. Hand hygiene guidelines include, but are not limited to:
          1. Hands shall be washed with soap and water when hands are visibly dirty or contaminated with proteinaceous material, are visibly soiled with blood or other body fluids, before eating, and after using a restroom.
          2. Use alcohol-based hand rubs for routine decontamination of hands for all clinical indications, except as provided in subparagraph (a).
          3. Indications for hand hygiene include contact with a patient’s intact skin, contact with environment surfaces/inanimate objects in the immediate vicinity of patients, before donning surgical or examination gloves, and after removal of gloves.
      13. To minimize the need for emergency mouth-to-mouth resuscitation, a practitioner shall ensure that mouthpieces, resuscitation bags, or other ventilation devices, appropriate to the patient population served, are available.
      14. All dental health care workers shall take appropriate precautions, pursuant to OSHA standard 29 C.F.R. 1910.1030, “Bloodborne Pathogens” or its successor, to prevent injuries caused by needles, scalpels, and other sharp instruments or devices during procedures. If a needlestick injury occurs, the dentist shall comply with the requirements established by OSHA.
      15. All sharp items and contaminated wastes must be packaged and disposed of according to the requirements established by any federal, Tennessee state, and/or local government agencies which regulate health or environmental standards.
      16. All dental health care workers who have exudative lesions or weeping dermatitis shall refrain from contact with equipment, devices, and appliances that may be used for or during patient care, where such contact holds potential for blood or body fluid contamination, and shall refrain from all patient care and contact until condition(s) resolves unless barrier techniques would prevent patient contact with the dental health care worker’s blood or body fluid.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-2-101, 63-5-105, 63-5-108, 63-5-115, and 63-5-124.*

***Administrative History:*** *Original rule certified June 7, 1974. Repeal filed August 26, 1980; effective December 1, 1980. New rule filed June 13, 2003; effective August 27, 2003.*

**0460-01-.12 UNPROFESSIONAL CONDUCT.** Pursuant to T.C.A. § 63-5-124, the Board is authorized to refuse to grant a license or certificate to an applicant or to discipline an individual licensed or certified by the Board if that individual has engaged in unprofessional conduct. Pursuant to its authority under

* + 1. § 63-5-124, the Board declares that unprofessional conduct includes, but is not limited to, the following:
       1. Exercising undue influence on the patient or client, including the promotion of the sale of services, goods, appliances or drugs in such manner as to exploit the patient or client for the financial gain of the practitioner or of a third party.
       2. Directly or indirectly offering, giving, soliciting, or receiving or agreeing to receive, any fee or other consideration to or from a third party for the referral of a patient or client or in connection with the performance of professional services.
       3. Failing to make available to a patient or client, upon request, copies of documents in the possession or under the control of the licensee which have been prepared for and paid for by the patient or client.
       4. Making false or materially incorrect or inconsistent entries in any patient records or in the records of any health care facility, school, institution or other work place location.
       5. Revealing of personally identifiable facts, data or information obtained in a professional capacity without the prior consent of the patient or client, except as authorized or required by law.
       6. Practicing or offering to practice beyond the scope permitted by law, or accepting and performing professional responsibilities which the licensee knows or has reason to know that he or she is not competent to perform, or performing without adequate supervision professional services which the licensee is authorized to perform only under the supervision of a licensed professional, except in an emergency situation where a person's life or health is in danger.
       7. Delegating professional responsibilities to a person when the licensee delegating such responsibilities knows or has reason to know that such person is not qualified, by training, by experience or by licensure, to perform them.
       8. Performing professional services which have not been duly authorized by the patient or client or his or her legal representative.
       9. Failing to maintain an accurate and legible written evaluation and treatment history for each patient.
       10. Failing to identify to a patient, patient’s guardian or the Board the name of an employee, employer, contractor, or agent who renders dental treatment or services upon request.
       11. Failing to report suspected child abuse to the proper authorities, as required by T.C.A. § 37- 1-403(a)(2).
       12. Failing to respond to written communications from the Department of Health, which are sent pursuant to T.C.A. § 63-1-117(a), to make available any relevant records with respect to an inquiry or complaint about the licensee's unprofessional conduct.
       13. Falsifying, altering or destroying treatment records in contemplation of an investigation by the Board or a lawsuit being filed by a patient.
       14. Intentionally presenting false or misleading testimony, statements, or records to the Board or the Board’s investigator or employees during the scope of any investigation, or at any hearing of the Board.
       15. Conspiring with any person to commit an act, or committing an act which would tend to coerce, intimidate, or preclude any patient or witness from testifying against a licensee in any disciplinary hearing, or retaliating in any manner against any patient or other person who testifies or cooperates with the Department of Health during any investigation involving the Board.
       16. Violating any lawful order of the Board previously entered in a disciplinary hearing, or failing to comply with a lawfully-issued subpoena of the Board.
       17. Violating any term of probation or condition or limitation imposed on the licensee by the Board.
       18. Practicing with an expired, retired, suspended or revoked license, permit, or registration.
       19. Prescribing controlled substances for a habitual drug user in the absence of substantial dental justification.
       20. Prescribing drugs for other than legitimate dental purposes.
       21. Providing prescriptions for any controlled substances listed in Schedules II, III, IV, and V, as provided in 21 C.F.R. Chapter 2, 1308.12 through .15, to patients with whom no dentist/patient relationship has been established. For purposes of this provision, a “dentist/patient” relationship exists where a dentist has provided dental treatment to a patient on at least one (1) occasion within the preceding year, or exists by having adequate documented knowledge of the specific patient history.
       22. Using or removing narcotics, drugs, supplies or equipment from any health care facility, school, institution or other work place location without prior authorization.
       23. Pre-signing blank prescription forms or using pre-printed or rubber stamped prescription forms containing the dentist’s signature or the name of any controlled substances listed in Schedules II, III, IV, and V, as provided in 21C.F.R. Chapter 2, 1308.12 through .15.
       24. Failing to exercise reasonable diligence to prevent partners, associates, and employees from engaging in conduct which would violate any provisions of the Tennessee Dental Practice Act or any rule, regulation, or order of the Board.
       25. Failing to avoid interpersonal relationships that could impair professional judgment or risk the possibility of exploiting the confidence of a patient, including committing any act of sexual abuse, misconduct or exploitation related to the licensee’s practice of dentistry.
       26. Termination of a dentist/patient relationship by a dentist, unless notice of the termination is provided to the patient. For purposes of this provision, a “dentist/patient” relationship exists where a dentist has provided dental treatment to a patient on at least one occasion within the preceding year.
           1. “Termination of a dentist/patient relationship by the dentist” means that the dentist is unavailable to provide dental treatment to a patient, under the following circumstances:

The office where the patient has received dental care has been closed permanently or for a period in excess of thirty (30) days; or

The dentist discontinues treatment of a particular patient for any reason, including non-payment of fees for dental services, although the dentist continues to provide treatment to other patients at the office location.

* + - * 1. The dentist who is the owner or custodian of the patient’s dental records shall mail notice of the termination of the dentist’s relationship to the patient, which notice shall provide the date that the termination becomes effective, and the date on which the dentist/patient relationship may resume, if applicable.
        2. The notice shall be mailed at least fourteen (14) days prior to the date of termination of the dentist/patient relationship, unless the termination results from an unforeseen emergency (such as sudden injury or illness), in which case the notice shall be mailed as soon as practicable under the circumstances.
      1. Interfering or attempting to interfere with the professional judgment of an individual who is licensed or certified by the Board. Examples of interfering with the professional judgment of an individual who is licensed or certified by the Board include, but are not limited to, the following:
         1. Setting a maximum or other standardized time for the performance of specific dental procedures.
         2. Establishing professional standards, protocols or practice guidelines which conflict with generally accepted standards within the dental profession.
         3. Entering into any agreement or arrangement for management services that:

interferes with a dentist’s exercise of his/her independent professional judgment;

encourages improper overtreatment or undertreatment by dentists; or

encourages impermissible referrals from unlicensed persons in consideration of a fee.

* + - * 1. Placing limitations or conditions upon communications that are clinical in nature with the dentist's patients.
        2. Precluding or restricting an individual’s ability to exercise independent professional judgment over all qualitative and quantitative aspects of the delivery of dental care.
        3. Penalizing a dentist for reporting violations of a law regulating the practice of dentistry.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 37-1-403, 63-1-117, 63-5-105, 63-5-108, and 63-5-124.*

***Administrative History:*** *Original rule certified June 7, 1974. Repeal filed August 26, 1980; effective December 1, 1980. Amendment filed May 28, 2004; effective August 11, 2004.*

# 0460-01-.13 ETHICS.

1. For licensed dentists, the Board adopts, as if fully set out herein and to the extent that it does not conflict with state law, rules or Board Position Statements, the American Dental Association (ADA) Principles of Ethics and Code of Professional Conduct as it may, from time to time, be amended. A copy of the ADA Principles of Ethics and Code of Professional Conduct may be obtained by contacting the American Dental Association at 211 East

Chicago Avenue, Chicago, IL 60611, or by phone at (312) 440-2500, or on the Internet at [http://www.ada.org.](http://www.ada.org/)

1. For licensed dental hygienists, the Board adopts, as if fully set out herein and to the extent that it does not conflict with state law, rules or Board Position Statements, the American Dental Hygienists' Association (ADHA) Code of Ethics for Dental Hygienists as it may, from time to time, be amended. A copy of the ADHA Code of Ethics for Dental Hygienists may be obtained by contacting the American Dental Hygienists' Association at 444 North Michigan Avenue, Suite 3400, Chicago, IL 60611, or by phone at (312) 440-8900, or on the Internet at [http://www.adha.org.](http://www.adha.org/)
2. For registered dental assistants, the Board adopts, as if fully set out herein and to the extent that it does not conflict with state law, rules or Board Position Statements, the American Dental Assistants Association (ADAA) Principles of Ethics and Professional Conduct as it may, from time to time, be amended. A copy of the ADAA Principles of Ethics and Professional Conduct may be obtained by contacting the American Dental Assistants Association at 203 North LaSalle Street, Chicago, IL 60601-1225, or by phone at (312) 541- 1550, or on the Internet at [http://www.dentalassistant.org.](http://www.dentalassistant.org/)

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, and 63-5-124.* ***Administrative History:*** *Original rule*

*certified June 7, 1974. Repeal filed August 26, 1980; effective December 1, 1980. New rule filed*

*October 20, 2003; effective January 3, 2004.*

# 0460-01-.14 MOBILE DENTAL CLINICS.

1. Mobile dental clinics shall be operated/owned only by a dentist licensed in Tennessee, an official agency of the state government or any subdivision thereof, any nonprofit organization, or any hospital. Dental hygienists and dental assistants shall not operate/own a mobile dental clinic.
2. All mobile dental clinics in Tennessee shall:
   1. Maintain all dental records as provided in Rule 0460-02-.12.
   2. Observe all patient rights as provided in Rule 0460-01-.16.
   3. Obtain written, informed consent when treating a minor.
   4. Comply with all applicable federal, state and local laws, regulations and ordinances regulating radiographic equipment, flammability, construction, and zoning.
   5. Obtain all applicable county and city licenses or permits to operate the facility.
   6. Comply with all applicable federal, state and local laws, regulations and ordinances regarding infection control and sanitation procedures, including:
      1. Providing access to a ramp or lift if services are provided to disabled persons.
      2. Having access to a properly functioning sterilization system.
      3. Having access to an adequate supply of potable water, including hot water.
      4. Having access to toilet facilities.
      5. Having a covered galvanized, stainless steel, or other non-corrosive metal container for deposit of refuse and waste materials; and,
      6. Compliance with Rule 0460-01-.11.
3. The mobile dental clinic must have:
   1. A dental treatment chair;
   2. A dental treatment light;
   3. A radiographic unit with appropriate processing equipment;
   4. A portable delivery system or an integrated system;
   5. An evacuation unit suitable for dental surgical use;
   6. Equipment to treat medical emergencies; and,
   7. Appropriate and sufficient dental instruments and infection control supplies.
4. School-based prevention programs whose mobile dental clinics provide only dental screenings, oral health education, oral evaluations, topical fluoride, and sealant application are not required to have the equipment listed in subparagraphs (3) (c), (3) (e) and (3) (f) of this rule.
5. The driver of the mobile dental clinic must possess a valid operator’s license appropriate for the type vehicle being driven and not have any violations related to the operation of a motor vehicle in the last three (3) years, and not have any violations involving alcohol or illegal substances related to the operation of a motor vehicle in the last ten (10) years.
6. All dental hygienist and dental assistants assisting the dentist must be currently licensed and registered with the Tennessee Board of Dentistry.
7. Dental hygienists may perform delegable procedures for patients of record of their employer dentist who reside in nursing homes pursuant to Rule 0460-03-.09 (2).
8. When treating a nursing home patient, the dentist must comply with Rule 0460-01-.15.
9. Violations of this rule subject the licensee/registrant to disciplinary action, pursuant to T.C.A.

§ 63-5-124.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-107, 63-5-108, 63-5-115, 63-5-121, and 63-5-*

1. ***Administrative History:*** *Original rule certified June 7, 1974. Repeal filed August 26, 1980; effective December 1, 1980. Repeal and new rule filed August 23, 2005; effective November 6, 2005. Amendment filed October 12, 2007; effective December 26, 2007.*

**0460-01-.15 TREATMENT OF NURSING HOME PATIENTS.** When treating a nursing home patient in a mobile clinic or in a nursing home, the dentist must:

* 1. Record in both the dental record and the nursing home patient record the procedures performed.
  2. Record in the dental record the name of the facility where the patient resides.
  3. Obtain written informed consent from the patient or if patient is unable to fully understand and give informed consent, consent must be obtained from the legal guardian of the patient. If a power of attorney is on file in the nursing home for the patient, the written informed consent must be obtained from the person who holds the authority under the power of attorney. It is the responsibility of the dentist to ascertain whether or not a power of attorney is on file for the patient before evaluation of the patient by the dentist; and,
  4. Consult with the patient’s physician when medically indicated.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, and 63-5-108.* ***Administrative History:*** *Original rule*

*certified June 7, 1974. Repeal filed August 26, 1980; effective December 1, 1980. Repeal and new rule*

*filed August 23, 2005; effective November 6, 2005.*

**0460-01-.16 PATIENT RIGHTS.** Each patient shall, at a minimum, be afforded the following rights:

1. To be treated with respect, consideration and dignity.
2. To privacy in treatment.
3. To have their records kept confidential and private.
4. To be provided information concerning their diagnosis, evaluation, treatment options and progress.
5. An opportunity to participate in decisions involving their health care.
6. To refuse any diagnostic procedure or treatment and be advised of the consequences of that refusal.
7. To obtain a copy or summary of their personal dental record, pursuant to T.C.A. §§ 63-2-101, et seq.
8. To have appropriate assessment and management of pain.
9. To be free from mental and physical abuse. Should this right be violated, the dentist must notify the Tennessee Department of Human Services, Adult Protective Services or Tennessee Department of Children’s Services immediately as required by law.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-2-101, 63-5-105, and 63-5-124.* ***Administrative History:***

*Original rule certified June 7, 1974. Repeal filed August 26, 1980; effective December 1, 1980. New rule*

*filed June 13, 2003; effective August 27, 2003.*

# 0460-01-.17 CONSUMER RIGHT-TO-KNOW REQUIREMENTS.

1. Malpractice Reporting Requirements - The threshold amount below which medical malpractice judgments, awards or settlements in which payments are awarded to complaining parties need not be reported pursuant to the “Health Care Consumer Right-To- Know Act of 1998” shall be twenty-five thousand dollars ($25,000).
2. Criminal Conviction Reporting Requirements - For purposes of the “Health Care Consumer Right-To-Know Act of 1998”, the following criminal convictions must be reported:
   1. Conviction of any felony; and
   2. Conviction or adjudication of guilt of any misdemeanor, regardless of its classification, in which any element of the misdemeanor involves any one or more of the following:
      1. Sex.
      2. Alcohol or drugs.
      3. Physical injury or threat of injury to any person.
      4. Abuse or neglect of any minor, spouse or the elderly.
      5. Fraud or theft.
   3. If any misdemeanor conviction reported under this rule is ordered expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be expunged from any profile.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-101, and 63-51-101, et seq.* ***Administrative History:***

*Original rule filed February 15, 2000; effective April 30, 2000.*

# 0460-01-.18 RESTRAINT OF PEDIATRIC AND SPECIAL NEEDS PATIENTS.

1. Purpose – The purpose of this rule is to recognize the unfortunate fact that pediatric and special needs patients may need to be restrained in order to prevent injury and to protect the health and safety of the patients, the dentist, and the dental staff. To achieve this it will be important to build a trusting relationship between the dentist, the dental staff and the patient. This will necessitate that the dentist establishes communication with the patient and promote a positive attitude towards oral and dental health in order to alleviate fear and anxiety and to deliver quality dental care.
2. Training Requirement – Prior to administering restraint, the dentist must have received formal training at a dental school or during an American Dental Association accredited residency program in the methods of restraint described in paragraph (4) of this rule.
3. Pre-Restraint Requirements
   1. Prior to administering restraint, the dentist shall consider:
      1. The need to diagnose and treat the patient;
      2. The safety of the patient, dentist, and staff;
      3. The failure of other alternate behavioral methods;
      4. The effect on the quality of dental care;
      5. The patient’s emotional development; and
      6. The patient’s physical condition.
   2. Prior to administering restraint, the dentist shall obtain written informed consent from the parent or legal guardian and document such consent in the dental record, unless the parent or legal guardian is restraining or immobilizing the patient by use of the method described in subparagraph (4) (b) of this rule.
4. Methods of Restraint
   1. The Hand-Over-Mouth Exercise (HOME) Method
      1. This method may be used for a healthy child who is able to understand and cooperate but who exhibits defiant, aggressive, or hysterical behavior during dental treatment.
      2. Use of this method shall never obstruct the patient’s airway nor be used:
         1. With patients whose age, disability, or emotional immaturity prevent them from being able to understand and/or cooperate;
         2. When patients are under the influence of medications which prevent them from being able to understand and/or cooperate;
         3. When patients have an airway obstruction or when restraint will prevent the patient from breathing; or,
         4. When the parent or legal guardian has not given written informed consent for this method to be utilized.
   2. The Physical Restraint or Medical Immobilization Method
      1. This method may be used to partially or completely immobilize the patient for required diagnosis and/or treatment if the patient cannot cooperate due to lack of maturity, mental or physical handicap, failure to cooperate after other behavior managements techniques have failed and/or when the safety of the patient, dentist, or dental staff would be at risk without using protective restraint. This method should only be used to reduce or eliminate untoward movement, protect the patient and staff from injury, and to assist in the delivery of quality dental treatment. If restraint or immobilization is deemed necessary, the least restrictive technique shall be used.
      2. Use of this method shall not be used:
         1. With cooperative patients;
         2. On patients who, due to their medical or systemic condition, cannot be immobilized safely;
         3. As punishment; or,
         4. Solely for the convenience of the dentist and/or dental staff.
5. Dental hygienists and dental assistants shall not use the methods described in paragraph (4) by themselves, but may assist the dentist as necessary.
6. The patient’s record shall include:
   1. Written informed consent from parents or legal guardians;
   2. Type of method used;
   3. Reason for use of that method;
   4. Duration of method used; and,
   5. If restraint or immobilization is used, type of restraint or immobilization used.
7. Parents or legal guardians must be informed in advance of what treatment the patient will receive and why the use of restraints may be required. Parents or legal guardians shall be informed of the office policy concerning parental presence, the benefits and risks of parental presence, and of their opportunity to choose a different practitioner for the child if they are not comfortable with the office policy.
8. Parents or legal guardians may not be denied access to the patient during treatment in the dental office unless the health and safety of the patient, parent or guardian, or dental staff would be at risk. The parent or guardian shall be informed of the reason they are denied access to the patient and both the incident of the denial and the reason for the denial shall be documented in the patient’s dental record.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, and 63-5-108.* ***Administrative History:*** *Original rule*

*filed December 28, 2004; effective March 13, 2005.*

# RULES OF

**TENNESSEE BOARD OF DENTISTRY**

**CHAPTER 0460-02**

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**0460-02-.01 LICENSURE PROCESS - BY EXAM AND BY CRITERIA (RECIPROCITY).**

1. The process for obtaining licensure by exam or by criteria (reciprocity) is as follows:
   1. An applicant shall obtain a Board application form from the Board Administrative Office, respond truthfully and completely to every question or request for information contained in the form and submit it along with all documentation and fees required by the form and this rule to the Board Administrative Office. It is the intent of this rule that all activities necessary to accomplish the filing of the required documentation be completed prior to filing a licensure application and that all documentation be filed simultaneously.
   2. An applicant shall cause to be submitted directly, from a dental school, college or university duly accredited by the Commission on Dental Accreditation of the American Dental Association, to the Board Administrative Office a certificate of graduation containing the institution’s Official Seal and which shows the following:
      1. The applicant’s transcript; and
      2. The degree and diploma conferred, or a letter from the Dean of the educational institution attesting to the applicant’s eligibility for the degree and diploma if the last term of dental school has not been completed at the time of application. However, no license shall be issued until official notification is received in the Board Administrative Office that the degree and diploma have been conferred.
   3. An applicant shall submit a signed “passport” style photograph taken within the preceding twelve (12) months.
   4. An applicant shall submit evidence of good moral character. Such evidence shall include at least two (2) letters attesting to the applicant’s character from dental professionals on the signator’s letterhead.
   5. An applicant shall submit proof of United States or Canadian citizenship or evidence of being legally entitled to live in the United States. Such evidence may include copies of birth certificates, naturalization papers, or current visa status.
   6. An applicant shall submit the required fees as provided in Rule 0460-01-.02 (1).
   7. An applicant shall disclose the circumstances surrounding any of the following:
      1. Conviction of any criminal law violation of any country, state, or municipality, except minor traffic violations.
      2. The denial of licensure application by any other state or the discipline of licensure in any state.
      3. Loss or restriction of hospital privileges.
      4. Any other civil suit judgment or civil suit settlement in which the applicant was a party defendant including, without limitation, actions involving malpractice, breach of contract, antitrust activity or any other civil action remedy recognized under any country’s or state’s statutory, common, or case law.
      5. Failure of any dental licensure examination.
   8. An applicant shall cause to be submitted to the Board’s administrative office directly from the vendor identified in the Board’s licensure application materials, the result of a criminal background check.
   9. An applicant shall submit evidence of current training in cardiopulmonary resuscitation (CPR) which is defined as successful completion of a BLS for Healthcare Providers, or CPR/AED for Professional Rescuers, or an equivalent course, which provides training for healthcare professionals in CPR and the use of an AED by a Board approved training organization. The course must be conducted in person and include a skills examination on a manikin with a certified instructor.
   10. An applicant shall indicate whether the applicant is physically capable of performing the procedures included in the practice of dentistry and if not, make explanation.
   11. An applicant shall successfully complete the Tennesee Board of Dentistry Ethics and Jurisprudence examination.
2. In addition to completing the process described in paragraph (1), an applicant for licensure by exam:
   1. Shall cause to be submitted a certificate of successful completion of the examinations for licensure as governed by Rule 0460-02-.05; and
   2. If an applicant for licensure by exam has ever held a license to practice dentistry in any other state or Canada, the applicant shall submit or cause to be submitted directly to the Board’s administrative office from each licensing board that has currently or has ever granted authority to practice dentistry indication that the applicant either holds a current active license and whether it is in good standing, or held a license which is currently inactive and whether it was in good standing at the time it became inactive.
3. In addition to completing the process described in paragraph (1), an applicant for licensure by criteria (reciprocity):
   1. Shall cause to be submitted directly to the Board’s administrative office from each licensing board that has currently or has ever granted authority to practice dentistry indication that the applicant previously held or currently holds a valid license to practice dentistry and is absent of any pending disciplinary charges or action or any current investigation by a disciplinary authority, and
      1. Shall cause to be submitted directly to the Board’s administrative office pertinent information about any disciplinary action imposed in any other state; and
      2. Shall provide a copy of all current and valid licenses to practice dentistry; and
      3. Shall provide the name of another state in which licensure to practice dentistry is or has been held; and
   2. Shall demonstrate intent to actively practice or teach in Tennessee by submitting proof of employment as a dentist or by submitting proof of starting a private dental practice; and
   3. Shall demonstrate that he/she has not failed previously any exams required by Rule 0460-02-.05 without subsequently retaking and passing such exams, if passage of such exams has ever been attempted; and
   4. Shall demonstrate that he/she has practiced dentistry in another state or states for at least five (5) years by submitting proof of employment as a dentist or by submitting proof of having had a private dental practice; or
   5. Shall demonstrate that he/she has taught in an American Dental Association accredited institution for at least five (5) years; or
   6. Shall demonstrate any combination of subparagraphs (d) and (e) for at least five (5) years; or
   7. Shall demonstrate that he/she has practiced dentistry in another state or states for at least two (2) years by submitting proof of employment as a dentist or by submitting proof of having had a private dental practice, and shall cause to be submitted a certificate of successful completion of an examination administered by another state, as provided in T.C.A. § 63-5-110(b)(6)(D); or
   8. Shall demonstrate that he/she has taught in an American Dental Association accredited institution for at least two (2) years, and shall cause to be submitted a certificate of successful completion of the examinations for licensure as governed by Rule 0460-02-

.05 or of an examination administered by another state, as provided in T.C.A. § 63-5- 110(b)(6)(E); or

* 1. Shall demonstrate any combination of subparagraphs (g) and (h) for at least two (2) years.

1. Application review and licensure decisions required by this rule shall be governed by Rule 0460-01-.04.

***Authority:*** *T.C.A. §§ 4-3-1011, 4-5-202, 4-5-204, 63-5-105, 63-5-107, 63-5-110, 63-5-111, 63-5-124, and*

*63-5-132.* ***Administrative History:*** *Original rule certified June 7, 1974. Repeal and new rule filed August 26, 1980; effective December 1, 1980. Amendment filed October 13, 1983; effective November 14, 1983.*

*Amendment filed September 24, 1987; effective November 8, 1987. Amendment filed June 8, 1989;*

*effective July 23, 1989. Amendment filed November 30, 1989; effective January 14, 1990. Amendment*

*filed April 30, 1991; effective June 14, 1991. Repeal and new rule filed December 11, 1991; effective*

*January 25, 1992. Amendment filed May 15, 1996; effective September 27, 1996. Amendment filed*

*February 9, 2000; effective April 24, 2000. Amendment filed October 20, 2003; effective January 3, 2004.*

*Amendment filed August 23, 2005; effective November 6, 2005. Amendment filed December 16, 2005;*

*effective March 1, 2006. Amendment filed March 17, 2006; effective May 31, 2006. Amendment filed*

*September 30, 2014; effective December 29, 2014. Amendments filed October 25, 2017; effective*

*January 23, 2018.*

**0460-02-.02 DUAL DEGREE LICENSURE PROCESS.** The Board may issue a license to practice dentistry in Tennessee to persons who hold both dental and medical degrees and meet the qualifications contained in this rule. The process for obtaining a license by this method is as follows:

1. An applicant shall obtain an application form from the Board Administrative Office, respond truthfully and completely to every question or request for information contained in the form and submit it along with all documentation and fees required by the form or this rule to the Board Administrative Office. It is the intent of this rule that all activities necessary to accomplish the filing of the required documentation be completed prior to filing a licensure application and that all documentation be filed simultaneously.
2. An applicant shall request that a transcript from a dental school, college or university be sent directly from the institution to the Board Administrative Office. The transcript must show that either a D.D.S. or D.M.D. degree was conferred and carry the official seal of the institution.
3. An applicant shall submit a signed and notarized passport photograph taken within the preceding twelve (12) months.
4. An applicant must submit evidence of good moral character and competence. Such evidence shall include at least two (2) letters attesting to the applicant’s character and ability from licensed dentists or physicians on the signator’s letterhead.
5. An applicant shall submit proof of United States or Canada citizenship or evidence of being legally entitled to live in the United States. Such evidence may include notarized copies of birth certificates, naturalization papers, or current visa status.
6. An applicant shall submit the licensure application fee and state regulatory fees as provided in rule 0460-01-.02 (1).
7. If the applicant has ever taken any Board-approved examination as provided in rule 0460-02-
8. (1) (a), an application will not be approved unless and/or until a certification is submitted which indicates that the applicant achieved passing scores on all parts of the examination.
9. An applicant shall indicate whether the applicant is physically capable of performing the procedures included in the practice of dentistry and if not, make explanation.
10. An applicant shall submit evidence of current training in cardiopulmonary resuscitation (CPR) which is defined as successful completion of a BLS for Healthcare Providers, or CPR/AED for Professional Rescuers, or an equivalent course, which provides training for healthcare professionals in CPR and the use of an AED by a Board approved training organization. The course must be conducted in person and include a skills examination on a manikin with a certified instructor.
11. An applicant shall disclose the circumstances surrounding any of the following:
    1. Conviction of any criminal law violation of a country, state or municipality, except minor traffic violations.
    2. The denial of licensure application by any other state or the disciplinary of licensure in any state.
    3. Loss or restriction of hospital privileges.
    4. Any other civil suit judgment or civil suit settlement in which the applicant was a party defendant including, without limitation, actions involving malpractice, breach of contract,

antitrust activity or any other civil action remedy recognized under any county’s or state’s statutory, common, or case law.

* 1. Failure of any dental and/or medical licensure examination.

1. An applicant shall cause to be submitted to the Board’s administrative office directly from the vendor identified in the Board’s licensure application materials, the result of a criminal background check.
2. An applicant shall submit or cause to be submitted the equivalent of a Tennessee Certificate of Endorsement from the licensing board(s) of every state or U.S. territory in which the applicant has ever been licensed as a dentist and/or physician which indicates the applicant either holds a current active license(s) and whether it is in good standing, or held a license(s) which is currently inactive and whether it was in good standing at the time it became inactive. An applicant must possess an active dental license which is in good standing in at least one

(1) other state or U.S. territory.

1. An applicant shall cause to be submitted a certification which indicates that a graduate training program in a specialty branch of dentistry listed in *T.C.A. § 63-5-112* or rule 0460-02-
2. has been successfully completed.
3. An applicant must apply for a specialty certification and successfully complete all requirements for that specialty certification as provided in rule 0460-02-.06 before application for licensure shall be granted.
4. An applicant shall submit a copy of an active, current license to practice medicine in Tennessee.
5. An applicant shall successfully complete the Tennessee Board of Dentistry Ethics and Jurisprudence examination.
6. Application review and licensure decisions required by this rule shall be governed by rule 0460-01-.04.

***Authority:*** *T.C.A. §§ 4-3-1011, 4-5-202, 4-5-204, 63-5-105, 63-5-107, 63-5-110, 63-5-111, and 63-5-124.*

***Administrative History:*** *Original rule certified June 7, 1974. Repeal and new rule filed August 26, 1980; effective December 1, 1980. Amendment filed October 13, 1983; effective November 14, 1983.*

*Amendment filed September 24, 1987; effective November 8, 1987. Amendment filed June 8, 1989;*

*effective July 23, 1989. Amendment filed April 30, 1991; effective June 14, 1991. Repeal and new rule*

*filed December 11, 1991; effective January 25, 1992. Amendment filed May 15, 1996; effective September*

*27, 1996. Amendment filed August 18, 2003; effective November 1, 2003. Amendment filed March 17,*

*2006; effective May 31, 2006. Amendment filed September 30, 2014; effective December 29, 2014.*

*Amendments filed October 25, 2017; effective January 23, 2018.*

**0460-02-.03 LIMITED AND EDUCATIONAL LIMITED LICENSURE PROCESS.** Any dentist who has

completed the requirements set forth in this rule may be issued a limited license for the practice of dentistry in American Dental Association accredited institutions, or dental education programs, or in federally-designated health professional shortage areas, or may be issued an educational limited license to practice dentistry under the auspices of a dental educational institution. The educational limited license limits the dentist's location and activity to teaching and practice in programs offered only through the educational institution. It does not authorize independent private practice in any location.

1. The process for obtaining a limited or an educational limited license is as follows:
   1. An applicant shall obtain an application form from the Board Administrative Office, respond truthfully and completely to every question or request for information contained

in the form and submit it along with all documentation and fees required by the form and this rule to the Board Administrative Office. It is the intent of this rule that all activities necessary to accomplish the filing of the required documentation be completed prior to filing a licensure application and that all documentation be filed simultaneously.

* 1. An applicant shall submit a signed “passport” style photograph taken within the preceding twelve (12) months.
  2. An applicant must submit evidence of good moral character and professional competence. Such evidence shall include at least two (2) letters attesting to the applicant’s character and ability from licensed dentists on the signator’s letterhead.
  3. An applicant shall submit proof of United States or Canadian citizenship or evidence of being legally entitled to live and work in the United States. Such evidence may include copies of birth certificates, naturalization papers, or current visa status.
  4. An applicant shall submit the required fees as provided in Rule 0460-01-.02 (1).
  5. An applicant shall submit evidence of current training in cardiopulmonary resuscitation (CPR) which is defined as successful completion of a BLS for Healthcare Providers, or CPR/AED for Professional Rescuers, or an equivalent course, which provides training for healthcare professionals in CPR and the use of an AED by a Board approved training organization. The course must be conducted in person and include a skills examination on a manikin with a certified instructor.
  6. An applicant shall indicate whether the applicant is physically capable of performing the procedures included in the practice of dentistry and if not, make explanation.
  7. An applicant shall disclose the circumstances surrounding any of the following:
     1. Conviction of any criminal law violation of any country, state or municipality, except minor traffic violations.
     2. The denial of licensure application by any other state or the discipline of licensure in any state.
     3. Loss or restriction of hospital privileges.
     4. Any other civil suit judgment or civil suit settlement in which the applicant was a party defendant including, without limitation, actions involving malpractice, breach of contract, antitrust activity or any other civil action remedy recognized under any country’s or state’s statutory, common, or case law.
     5. Failure of any dental licensure examination.
  8. An applicant shall cause to be submitted to the Board’s administrative office directly from the vendor identified in the Board’s licensure application materials, the result of a criminal background check.
  9. An applicant shall submit or cause to be submitted the equivalent of a Tennessee Certificate of Endorsement from the licensing board(s) of every state in which the applicant has ever been licensed which indicates the applicant either holds a current active license and whether it is in good standing, or held a license which is currently inactive and whether it was in good standing at the time it became inactive.
  10. An applicant shall successfully complete the Tennessee Board of Dentistry Ethics and Jurisprudence examination.

1. In addition to completing the process described in paragraph (1), an applicant for limited licensure:
   1. Shall cause a transcript from a dental school, college or university to be sent directly from the institution to the Board Administrative Office that shows the equivalent of the

D.D.S. or the D.M.D. degree was conferred and carries the official seal of the institution; and

* 1. Shall cause to be submitted, directly from Educational Credential Evaluators, Inc. ([www.ece.org](http://www.ece.org/)) to the Board Administrative Office, a “Course-By-Course Evaluation Report” that indicates the applicant has successfully completed the equivalent of four

(4) years of study in a dentistry program in the United States; and

* 1. Shall cause to be submitted, directly from the educational institution to the Board Administrative Office, certification of successful completion of a graduate training program in a recognized specialty branch of dentistry from an advanced specialty program accredited by the American Dental Association; and
  2. Shall cause to be submitted, directly from the examination agency to the Board Administrative Office, certification of successful completion of the National Board examination; and
  3. Shall cause, if practice is to occur in American Dental Association accredited institutions or dental education programs, the Dean or Director of the dental educational institution at which the applicant is to be employed to submit upon application for licensure and renewal of licensure, on behalf of the applicant, a letter of recommendation for limited licensure and a copy of the contract employing the applicant as a faculty member at the institution; or
  4. Shall submit when applying for licensure and when applying for renewal of licensure, if practice is to be in a federally-designated health professional shortage area, proof of employment as a dentist or proof of starting/maintaining a private dental practice; and
  5. If the applicant has ever taken any regional testing agency examination or any other Board-approved examination as provided in rule 0460-02-.05, an application will not be approved unless and/or until a certification is submitted which indicates that the applicant achieved passing scores on all parts of the examination.

1. In addition to completing the process described in paragraph (1), an applicant for educational limited licensure:
   1. Shall cause a transcript from a dental school, college or university to be sent, directly from the institution to the Board Administrative Office, that shows the degree was conferred and carries the official seal of the institution; and
   2. Shall cause the Dean or Director of the dental educational institution at which the applicant is to be employed to submit upon application for licensure and renewal of licensure, on behalf of the applicant, a letter of recommendation for educational limited licensure and a copy of the contract employing the applicant as a faculty member at the institution; and
   3. Shall possess an active license which is in good standing in at least one (1) other state that was active for at least one (1) year prior to application; and
   4. If the applicant has ever taken any regional testing agency examination or any other Board-approved examination as provided in rule 0460-02-.05, an application will not be approved unless and/or until a certification is submitted which indicates that the applicant achieved passing scores on all parts of the examination.
2. When a limited or educational limited licensee is employed at an educational institution or program, the licensee shall cause the Dean or Director of the educational institution or program to immediately notify the Board in writing of the termination of the licensee’s employment and the reasons therefore. Such notification terminates the licensee’s authority to practice in Tennessee.
3. When a limited licensee is no longer practicing dentistry in a federally-designated health professional shortage area, the licensee shall immediately notify the Board in writing. Such notification terminates the licensee’s authority to practice in Tennessee.
4. Limited and educational limited licensees are subject to all rules governing renewal, retirement, reinstatement and reactivation as provided by Rules 0460-02-.08 and .09. These licenses are also subject to disciplinary action for the same causes and pursuant to the same procedures as active licenses. Under no circumstance shall a limited or educational limited license be renewed without payment of the required biennial renewal fee as stated in Rule 0460-01-.02, and completion of the annual continuing education requirement as stated in Rule 0460-01-.05 (1).
5. Application review and licensure decisions required by this rule shall be governed by Rule 0460-01-.04.

***Authority:*** *T.C.A. §§ 4-3-1011, 4-5-202, 4-5-204, 63-5-105, 63-5-107, 63-5-110, 63-5-111, and 63-5-124.*

***Administrative History:*** *Original rule certified June 7, 1974. Repeal and new rule filed August 26, 1980; effective December 1, 1980. Amendment filed October 13, 1983; effective November 14, 1983.*

*Amendment filed September 21, 1989; effective November 5, 1989. Amendment filed April 30, 1991;*

*effective June 14, 1991. Repeal and new rule filed December 11, 1991; effective January 25, 1992.*

*Amendment filed May 15, 1996; effective September 27, 1996. Amendment filed February 9, 2000;*

*effective April 24, 2000. Amendment filed April 10, 2001; effective June 24, 2001. Amendment filed April*

*10, 2002; effective June 24, 2002. Amendment filed August 18, 2003; effective November 1, 2003.*

*Amendment filed October 20, 2003; effective January 3, 2004. Amendment filed March 17, 2006; effective*

*May 31, 2006. Amendment filed July 10, 2006; effective September 23, 2006. Amendment filed*

*September 30, 2014; effective December 29, 2014. Amendments filed October 25, 2017; effective*

*January 23, 2018.*

**0460-02-.04 LICENSURE EXEMPTION PROCESS.** Any person who pursuant to *T.C.A. § 63-5-109,*

may be eligible to practice dentistry in Tennessee without a Tennessee dental license or with a Board issued exemption from licensure may practice or secure an exemption upon compliance with any of the following which apply to the person’s circumstances:

1. Dentists licensed in Tennessee who intend to call into Tennessee, a dentist licensed in another state for consultative or operative purposes, must obtain prior or advance approval by submitting a letter of request to the Board Administrative Office. In emergency situations, telephone requests for prior approval may be utilized.
2. The director of any special project not affiliated with a state supported institution or public health agency who intends to employ dentists licensed in another state must obtain approval of the special project by submitting a letter of request to the Board Administrative Office which sets forth all particulars of the special project. Dentists employed in the approved special projects may practice only until the next Board-approved examination as provided in rule 0460-02-.05 (1) (a). However, dentists employed in such projects who are under the

sponsorship of a dentist licensed in Tennessee and are under the auspices of a local dental society may only be employed for a period of six (6) months.

1. The Director or Owner of any agency other than a licensed hospital which intends to employ dental interns, externs or graduates of dental schools when such individuals are not licensed in any state must obtain approval of the agency by submitting a written request for approval to the Board Administrative Office which sets forth the particulars of the agency and justification for employing such individuals.
2. The Director of any research or development project employing personnel who will be performing dental procedures must obtain approval of the project by submitting a written request for approval to the Board Administrative Office which sets forth the particulars of the project and contains evidence that the project is under the auspices and direction of a recognized educational institution or the Tennessee Department of Health.
3. The Dean of the dental teaching institution which intends to employ or utilize unlicensed graduates of dental schools, colleges or universities as clinical instructors must submit a written application for exemption to the Board Administrative Office which contains the following:
   1. The duties to be performed by the graduates, and
   2. The method of supervision imposed by the institution over the graduates, and
   3. A list of all graduates requiring exemption, and
   4. The student clinical instructor exemption fee as provided in rule 0460-01-.02 (1) for each graduate requiring exemption.
4. Exemptions granted pursuant to paragraph (5) of this rule shall be effective only until the next scheduled applicable examination of the Board and shall not be extended.
5. Application review and decisions required by this rule are governed by rule 0460-01-.04.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-105(7), and 63-5-109.* ***Administrative History:***

*Original rule filed December 11, 1991; effective January 25, 1992. Amendment filed May 15, 1996;*

*effective September 27, 1996. Amendment filed August 18, 2003; effective November 1, 2003.*

**0460-02-.05 EXAMINATIONS.** All persons intending to apply for licensure as a dentist in Tennessee must successfully complete the examinations provided by this rule, except for educational limited licensure applicants and dual degree licensure applicants who need not complete any licensure examinations other than the Tennessee Board of Dentistry Ethics and Jurisprudence examination; limited licensure applicants who must successfully complete only the National Board examination and Board of Dentistry Ethics and Jurisprudence examination; criteria (reciprocity) applicants who are qualifying pursuant to Rule 0460-02-.01(3)(d), (e), or (f) and need not complete any licensure examinations other than the Tennessee Board of Dentistry Ethics and Jurisprudence examination; and criteria (reciprocity) applicants who are qualifying pursuant to Rule 0460-02-.01(3)(g), (h), or (i) and must successfully complete only the Board of Dentistry Ethics and Jurisprudence examination and a regional testing agency examination or examination given by another state as provided in T.C.A. § 63-5-110(b)(6)(D) or (E). Completion of the required examinations is a prerequisite for application for licensure. Certification of successful completion must be submitted as part of the application process.

1. The Board adopts as its licensure examinations and requires, with the previously noted exceptions, successful completion of all of the following examinations as a prerequisite for licensure:
   1. Any Board-approved examination including, but not limited to, the examinations offered by:
      1. The Southern Regional Testing Agency (SRTA)
      2. The Western Regional Examining Board (WREB)
   2. The National Board if the applicant graduated from a dental college, school or university after 1972.
   3. The Tennessee Board of Dentistry Ethics and Jurisprudence examination.
2. Admission to, application for and the fees required to sit for the regional examinations and the National Board examinations are governed by and must be submitted to the testing agency. Admission to, application for and the fees required to sit for any other Board-approved examination must be submitted to the Board as provided in rule 0460-01-.02, or at the Board’s option, its designated exam administrator.
3. Passing scores on the regional and National Board examinations are determined by the testing agency. Such passing scores as certified to the Board are adopted by the Board as constituting successful completion of those examinations. Passing scores for any other Board-approved examination are determined by the Board.
4. Applicants must supply or furnish their own patients, instruments and materials as required by the testing agency, the Board, or the Board’s designated exam administrator.
5. Applicant’s who fail to successfully complete any of the examinations may apply for reexamination.
6. Oral examination may be required pursuant to rule 0460-01-.04.
7. The Board adopts as its own, the determination made by the regional testing agencies and the National Boards of the length of time that a passing score on their respective examinations will be effective for purposes of measuring competency and fitness for dental licensure; however, an applicant’s test scores from any Board-approved examination as provided in subparagraph (1) (a) which were taken over five (5) years before application was made for licensure in Tennessee will be considered by the Board on a case by case basis after the applicant appears before the Board for an examination.
8. Applicants for licensure who have failed three (3) times the National Board or any Board- approved examination as provided in subparagraph (1) (a) must successfully complete a remedial course of post-graduate studies at a school accredited by the American Dental Association before consideration for licensure by the Board. The applicant shall cause the program director of the post-graduate program to provide written documentation of the content of such course and certify successful completion.
9. If an applicant has successfully completed a clinical board examination administered by another state and is applying for licensure pursuant to Rule 0460-02-.01 (3) (g), (h), or (i), it is that applicant’s responsibility to submit documentation substantiating the appropriateness of such examination. The Board shall make the final decision to accept or reject such examination.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-107, 63-5-110, 63-5-111, 63-5-114, and 63-5-124.*

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*Amendments filed October 25, 2017; effective January 23, 2018.*

# 0460-02-.06 SPECIALTY CERTIFICATION.

1. Recognized Specialties - The Board recognizes and will issue specialty certification in the following branches of dentistry:
   1. Dental Public Health;
   2. Endodontics;
   3. Oral and Maxillofacial Radiology;
   4. Oral and Maxillofacial Surgery;
   5. Oral and Maxillofacial Pathology;
   6. Orthodontics and Dentofacial Orthopedics;
   7. Pediatric Dentistry (Pedodontics);
   8. Periodontics;
   9. Prosthodontics.
2. Certification - To become certified as a specialist in a particular branch of dentistry an applicant must be licensed as a dentist in Tennessee except those persons eligible for licensure pursuant to rule 0460-02-.02, and comply with the following:
   1. An applicant shall obtain a specialty application form from the Board Administrative Office, respond truthfully and completely to every question or request for information contained in the form and submit it along with all documentation and fees required by the form or this rule to the Board Administrative Office.
   2. An applicant shall submit the specialty certification application fee as provided in rule 0460-01-.02 (1).
   3. An applicant shall submit verification of one of the following:
      1. Successful completion of the specialty training as provided in the section of this rule for the specific specialty that the applicant is applying for; or
      2. Certification as a specialist by the American Board of the particular specialty for which application is made. A letter must be sent directly from the secretary of the American Board of the particular specialty to the Board Administrative Office which indicates that the applicant is certified by the American Board in that specialty and that the applicant is in good standing. All such certificates approved by the Board may be accepted as sufficient for specialty certification in lieu of submitting proof of successful completion of a residency program in a specialty. Acceptance of such certificates is discretionary with the Board.
   4. An applicant shall submit any other documentation required by the Board after review of the application.
   5. An applicant who is certified as a specialist in another state shall have that state’s licensing board send proof to the Board Administrative Office which indicates that the applicant is certified in that specialty and that the applicant is in good standing.
   6. Application review and decisions required by this rule are governed by rule 0460-01-.04.
3. Examination - All specialty applicants shall submit to an oral examination even if certification from an American Board in a specialty is accepted in lieu of submitting proof of successful completion of a residency program in a specialty.
4. Dental Public Health - The requirements for certification in this specialty shall be those required by the American Dental Association as regards its regulation of this specialty branch of dentistry.
5. Endodontics - An applicant must submit certification of successful completion of at least two

(2) years of postgraduate training in Endodontics at the university level in a program approved by the Council on Dental Education of the American Dental Association and the Board. Such evidence shall include either a transcript which indicates completion of the postgraduate training in Endodontics or a certificate of completion letter from the director of the program on letterhead submitted directly from the school to the Board Administrative Office.

1. Oral and Maxillofacial Pathology - An applicant must submit certification of successful completion of two (2) years of postgraduate training in Oral Pathology or Oral and Maxillofacial Pathology at the university level in a program approved by the Council on Dental Education of the American Dental Association and the Board. Such evidence shall include either a transcript which indicates completion of the postgraduate training in oral pathology or oral and maxillofacial pathology or a certificate of completion letter from the director of the program on letterhead submitted directly from the school to the Board Administrative Office.
2. Oral and Maxillofacial Radiology – An applicant must submit certification of successful completion of graduate study in Oral and Maxillofacial Radiology of at least two (2) years in a school approved or provisionally approved by the Commission on Dental Accreditation of the American Dental Association. Such evidence shall include either a transcript which indicates completion of the postgraduate training in oral and maxillofacial radiology or a certificate of completion letter from the director of the program submitted directly from the school to the Board Administrative Office.
3. Oral and Maxillofacial Surgery.
   1. An applicant must provide to the Board Administrative Office certification of successful completion of advanced study in Oral and Maxillofacial Surgery of four (4) years or more in a graduate school or hospital accredited by the Commission on Dental Accreditation (CODA) or the American Dental Association and the Board. Such evidence shall include either a transcript which indicates completion of the postgraduate training in oral and maxillofacial surgery or a certificate of completion letter from the director of the program submitted directly from the school to the Board Administrative Office.
   2. Oral and Maxillofacial Surgery is the specialty area of the treatment of the oral cavity and maxillofacial area or adjacent or associated structures and their impact on the human body that includes the performance of the following areas of Oral and Maxillofacial Surgery, as described in the most recent version of the Parameters and Pathways: Clinical Practice Guidelines for Oral and Maxillofacial Surgery of the American Association of Oral and Maxillofacial Surgeons:
      1. Patient assessment;
      2. Anesthesia in outpatient facilities, as provided in T.C.A. §§ 63-5-105 (6) and 63-5- 108 (g);
      3. Dentoalveolar surgery;
      4. Oral and craniomaxillofacial implant surgery;
      5. Surgical correction of maxillofacial skeletal deformities;
      6. Cleft and craniofacial surgery;
      7. Trauma surgery;
      8. Temporomandibular joint surgery;
      9. Diagnosis and management of pathologic conditions;
      10. Reconstructive surgery including the harvesting of extra oral/distal tissues for grafting to the oral and maxillofacial region; and
      11. Cosmetic maxillofacial surgery.
   3. The Tennessee Board of Dentistry determines that the dental practice of Oral and Maxillofacial Surgery includes the following procedures which the Board finds are included in the curricula of dental schools accredited by the American Dental Association, Commission on Dental Accreditation, post-graduate training programs or continuing education courses:
      1. Rhinoplasty;
      2. Blepharoplasty;
      3. Rytidectomy;
      4. Submental liposuction;
      5. Laser resurfacing;
      6. Browlift, either open or endoscopic technique;
      7. Platysmal muscle plication;
      8. Dermabrasion;
      9. Otoplasty;
      10. Lip augmentation; and
      11. Botox injections or future FDA approved neurotoxins.
   4. Any licensee who lacks the following qualifications and nevertheless performs the procedures and surgery identified in subparagraph (c) shall be subject to discipline by the Board under T.C.A. § 63-5-124, including provisions regarding malpractice, negligence, incompetence or unprofessional conduct:
      1. Has successfully completed a residency in Oral and Maxillofacial Surgery accredited by the American Dental Association, Commission on Dental Accreditation (CODA); and
      2. Has successfully completed a clinical fellowship, of at least one (1) continuous year in duration, in esthetic (cosmetic) surgery accredited by the American Association of Oral and Maxillofacial Surgeons or by the American Dental Association Commission on Dental Accreditation; or
      3. Holds privileges issued by a credentialing committee of a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to perform these procedures.
   5. The Board, pursuant to its authority under T.C.A. § 63-5-124, determines that performance of the surgery and procedures identified in subparagraph (c) without the qualifications set out above shall be considered unprofessional conduct and subject to discipline by the Board as such.
4. Orthodontics and Dentofacial Orthopedics - An applicant must submit, with the application form, documentation of successful completion of one (1) of the following:
   1. Certification of successful completion of two (2) academic years of training in Orthodontics and Dentofacial Orthopedics in an approved Postgraduate Department of an accredited dental school, college or university. Such evidence shall include either a transcript which indicates completion of the postgraduate training in orthodontics and Dentofacial orthopedics or a certificate of completion letter from the director of the program on letterhead submitted directly from the school to the Board Administrative Office.
   2. Certification of successful completion of an organized preceptorship training program in Orthodontics and Dentofacial Orthopedics approved by the Council on Dental Education of the American Dental Association and the Board. Such evidence shall include, but not be dispositive of this requirement, a notarized certificate of completion furnished by the Board and issued by the director of the preceptorship training program, to be submitted directly from the school to the Board Administrative Office.
5. Pediatric Dentistry (Pedodontics) - An applicant must submit to the Board Administrative Office certification of successful completion of at least two (2) years of graduate or post graduate study in Pediatric Dentistry according to the following:
   1. If such study is completed in whole or in part at a dental school, college or university, the graduate or postgraduate program must be approved by the Council on Dental Education of the American Dental Association.
   2. The graduate or postgraduate program need not lead to an advanced degree.
   3. The program of study may be pursued in hospitals or clinics or other similar institutions.
   4. One (1) academic year of graduate or postgraduate study will be considered as equivalent to one (1) calendar year.
   5. Such evidence shall include either a transcript which indicates completion of the postgraduate training in pediatric dentistry (Pedodontics) or a certificate of completion letter from the director of the program on letterhead submitted directly from the school to the Board Administrative Office.
6. Periodontics - An applicant must submit certification of successful completion of at least two

(2) years of postgraduate training in Periodontics at the university level in a program approved by the Commission on Dental Education of the American Dental Association and by the Board. Such evidence shall include either a transcript which indicates completion of the postgraduate training in periodontics or a certificate of completion letter from the director of the program on letterhead submitted directly from the school to the Board Administrative Office.

1. Prosthodontics - An applicant must submit certification of successful completion of at least two (2) years of a postdoctoral education in prosthodontics in a program approved by the Commission on Dental Accreditation of the American Dental Association and the Board. Such evidence shall include either a transcript which indicates completion of the postgraduate training in prosthodontics or a certificate of completion letter from the director of the program on letterhead submitted directly from the school to the Board Administrative Office.
2. General Rules Governing Specialty Practice
   1. Scope of Practice - Dentists certified in a specialty branch of dentistry must devote and confine a majority of their practice to the certified specialty only. Any specialty certified dentists who do not so confine their practice or who return to general practice must retire specialty certification on forms obtained from and submitted to the Board Administrative Office.
   2. A current and active dental license issued by the Board is a prerequisite to the continued practice under any specialty certification.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-107, 63-5-108, 63-5-110, 63-5-112, 63-5-113, and*

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*30, 2014; effective December 29, 2014.*

# 0460-02-.07 ANESTHESIA AND SEDATION.

1. Definitions
   1. Advanced Cardiac Life Support (ACLS). A certification that means a person has successfully completed an advanced cardiac life support course offered by a recognized accrediting organization.
   2. American Society of Anesthesiologists (ASA) Patient Physical Status Classification
      1. ASA I - A normal healthy patient.
      2. ASA II - A patient with mild systemic disease.
      3. ASA III - A patient with severe systemic disease.
      4. ASA IV - A patient with severe systemic disease that is a constant threat to life.
      5. ASA V - A moribund patient who is not expected to survive without the operation.
      6. ASA VI - A declared brain-dead patient whose organs are being removed for donor purposes.
      7. E - Emergency operation of any variety (used to modify one of the above classifications, i.e., ASA III-E).
   3. Antianxiety premedication (anxiolysis). The prescription of pharmacologic substances for the relief of anxiety and apprehension.
   4. Certified Registered Nurse Anesthetist (CRNA). A registered nurse currently licensed by the Tennessee Board of Nursing who is currently certified as such by the American Association of Nurse Anesthetists.
   5. Conscious sedation. A minimally depressed level of consciousness that retains the patient’s ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command and that is produced by a pharmacological or non-pharmacological method or a combination thereof.
   6. Deep sedation. An induced state of depressed consciousness accompanied by partial loss of protective reflexes, including the inability to continually maintain an airway independently and/or to respond purposefully to physical stimulation or verbal command, and is produced by a pharmacological or non-pharmacological method or a combination thereof.
   7. Enteral. Any technique of administration in which the agent is absorbed through the gastrointestinal (GI) tract or oral mucosa [i.e, oral, rectal, sublingual].
   8. General anesthesia. An induced state of unconsciousness accompanied by partial or complete loss of protective reflexes, including the inability to continually maintain an airway independently and respond purposefully to physical stimulation or verbal command, and is produced by a pharmacological or non-pharmacological method or a combination thereof.
   9. Hospital. A hospital licensed by the Department of Health’s Division of Health Care Facilities.
   10. Inhalation. A technique of administration in which a gaseous or volatile agent is introduced into the pulmonary tree and whose primary effect is due to absorption through the pulmonary bed.
   11. Nitrous oxide inhalation analgesia. The administration by inhalation of a combination of nitrous oxide and oxygen producing an altered level of consciousness that retains the patient’s ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command.
   12. Pediatric Advanced Life Support (PALS). A certification that means a person has successfully completed an pediatric advanced life support course offered by a recognized accrediting organization.
   13. Parenteral. A technique of administration in which the drug bypasses the gastrointestinal (GI) tract [i.e., intramuscular (IM), intravenous (IV), intransal (IN), submucosal (SM), subcutaneous (SC)].
   14. Physician. A person licensed to practice medicine and surgery pursuant to Tennessee Code Annotated Title 63, Chapters 6 or 9.
2. Permits required.
   1. No permit is required for the administration of nitrous oxide inhalation analgesia; however, dentists must comply with the provisions of 0460-02-.07 (4).
   2. No permit is required for the use of antianxiety premedication (anxiolysis); however, dentists must comply with the provisions of 0460-02-.07 (5).
   3. Dentists must obtain a permit to administer conscious sedation. A conscious sedation permit may be limited or comprehensive.
      1. A limited conscious sedation permit authorizes dentists to administer conscious sedation by the enteral and/or combination inhalation-enteral method.
      2. A comprehensive conscious sedation permit authorizes a dentist to administer conscious sedation by the enteral, combination inhalation-enteral or parenteral method.
      3. Children thirteen (13) and under
         1. Dentists who administer conscious sedation by any method to children thirteen (13) and under must have a comprehensive conscious sedation permit.
         2. Agents used to produce conscious sedation/deep sedation/general anesthesia in children thirteen (13) years of age and under must be given under the direct supervision of the dentist.
      4. Dentists issued limited or comprehensive conscious sedation permits must comply with rule 0460-02-.07 (6).
   4. Dentists must obtain a permit to administer deep sedation/general anesthesia and comply with rule 0460-02-.07 (7).
3. Determination of degree of sedation
   1. The degree of sedation or consciousness level of a patient is the determinant for the application of these rules, not the route of administration. Determining the degree of sedation or level of consciousness of a patient is based upon:
      1. The type and dosage of medication that was administered or was proposed for administration to the patient;
      2. The age, physical size and medical condition of the patient receiving the medication; and
      3. The degree of sedation or level of consciousness that should reasonably be expected to result from that type and dosage of medication.
   2. In a proceeding of the board at which the board must determine the degree of sedation or level of consciousness of a patient, the board will base its findings on the provisions of subparagraph (a).
4. Nitrous oxide inhalation analgesia.
   1. Nitrous oxide may be administered by a licensed dentist or a licensed and properly certified dental hygienist under the direct supervision of a licensed dentist. The administering or supervising dentist must be on the premises at all times that nitrous oxide is in use.
   2. An authorized person must constantly monitor each patient receiving nitrous oxide. In addition to dentists, any licensed dental hygienist or registered dental assistant who has complied with rules 0460-03-.06 or 0460-04-.05 is an authorized person and may monitor patients who are receiving nitrous oxide.
   3. Monitoring nitrous oxide. Monitoring patients receiving nitrous oxide inhalation analgesia as an adjunct to dental or to dental hygiene procedures consists of continuous direct clinical observation of the patient and begins after the dentist or dental hygienist has initiated the analgesia. The dentist must be notified of any change in the patient which might indicate an adverse effect on the patient. Those certified in nitrous oxide monitoring may terminate the administration of nitrous oxide inhalation analgesia.
   4. All equipment for the administration of nitrous oxide must be designed specifically to guarantee that an oxygen concentration of no less than thirty percent (30%) can be administered to the patient.
   5. All equipment for the administration of nitrous oxide must be equipped with a scavenger system.
5. Antianxiety premedication (anxiolysis).
   1. The regulation and monitoring of this modality of treatment are the responsibility of the ordering dentist. The drugs used should carry a margin of safety wide enough to never render unintended loss of consciousness. If the administration is for antianxiety purposes, the appropriate initial dosing of a single enteral drug can be no more than the maximum recommended dose (MRD) of a drug that can be prescribed for non- monitored home use. The co-administration of nitrous oxide is allowed. If the MRD is exceeded then a limited conscious sedation permit is required.
   2. A dentist using antianxiety premedication must employ auxiliary personnel who are certified in BLS for Healthcare Providers, or CPR/AED for Professional Rescuers, or an equivalent course, which provides training for healthcare professionals in CPR and the use of an AED by a Board approved training organization. The course must be conducted in person and include a skills examination on a manikin with a certified instructor.
   3. All antianxiety premedications and all sedation techniques (except nitrous oxide and oxygen) used for children age thirteen (13) and under require a comprehensive conscious sedation permit.
6. Conscious sedation.
   1. Dentists must obtain a permit from the Board of Dentistry to administer conscious sedation in the dental office. Conscious sedation permits are either limited or comprehensive.
      1. To obtain a limited conscious sedation permit, a dentist must provide proof of current certification in ACLS (a pediatric dentist may substitute PALS), and must provide proof of one (1) of the following:
         1. Completion of an ADA accredited postdoctoral training program which affords comprehensive training necessary to administer and manage enteral and/or combination inhalation-enteral conscious sedation, or
         2. Completion of a continuing education course which consists of a minimum of twenty four (24) hours of didactic instruction plus ten (10) clinically- oriented experiences which provide competency in enteral and/or combination inhalation-enteral conscious sedation.
      2. To obtain a comprehensive conscious sedation permit, a dentist must provide proof of current certification in ACLS (a pediatric dentist may substitute PALS), and must provide proof of one (1) of the following:
         1. Completion of an ADA accredited postdoctoral training program which affords comprehensive training to administer and manage parenteral conscious sedation, or
         2. Completion of a continuing education course consisting of a minimum of sixty (60) hours of didactic instruction plus the management of at least twenty (20) patients which provides competency in parenteral conscious sedation. The course content must be consistent with that described for an approved continuing education program in these techniques in the ADA Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry, 2000 edition, or its successor publication.
      3. Dentists who provide conscious sedation for children must provide evidence of adequate training in pediatric sedation techniques and in pediatric resuscitation including the recognition and management of pediatric airway and respiratory problems.
      4. A dentist who utilizes a Certified Registered Nurse Anesthetist (CRNA) to administer conscious sedation must have a valid comprehensive conscious sedation permit.
      5. A dentist may utilize a physician (MD or DO), who is a member of the anesthesiology staff of an accredited hospital, or a permitted dentist to administer conscious sedation in that dentist’s office. Such person must remain on the premises of the dental facility until all patients given conscious sedation meet discharge criteria. The office must comply with the general rules for conscious sedation, i.e. rule 0460-02-.07 (6) (b). A dentist utilizing such person and complying with these provisions does not require a conscious sedation permit.
   2. General rules for conscious sedation.
      1. Physical facilities.
         1. The treatment room must be large enough to accommodate the patient adequately on a table or in a dental chair and to allow an operating team, consisting of at least two persons, to move freely about the patient.
         2. The operating table or dental chair must allow the patient to be placed in a position such that the operating team can maintain the airway, allow the operating team to alter the patient’s position quickly in an emergency, and provide a firm platform for the management of cardiopulmonary resuscitation.
         3. The lighting system must be adequate to allow an evaluation of the patient’s skin and mucosal color and provide adequate light for the procedure.
         4. Suction equipment must be available that allows aspiration of the oral and pharyngeal cavities.
         5. A system for delivering oxygen must have adequate full-face masks and appropriate connectors, and be capable of delivering oxygen to the patient under positive pressure.
         6. A recovery area must be provided that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area may be the treatment room. A member of the staff must be able to observe the patient at all times during the recovery.
         7. An alternate lighting system sufficiently intense to allow completion of any procedure and an alternate suction device that will function effectively must be available for emergency use at the time of a general power failure.
         8. In offices where pediatric patients are treated, appropriate sized equipment must be available.
         9. Inspections of the anesthesia and sedation equipment shall be made each day the equipment is used and a log kept recording the inspection and its results.
      2. Personnel.
         1. During conscious sedation at least one (1) person, in addition to the operating dentist, must be present.
         2. Members of the operating team must be trained for their duties according to protocol established by the dentist and must be currently certified in BLS for Healthcare Providers, or CPR/AED for Professional Rescuers, or an equivalent course, which provides training for healthcare professionals in CPR and the use of an AED by a Board approved training organization. The course must be conducted in person and include a skills examination on a manikin with a certified instructor.
         3. All operatory room and/or recovery personnel who provide clinical care shall hold a current, appropriate Tennessee license/registration pursuant to Tennessee Code Annotated, Title 63.
         4. Unlicensed/unregistered personnel may not be assigned duties or responsibilities that require professional licensure.
         5. Notwithstanding the provisions of part (iv), duties assigned to unlicensed/unregistered personnel shall be in accordance with their training, education, and experience and under the direct supervision of a licensed dentist.
      3. Patient evaluation. Patients subjected to conscious sedation must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this may be simply a review of their current medical

history and medication use. However with individuals who may not be medically stable or who have a significant health disability (ASA III, IV) consultation with their primary care physician or consulting medical specialist is recommended.

* + 1. Dental records. The dental record must include:
       1. A medical history including current medications and drug allergies;
       2. Informed consent for the type of anesthesia used;
       3. Baseline vital signs including blood pressure and pulse. If determination of baseline vital signs is prevented by the patient’s age, physical resistance or emotional condition, the reason(s) should be documented;
       4. A time-oriented anesthesia record which includes the drugs and dosage administered;
       5. Documentation of complications or morbidity; and
       6. Status of the patient on discharge.
    2. Monitoring
       1. Direct clinical observation of the patient must be continuous;
       2. Interval recording of blood pressure and pulse must occur;
       3. Oxygen saturation must be evaluated continuously by a pulse oximeter;
       4. The patient must be monitored during recovery by trained personnel until stable for discharge;
       5. If monitoring procedures are prevented by the patient’s age, physical resistance or emotional condition, the reason(s) should be documented; and
       6. If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient returns to the intended level of sedation.
    3. Emergency management.
       1. Written protocols must be established by the dentist to manage emergencies related to conscious sedation including but not limited to laryngospasm, bronchospasm, emesis and aspiration, airway occlusion by foreign body, angina pectoris, myocardial infarction, hypertension, hypotension, allergic and toxic reactions, convulsions, hyperventilation and hypoventilation.
       2. Training to familiarize the operating team with these protocols must be periodic and current. Regular staff education programs and training sessions shall be provided and documented which include sessions on emergencies, life safety, medical equipment, utility systems, infection control, and hazardous waste practices.
       3. A cardiac defibrillator or automated external defibrillator must be available.
       4. Equipment and drugs on a list available from the Board and currently indicated for the treatment of the above listed emergency conditions must be present and readily available for use. Emergency protocols must include training in the use of this equipment and these drugs.
    4. Recovery and discharge.
       1. Patients must be monitored for adequacy of ventilation and circulation. The dental record must reflect that ventilation and circulation are stable and the patient is appropriately responsive prior to discharge.
       2. The dental office must develop specific criteria for discharge parameters for conscious sedation for both adult and pediatric patients.
       3. The dental record must reflect that appropriate discharge instructions were given, and that the patient was discharged into the care of a responsible person.

1. Deep sedation/general anesthesia.
   1. Dentists must obtain a permit from the Board of Dentistry to administer deep sedation/general anesthesia in the dental office.
      1. Obtaining the permit
         1. To obtain a deep sedation/general anesthesia permit, a dentist must provide proof of current certification in ACLS (a pediatric dentist may substitute PALS), and must provide certification of one (1) of the following:
            1. Successful completion of a minimum of one (1) year advanced training in anesthesiology and related academic subjects beyond the undergraduate dental school level in a training program as described in the most recent version of the ADA Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry, or
            2. Proof of successful completion of a graduate program in oral and maxillofacial surgery which has been approved by the Commission on Accreditation of the American Dental Association; or
            3. Proof of successful completion of a residency program in general anesthesia of not less than one (1) calendar year that is approved by the Board of Directors of the American Dental Society of Anesthesiology for eligibility for the Fellowship in General Anesthesia or proof that the applicant is a Diplomate of the American Board of Dental Anesthesiology.
         2. Dentists who provide deep sedation/general anesthesia for children must provide evidence of adequate training in pediatric sedation techniques, in general anesthesia, and in pediatric resuscitation including the recognition and management of pediatric airway and respiratory problems.
      2. A dentist may utilize a physician (MD or DO), who is a member of an anesthesiology staff of an accredited hospital, or another dentist who holds a deep sedation/general anesthesia permit to administer deep sedation or general anesthesia in that dentist’s office. Such person must remain on the premises of

the dental facility until all patients given deep sedation or general anesthesia meet discharge criteria. The office must comply with the general rules for deep sedation/general anesthesia, i.e. rule 0460-02-.07 (7) (b). A dentist utilizing such person and complying with these provisions does not require a deep sedation/general anesthesia permit.

* + 1. A dentist who utilizes a Certified Registered Nurse Anesthetist (CRNA) to administer deep sedation/general anesthesia must have a valid deep sedation/general anesthesia permit.
    2. A dentist who holds a deep sedation/general anesthesia permit may administer conscious sedation.
  1. General rules for deep sedation/general anesthesia.
     1. Physical facilities.
        1. The treatment room must be large enough to accommodate the patient adequately on a table or in a dental chair and to allow an operating team, consisting of at least three (3) persons, to move freely about the patient.
        2. The operating table or dental chair must allow the patient to be placed in a position such that the operating team can maintain the airway, allow the operating team to alter the patient’s position quickly in an emergency, and provide a firm platform for the management of cardiopulmonary resuscitation.
        3. The lighting system must be adequate to allow an evaluation of the patient’s skin and mucosal color and provide adequate light for the procedure.
        4. Suction equipment must be available that allows aspiration of the oral and pharyngeal cavities.
        5. A system for delivering oxygen must have adequate full-face masks and appropriate connectors, and be capable of delivering oxygen to the patient under positive pressure.
        6. A recovery area must be provided that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area may be the treatment room. A member of the staff must be able to observe the patient at all times during the recovery.
        7. An alternate lighting system sufficiently intense to allow completion of any procedure and an alternate suction device that will function effectively must be available for emergency use at the time of a general power failure.
        8. In offices where pediatric patients are treated, appropriate sized equipment must be available.
        9. Inspections of the deep sedation/general anesthesia equipment shall be made each day the equipment is used and a log kept recording the inspection and its results.
     2. Personnel.
        1. During deep sedation/general anesthesia at least two (2) persons, in addition to the operating dentist, must be present.
        2. Members of the operating team must be trained for their duties according to protocol established by the dentist and must be currently certified in BLS for Healthcare Providers, or CPR/AED for Professional Rescuers, or an equivalent course, which provides training for healthcare professionals in CPR and the use of an AED by a Board approved training organization. The course must be conducted in person and include a skills examination on a manikin with a certified instructor.
        3. When the same individual administering the deep sedation/general anesthesia is performing the dental procedure, there must be a second (2nd) individual trained in patient monitoring.
        4. All operatory room and/or recovery personnel who provide clinical care shall hold a current, appropriate Tennessee license/registration pursuant to Tennessee Code Annotated, Title 63.
        5. Unlicensed/unregistered personnel may not be assigned duties or responsibilities that require professional licensure.
        6. Notwithstanding the provisions of subpart (v), duties assigned to unlicensed/unregistered personnel shall be in accordance with their training, education, and experience and under the direct supervision of a licensed dentist.
     3. Patient evaluation. Patients subjected to deep sedation/general anesthesia must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this may be simply a review of their current medical history and medication use. However with individuals who may not be medically stable or who have a significant health disability (ASA III, IV) consultation with their primary care physician or consulting medical specialist is recommended.
     4. Dental records. The dental record must include:
        1. A medical history including current medications and drug allergies;
        2. Informed consent for the type of anesthesia used;
        3. Baseline vital signs including blood pressure, pulse and temperature. If determination of baseline vital signs is prevented by the patient’s age, physical resistance or emotional condition the reason(s) should be documented;
        4. A time-oriented anesthesia record which includes the drugs and dosage administered and an interval recording of blood pressure and pulse;
        5. Documentation of complications or morbidity; and
        6. Status of the patient on discharge.
     5. Monitoring.
        1. Direct clinical observation of the patient must be continuous;
        2. Interval recording of blood pressure and pulse must occur;
        3. Oxygen saturation must be monitored continuously by pulse oximeter;
        4. Continuous EKG monitoring with electrocardioscope must occur;
        5. Respirations must be monitored by end tidal CO2 unless precluded or invalidated by the nature of the patient, procedure, or equipment;
        6. If anesthetic agents implicated in the etiology of malignant hyperthermia are used, body temperature must continuously be monitored; and
        7. The patient must be monitored during recovery by trained personnel until stable for discharge.
     6. Emergency management.
        1. Written protocols must be established by the dentist to manage emergencies related to deep sedation/general anesthesia including but not limited to laryngospasm, bronchospasm, emesis and aspiration, airway occlusion by foreign body, angina pectoris, myocardial infarction, hypertension, hypotension, allergic and toxic reactions, convulsions, hyperventilation and hypoventilation.
        2. If anesthetic agents implicated in the etiology of malignant hyperthermia are used, protocols to treat the malignant hyperthermia must be established.
        3. Training to familiarize the operating team with these protocols must be periodic and current. Regular staff education programs and training sessions shall be provided and documented which include sessions on emergencies, life safety, medical equipment, utility systems, infection control, and hazardous waste practices.
        4. A cardiac defibrillator or automated external defibrillator must be available.
        5. Equipment and drugs on a list available from the Board and currently indicated for the treatment of the above listed emergency conditions must be present and readily available for use. Emergency protocols must include training in the use of this equipment and these drugs.
     7. Recovery and discharge.
        1. Patients must be monitored for adequacy of ventilation and circulation. The dental record must reflect that ventilation and circulation are stable and the patient is appropriately responsive prior to discharge.
        2. The dental office must develop specific criteria for discharge parameters for deep sedation/general anesthesia for both adult and pediatric patients.
        3. The dental record must reflect that appropriate discharge instructions were given, and that the patient was discharged into the care of a responsible adult.

1. Continuing education. In order to maintain a limited or comprehensive conscious sedation or deep sedation/general anesthesia permit, a dentist must:
   1. Maintain current certification in ACLS (a pediatric dentist may substitute PALS); or
   2. Certify attendance every two (2) years at a board approved course comparable to ACLS or PALS and devoted specifically to the prevention and management of emergencies associated with conscious sedation or deep sedation/general anesthesia; and
   3. Obtain a minimum of four (4) hours of continuing education in the subject of anesthesia and/or sedation as part of the required forty (40) hours of continuing education for dental licensure. ACLS or PALS certification shall not be included as any part of the required four (4) hours.
2. Reporting injury or mortality.
   1. A written report shall be submitted to the board by the dentist within thirty (30) days of any anesthesia-related incident resulting in patient injury or mortality, which occurred when the patient was under the care of the dentist and required hospitalization. In the event of patient mortality, concurrent with a sedation or anesthesia-related incident, this incident must be reported to the board within two (2) working days, to be followed by the written report within thirty (30) days.
   2. A written report shall include:
      1. Description of dental procedure;
      2. Description of preoperative physical condition of the patient;
      3. List of the drugs and dosages administered;
      4. Detailed description of techniques utilized in administering the drugs;
      5. Description of adverse occurrence to include:
         1. Detailed description of symptoms of any complications including, but not limited to, onset and type of symptoms in the patient;
         2. Treatment instituted on patient; and
         3. Response of the patient to treatment; and
      6. Description of the patient’s condition on termination of any procedure undertaken.
3. Permit process (limited conscious sedation, comprehensive conscious sedation, deep sedation/general anesthesia).
   1. To obtain a limited or comprehensive conscious sedation permit or deep sedation/general anesthesia permit, a dentist must apply on an application form provided by the board and submit the appropriate fee as established by the board.
   2. The applicant must submit acceptable proof to the Board:
      1. For a limited conscious sedation permit:
         1. That the educational requirements of 0460-02-.07 (6) (a) 1. are met; and
         2. Compliance with general rules 0460-02-.07 (6) (b).
      2. For a comprehensive conscious sedation permit:
         1. That the educational requirements of 0460-02-.07 (6) (a) 2. are met; and
         2. Compliance with general rules 0460-02-.07 (6) (b).
      3. For a deep sedation/general anesthesia permit:
         1. That the educational requirements of 0460-02-.07 (7) (a) have been met; and
         2. Compliance with general rules 0460-02-.07 (7) (b).
   3. A permit must be renewed every two (2) years by payment of the appropriate renewal fee as established by the board and by certification of the continuing education requirement [0460-02-.07 (8)] and by certification of compliance with the general rules for conscious sedation [0460-02-.07 (6) (b)] or deep sedation/general anesthesia [0460- 02-.07 (7) (b)].
4. Anesthesia Consultants
   1. In addition to the Board Consultant and his/her duties, as provided in Rule 0460-01-.03, Anesthesia Consultants shall be appointed by the board to assist the board in the administration of this rule. All Anesthesia Consultants shall be licensed to practice dentistry in Tennessee and shall all hold current, valid comprehensive conscious sedation or deep sedation/general anesthesia permits.
   2. The Anesthesia Consultants shall be:
      1. A periodontist;
      2. A pediatric dentist;
      3. A general dentist; and
      4. Two (2) oral and maxillofacial surgeons.
   3. The Anesthesia Consultants shall advise the Board of Dentistry regarding the continuing education courses, to be approved by the Board, to satisfy the requirements in subpart (6) (a) 1. (ii), item (6) (a) 2. (i) (II) and subparagraph (8) (b).

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-107, 63-5-108, 63-5-112, 63-5-115, 63-5-117, 63-*

* 1. *, and 63-5-124.* ***Administrative History:*** *Original rule filed December 11, 1991; effective January*

*25, 1992. Amendment filed May 15, 1996; effective September 27, 1996. Amendment filed February 18,*

*2003; effective May 4, 2003. Amendment filed December 28, 2004; effective March 13, 2005. Amendment*

*filed July 10, 2006; effective September 23, 2006. Amendment filed September 25, 2008; effective*

*December 9, 2008. Amendments filed October 22, 2010; effective January 20, 2011. Amendments filed*

*September 30, 2014; effective December 29, 2014. Amendments filed March 24, 2015; effective June 22,*

*2015.*

**0460-02-.08 LICENSURE RENEWAL.** All licensed dentists must renew their licenses to be able to legally continue in practice. Licensure renewal is governed by the following:

* + 1. Renewal application
       1. The due date for licensure renewal is the last day of the month in which a licensee’s birthday falls pursuant to the Division of Health Related Boards “birthdate renewal system” contained on the renewal certificate as the expiration date.
       2. Methods of Renewal
          1. Internet Renewals - Individuals may apply for renewal and pay the necessary fees via the Internet. The application to renew can be accessed at:

[www.tennesseeanytime.org](http://www.tennesseeanytime.org/)

* + - * 1. Paper Renewals - For individuals who have not renewed their license online via the Internet, a renewal application form will be mailed to each individual licensed by the Board to the last address provided to the Board. Failure to receive such notification does not relieve the licensee from the responsibility of meeting all requirements for renewal.
      1. A license issued pursuant to these rules is renewable by the expiration date. To be eligible for renewal an individual must submit to the Division of Health Related Boards on or before the expiration date the following:
         1. A completed renewal application form.
         2. The renewal and state regulatory fees as provided in Rule 0460-01-.02.
         3. If licensed pursuant to rule 0460-02-.03, a letter of request accompanied by a letter of recommendation from the dean or director of the educational institution.
         4. Proof of successful completion of the Tennessee Board of Dentistry Ethics and Jurisprudence examination.
      2. Licensees who fail to comply with the renewal rules or notification received by them concerning failure to timely renew shall have their licenses processed pursuant to Rule 1200-10-01-.10.
    1. Reinstatement of an Expired License - Reinstatement of a license that has expired may be accomplished upon meeting the following conditions:
       1. Payment of all past due renewal fees, state regulatory fees and the reinstatement fee, as established in Rule 0460-01-.02; and
       2. Provide documentation of successfully completing continuing education requirements for the entire time the license was expired, pursuant to Rule 0460-01-.05; and
       3. Submit proof of successful completion of the Tennessee Board of Dentistry Ethics and Jurisprudence examination.
       4. Any licensee who fails to renew licensure prior to the expiration of the second (2nd) year after which renewal is due may be required to meet other conditions as the Board may deem necessary to protect the public.
    2. Anyone submitting a renewal form, reinstatement/reactivation application, or letter which is found to be untrue may be subject to disciplinary action as provided in T.C.A. § 63-5-124.
    3. Renewal issuance decisions pursuant to this rule may be made administratively, upon review by the Board.
    4. Application review and decisions required by this rule shall be governed by rule 0460-01-.04.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-1-107, 63-1-108, 63-5-105, 63-5-107, 63-5-110, 63-5-111, 63-*

* 1. *, 63-5-124, and 63-5-129.* ***Administrative History:*** *Original rule filed December 11, 1991; effective*

*January 25, 1992. Amendment filed February 12, 1996; effective April 27, 1996. Amendment filed April 10,*

*2001; effective June 24, 2001. Amendment filed August 21, 2002; effective November 4, 2002.*

*Amendment filed August 18, 2003; effective November 1, 2003. Amendments filed October 25, 2017;*

*effective January 23, 2018.*

# 0460-02-.09 LICENSURE RETIREMENT AND REACTIVATION.

* + 1. Licensees who wish to retain their licenses but not actively practice may avoid compliance with the licensure renewal process, continuing education and CPR requirements by doing the following:
       1. Obtain from, complete and submit to the Board Administrative Office an affidavit of retirement form.
       2. Submit any documentation which may be required by the form to the Board Administrative Office.
    2. Any licensee whose license has been retired may reenter active practice by doing the following:
       1. Submit a written request for licensure reactivation to the Board Administrative Office; and
       2. Pay the licensure renewal fees and state regulatory fee as provided in rule 0460-01-

.02(1), and if retirement was pursuant to rule 0460-02-.08(5) and reactivation was requested prior to the expiration of one (1) year from the date of retirement, the Board may require payment of the late renewal fee and past due licensure renewal and state regulatory fees as provided in rule 0460-01-.02(1).

* + - 1. If requested, after review by the Board a designated Board member or the Board consultant, appear before the Board, a Board member or the Board consultant for an interview regarding continued competence in the event of licensure retirement in excess of two (2) years.
      2. Comply with the continuing education provisions of rule 0460-01-.05(6) applicable to reactivation of retired licenses.
      3. Submit proof of successful completion of the Tennessee Board of Dentistry Ethics and Jurisprudence examination.
    1. Application review and decisions required by this rule shall be governed by rule 0460-01-.04.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-107, 63-5-110, 63-5-111, 63-5-117, 63-5-124, and 63-*

*5-129.* ***Administrative History:*** *Original rule filed December 11, 1991; effective January 25, 1992.*

*Amendment filed March 20, 1996; effective June 3, 1996. Amendment filed August 21, 2002; effective*

*November 4, 2002. Amendments filed October 25, 2017; effective January 23, 2018.*

# 0460-02-.10 ADVERTISING.

1. Policy Statement. The lack of sophistication on the part of many members of the public concerning dental services, the importance of the interests affected by the choice of a dentist

and the foreseeable consequences of unrestricted advertising by dentists, which is recognized to pose special possibilities for deception, require that special care be taken by dentists to avoid misleading the public. The dentist must be mindful that the benefits of advertising depend upon its reliability and accuracy. Since advertising by dentists is calculated and not spontaneous, reasonable regulation designed to foster compliance with appropriate standards serves the public interest without impeding the flow of useful, meaningful, and relevant information to the public.

1. Definitions.
   1. Advertisement. Informational communication to the public in any manner designed to attract public attention to the practice of a dentist who is licensed to practice dentistry in Tennessee.
   2. Licensee. Any person holding a license to practice dentistry in the State of Tennessee. Where applicable this shall include dental partnerships and/or corporations.
   3. Material Fact. Any fact which an ordinary reasonable and prudent person would need to know or rely upon in making an informed decision concerning the choice of dental practitioners to serve his or her particular dental needs.
   4. Bait and Switch Advertising. An alluring but insincere offer to sell a product or service which the advertiser in truth does not intend or want to sell or provide. Its purpose is to switch consumers from buying or receiving the advertised merchandise or services, in order to sell or provide something else, usually at a higher fee or on a basis more advantageous to the advertiser.
   5. Discounted Fee. Shall mean a fee offered or charged by a person or organization for any dental product or service that is less than the fee the person or organization usually offers or charges for the product or service. Products or services expressly offered free of charge shall not be deemed to be offered at a ‘‘discounted fee’’.
2. Advertising Dental Fees and Services
   1. Fixed Fees. Fixed fees may be advertised for any service.
      1. It is presumed unless otherwise stated in the advertisement that a fixed fee for a service shall include the cost of all professional recognized components within generally accepted standards that are required to complete the service.
   2. Ranges of Fees. A range of fees may be advertised for services and the advertisement must disclose the factors used in determining the actual fee, necessary to prevent deception of the public.
   3. Discount Fees. Discount fees may be advertised if:
      1. The discount fee is in fact lower than the licensee’s customary or usual fee charged for the service; and
      2. The licensee provides the same quality and components of service and material at the discounted fee that are normally provided at the regular nondiscounted fee for that service.
   4. Related Services and Additional Fees. Related services which may be required in conjunction with the advertised service for which additional fees will be charged must be identified as such in any advertisement.
   5. Time Period of Advertised Fees. Advertised fees shall be honored for those seeking the advertised services during the entire time period stated in the advertisement whether or not the services are actually rendered or completed within that time.
      1. If no time period is stated in the advertisement of fees, the advertised fee shall be honored for thirty (30) days from the last date of publication or until the next scheduled publication whichever is later whether or not the services are actually rendered or completed within that time.
3. Advertising Content. The following acts or omissions in the context of advertisement by any licensee shall constitute unethical and unprofessional conduct, and subject the licensee to disciplinary action pursuant to *T.C.A. § 63-5-124(a)(18).*
   1. Claims that the services performed, personnel employed, materials or office equipment used are professionally superior to that which is ordinarily performed, employed or used, or that convey the message that one licensee is better than another when superiority of services, personnel, materials or equipment cannot be substantiated.
   2. The misleading use of an unearned or non-health degree in any advertisement.
   3. Promotion of a professional service which the licensee knows or should know is beyond the licensee’s ability to perform.
   4. Techniques of communication which intimidate, exert undue pressure or undue influence over a prospective patient.
   5. Any appeals to an individual’s anxiety in an excessive or unfair manner.
   6. The use of any personal testimonial attesting to a quality or competence of a service or treatment offered by a licensee that is not reasonably verifiable.
   7. Utilization of any statistical data or other information based on past performances for predication of future services, which creates an unjustified expectation about results that the licensee can achieve.
   8. The communication of personal identifiable facts, data, or information about a patient without first obtaining patient consent.
   9. Any misrepresentation of a material fact.
   10. The knowing suppression, omission or concealment of any material fact or law without which the advertisement would be deceptive or misleading.
   11. Statements concerning the benefits or other attributes of dental procedures or products that involve significant risks without including:
       1. A realistic assessment of the safety and efficiency of those procedures or products; and
       2. The availability of alternatives; and
       3. Where necessary to avoid deception, descriptions or assessment of the benefits or other attributes of those alternatives.
   12. Any communication which creates an unjustified expectation concerning the potential results of any dental treatment.
   13. Failure to comply with the rules governing advertisement of dental fees and services, specialty advertisement and advertising records.
   14. The use of ‘‘bait and switch’’ advertisements. Where the circumstances indicate ‘‘bait and switch’’ advertising, the Board may require the licensee to furnish data or other evidence pertaining to those sales at the advertised fee as well as other sales.
   15. Misrepresentation of a licensee’s credentials, training, experience or ability.
   16. Failure to include the corporation, partnership or individual licensee’s name and address and telephone number in any advertisement. Any dental corporation, partnership or association which advertises by use of a trade name or otherwise fails to list all licensees practicing at a particular location shall:
       1. Upon request provide a list of all licensees at that location; and
       2. Maintain and conspicuously display at the licensee’s office, a directory listing all licensees practicing at that location.
   17. Failure to disclose the fact of giving compensation or anything of value to representative of the press, radio, television or other communicative medium in anticipation of or in return for any advertisement (for example, newspaper article) unless the nature, format or medium of such advertisement make the fact of compensation apparent.
   18. After thirty (30) days, the use of the name of any licensee formerly practicing at or associated with any advertised location or on office signs or buildings. (This rule shall not apply in the case of a retired or deceased former associate who practiced dentistry in association with one or more of the present occupants if the status of the former associate is disclosed in any advertisement or sign).
   19. Stating or implying that a certain licensee provides all services when any such services are performed by another licensee.
   20. Directly or indirectly offering, giving, receiving, or agreeing to receive any fee or other consideration to or from a third party for the referral of a patient in connection with the performance of professional services.
4. Specialty Advertising
   1. A licensee may not advertise using the terms, specialist, specialty, specializing or practice limited to unless:
      1. The licensee has obtained a certification from the Board pursuant to *T.C.A. § 63- 5-112* and rules promulgated pursuant thereto, and
      2. The branch of dentistry so advertising is listed as a specialty branch of dentistry in

*T.C.A. § 63-5-112* or rules promulgated pursuant thereto.

* 1. A licensee who possesses a verifiable combination of education and experience is not prohibited from including in his practice one or more specialty branches of dentistry. However, any advertisement of such practice shall:
     1. Not use the terms specialty, specializing, specialist or practice limited to; and
     2. Contain the statement ‘‘the services are being performed or provided by a general dentist’’, and such statement must appear or be expressed in the advertisement as conspicuously as the branch of dentistry advertised.
  2. Specific Areas of Practice - Notwithstanding Rule 0460-02-.10(4)(o), any licensee who advertises credentials in a branch of dentistry other than those enumerated in *T.C.A. § 63-5-112* or as recognized by Rule by the Board, who has been granted credentialed status to include the terms “associate fellow”, “fellow” or “diplomate” by a bona fide national organization which is not recognized as a certifying Board by the American Dental Association or the Board of Dentistry, but grants “associate fellow”, “fellow” or “diplomate” status based on the dentist’s postgraduate education, training, experience, and an oral and written examination predicated upon valid and reliable principles, may utilize one of the following terms: “associate fellow”, “fellow” or “diplomate” in an advertisement and refer to the area of dental practice in which the credential is obtained if the same is accompanied by the following disclaimer appearing as conspicuously as the credential advertised:

“This area of practice is not recognized as a specialty by the Tennessee Board of Dentistry.”

* 1. The term “Board Certified” may not be used in any advertisement unless associated with a recognized specialty enumerated in *T.C.A. § 63-5-112* certified by the American Dental Association or the Board of Dentistry.

1. Advertising Records and Responsibility
   1. Each licensee who is a principal partner, or officer of a firm or entity identified in any advertisement, is jointly and severally responsible for the form and content of any advertisement. This provision shall also include any licensed professional employees acting as an agent of such or entity.
   2. Any and all advertisement are presumed to have been approved by the licensee named therein.
   3. A recording of every advertisement communicated by electronic media, and a copy of every advertisement communicated by print media, and a copy of any other form of advertisement shall be retained by the licensee for a period of two (2) years from the last date of broadcast or publication and be made available for review upon request by the board or its designee.
   4. At the time any type of advertisement is placed, the licensee must possess and rely upon information which, when produced, would substantiate the truthfulness of any assertion, omission or representation of material fact set forth in the advertisement or public communication.
2. Use of Titles - Any person who possesses a valid, current and active license issued by the Board that has not been suspended or revoked has the right to use the titles “Dentist,” “Doctor of Dental Surgery,” “D.D.S.,” “Doctor of Dental Medicine,” or “D.M.D.” and to practice dentistry, as defined in T.C.A. § 63-5-108. Any person licensed by the Board to whom this rule applies must use one of the titles authorized by this rule in every “advertisement” [as that term is defined in rule 0460-02-.10 (2) (a)] he or she publishes. The failure to do so will constitute an omission of a material fact which makes the advertisement misleading and deceptive and subjects the dentist to disciplinary action pursuant to T.C.A. § 63-5-124 (a) (1), (a) (3), and (a) (19).
3. Severability. It is hereby declared that the sections, clauses, sentences and part of these rules are severable, are not matters of mutual essential inducement, and any of them shall be exscinded if these rules would otherwise be unconstitutional or ineffective. If any one or more sections, clauses, sentences or parts shall for any reason be questioned in court, and shall be adjudged unconstitutional or invalid, such judgment shall not affect, impair or invalidate the remaining provisions thereof, but shall be confined in its operation to the specific provision or provisions so held unconstitutional or invalid, and the inapplicability or invalidity of any section, clause, sentence or part in any one or more instances shall not be taken to affect or prejudice in any way its applicability or validity in any other instance.

***Authority:*** *T.C.A. §§ 4-5-202, 63-1-145, 63-5-105, 63-5-108, 63-5-112, 63-5-113, and 63-5-124.*

***Administrative History:*** *Original rule certified June 7, 1974. Repeal filed August 26, 1980; effective December 1, 1980. New rule filed December 11, 1991; effective January 25, 1992. Amendment filed May*

*15, 1996; effective September 27, 1996. Amendment filed December 7, 1998; effective February 20, 1999.*

*Amendment filed September 25, 2008; effective December 9, 2008.*

# 0460-02-.11 REGULATED AREAS OF PRACTICE.

1. Policy Statement - The scope of the practice of dentistry in Tennessee is broadly defined and includes many aspects which if not particularly regulated could lead to serious ramifications for the consuming public. This rule is to designate specific areas in the practice of dentistry for regulation, the violation of which may result in disciplinary action pursuant to *T.C.A. §§ 63-5- 124(a)(1), 63-5-124(3), 63-5-124(4), 63-5-124(7), 63-5-124(8), 63-5-124(16)* or *63-5-124(18).*
2. Prescribing, Dispensing, or Otherwise Distributing Pharmaceuticals
   1. Dentists who elect to dispense pharmaceuticals for compensation or otherwise distribute pharmaceuticals must comply with the following:
      1. All Federal Regulations (21 CFR 1304 through 1308) for the dispensing of controlled substances.
      2. Requirements for dispensing of non-controlled drugs are as follows:
         1. Drugs are to be dispensed in an appropriate container labeled with at least, the following:
            1. Patient’s name
            2. Date
            3. Complete directions for usage
            4. The dentist’s name and address
            5. A unique number, or the name and strength of the medication
   2. Dentists may prescribe, dispense or otherwise distribute the controlled substances listed in Schedules II, III, IV, and V, as provided in 21 C.F.R. Chapter 2, 1308.12 through .15, only to individuals with whom they have established a dentist/patient relationship and for whom they have provided dental services. For purposes of this provision, a “dentist/patient” relationship exists where a dentist has provided dental treatment to a patient on at least one (1) occasion within the preceding year, or exists by having adequate documented knowledge of the specific patient history.
   3. Dentists must confine their prescription, dispensing or distributing of pharmaceuticals to those which are directly associated with and recognized for the treatment of an identified dental procedure, ailment or infirmity.
   4. Dentists must not prescribe, dispense or otherwise distribute controlled substances in amounts, or for durations not medically or dentally necessary, advisable or justified by an existing, identifiable dental procedure, ailment or infirmity.
   5. Dentists must record in patient records all pharmaceuticals dispensed, prescribed or otherwise distributed to patients. A separate log must be maintained for all controlled substances dispensed by a dentist.
   6. It is not the intention of this rule to interfere with the individual dentist’s appropriate use of professional samples, nor to interfere in any way with the dentists right to directly administer drugs or medicines to any patient.
   7. Dentists shall only allow licensed or registered auxiliary staff to give/hand medications to a patient and only after the dentist has verified that the medication about to be given is the correct medication and correct dosage prescribed. Under no circumstances shall the dentist allow auxiliary staff to place medications directly in the mouth of a patient or on the patient such as actisite, nitrous oxide, any other medicated dental material, etc., with the exception of a topical anesthetic pursuant to T.C.A. §§ 63-5-108 (b) (12) and/or

(d) (3), and any other procedure authorized by Rule 0460-03-.09 (1).

* 1. Nothing in these rules shall be interpreted to interfere with the ability of properly credentialed dentists who practice in the hospital setting to reinstate, continue, and/or rewrite for their patients all prescriptions which are medically or dentally advisable or justified for such dental procedure(s) or treatment(s), including prescriptions for ancillary medical conditions, so long as:
     1. such medical prescriptions are rational to the practice of dentistry; and
     2. the treating dentist only orders such medical prescriptions in consultation with the patient’s treating physician; and
     3. the treating dentist only re-orders such medical prescriptions which already have been ordered by the patient’s treating physician and which prescription orders would remain in effect for the patient but for the JCAHO standard against automatic reinstatement in the hospital setting.

1. Third Party Payor Practices. The following acts or omissions by or on behalf of any dentist may be grounds for disciplinary action:
   1. Abrogating the deductible or repeatedly or regularly waving co-payment or both provisions of any insurance contract or dental plan by forgiving any or all of a patient’s obligations for payment of said deductible or co-payment or both without first notifying the insurance company or dental plan in writing of the intent to do so.
   2. Rebating or repeatedly or regularly waiving or offering to rebate to an insured any payment by the insured’s third-party payor to the licensee for services or treatments rendered under the insured’s policy, without first notifying the insurance company or dental plan in writing of the intent to do so.
   3. Submitting to a third-party payor a claim for a service or treatment at an inflated fee or charge or one greater than the licensee usually charges for the service or treatment when such is rendered without third-party reimbursement.
   4. Knowingly incorrectly reporting services rendered, reporting incorrect treatment dates, or reporting charges for services not rendered, or filing claims prior to completion of services for the purpose of obtaining payment from a third-party payor unless the payor is notified in writing at the time of filing for payment.
2. Laboratory Work Orders
   1. A written work order must accompany all dental laboratory work sent by a dentist to a commercial dental laboratory or private dental laboratory technician outside the physical confines of the ordering dentist’s office.
   2. A copy of all written work orders required by this rule must be kept on file by the ordering dentist for a period of two (2) years from the date the order was issued.
   3. All written work orders required by this rule must include the following information:
      1. Date signed.
      2. The name and address of the commercial dental laboratory or private dental laboratory technician.
      3. The name or identification number of the patient for whom the act or service is ordered.
      4. The licensed dentist’s name, address, and license number.
      5. The signature of the licensed dentist.
      6. The description of the kind and type of appliance, process, fabrication, service, or material ordered.
3. Unauthorized Practice - Any dentist who permits any dental hygienist or dental assistant to perform any acts or services other than those specifically assignable or delegable pursuant to T.C.A. § 63-5-108 and/or Rule 0460-03-.09 and/or 0460-04-.01 and 0460-04-.08 may be subject to discipline pursuant to T.C.A. § 63-5-116(a).
4. Universal Precautions for the Prevention of HIV Transmission - The Board adopts Rules 1200-14-03-.01 through 1200-14-03-.03 inclusive, of the Department of Health, and as they may from time to time be amended, as its rules governing the process for implementing universal precautions for the prevention of HIV transmission for health care workers under its jurisdiction.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-107, 63-5-108, 63-5-109, 63-5-116, 63-5-122, and*

*63-5-124.* ***Administrative History:*** *Original rule certified June 7, 1974. Repeal filed August 26, 1980;*

*effective December 1, 1980. New rule filed December 11, 1991; effective January 25, 1992. Amendment*

*filed June 20, 1994; effective September 3, 1994. Amendment filed June 29, 1994; effective September*

*12, 1994. Amendment filed May 15, 1996; effective September 27, 1996. Amendment filed February 9,*

*2000; effective April 24, 2000. Amendment filed October 20, 2003; effective January 3, 2004. Amendment*

*filed May 28, 2004; effective August 11, 2004. Amendment filed September 25, 2008; effective December*

*9, 2008.*

# 0460-02-.12 DENTAL RECORDS.

1. Purposes - The purposes of these rules are:
   1. To recognize that dental records are an integral part of the practice of dentistry as defined in T.C.A. § 63-5-108.
   2. To give dentists, their professional and non-professional staff, and the public direction about the content, transfer, retention, and destruction of those records.
   3. To recognize that a distinction exists between a dentist’s records for a patient receiving services in the dentist’s office and those records created by the dentist for that patient for purposes of services provided in a hospital as defined by T.C.A. § 68-11-302 (4) and that the distinction exists regardless of the fact that the dentist may also be an employee of the hospital or of a dental group employed or owned by the hospital.
2. Conflicts - As to dental records, these rules should be read in conjunction with the provisions of T.C.A. §§ 63-2-101 and 102, and are not intended to conflict with those statutes in any way. Those statutes, along with these rules, govern the subjects that they cover in the absence of other controlling state or federal statutes or rules to the contrary.
3. Applicability - These rules regarding dental records shall apply only to those records, the information for which was obtained by dentists or their professionally licensed employees, or those over whom they exercise supervision, for purposes of services provided in any clinical setting other than those provided in a hospital as defined by T.C.A. § 68-11-302 (4), a hospital emergency room or hospital outpatient facility.
4. Dental Records -
   1. Duty to Create and Maintain Dental Records - As a component of the standard of care and of minimal competency a dentist must cause to be created and cause to be maintained a dental record for every patient for whom he or she, and/or any of his or her professionally licensed or registered supervisees, performs services or provides professional consultation.
   2. Duty to Release Dental Records - A dentist shall not withhold records for non-payment of current or prior dental services.
   3. Notice - Anywhere in these rules where notice is required to be given to patients of any dentist, that notice shall be required to be issued within thirty (30) days of the date of the event that triggers the notice requirement, and may be accomplished by public notice.
   4. Distinguished from Hospital Dental Records - The dental records covered by these rules are separate and distinct from those records generated for the patient by the dentist during the course of providing dental services for the patient in a hospital as defined by T.C.A. § 68-11-302 (4) regardless of the fact that the dentist may also be an employee of the hospital or of a dental group employed or owned by the hospital.
      1. The provisions of T.C.A. Title 68, Part 11, Chapter 3 govern dental records generated in a hospital as defined by T.C.A. § 68-11-302 (4).
      2. The dental records covered by these rules are those:
         1. That are created prior to the time of the patient’s admission to, or confinement and/or receipt of services in, a hospital as defined by T.C.A. § 68-11-302 (4), hospital emergency room and/or hospital outpatient facility, and/or
         2. That are created after the patient’s discharge from a hospital as defined by

T.C.A. § 68-11-302 (4), hospital emergency room or hospital outpatient facility.

* + - 1. That are created during the practice of dentistry as defined by T.C.A. § 63- 5-108 outside of a hospital as defined by T.C.A. § 68-11-302 (4), hospital emergency room or hospital outpatient facility.
    1. Even though the records covered by these rules may, of necessity, reference provision of services in the hospital setting and the necessary initial work-up and/or follow-up to those services, that does not make them “hospital records” that are regulated by or obtainable pursuant to T.C.A. Title 68, Part 11, Chapter 3.
  1. Content -
     1. All dental records, or summaries thereof, produced in the course of the practice of dentistry for all patients, shall include all information and documentation listed in T.C.A. § 63-2-101 (c) (2).
     2. All dental records, or summaries thereof, produced in the course of the practice of dentistry for all patients, shall include such additional information that is necessary to ensure that a subsequent reviewing or treating dentist can both ascertain the basis for the diagnosis, treatment plan and outcomes, and provide continuity of care for the patient.
     3. X-rays and X-ray interpretations are considered to be part of the dental records.
     4. At a minimum, all dental patient records shall include:
        1. A charting of the patient’s teeth conditions.
        2. Concise description and treatment date for services performed.
        3. Concise medical history.
        4. Notation of dates, types, and amounts of pharmaceuticals prescribed or dispensed.
        5. Readable x-rays when required for services rendered.
  2. Transfer -
     1. Records of Dentists upon Death or Retirement - When a dentist retires or dies while in practice, patients seen by the dentist in his/her office during the immediately preceding thirty-six (36) months shall be notified by the deceased dentist’s or retiring dentist’s authorized representative and urged to find a new dentist and be informed that upon authorization, copies of the records will be sent to the new dentist.
     2. Records of Dentists upon Departure from a Group - The responsibility for notifying patients of a dentist who departs from a group practice shall be governed by the dentist’s employment contract.
        1. Whomever is responsible for that notification must notify patients seen by the dentist in his/her office during the immediately preceding thirty-six (36) months of his/her departure.
        2. Except where otherwise governed by provisions of the dentist’s contract, those patients shall also be notified of the dentist’s new address and offered the opportunity to have copies of their dental records forwarded to the departing dentist at his or her new practice. The dental group shall not withhold the dental records of any patient who has authorized their transfer to the departing dentist or any other dentist.
        3. The choice of dentists in every case should be left to the patient, and the patient should be informed that upon authorization his/her records will be sent to the dentist of the patient’s choice.
     3. Sale of a Dental Practice - A dentist or the estate of a deceased dentist may sell the elements that comprise his/her practice, one of which is its goodwill, i.e., the opportunity to take over the patients of the seller by purchasing the dentist’s patient records. Therefore, the transfer of records of patients is subject to the following:
        1. The dentist (or the estate) must ensure that all patient dental records are transferred to another dentist or entity that is held to the same standards of confidentiality as provided in these rules.
        2. Patients seen by the dentist in his/her office during the immediately preceding thirty-six (36) months shall be notified that the dentist (or the estate) is transferring the practice to another dentist or entity who will retain custody of their records and that, at their written request, the copies of their records will be sent to another dentist or entity of their choice.
     4. Abandonment of Records - For purposes of this section of the rules death of a dentist shall not be considered as abandonment.
        1. It shall be a prima facie violation of T.C.A. § 63-5-124 (a) (1) for a dentist to abandon his practice without making provision for the security, or transfer, or otherwise establish a secure method of patient access to their records.
        2. Upon notification that a dentist in a practice has abandoned his practice and has not made provision for the security, transfer, or establishment of a secure method of patient access to their records, patients should take all reasonable steps to obtain their dental records by whatever lawful means available and should immediately seek the services of another dentist.
  3. Retention of Dental Records - Dental records shall be retained for a period of not less than seven (7) years from the dentist’s or his supervisees’ last professional contact with the patient except for the following:
     1. Dental records for incompetent patients shall be retained indefinitely.
     2. Dental records of minors shall be retained for a period of not less than one (1) year after the minor reaches the age of majority or seven (7) years from the date of the dentist’s or his supervisees’ last professional contact with the patient, whichever is longer.
     3. Notwithstanding the foregoing, no dental record involving services which are currently under dispute shall be destroyed until the dispute is resolved.
  4. Destruction of Dental Records -
     1. No dental record shall be singled out for destruction other than in accordance with established office operating procedures that are consistent with these rules.
     2. Records shall be destroyed only in the ordinary course of business according to established office operating procedures that are consistent with these rules.
     3. Records may be destroyed by burning, shredding, or other effective methods in keeping with the confidential nature of the records.
     4. When records are destroyed, the time, date and circumstances of the destruction shall be recorded and maintained for future reference. The record of destruction need not list the individual patient dental records that were destroyed but shall be sufficient to identify which group of destroyed records contained a particular patient’s dental records.

1. Violations - Violation of any provision of these rules is grounds for disciplinary action pursuant to T.C.A. §§ 63-5-124 (a) (1), and/or (2).

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-2-101, 63-2-102, 63-5-105, 63-5-108, 63-5-121, and 63-5-124.*

***Administrative History:*** *Original rule filed October 20, 2003; effective January 3, 2004.*

# 0460-02-.13 FREE HEALTH CLINIC, INACTIVE PRO BONO AND VOLUNTEER PRACTICE REQUIREMENTS.

1. Free Health Clinic Practice Pursuant to T.C.A. § 63-1-201
   1. Any dentist licensed to practice dentistry in this state or any other state who has not been disciplined by any dentistry licensure board may have their license converted to or receive a Tennessee “Special Volunteer License,” as defined in T.C.A. § 63-1-201, which will entitle the licensee to practice without remuneration solely within a “free health clinic,” as defined by T.C.A. § 63-1-201, at a specified site or setting by doing the following:
      1. Obtaining from the Board’s administrative office a “Special Volunteer License” application, completing it and submitting it along with any required documentation to the Board’s administrative office; and
      2. Have the licensing authority of every state in which the dentist holds or ever held a license to practice dentistry submit directly to the Board’s administrative office the equivalent of a “certificate of fitness” as described in T.C.A. § 63-1-118 which shows that the license has never been subjected to any disciplinary action and is free and clear of all encumbrances; and
      3. For dentists who have not been licensed in Tennessee, comply with all provisions of subparagraphs (1) (c), (1) (d), (1) (e), (1) (g) and (1) (h) of rule 0460-02-.01 and the Health Care Consumer-Right-To-Know Act compiled at T.C.A. §§ 63-51- 101, et seq.; and
      4. Submitting the specific location of the site or setting of the free health clinic in which the licensee intends to practice along with proof of the clinic’s private, and not-for-profit status.
   2. A dentist holding a Special Volunteer License is not required to pay any fee for its issuance or the required biennial renewal pursuant to the Division of Health Related Board’s biennial birthdate renewal system.
   3. A dentist holding a Special Volunteer License may not do any of the following:
      1. Practice dentistry anywhere other than in the free health clinic site or setting specified in the application; and
      2. Charge any fee or receive compensation or remuneration of any kind from any person or third party payor including insurance companies, health plans and state or federal benefit programs for the provision of medical or any other services; and
      3. Practice for any free health clinic that imposes any charge on any individual to whom health care services are rendered or submits charges to any third party payor including insurance companies, health plans and state or federal benefit programs for the provision of any services.
   4. Special Volunteer Licenses are subject to all of the following
      1. All rules governing renewal, retirement, reinstatement and reactivation as provided by rules 0460-02-.08 and .09, except those requiring the payment of any fees; and
      2. The rules governing continuing education and cardio pulmonary resuscitation as provided by rule 0460-01-.05; and
      3. Disciplinary action for the same causes and pursuant to the same procedures as all other licenses issued by the Board.
2. Inactive Pro Bono Practice Pursuant to T.C.A. § 63-5-132 – Applicants who intend to exclusively practice dentistry without compensation on patients who receive dentistry services from organizations granted a determination of exemption pursuant to Section 501 (c)(3) of the Internal Revenue Code may obtain an inactive pro bono license to do so as follows:
   1. Applicants who currently hold a valid Tennessee license to practice dentistry issued by the Board pursuant to this rule which is in good standing must:
      1. Retire their active licenses pursuant to the provisions of rule 0460-02-.09; and
      2. Have submitted to the Board Administrative Office directly from the qualified organization proof of the determination of exemption issued pursuant to Section 501 (c)(3) of the Internal Revenue Code; and
      3. Submit a written certification that they are practicing dentistry exclusively on the patients of the qualified entity and that such practice is without compensation.
   2. Applicants who do not currently hold a valid Tennessee license to practice dentistry must:
      1. Obtain a license by complying with all provisions of subparagraphs (1) (c), (1) (d),

(1) (e), (1) (g), (1) (h) and (2) (b) of rule 0460-02-.01 and the Health Care Consumer-Right-To-Know Act compiled at T.C.A. §§ 63-51-101, et seq.; and

* + 1. Have submitted to the Board Administrative Office directly from the qualified organization proof of the determination of exemption issued pursuant to Section 501 (c)(3) of the Internal Revenue Code; and
    2. Submit a written certification that they are practicing dentistry exclusively on the patients of the qualified entity and that such practice is without compensation.
  1. Inactive pro bono licenses are subject to all rules governing renewal, retirement, reinstatement and reactivation as provided by rules 0460-02-.08 and .09, and are subject to all rules governing continuing education and cardio pulmonary resuscitation as provided by rule 0460-01-.05. These licenses are also subject to disciplinary action for the same causes and pursuant to the same procedures as active licenses.

1. Practice Pursuant to the “Volunteer Health Care Services Act” T.C.A. §§ 63-6-701, et seq.
   1. Any dentist licensed in this or any other state, territory, district or possession of the United States whose license is not under a disciplinary order of suspension or revocation may practice dentistry in this state but only under the auspices of an organization that has complied with the provisions of this rule and T.C.A. §§ 63-6-701 through 707 and rule 1200-10-01-.12 of the Division of Health Related Boards.
   2. Any person who may lawfully practice dentistry in this or any other state, territory, district or possession of the United States under an exemption from licensure and who is not under a disciplinary order of suspension or revocation and who is not and will not “regularly practice,” as defined by T.C.A. § 63-6-703 (3) may practice dentistry in this state but only under the auspices of an organization that has complied with the provisions of this rule and T.C.A. §§ 63-6-701 through 707 and rule 1200-10-01-.12 of the Division of Health Related Boards.
   3. A dentist or anyone who practices under an exemption from licensure pursuant to this rule may not charge any fee or receive compensation or remuneration of any kind from any person or third party payor including insurance companies, health plans and state or federal benefit programs for the provision of dentistry or any other services; and may not practice for any organization that imposes any charge on any individual to whom health care services are rendered or submits charges to any third party payor including insurance companies, health plans and state or federal benefit programs for the provision of any services.
   4. Any organization that organizes or arranges for the voluntary provision of health care services on residents of Tennessee may utilize persons described in subparagraphs (a) and (b) to practice dentistry only when it has complied with the provisions of T.C.A. §§ 63-6-701 through 707 and rule 1200-10-01-.12 of the Division of Health Related Boards.
2. Application review and licensure decisions for these types of licensure shall be governed by rule 0460-01-.04.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-1-201, 63-5-105, 63-5-110, 63-5-132, 63-5-134, and 63-6-701*

*through 63-6-707.* ***Administrative History:*** *Original rule filed December 16, 2005; effective March 1,*

*2006. Amendment filed August 4, 2009; effective November 2, 2009.*

# 0460-02-.14 TAMPER-RESISTANT PRESCRIPTIONS.

1. Purpose.

This rule is designed to implement the law requiring that licensed dentists have all written, typed, or computer-generated prescriptions issued on tamper-resistant prescription paper.

1. Definitions.

The following definitions are applicable to this rule:

* 1. “Drug” shall have the same meaning as set forth in T.C.A. § 63-10-204(16).
  2. “Prescriber” means an individual licensed in Tennessee as a medical doctor, podiatrist, advanced practice nurse with a certificate of fitness to prescribe, dentist, optometrist, osteopathic physician, or physician’s assistant.
  3. “Prescription order” shall have the same meaning as set forth in T.C.A. § 63-10- 204(34).
  4. “Tamper-resistant prescription” means a written prescription order with features that are designed to prevent unauthorized copying, erasure, modification, and use of counterfeit prescription forms.

1. Tamper-Resistant Prescription Requirements.
   1. A prescriber shall ensure that all handwritten, typed, or computer-generated prescription orders are issued on tamper-resistant prescriptions. Tamper-resistant prescriptions shall contain the following features:
      1. Either a void or illegal pantograph or a watermark designed to prevent copying;
      2. Either quantity check-off boxes with refill indicators or a uniform, non-white background color designed to prevent erasure or modification; and
      3. Security features and descriptions listed on the prescriptions designed to prevent use of counterfeit forms.
2. Security Measures and Recordkeeping.
   1. Each prescriber shall undertake adequate safeguards and security measures to ensure against loss, improper destruction, theft, or unauthorized use of the tamper-resistant prescriptions in the prescriber’s possession.
3. Use of Tamper-Resistant Prescriptions.
   1. Facsimile Prescription Transmission.
      1. Prescriptions sent by facsimile transmission are not required to be placed on tamper-resistant prescription paper.
      2. If a prescriber transmits a prescription order to a pharmacy by facsimile transmission, the prescriber or someone designated by the prescriber shall document in the patient’s medical record the name of the drug, strength, and quantity prescribed. The prescriber may, but is not required to, document the means by which the prescription was transmitted.
   2. Electronic Prescription Transmission.
      1. Prescriptions sent by electronic transmission are not required to be placed on tamper-resistant prescription paper.
      2. If a prescriber transmits a prescription order to a pharmacy by electronic transmission, the prescriber shall document the prescription in the patient’s file and in accordance with the applicable laws and rules for each of the prescribers’ respective professions as well as applicable federal laws and rules. The prescriber may, but is not required to, document the means by which the prescription was transmitted.

***Authority:*** *Chapter 1035 of the Public Acts of 2008 and T.C.A. §§ 53-10-401, 63-5-105, and 63-5-122. [effective October 1, 2008 for TennCare prescriptions and July 1, 2009 for non-TennCare prescriptions].* ***Administrative History:*** *Public necessity rule filed June 25, 2009; effective through December 7, 2009. Public necessity rule filed June 25, 2009 expired; on December 8, 2009, the rule reverted to its prior status. Emergency rule filed December 21, 2009; effective through June 19, 2010. Original rule filed March 22, 2010; effective June 20, 2010.*

# RULES OF

**TENNESSEE BOARD OF DENTISTRY**

**CHAPTER 0460-03**

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**0460-03-.01 LICENSURE PROCESS.** To practice as a dental hygienist in Tennessee a person must possess a lawfully issued license from the Board. The process for obtaining a license is as follows:

1. An applicant shall obtain a Board application form from the Board Administrative Office, respond truthfully and completely to every question or request for information contained in the form and submit it along with all documentation and fees required by the form and this rule to the Board Administrative Office. It is the intent of this rule that all activities necessary to accomplish the filing of the required documentation be completed prior to filing a licensure application and that all documentation be filed simultaneously at least sixty (60) days prior to the next scheduled Board meeting.
2. An applicant shall cause to be submitted directly, from a dental hygiene school, college or university approved or provisionally approved by the Commission on Dental Accreditation of the American Dental Association, to the Board Administrative Office, a certificate of graduation containing the institutions Official Seal and which shows the following:
   1. The applicant’s transcript; and
   2. The degree and diploma conferred, or a letter from the dean of the educational institution attesting to the applicant’s eligibility for the degree and diploma if the last term of dental hygiene school has not been completed at the time of application. However, no license shall be issued until official notification is received in the Board Administrative Office that the degree and diploma have been conferred.
3. An applicant shall submit:
   1. proof of having attained at least eighteen (18) years of age; and
   2. a signed “passport” style photograph taken within the preceding twelve (12) months.
4. An applicant shall submit evidence of good moral character. Such evidence shall include at least two (2) letters attesting to the applicant’s character from dental professionals on the signator’s letterhead.
5. An applicant shall submit proof of United States or Canadian citizenship or evidence of being legally entitled to live in the United States. Such evidence may include copies of birth certificates, naturalization papers, or current visa status.
6. An applicant shall submit the licensure application fee and state regulatory fee as provided in rules 0460-01-.02 (2).
7. An applicant shall cause to be submitted a certificate of successful completion of the examinations for licensure as governed by rule 0460-03-.05.
8. An applicant shall disclose the circumstances surrounding any of the following:
   1. Conviction of any criminal law violation of any country, state, or municipality, except minor traffic violations.
   2. The denial of licensure application by any other State or the discipline of licensure in any state.
   3. Any other civil suit judgment or civil suit settlement in which the applicant was a party defendant including, without limitation, actions involving malpractice, breach of contract, antitrust activity or any other civil action remedy recognized under any country’s or state’s statutory, common, or case law.
   4. Failure of any dental or dental hygiene licensure examination.
9. An applicant shall cause to be submitted to the Board’s administrative office directly from the vendor identified in the Board’s licensure application materials, the result of a criminal background check.
10. Failure to make application for licensure within ninety (90) days after a person has successfully completed all requirements for licensure may result in denial of any subsequently filed application unless good cause is shown for failure to do so.
11. An applicant shall submit evidence of current training in cardiopulmonary resuscitation (CPR) which is defined as successful completion of a BLS for Healthcare Providers, or CPR/AED for Professional Rescuers, or an equivalent course, which provides training for healthcare professionals in CPR and the use of an AED by a Board approved training organization. The course must be conducted in person and include a skills examination on a manikin with a certified instructor.
12. If an applicant has ever held a license to practice in any other state or Canada, the applicant shall submit or cause to be submitted the equivalent of a Tennessee Certificate of Endorsement from each such licensing board which indicates the applicant either holds a current active license and whether it is in good standing, or held a license which is currently inactive and whether it was in good standing at the time it became inactive.
13. An applicant shall successfully complete the Tennessee Board of Dentistry Ethics and Jurisprudence examination.
14. Application reviews and licensure decisions required by this rule shall be governed by rule 0460-01-.04.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-105(3), 63-5-105(4), 63-5-105(7), 63-5-107, 63-5-*

*107(a), 63-5-107(c), 63-5-111, 63-5-111(a), 63-5-111(b)(2), 63-5-114, and 63-5-124.* ***Administrative***

***History:*** *Original rule certified June 7, 1974. Repeal and new rule filed December 11, 1991; effective January 25, 1992. Amendment filed May 15, 1996; effective September 27, 1996. Amendment filed*

*February 9, 2000; effective April 24, 2000. Amendment filed April 10, 2001; effective June 24, 2001.*

*Amendment filed March 17, 2006; effective May 31, 2006. Amendment filed September 30, 2014; effective*

*December 29, 2014. Amendments filed October 25, 2017; effective January 23, 2018.*

**0460-03-.02 CRITERIA APPROVAL LICENSURE PROCESS (RECIPROCITY).** Dental hygienists who

are licensed in other states may obtain a license to practice in Tennessee by the following process:

1. An applicant shall obtain a Board application form from the Board’s Administrative Office, respond truthfully and completely to every question or request for information contained in the form and submit it along with all documentation and fees required by the form and this rule to the Board’s Administrative Office. It is the intent of this rule that all activities necessary to accomplish the filing of the required documentation be completed prior to filing a licensure application.
2. An applicant shall cause to be submitted directly, from a dental hygiene school, college or university approved or provisionally approved by the Commission on Dental Accreditation of the American Dental Association, to the Board Administrative Office, a certificate of graduation containing the institutions official seal and which shows the following:
   1. The applicant’s transcript; and
   2. The degree and diploma conferred.
3. An applicant shall cause to be submitted directly from the American Dental Association, to the Board Administrative Office, proof of successful completion of the National Board examination if the person graduated from a dental hygiene college, school or university after 1972.
4. An applicant shall submit:
   1. proof of having attained at least eighteen (18) years of age; and
   2. a signed “passport” style photograph taken within the preceding twelve (12) months.
5. An applicant shall submit evidence of good moral character. Such evidence shall include at least two (2) letters attesting to the applicant’s character, standing and ability from dentists on the signator’s letterhead.
6. An applicant shall submit proof of United States or Canadian citizenship or evidence of being legally entitled to live in the United States. Such evidence may include copies of birth certificates, naturalization papers, or current visa status.
7. An applicant shall submit the licensure application fee and state regulatory fee as provided in rules 0460-01-.02 (2). Also, if licensure is granted, the new licensee must submit the criteria approval licensure fee provided in Rule 0460-01-.02 (2) before a license will be issued.
8. An applicant shall disclose the circumstances surrounding any of the following:
   1. Conviction of any criminal law violation of any country, state, or municipality, except minor traffic violations.
   2. The denial of licensure application by any other state or the discipline of licensure in any state.
   3. Any other civil suit judgment or civil suit settlement in which the applicant was a party defendant including, without limitation, actions involving malpractice, breach of contract, antitrust activity or any other civil action remedy recognized under any country’s or state’s statutory, common, or case law.
   4. Failure of any dental or dental hygiene licensure examination.
9. An applicant shall cause to be submitted to the Board’s administrative office directly from the vendor identified in the Board’s licensure application materials, the result of a criminal background check.
10. An applicant shall submit evidence of current training in cardiopulmonary resuscitation (CPR) which is defined as successful completion of a BLS for Healthcare Providers, or CPR/AED for Professional Rescuers, or an equivalent course, which provides training for healthcare professionals in CPR and the use of an AED by a Board approved training organization. The course must be conducted in person and include a skills examination on a manikin with a certified instructor.
11. The applicant shall submit or cause to be submitted the equivalent of a Tennessee Certificate of Endorsement from each licensing board of each State in which licensure is or was ever held which indicates the applicant either holds a current active license and whether it is in good standing, or held a license which is currently inactive and whether it was in good standing at the time it became inactive. An applicant must possess an active, current license which is in good standing in at least one other state.
12. An applicant must submit a personal or professional resume on a form provided by the Board.
13. An applicant must submit evidence satisfactory to the Board of all the following:
    1. Active, licensed practice of dental hygiene in a private office setting, or in post-graduate dental hygiene study or in service as a dental hygiene faculty member for three (3) of the five (5) years immediately preceding application. Temporary absences from employment during the three (3) year period may under individual circumstances not be considered as a disqualifying factor at the discretion of the Board.
    2. If requested, ability to provide patient care on a continuing basis.
14. Unless an applicant subsequently retakes and passes a failed examination, an applicant must never have failed any Board-approved examination as provided in rule 0460-03-.05 to be eligible for licensure under the criteria approval process described in this rule.
15. An applicant must successfully complete the Tennessee Board of Dentistry Ethics and Jurisprudence examination.
16. Application review and licensure decisions required by this rule shall be governed by Rule 0460-01-.04.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-107, 63-5-111, 63-5-114, and 63-5-124.*

***Administrative History:*** *Original rule certified June 7, 1974. Repeal and new rule filed December 11, 1991; effective January 25, 1992. Amendment filed June 29, 1994; effective September 12, 1994.*

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*filed April 10, 2001; effective June 24, 2001. Amendment filed April 10, 2002; effective June 24, 2002.*

*Amendment filed July 21, 2004; effective October 4, 2004. Amendment filed August 23, 2005; effective*

*November 6, 2005. Amendment filed March 17, 2006; effective May 31, 2006. Amendment filed August 4,*

*2009; effective November 2, 2009. Amendment filed September 30, 2014; effective December 29, 2014.*

*Amendments filed October 25, 2017; effective January 23, 2018.*

**0460-03-.03 EDUCATIONAL LICENSURE PROCESS.** A dental hygienist licensed in another state may obtain a license to practice in Tennessee under the auspices of a dental or dental hygiene educational institution. This type of license limits only practice location and not services allowed to be performed. The practice location for dental hygienists who have this type of licensure is limited to programs offered by the

educational institution and does not authorize practice outside the institution. The process for obtaining a limited educational license is as follows:

1. An applicant shall obtain a Board application form from the Board Administrative Office, respond truthfully and completely to every question or request for information contained in the form and submit it along with all documentation and fees required by the form and this rule to the Board Administrative Office. It is the intent of this rule that all activities necessary to accomplish the filing of the required documentation be completed prior to filing a licensure application and that all documentation be filed simultaneously.
2. An applicant shall request that a transcript from a dental hygiene school, college or university be sent directly from the institution to the Board Administrative Office. The transcript must show that the degree was conferred and carry the Official Seal of the institution.
3. An applicant shall submit:
   1. proof of having attained at least eighteen (18) years of age; and
   2. a signed “passport” style photograph taken within the preceding twelve (12) months.
4. An applicant shall submit evidence of good moral character and competence. Such evidence shall include at least two (2) letters attesting to the applicant’s character and ability from licensed dentists on the signator’s letterhead.
5. An applicant shall submit proof of United States or Canadian citizenship or evidence of being legally entitled to live in the United States. Such evidence may include copies of birth certificates, naturalization papers, or current visa status.
6. An applicant shall submit the licensure application fee and state regulatory fees as provided in rules 0460-01-.02 (2). Also, if licensure is granted, the new licensee must submit the educational licensure fee provided in Rule 0460-01-.02 (2) before a license will be issued.
7. An applicant shall submit evidence of current training in cardiopulmonary resuscitation (CPR) which is defined as successful completion of a BLS for Healthcare Providers, or CPR/AED for Professional Rescuers, or an equivalent course, which provides training for healthcare professionals in CPR and the use of an AED by a Board approved training organization. The course must be conducted in person and include a skills examination on a manikin with a certified instructor.
8. An applicant shall disclose the circumstances surrounding any of the following:
   1. Conviction of any criminal law violation of any country, state, or municipality, except minor traffic violations.
   2. The denial of licensure application by any other state or the discipline of licensure in any state.
   3. Any other civil suit judgment or civil suit settlement in which the applicant was a party defendant including, without limitation, actions involving malpractice, breach of contract, antitrust activity or any other civil action remedy recognized under any country’s or state’s statutory, common, or case law.
   4. Failure of any professional licensure examination.
9. An applicant shall cause to be submitted to the Board’s administrative office directly from the vendor identified in the Board’s licensure application materials, the result of a criminal background check.
10. An applicant shall submit or cause to be submitted the equivalent of Tennessee Certificate of Endorsement from the licensing board(s) of every state in which the applicant has ever been licensed which indicates the applicant either holds a current active license and whether it is in good standing, or held a license which is currently inactive and whether it was in good standing at the time it became inactive. An applicant must possess an active license in good standing in at least one (1) state. That license must have been active for at least one (1) year prior to application.
11. An applicant must successfully complete the Tennessee Board of Dentistry Ethics and Jurisprudence examination.
12. The dean or director of the dental or dental hygiene educational institution at which the applicant is to be employed shall submit on behalf of the applicant the following:
    1. A letter of recommend for educational licensure; and
    2. a copy of the contract employing the applicant in a faculty position at the institution.
13. The dean or director of the educational institution shall immediately notify the Board in writing of the termination of any licensee’s employment and the reasons therefore delivered to the Board Administrative Office. Such notification terminates the licensee’s authority to practice in Tennessee.
14. Any person holding an educational license is subject to all disciplinary provisions of the Tennessee Dental Practice Act.
15. Application review and licensure decisions shall be required by this rule governed by rule 0460-01-.04.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-107, 63-5-110, 63-5-111, 63-5-114, and 63-5-124.*

***Administrative History:*** *Original rule certified June 7, 1974. Repeal and new rule filed December 11, 1991; effective January 25, 1992. Amendment filed March 20, 1996; effective June 3, 1996. Amendment*

*filed May 15, 1996; effective September 27, 1996. Amendment filed February 9, 2000; effective April 24,*

*2000. Amendment filed April 10, 2001; effective June 24, 2001. Amendment filed April 10, 2002; effective*

*June 24, 2002. Amendment filed March 17, 2006; effective May 31, 2006. Amendment filed September 30,*

*2014; effective December 29, 2014. Amendments filed October 25, 2017; effective January 23, 2018.*

**0460-03-.04 LICENSURE EXEMPTION PROCESS.** Any person who, pursuant to *T.C.A. § 63-5-109,*

may be eligible to practice in Tennessee without a Tennessee license or with a Board issued exemption from licensure may practice or secure an exemption upon compliance with any of the following which apply to the person’s circumstances:

1. Dentists licensed in Tennessee who intend to call into Tennessee, a dental hygienist licensed in another state for consultative or operative purposes, must obtain prior or advance approval by submitting a letter of request to the Board Administrative Office. In emergency situations, telephone requests for prior approval may be utilized.
2. The director of any special project not affiliated with a state supported institution or public health agency who intends to employ dental hygienists licensed in other states must obtain approval of the special project by submitting a letter of request to the Board Administrative Office which sets forth all particulars of the special project. Dental hygienists employed in the approved special projects may practice only until the next Board-approved examination as

provided in rule 0460-03-.05 (1) (a), or their licensure by criteria approval, whichever comes first. However, dental hygienists employed in such projects who are under the sponsorship of a dentist licensed in Tennessee and are under the auspices of a local dentist licensed in Tennessee and are under the auspices of a local dental society may only be employed for a period of six (6) months pursuant to this type exemption.

1. The director or owner of any agency other than a licensed hospital which intends to employ graduates of dental hygiene schools when such individuals are not licensed in any state must obtain approval of the agency by submitting a written request for approval to the Board Administrative Office which sets forth particulars of the agency and justification for employing such individuals.
2. The director of any research or development project employing personnel who will be performing dental hygiene procedures must obtain approval of the project by submitting a written request for approval to the Board Administrative Office which sets forth the particulars of the project and contains evidence that the project is under the auspices and direction of a recognized educational institution or the Tennessee Department of Health.
3. The Dean of the dental hygienist teaching institution which intends to employ or utilize unlicensed graduates of dental hygiene schools, college or universities as clinical instructors must submit a written application for exemption to the Board Administrative Office which contains the following:
   1. The duties to be performed by the graduates; and
   2. The method of supervision imposed by the institution over the graduates, and
   3. A list of all graduates requiring exemption; and
   4. The student clinical instructor exemption fee as provided in rule 0460-01-.02 (2) for each graduate requiring exemption.
4. Exemptions granted pursuant to paragraph (5) of this rule shall be effective only until the next scheduled applicable examination of the Board and shall not be extended.
5. Application review and decisions required by this rule shall be governed by rules 0460-01-.03 and 0460-01-.04.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-109, and 63-5-114.* ***Administrative History:*** *Original rule certified June 7, 1974. Repeal and new rule filed December 11, 1991; effective January 25, 1992. Amendment filed May 15, 1996; effective September 27, 1996. Amendment filed August 18, 2003;*

*effective November 1, 2003.*

**0460-03-.05 EXAMINATIONS.** Where successful completion of an examination is required by the rules governing the type of licensure applied for, those examinations are governed by this rule:

1. The Board adopts the following as its licensure examinations and requires their successful completion, where required by the rules governing the licensure process, as a prerequisite for licensure:
   1. Any Board-approved examination including, but not limited to, the examinations offered by:
      1. The Southern Regional Testing Agency (SRTA)
      2. The Western Regional Examining Board (WREB)
   2. The National Board if the person graduated from a dental hygiene college, school or university after 1972.
   3. The Tennessee Board of Dentistry Ethics and Jurisprudence examination
2. Admission to, application for and the fees required to sit for the regional examinations and the National Board examinations are governed by and must be submitted to the testing agency. Admission to, application for and the fees required to sit for any other Board-approved examination must be submitted to the Board as provided in rule 0460-01-.02, or at the Board’s option, its designated exam administrator.
3. Passing scores on the regional and National Board examinations are determined by the testing agency. Such passing scores as certified to the Board are adopted by the Board as constituting successful completion of those examinations. Passing scores for any other Board-approved examination are determined by the Board.
4. Applicants must supply or furnish their own patients, instruments and materials as required by the testing agency, the Board, or the Board’s designated exam administrator.
5. Applicants who fail to successfully complete any of the examinations may apply for reexamination.
6. Oral examination may be required pursuant to rule 0460-01-.04.
7. The Board adopts as its own, the determination made by the regional testing agencies and the National Boards of the length of time that a passing score on their respective examinations will be effective for purposes of measuring competency and fitness for dental hygiene licensure.
8. Applicants for licensure who have failed three (3) times the National Board or any other Board-approved examination as provided in subparagraph (1) (a) must successfully complete a remedial course of post-graduate studies at a school accredited by the American Dental Association before consideration for licensure by the Board. The applicant shall cause the program director of the post-graduate program to provide written documentation of the content of such course and certify successful completion.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-107, 63-5-110, 63-5-111, 63-5-114, and 63-5-124.*

***Administrative History:*** *Original rule certified June 7, 1974. Repeal and new rule filed December 11, 1991; effective January 25, 1992. Amendment filed May 15, 1996; effective September 27, 1996.*

*Amendment filed August 28, 2001; effective November 11, 2001. Amendment filed April 10, 2002;*

*effective June 24, 2002. Amendment filed August 18, 2003; effective November 1, 2003. Amendment filed*

*April 5, 2006; effective June 19, 2006. Amendments filed October 25, 2017; effective January 23, 2018.*

**0460-03-.06 NITROUS OXIDE CERTIFICATION.** Licensed dental hygienists may administer and/or monitor nitrous oxide upon issuance of certification after successful completion of a Board-approved Nitrous Oxide Certification Course and in compliance with T.C.A. § 63-5-108(d) and this rule. To become certified, the licensed dental hygienist must complete and abide by the following process and rules:

1. Application and Qualifications for Certification
   1. Licensed dental hygienists in good standing with the Tennessee Board of Dentistry are eligible to take the Board-approved nitrous oxide certification course.
   2. Licensed dental hygienists, who have successfully completed a comparable dental hygiene training program on nitrous oxide administration and monitoring in another

state, which is comparable to the Board-approved course, are eligible to apply directly to the Board for certification in administering and monitoring nitrous oxide without additional training, provided the course is determined by the Board consultant to be equivalent to the Board-approved course in Tennessee. The information regarding content of the course and proof of completion must be sent directly from the course provider to the Board’s administrative office. If a certification or permit was issued by the other state, verification of the certificate or permit must be received directly from the other board. If it is determined that the course is not equivalent, the licensed dental hygienist will be required to comply with the provisions of subparagraph (1)(a) before certification can be issued.

1. Monitoring Certification.
   1. A licensed dental hygienist who, on the effective date of this rule, possesses a certificate to monitor shall not begin to administer nitrous oxide unless and until the licensed dental hygienist has completed a Board-approved administration and monitoring certification course and has received certification issued by the Board.
   2. Licensed dental hygienists with a monitoring certificate shall only monitor nitrous oxide sedation for patients of the employer dentist in accordance with the definition for monitoring nitrous oxide, as provided in Rule 0460-02-.07.
   3. Licensed dental hygienists with certification in monitoring of nitrous oxide shall prominently display, at their of employment, the current renewal certificate, which is received upon licensure and renewal.
   4. Certification in monitoring nitrous oxide is only valid as long as the licensed dental hygienist has a current license to practice dental hygiene. If the license expires or is retired, the certification is also considered expired or retired and the dental hygienist may not monitor nitrous oxide until the license is reinstated or reactivated.
2. Administration and Monitoring Certification.
   1. A licensed dental hygienist, with or without monitoring certification, must apply for and complete a Board-approved certification course in the administration and monitoring of nitrous oxide and obtain their certification, issued by the Board, before he/she can administer nitrous oxide and monitor any patient.
   2. Certification in administration and monitoring of nitrous oxide is only valid as long as the licensed dental hygienist has a current license to practice dental hygiene. If the license expires or is retired, the certification is also considered expired or retired and the dental hygienist may not administer and/or monitor nitrous oxide until the license is reinstated or reactivated.
   3. Licensed dental hygienists who possess a certification in administration and monitoring of nitrous oxide shall prominently display, at their place of employment, the current renewal certificate, which is received upon licensure and renewal.
   4. Duly licensed dental hygienists with nitrous oxide administration certification may administer nitrous oxide only under the direct supervision of a licensed dentist.
   5. A licensed dental hygienist may not administer and monitor nitrous oxide to more than one (1) patient at a time and must physically remain in the operatory at all times with the patient.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-108, and 63-5-115.* ***Administrative History:*** *Original rule certified June 7, 1974. Repeal and new rule filed December 11, 1991; effective January 25, 1992. Amendment filed May 15, 1996; effective September 27, 1996. Amendment filed February 18, 2003;*

*effective May 4, 2003. Amendment filed September 17, 2003; effective December 1, 2003. Amendment*

*filed September 30, 2014; effective December 29, 2014.*

**0460-03-.07 LICENSURE RENEWAL.** All licensed dental hygienists must renew their licenses to be able to legally continue in practice. Licensure renewal is governed by the following:

1. Renewal application
   1. The due date for licensure renewal is the last day of the month in which a licensee’s birthday falls pursuant to the Division of Health Related Boards “birthdate renewal system” contained on the renewal certificate as the expiration date.
   2. Methods of Renewal
      1. Internet Renewals - Individuals may apply for renewal and pay the necessary fees via the Internet. The application to renew can be accessed at:

[www.tennesseeanytime.org](http://www.tennesseeanytime.org/)

* + 1. Paper Renewals - For individuals who have not renewed their license online via the Internet, a renewal application form will be mailed to each individual licensed by the Board to the last address provided to the Board. Failure to receive such notification does not relieve the licensee from the responsibility of meeting all requirements for renewal.
  1. A license issued pursuant to these rules is renewable by the expiration date. To be eligible for renewal an individual must submit to the Division of Health Related Boards on or before the expiration date the following:
     1. A completed renewal application form.
     2. The renewal and state regulatory fees as provided in Rule 0460-01-.02.
     3. If licensed pursuant to rule 0460-03-.03, a letter of request accompanied by a letter of recommendation from the dean or director of the educational institution.
     4. Proof of successful completion of the Tennessee Board of Dentistry Ethics and Jurisprudence examination
  2. Licensees who fail to comply with the renewal rules or notification received by them concerning failure to timely renew shall have their licenses processed pursuant to rule 1200-10-01-.10.

1. Reinstatement of an Expired License - Reinstatement of a license that has expired may be accomplished upon meeting the following conditions:
   1. Payment of all past due renewal fees, state regulatory fees and the reinstatement fee as established in rule 0460-01-.02; and
   2. Provide documentation of successfully completing continuing education requirements for the entire time the license was expired, pursuant to Rule 0460-01-.05; and
   3. Submit proof of successful completion of the Tennessee Board of Dentistry Ethics and Jurisprudence examination.
   4. Any licensee who fails to renew licensure prior to the expiration of the second (2nd) year after which renewal is due may be required to meet other conditions as the Board may deem necessary to protect the public.
2. Anyone submitting a renewal form, reinstatement/reactivation application, or letter which is found to be untrue may be subject to disciplinary action as provided in T.C.A. § 63-5-124.
3. Renewal issuance decisions pursuant to this rule may be made administratively, upon review by the Board.
4. Application review and decisions required by this rule shall be governed by rule 0460-01-.04.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-1-107, 63-1-108, 63-5-105, 63-5-105(7), 63-5-107, 63-5-110,*

* + 1. *, 63-5-114, 63-5-117, 63-5-124, and 63-5-129.* ***Administrative History:*** *Original rule filed*

*December 11, 1991; effective January 25, 1992. Amendment filed December 5, 1994; effective February*

*18, 1995. Amendment filed February 12, 1996; effective April 27, 1996. Amendment filed April 10, 2001;*

*effective June 24, 2001. Amendment filed August 21, 2002; effective November 4, 2002. Amendment filed*

*August 18, 2003; effective November 1, 2003. Amendments filed October 25, 2017; effective January 23,*

*2018.*

# 0460-03-.08 LICENSURE RETIREMENT AND REACTIVATION.

* + - 1. Licensees who wish to retain their licenses but not actively practice may avoid compliance with the licensure renewal process, continuing education and CPR requirements by doing the following:
         1. Obtain from, complete and submit to the Board Administrative Office an affidavit of retirement form.
         2. Submit any documentation which may be required by the form to the Board Administrative Office.
      2. Any licensee whose license has been retired may reenter active practice by doing the following:
         1. Submit a written request for licensure reactivation to the Board Administrative Office; and
         2. Pay the licensure renewal fee and state regulatory fee as provided in rule 0460-01-

.02(2). If retirement was pursuant to rule 0460-03-.07(5) and reactivation was requested prior to the expiration of one (1) year from the date of retirement, the Board may require payment of the late renewal fee and past due licensure renewal and state regulatory fees as provided in rule 0460-01-.02(2).

* + - * 1. If requested, after review by the Board or a designated Board member or the Board consultant, appear before the Board, a Board member or the Board consultant for an interview regarding continued competence in the event of licensure retirement in excess of two (2) years.
        2. Comply with the continuing education provisions of rule 0460-01-.05(6) applicable to reactivation of retired licenses.
        3. Submit proof of successful completion of the Tennessee Board of Dentistry Ethics and Jurisprudence examination.
      1. Application review and decisions required by this rule shall be governed by rule 0460-01-.04.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-107, 63-5-110, 63-5-111, 63-5-114, 63-5-117, 63-*

* 1. *, and 63-5-129.* ***Administrative History:*** *Original rule filed December 11, 1991; effective January*

*25, 1992. Amendment filed March 20, 1996; effective June 3, 1996. Amendment filed August 21, 2002;*

*effective November 4, 2002. Amendments filed October 25, 2017; effective January 23, 2018.*

**0460-03-.09 SCOPE OF PRACTICE.** Licensed Dental Hygienists may only practice under direct and/or general supervision in the employment of a licensed dentist consistent with the provisions of T.C.A. Title 63, Chapter 5.

* + 1. Delegable or Assignable Procedures – In addition to those duties of the licensed dental hygienist which are commonly recognizable by the dental profession for safe performance, pursuant to T.C.A. § 63-5-108 a licensed dental hygienist may perform the following duties which are assigned or delegated to the licensed dental hygienist by the employer dentist:
       1. The removal of all hard and soft deposits and stains from the human teeth to the depth of the gingival sulcus, polishing natural and restored surfaces of teeth, performing clinical examination of teeth and surrounding tissues for diagnosis by the dentist, and performing other such procedures as may be delegated by the dentist consistent with the provisions of T.C.A. Chapter 5, Title 63.
       2. Prophylaxis.
       3. The application of sealants.
       4. The exposure of radiographs, including digital, of the mouth, gums, jaws, teeth or any portion thereof for dental diagnosis.
       5. The application of topical fluorides.
       6. The instruction of patients in dietary principles.
       7. Demonstration of oral hygiene procedures and oral health care regimen.
       8. The taking and recording of a patient’s blood pressure, pulse, temperature, and medical history and charting of oral conditions.
       9. The serving as chairside assistant.
       10. The maintenance of instrument and operatory infection control
       11. The preparation of instrument trays
       12. The placement and removal of matrices for restoration.
       13. The removal of cement from restorations and bands.
       14. The removal of sutures and staples.
       15. The fabrication, placement and removal of temporary restorations.
       16. The placement and removal of rubber dam.
       17. The placement and removal of socket dressings.
       18. The placement and removal of periodontal dressings.
       19. The taking of dental plaque smears.
       20. The taking of alginate impressions for any purpose other than permanent restorations.
       21. The removal of ligature and arch wires.
       22. Bending, selecting and pre-sizing arch wires and placing arch wires after final adjustment and approval by the dentist.
       23. The selection, prefitting, cementation, curing, and removing of orthodontic bands or brackets.
       24. The placement and removal of pre-treatment separators.
       25. Removal of loose or broken bands or brackets. (zz) Placement of springs on wires.

(aa) Placement of hooks on brackets.

(bb) Placement of chain elastics on brackets. (cc) Ligation of arch wires to brackets.

(dd) Packing and removing retraction cord, with or without vasoactive chemicals, for restorative dental procedures.

(ee) Removal of excess cement from the surfaces of the teeth.

(ff) The placement of amalgam in prepared cavities for condensation by the dentist. (gg) Placement of cavity bases and liners.

(hh) Sulcular irrigation with antimicrobial agents only when prescribed by the employer/supervising dentist.

(ii) Application of desensitizing agents.

(jj) Application of topical anesthetic and anti-inflammatory agents. (kk) Placement of antibiotic-treated materials, if prescribed.

(ll) Application of tooth conditioners for bonding.

(mm) Selecting and pre-fitting of stainless steel crowns or other pre-formed crowns for insertion by the dentist.

(nn) The taking of oral cytologic smears (oo) Performing pulp testing.

(pp) Packing of pulpotomy paste.

(qq) Drying canals with absorbent paper points.

(rr) Calling in prescriptions to the pharmacist as instructed by the employer/dentist. (ss) Fitting, adjusting and cementation of correctional appliances.

(tt) Wound care as directed. (uu) Irrigating extraction site.

(vv) Placement of exposure chains and attachments.

(ww) The use of lasers for examination and/or for periodontal treatment under the supervision of a Tennessee licensed dentist.

(xx) Other duties specifically approved by the Board at a regularly scheduled meeting of the Board.

* + 1. Dental hygienists may perform delegable procedures for patients of record of their employer dentist who reside in nursing homes pursuant to the following protocol:
       1. A letter from the employer dentist must be entered in both the dentist’s and the nursing home’s patient records which includes all of the following:
          1. Patient’s name;
          2. Facility name;
          3. Procedures to be performed including the frequency of services if on a regular basis and unchanged;
          4. Family or patient consent if possible;
          5. Patient’s physician’s consent;
          6. Consent of facility supportive staff to aid hygienist if needed.
          7. Consent of facility for registered nurse or physician to be available upon code.
       2. If any major variation of this protocol is required, approval of the Board must be obtained pursuant to rule 0460-01-.03(4)(b)3.(vi).
    2. Under the direct supervision of a licensed dentist, licensed dental hygienists may perform services including, but not limited to, root planing and subgingival curettage.
    3. Administration and/or monitoring of nitrous oxide sedation must be under the direct supervision of a licensed dentist, and the licensed dental hygienist must possess certification pursuant to Rule 0460-03-.06.
    4. Administration of local anesthesia must be under the direct supervision of a licensed dentist who, at that time, is physically present at the same office location. The licensed dental hygienist must possess certification pursuant to Rule 0460-03-.12.
    5. Performance of restorative or prosthetic functions must be under the direct supervision of a licensed dentist, and the licensed dental hygienist must possess certification pursuant to Rule 0460-03-.10.
    6. Prohibited Procedures - In addition to the duties defined as the practice of dentistry by T.C.A.

§ 63-5-108, licensed dental hygienists are not permitted to perform the following:

* + - 1. Comprehensive examination, diagnosis and treatment planning;
      2. Surgical or cutting procedures on hard or soft tissue, including laser, air abrasion or micro-abrasion procedures, except curettage or root planing;
      3. Fitting, adjusting, and placement of prosthodontics appliances;
      4. Issuance of prescription medications or medications not authorized by Rule 0460-03-

.09 (1), or work authorizations;

* + - 1. Performance of direct pulp capping, pulpotomy, and other endodontic procedures not authorized by T.C.A. § 63-5-108 or Rule 0460-03-.09 (1);
      2. Approving the final occlusion;
      3. Placement of sutures;
      4. Administration of conscious sedation or general anesthesia.
      5. Administration of local anesthesia on patients without certification as provided in Rule 0460-03-.12.
      6. Administration or monitoring of nitrous oxide without certification as provided in Rule 0460-03-.06;
      7. Use of a high-speed handpiece intraorally;
    1. In no event shall a licensed dental hygienist perform dental services inconsistent with T.C.A. § 63-5-108. Licensed dental hygienists who perform procedures not delegable pursuant to this rule or procedures specifically prohibited by T.C.A. § 63-5-108 or who perform procedures without the direct supervision of a dentist, or who administer or monitor nitrous oxide without certification or who perform restorative or prosthetic functions without certification are in violation of the rules governing those procedures, and may be subject to disciplinary action pursuant to T.C.A. § 63-5-116.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-107, 63-5-108, 63-5-115, 63-5-116, and 63-5-124.*

***Administrative History:*** *Original rule filed December 11, 1991; effective January 25, 1992. Amendment*

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*October 12, 2007; effective December 26, 2007. Amendment filed September 25, 2008; effective*

*December 9, 2008. Amendments filed October 22, 2010; effective January 20, 2011.*

# 0460-03-.10 RESTORATIVE AND PROSTHETIC CERTIFICATIONS.

1. Dental hygienists who have a minimum of two (2) years continuous full-time employment within the past three (3) years in a dental practice as a licensed dental hygienist are eligible for admission to Board-approved certification courses in restorative and/or prosthetic functions. A licensed dental hygienist must complete a Board-approved certification course in

(Rule 0460-03-.10, continued)

restorative or prosthetic functions and obtain the appropriate certification, issued by the Board, before he/she can perform restorative or prosthetic functions on any patient.

1. Certification in restorative or prosthetic functions is only valid as long as the licensed dental hygienist has a current license to practice dental hygiene. If the license expires or is retired, the certification is also considered expired or retired and the dental hygienist may not perform restorative or prosthetic functions until the license is reinstated or reactivated.
2. Licensed dental hygienists who possess a certification in restorative or prosthetic functions shall prominently display their current renewal certificate at their place of employment.
3. Licensed dental hygienists with certification in restorative or prosthetic functions may perform restorations or prosthetic functions only under the direct supervision and full responsibility of a licensed dentist.
4. Prohibited Procedures – The following procedures are prohibited for all dental hygienists, including those who have certification in restorative or prosthetic functions:
   1. Restorative Functions
      1. Diagnosing need for restorations;
      2. Preparation/Cutting of the tooth or soft tissue;
      3. Modifying existing structure;
      4. Removal of caries, bases or liners; and
      5. Use of high-speed handpieces intraorally.
   2. Prosthetic Functions
      1. Diagnosing need for any prosthetic appliance;
      2. Establishing vertical dimension of occlusion and interocclusal records;
      3. Delivering and/or adjusting appliance; and
      4. Use of high-speed handpieces intraorally.
5. Licensed dental hygienists, who have successfully completed a comparable hygienist training program in another state in restorative or prosthetic functions, are eligible to apply directly to the Board for a restorative or prosthetic functions certificate without additional training, provided the course is determined by the Board consultant to be equivalent to the Board- approved course in Tennessee. The information regarding content of the course and proof of completion must be sent directly from the course provider to the Board’s administrative office. If a certification or permit was issued by the other state, verification of the certificate or permit must be received directly from the other board. If it is determined that the course is not equivalent, the licensed dental hygienist will be required to comply with the provisions of paragraph (1) before certification can be issued.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-108, and 63-5-115.* ***Administrative History:***

*Original rule filed August 3, 2005; effective October 17, 2005. Amendment filed October 12, 2007;*

*effective December 26, 2007. Amendment filed September 30, 2014; effective December 29, 2014.*

# 0460-03-.11 FREE HEALTH CLINIC AND VOLUNTEER PRACTICE REQUIREMENTS.

1. Free Health Clinic Practice Pursuant to T.C.A. § 63-1-201
   1. Any individual licensed to practice as a dental hygienist in this state or any other state who has not been disciplined by any licensure board may have their license converted to or receive a Tennessee “Special Volunteer License,” as defined in T.C.A. § 63-1-201, which will entitle the licensee to practice without remuneration solely within a “free health clinic,” as defined by T.C.A. § 63-1-201, at a specified site or setting by doing the following:
      1. Obtaining from the Board’s administrative office a “Special Volunteer License” application, completing it and submitting it along with any required documentation to the Board’s administrative office; and
      2. Have the licensing authority of every state in which the individual holds or ever held a license to practice as a dental hygienist submit directly to the Board’s administrative office the equivalent of a “certificate of fitness” as described in

T.C.A. § 63-1-118 which shows that the license has never been subjected to any disciplinary action and is free and clear of all encumbrances; and

* + 1. For dental hygienists who have not been licensed in Tennessee, comply with all provisions of subparagraph (3) (b) and paragraphs (4), (5), (8) and (9) of rule 0460-03-.01; and
    2. Submitting the specific location of the site or setting of the free health clinic in which the licensee intends to practice along with proof of the clinic’s private, and not-for-profit status.
  1. A dental hygienist holding a Special Volunteer License is not required to pay any fee for its issuance or the required biennial renewal pursuant to the Division of Health Related Board’s biennial birthdate renewal system.
  2. A dental hygienist holding a Special Volunteer License may not do any of the following:
     1. Practice as a dental hygienist anywhere other than in the free health clinic site or setting specified in the application; and
     2. Charge any fee or receive compensation or remuneration of any kind from any person or third party payor including insurance companies, health plans and state or federal benefit programs for the provision of medical or any other services; and
     3. Practice for any free health clinic that imposes any charge on any individual to whom health care services are rendered or submits charges to any third party payor including insurance companies, health plans and state or federal benefit programs for the provision of any services.
  3. Special Volunteer Licenses are subject to all of the following
     1. All rules governing renewal, retirement, reinstatement and reactivation as provided by rules 0460-03-.07 and .08, except those requiring the payment of any fees; and
     2. The rules governing continuing education and cardio pulmonary resuscitation as provided by rule 0460-01-.05; and
     3. Disciplinary action for the same causes and pursuant to the same procedures as all other licenses issued by the Board.

1. Practice Pursuant to the “Volunteer Health Care Services Act” T.C.A. §§ 63-6-701, et seq.
   1. Any dental hygienist licensed in this or any other state, territory, district or possession of the United States whose license is not under a disciplinary order of suspension or revocation may practice as a dental hygienist in this state but only under the auspices of an organization that has complied with the provisions of this rule and T.C.A. §§ 63-6- 701 through 707 and rule 1200-10-01-.12 of the Division of Health Related Boards.
   2. Any person who may lawfully practice as a dental hygienist in this or any other state, territory, district or possession of the United States under an exemption from licensure and who is not under a disciplinary order of suspension or revocation and who is not and will not “regularly practice,” as defined by T.C.A. § 63-6-703 (3) may practice as a dental hygienist in this state but only under the auspices of an organization that has complied with the provisions of this rule and T.C.A. §§ 63-6-701 through 707 and rule 1200-10-01-.12 of the Division of Health Related Boards.
   3. A dental hygienist or anyone who practices under an exemption from licensure pursuant to this rule may not charge any fee or receive compensation or remuneration of any kind from any person or third party payor including insurance companies, health plans and state or federal benefit programs for the provision of services; and may not practice for any organization that imposes any charge on any individual to whom health care services are rendered or submits charges to any third party payor including insurance companies, health plans and state or federal benefit programs for the provision of any services.
   4. Any organization that organizes or arranges for the voluntary provision of health care services on residents of Tennessee may utilize persons described in subparagraphs (a) and (b) to practice as dental hygienists only when it has complied with the provisions of

T.C.A. §§ 63-6-701 through 707 and rule 1200-10-01-.12 of the Division of Health Related Boards.

1. Application review and licensure decisions for these types of licensure shall be governed by rule 0460-01-.04.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-1-201, 63-5-105, 63-5-111, 63-5-114, 63-5-134, and 63-6-701*

*through 63-6-707.* ***Administrative History:*** *Original rule filed December 16, 2005; effective March 1,*

*2006. Amendment filed August 4, 2009; effective November 2, 2009.*

**0460-03-.12 ADMINISTRATION OF LOCAL ANESTHESIA CERTIFICATION.** A licensed dental

hygienist in Tennessee must obtain certification to administer local anesthesia before he/she can administer local anesthesia on any patient.

1. Qualifications for Certification – One (1) of the following qualifications must be completed:
   1. Be a graduate of an ADA Commission on Dental Accreditation approved dental hygiene program which teaches the administration of local anesthesia to clinical competency; or
   2. Complete a Board-approved certification course in administration of local anesthesia; or
   3. Have completed a comparable dental hygiene training program on administration of local anesthesia in another state, which is comparable to the Board-approved course. The licensed dental hygienist is eligible to apply directly to the Board for certification in administration of local anesthesia without additional training, provided the course is

determined by the Board consultant to be equivalent to the Board-approved course in Tennessee. The course provider must submit the curriculum, including the number of hours and injections required in the course, and a letter attesting that the course was taught to clinical competency to the Board’s Administrative Office. If a certification or permit was issued by the other state, verification of the certificate or permit must be received directly from the other board. If it is determined that the course is not equivalent, the licensed dental hygienist will be required to comply with the provisions of subparagraphs (a) or (b) before certification can be issued.

1. Procedures for Certification – After successful completion of a Board-approved certification course, an ADA Commission on Dental Accreditation dental hygiene program which included instruction in the administration of local anesthesia or a certification course from another state that is equivalent to the Board-approved course, an applicant shall:
   1. Submit a completed application on a form provided by the Board Administrative Office; and
   2. Submit the Local Anesthesia Certification Fee required by 0460-01-.02; and
   3. Cause verification of successful completion of the course attesting that the course was taught to demonstrate clinical competency to be sent directly from the school to the Board Administrative Office. If the course was Board-approved, a temporary permit will be issued pending verification of completion of the externship.
2. Conditions of Certification
   1. Certification in administration of local anesthesia is valid only when the dental hygienist has a current license to practice dental hygiene. If the license expires or is retired, the certification is also considered expired or retired and the dental hygienist may not perform administration of local anesthesia until the license is reinstated or reactivated.
   2. A licensed dental hygienist with certification to administer local anesthesia shall prominently display, at the place of employment, the current renewal certificate, which is received upon licensure and renewal.
   3. A licensed dental hygienist with certification to administer local anesthesia shall administer local anesthesia only under the direct supervision of a licensed dentist who
      1. Examines the patient before prescribing the procedures to be performed; and
      2. Is physically present at the same office location when the local anesthesia is administered; and
      3. Designates a patient of record upon whom the procedures are to be performed and describes the procedures to be performed; and
      4. Examines the patient upon completion of the procedures.
   4. Following the administration of local anesthesia by a licensed dental hygienist the following information shall be documented in the patient record:
      1. Date and time of administration;
      2. Identity of individual administering;
      3. Type of anesthesia administered;
      4. Dosage/amount administered;
      5. Location/site of administration; and
      6. Any adverse reaction.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-108, 63-5-115, and 63-5-116.* ***Administrative***

***History:*** *Original rule filed October 12, 2007; effective December 26, 2007. Amendment filed September 30, 2014; effective December 29, 2014.*

# RULES OF

**TENNESSEE STATE BOARD OF DENTISTRY**

**CHAPTER 0460-04**

**RULES GOVERNING THE PRACTICE OF DENTAL ASSISTANTS TABLE OF CONTENTS**

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**0460-04-.01 LEVELS OF PRACTICE.** It is the intent of the Board to authorize two distinct levels of practice for dental assistants in dental offices in Tennessee.

1. Practical Dental Assistants
   1. Definition - A practical dental assistant is an auxiliary employee of a licensed dentist(s) who is receiving practical chair side dental assisting training from a licensed dentist(s) or is a dental assistant student in an educational institution accredited by the Commission on Dental Accreditation of the American Dental Association.
   2. Scope of Practice
      1. A practical dental assistant must be under the direct supervision of a licensed dentist.
      2. It is the intent of this rule that practical dental assistants not invade the practice procedures only allowed to be assigned or delegated to registered dental assistants or licensed dental hygienists.
2. Registered Dental Assistant
   1. Definition - A dental assistant who has received a registration from the Board pursuant to rule 0460-04-.02.
   2. Scope of Practice - A registered dental assistant may perform those additional procedures for which they have received Board certification as provided by Rule 0460- 04-.08 under the direct supervision of a dentist.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-105(4), 63-5-105(7), 63-5-108, 63-5-108(c), 63-5-*

*115, 63-5-116, 63-5-117, and 63-5-124.* ***Administrative History:*** *Original rule certified June 7, 1974.*

*Repeal filed August 26, 1980; effective December 1, 1980. Repeal and new rule filed December 11, 1991;*

*effective January 25, 1992. Amendment filed June 29, 1994; effective September 12, 1994. Amendment*

*filed October 9, 1997; effective December 23, 1997. Amendment filed February 9, 2000; effective April 24,*

*2000. Amendment filed October 12, 2007; effective December 26, 2007.*

**0460-04-.02 REGISTRATION PROCESS.** To practice as a dental assistant beyond the scope of a practical dental assistant a person must possess a lawfully issued registration from the Board. The process for obtaining a registration is as follows:

1. An applicant shall obtain a Board application form from the Board Administrative Office, respond truthfully and completely to every question or request for information contained in the form and submit it along with all documentation and fees required by the form and this rule to the Board Administrative Office. It is the intent of this rule that all activities necessary to accomplish the filing of the required documentation be completed prior to filing a registration application and that all documentation be filed simultaneously.
2. An applicant shall submit:
   1. proof of having graduated from a high school or submit proof of possession of a general educational development (g.e.d.) certificate; and
   2. proof of having attained at least eighteen (18) years of age; and
   3. a signed “passport” style photograph taken within the preceding twelve (12) months.
3. An applicant shall submit evidence of good moral character. Such evidence shall include at least two (2) letters attesting to the applicant’s character from dental professionals on the signator’s letterhead.
4. An applicant shall submit proof of United States or Canadian citizenship or evidence of being legally entitled to live in the United States. Such evidence may include copies of birth certificates, naturalization papers, or current visa status.
5. An applicant shall submit the registration application fee and state regulatory fee provided in rule 0460-01-.02 (3).
6. An applicant shall disclose the circumstances surrounding any of the following:
   1. Conviction of any criminal law violation of any country, state, or municipality, except minor traffic violations.
   2. The denial of registration application by any other state or the discipline of registration in any state.
   3. Failure of any professional licensure examinations.
7. An applicant shall cause to be submitted to the Board’s administrative office directly from the vendor identified in the Board’s registration application materials, the result of a criminal background check.
8. If an applicant has ever held a registration of any kind to practice dental assistance in any other state or Canada, the applicant shall submit or cause to be submitted the equivalent of the Tennessee Certificate of Endorsement from each such licensing board which indicates the applicant either holds a current active registration which is in good standing, or holds a registration which is currently inactive and whether it was in good standing at the time it became inactive.
9. An applicant shall submit evidence of current training in cardiopulmonary resuscitation (CPR) which is defined as successful completion of a BLS for Healthcare Providers, or CPR/AED for Professional Rescuers, or an equivalent course, which provides training for healthcare professionals in CPR and the use of an AED by a Board approved training organization. The course must be conducted in person and include a skills examination on a manikin with a certified instructor.
10. An applicant must successfully complete the Tennessee Board of Dentistry Ethics and Jurisprudence examination.
11. Application review and registration decisions required by this rule shall be governed by rule 0460-01-.04.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-107, 63-5-108, 63-5-111, 63-5-115, and 63-5-124.*

***Administrative History:*** *Original rule certified June 7, 1974. Repeal filed August 26, 1980; effective December 1, 1980. New rule filed December 11, 1991; effective January 25, 1992. Amendment filed June*

*29, 1994; effective September 12, 1994. Amendment filed December 5, 1994; effective February 18, 1995.*

*Amendment filed May 15, 1996; effective September 27, 1996. Amendment filed February 9, 2000;*

*effective April 24, 2000. Amendment filed March 14, 2001; effective May 28, 2001. Amendment filed April*

*10, 2002; effective June 24, 2002. Amendments filed March 17, 2006; effective May 31, 2006.*

*Amendment filed October 12, 2007; effective December 26, 2007. Amendment filed September 30, 2014;*

*effective December 29, 2014. Amendments filed October 25, 2017; effective January 23, 2018.*

# 0460-04-.03 REPEALED.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-108, 63-5-111, and 63-5-115.* ***Administrative***

***History:*** *Original rule certified June 7, 1974. Repeal filed August 26, 1980; effective December 1, 1980.*

*New rule filed December 11, 1991; effective January 25, 1992. Amendment filed March 20, 1996; effective*

*June 3, 1996. Amendment filed May 15, 1996; effective September 27, 1996. Amendment filed April 10,*

*2002; effective June 24, 2002. Amendment filed December 16, 2005; effective March 1, 2006. Repeal filed*

*October 12, 2007; effective December 26, 2007.*

**0460-04-.04 CORONAL POLISHING CERTIFICATION.** Dental assistants who, pursuant to this rule and

* + 1. § 63-5-108 (d), receive certification to perform coronal polishing may only do so under the restrictions contained in this rule.
       1. Definition - Coronal Polishing shall mean the polishing of the enamel and restorations on the clinical crown of human teeth by utilizing a combination of a polishing agent and a slow speed handpiece, a prophy angle, a rubber cup, or any home care cleaning device.
       2. Qualifications – An applicant for a coronal polishing certification must be registered as a dental assistant in Tennessee prior to applying for admission to an education course in coronal polishing. The sequence of the certification process is as follows:
          1. An applicant must apply for and successfully complete an educational course, as provided in this rule, as a prerequisite for certification; or
          2. An applicant who has successfully completed a coronal polishing course in another state which was approved by the board in the other state, which the Board consultant has determined as equivalent to the Board-approved course in Tennessee, is eligible to apply directly to the Board for certification. If a certification or permit was issued by the other state, verification of the certificate or permit must be received directly from that state. The information regarding content of the course and proof of completion must be sent directly from the course provider to the Board’s administrative office; or
          3. Applicants who have successfully completed an ADA accredited dental assisting program which included coronal polishing in the curriculum are eligible to apply for the certification upon completion of the program. Within thirty (30) days of an applicant’s completion of the program, the program director/instructor must submit a letter to the Board administrator verifying that coronal polishing was included in the curriculum and a written and clinical examination was passed by the applicant. Upon receipt of the letter from the program director/instructor and the application and fees, the certification for coronal polishing will be issued.
       3. Retention of Certification - Certification for coronal polishing is only valid as long as the registered dental assistant has a current registration. If the registration expires or is retired, the certification is also considered expired or retired, and the dental assistant may not engage in coronal polishing until the registration is reinstated or reactivated.
       4. Examination - The certification course must contain both a written and a clinical examination that covers the curriculum in Rule 0460-05-.03(2)(c)4(i) and (ii). The passing grade for each examination is set at seventy-five percent (75%). A student who fails either examination may retake the examination two (2) additional times before having to repeat the course in order to retake the examination.
       5. Supervision
          1. Any time a dental assistant is allowed to perform coronal polishing after receiving certification, the employer dentist must be physically on the office premises at all times during the polishing and must also:

Examine each patient immediately prior to the polishing to determine health, calculus and scalable stain free and to certify the need for coronal polishing; and

Examine each patient immediately after the polishing is completed to evaluate the results.

* + - * 1. A dental assistant may not perform coronal polishing for patients who have not been examined immediately prior to being assigned for polishing.
      1. Application review and decisions required by this rule shall be governed by Rule 0460-01-.04.

***Authority:*** *T.C.A §§ 4-3-1011, 4-5-202, 4-5-204, 63-5-105, 63-5-107, 63-5-108, 63-5-111, and 63-5-115.*

***Administrative History:*** *Original rule certified June 7, 1974. Repeal filed August 26, 1980; effective December 1, 1980. New rule filed December 11, 1991; effective January 25, 1992. Amendment filed*

*December 5, 1994; effective February 18, 1995. Amendment filed October 17, 1995; effective December*

*31, 1995. Amendment filed March 20, 1996; effective June 3, 1996. Amendment filed May 15, 1996;*

*effective September 27, 1996. Amendment filed June 18, 2003; effective September 1, 2003. Amendment*

*filed September 17, 2003; effective December 1, 2003. Amendment filed October 12, 2007; effective*

*December 26, 2007. Amendment filed September 25, 2008; effective December 9, 2008. Amendment filed*

*October 22, 2010; effective January 20, 2011. Amendments filed December 20, 2011; effective March 19,*

*2012.*

**0460-04-.05 NITROUS OXIDE CERTIFICATION.** Dental assistants may not administer nitrous oxide to patients but may monitor nitrous oxide sedation (as defined in rule 0460-02-.07) upon becoming certified pursuant to the following process:

1. A dental assistant must be currently registered, pursuant to Rule 0460-04-.02, by the Board in order to be eligible to attend a certification course in monitoring nitrous oxide and/or qualify for certification.
2. To be eligible for certification, the registered dental assistant must successfully complete a Board-approved nitrous oxide monitoring certification course, or have successfully completed a comparable training course in another state, or be currently enrolled in an ADA-accredited or Board-approved program which offers this course as part of their curriculum. Once eligible for certification, the registered dental assistant shall not monitor nitrous oxide until certification has been issued by the Board.
3. If the registered dental assistant completed a nitrous oxide monitoring course in another state which was approved by the board in the other state, the Board consultant must determine the course to be equivalent to the Board-approved course in Tennessee. The information regarding content of the course and proof of completion must be sent directly from the course provider to the Board’s administrative office. If a certification or permit was issued by the other state, verification of the certificate or permit must be received directly from the other board. Once eligible for certification, the registered dental assistant shall not monitor nitrous oxide until certification has been issued by the Board.
4. Nitrous oxide monitoring certification shall be added to the registration of the registered dental assistant, if the registered dental assistant has successfully completed a Board-approved certification course and notification of completion has been submitted to the Board’s Administrative Office by the course director on a form provided by the Board.
5. Registered dental assistants with nitrous oxide monitoring certification shall only monitor patients under the direct supervision of a licensed Tennessee dentist. This assistant shall not monitor more than one (1) patient at a time and shall physically remain with the patient at all times.
6. Registered dental assistants with nitrous oxide monitoring certification are not permitted to administer nitrous oxide. This assistant is only permitted to adjust the dosage or terminate the nitrous oxide at the specific direction and under the protocol of the supervising dentist or in cases of patient distress.
7. Registered dental assistants with nitrous oxide monitoring certification shall prominently display their current registration certificate, which is received upon registration and renewal, at their place of employment.
8. Certification in monitoring nitrous oxide is only valid as long as the registered dental assistant has a current registration. If the registration expires or is retired, the certification is also considered expired or retired and the dental assistant may not monitor nitrous oxide until the registration is reinstated or reactivated.
9. Application review and decisions required by this Rule shall be governed by 0460-01-.04.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-105(3), 63-5-105(4), 63-5-105(7), 63-5-108, 63-5-*

*108(b) through 63-5-108(d), and 63-5-115.* ***Administrative History:*** *Original rule certified June 7, 1974. Repeal filed August 26, 1980; effective December 1, 1980. Amendment filed October 13, 1983; effective*

*November 14, 1983. Repeal and new rule filed December 11, 1991; effective January 25, 1992.*

*Amendment filed February 18, 2003; effective May 4, 2003. Amendment filed September 17, 2003;*

*effective December 1, 2003. Amendment filed October 12, 2007; effective December 26, 2007.*

**0460-04-.06 REGISTRATION RENEWAL.** All dental assistants issued registrations by the Board must renew those registrations to be able to legally continue in practice. Registration renewal is governed by the following:

1. Renewal application
   1. The due date for registration renewal is the last day of the month in which a registrant’s birthday falls pursuant to the Division of Health Related Boards “birthdate renewal system” contained on the renewal certificate as the expiration date.
   2. Methods of Renewal
      1. Internet Renewals - Individuals may apply for renewal and pay the necessary fees via the Internet. The application to renew can be accessed at:

(Rule 0460-04-.06, continued)

[www.tennesseeanytime.org](http://www.tennesseeanytime.org/)

* + 1. Paper Renewals - For individuals who have not renewed their registration online via the Internet, a renewal application form will be mailed to each individual registered by the Board to the last address provided to the Board. Failure to receive such notification does not relieve the registrant from the responsibility of meeting all requirements for renewal.
  1. A registration issued pursuant to these rules is renewable by the expiration date. To be eligible for renewal an individual must submit to the Division of Health Related Boards on or before the expiration date the following:
     1. A completed renewal application form.
     2. The renewal and state regulatory fees as provided in Rule 0460-01-.02.
     3. Proof of successful completion of the Tennessee Board of Dentistry Ethics and Jurisprudence examination.
  2. Registrants who fail to comply with the renewal rules or notification received by them concerning failure to timely renew shall have their registrations processed pursuant to rule 1200-10-01-.10.

1. Reinstatement of an Expired Registration - Reinstatement of a registration that has expired may be accomplished upon meeting the following conditions:
   1. Payment of all past due renewal fees, state regulatory fees and the reinstatement fee as established in rule 0460-01-.02; and
   2. Provide documentation of successfully completing continuing education requirements for the entire time the registration was expired, pursuant to Rule 0460-01-.05; and
   3. Submit proof of successful completion of the Tennessee Board of Dentistry Ethics and Jurisprudence examination.
   4. Any registrant who fails to renew registration prior to the expiration of the second (2nd) year after which renewal is due may be required to meet other conditions as the Board may deem necessary to protect the public.
2. Anyone submitting a renewal form, reinstatement/reactivation application, or letter which is found to be untrue may be subject to disciplinary action as provided in T.C.A. § 63-5-124.
3. Renewal issuance decisions pursuant to this rule may be made administratively, upon review by the Board.
4. Application review and decisions required by this rule shall be governed by rule 0460-01-.04.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-1-107, 63-1-108, 63-5-105, 63-5-105(7), 63-5-107, 63-5-108,*

* + 1. *, 63-5-115, 63-5-117, 63-5-124, and 63-5-129.* ***Administrative History:*** *Original rule certified*

*June 7, 1974. Repeal filed August 26, 1980; effective December 1, 1980. New rule filed December 11,*

*1991; effective January 25, 1992. Amendment filed February 12, 1996; effective April 27, 1996.*

*Amendment filed April 10, 2001; effective June 24, 2001. Amendment filed August 21, 2002; effective*

*November 4, 2002. Amendment filed August 18, 2003; effective November 1, 2003. Amendments filed*

*October 25, 2017; effective January 23, 2018.*

# 0460-04-.07 REGISTRATION RETIREMENT AND REACTIVATION.

* + - 1. Registrants who wish to retain their registration but not actively practice may avoid compliance with the registration renewal process, continuing education and CPR requirements by doing the following:
         1. Obtain from, complete and submit to the Board Administrative Office an affidavit of retirement form.
         2. Submit any documentation which may be required by the form to the Board Administrative Office.
      2. Any registrant whose registration has been retired may reenter active practice by doing the following:
         1. Submit a written request for reactivation to the Board Administrative Office; and
         2. Pay the registration renewal fee and state regulatory fee as provided in rule 0460-01-

.02 (3). If retirement was pursuant to rule 0460-04-.06 (5) and reactivation was requested prior to the expiration of one (1) year from the date of retirement, the Board may require payment of the late renewal fee and past due renewal and state regulatory fees as provided in rule 0460-01-.02 (3).

* + - * 1. If requested, after review by the Board, a designated Board member, or the Board consultant, appear before the Board, a designated Board member, or the Board consultant, for an interview regarding continued competence in the event of retirement in excess of two (2) years.
        2. Comply with the continuing education provisions of rule 0460-01-.05 (6) applicable to reactivation of retired registrations.
        3. Submit proof of successful completion of the Tennessee Board of Dentistry Ethics and Jurisprudence examination.
      1. Application review and decisions required by this rule shall be governed by rule 0460-01-.04.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-107, 63-5-108, 63-5-111, 63-5-115, 63-5-117, 63-*

* 1. *, and 63-5-129.* ***Administrative History:*** *Original rule certified June 7, 1974. Repeal and new rule filed December 11, 1991; effective January 25, 1992. Amendment filed March 20, 1996; effective June 3,*

*1996. Amendment filed August 21, 2002; effective November 4, 2002. Amendment filed August 4, 2009;*

*effective November 2, 2009. Amendments filed October 25, 2017; effective January 23, 2018.*

# 0460-04-.08 SCOPE OF PRACTICE.

* + 1. A lawfully licensed and duly registered dentist may delegate to dental assistants those procedures for which they have received adequate training and for which the dentist exercises direct supervision and full responsibility, except as follows:
       1. Those procedures which require professional judgment and skill of a dentist as defined in the Dental Practice Act or rules of the Board.
       2. Those clinical procedures which are primarily concerned with the practice of dentistry or dental hygiene and which are allocated by the Dental Practice Act or Rules of the Tennessee Board of Dentistry specifically and solely to licensed dentists and/or licensed dental hygienists.
    2. Registered dental assistants, with additional Board-approved training, may, under the direct supervision of a licensed dentist perform the following procedures:
       1. Coronal polishing, pursuant to Rule 0460-04-.04; and
       2. Monitoring nitrous oxide, pursuant to Rule 0460-04-.05; and
       3. Application of sealants, pursuant to Rule 0460-04-.09.
       4. Performance of expanded restorative functions, pursuant to Rule 0460-04-.10.
       5. Performance of expanded prosthetic functions, pursuant to Rule 0460-04-.10.
       6. Exposure of dental radiographs, pursuant to Rule 0460-04-.11.
    3. Delegable or Assignable Procedures - In addition to those duties of the practical dental assistant or registered dental assistant which are commonly recognizable by the dental profession for safe performance, pursuant to T.C.A. § 63-5-108, a practical dental assistant or registered dental assistant may perform the following duties which are assigned or delegated by the employer/supervising dentist:
       1. The processing of radiographs, including digital, of the mouth, gums, jaws, teeth or any portion thereof for dental diagnosis.
       2. The application of topical fluorides.
       3. The instruction of patients in dietary principles.
       4. The taking and recording of a patient’s blood pressure, pulse, temperature, and medical history, and charting of oral conditions.
       5. The maintenance of instrument and operatory infection control
       6. The preparation of instrument trays
       7. The placement and removal of matrices for restoration.
       8. The removal of cement from restorations and bands.
       9. The removal of sutures and staples.
       10. The fabrication, placement and removal of temporary restorations.
       11. The placement and removal of rubber dam.
       12. The placement and removal of socket dressings.
       13. The placement and removal of periodontal dressings.
       14. The taking of dental plaque smears.
       15. The taking of alginate impressions for any purpose other than permanent restorations.
       16. The removal of ligature and arch wires.
       17. Bending, selecting and pre-sizing arch wires and placing arch wires after final adjustment and approval by the dentist.
       18. The selection, prefitting, cementation, curing, and removing of orthodontic bands or brackets.
       19. Placement and removal of pre-treatment separators.
       20. Removal of loose or broken bands or brackets.
       21. Placement of springs on wires.
       22. Placement of hooks on brackets.
       23. Placement of chain elastics on brackets.
       24. Ligation of arch wires to brackets.
       25. Packing and removing retraction cord, with or without vasoactive chemicals, for restorative dental procedures.
       26. Removal of cement excess from supragingival surface of teeth by hand instruments only.

(aa) The placement of amalgam in prepared cavities for condensation by the dentist. (bb) The application of topical anesthetics.

(cc) The application of desensitizing agents. (dd) Placement of cavity bases and liners.

(ee) Application of tooth conditioners for bonding.

(ff) Selecting and pre-fitting of stainless steel crowns or other pre-formed crowns for insertion by the dentist.

(gg) The taking of oral cytologic smears. (hh) Performing pulp testing.

(ii) Packing of pulpotomy paste.

(jj) Drying canals with absorbent paper points.

(kk) Demonstration of oral hygiene procedures and oral health care regimen

(ll) Calling in prescriptions to the pharmacist as instructed by the employer/dentist. (mm) Fitting, adjusting and cementation of correctional appliances.

(nn) Wound care as directed. (oo) Irrigating extraction site.

(pp) Placement of exposure chains and attachments.

(qq) Other duties specifically approved by the Board at a regularly scheduled meeting of the Board.

* + 1. Prohibited Procedures—In addition to the duties defined as the practice of dentistry or dental hygiene by T.C.A. § 63-5-108, dental assistants are not permitted to perform the following:
       1. Examination, diagnosis and treatment planning;
       2. Surgical or cutting procedures on hard or soft tissue, including laser, air abrasion or micro-abrasion procedures, including curettage or root planing;
       3. Fitting, adjusting, and placement of prosthodontics appliances;
       4. Issuance of prescription medications or medications not authorized by T.C.A. § 63-5- 108 (c) or Rule 0460-04-.08 (3), or work authorizations;
       5. Performance of direct pulp capping, pulpotomy, and other endodontic procedures not authorized by T.C.A. § 63-5-108(c) or Rule 0460-04-.08 (3);
       6. Approving the final occlusion;
       7. Placement of sutures;
       8. Administration of local anesthesia, nitrous oxide, conscious sedation, or general anesthesia;
       9. Monitoring of nitrous oxide without certification as provided in Rule 0460-04-.05 and 0460-04-.08 (2);
       10. Coronal polishing without certification as provided in Rule 0460-04-.04 and 0460-04-.08 (2);
       11. Application of sealants without certification as provided by Rule 0460-04-.09 and 0460- 04-.08 (2);
       12. Use of a high-speed handpiece intraorally;
       13. Utilization of laser equipment and technology in the course of the performance of their duties unless specifically authorized by T.C.A. § 63-5-108 (c) or Rule 0460-04-.08 (3). Only dentists licensed by the Tennessee Board of Dentistry shall be authorized to perform procedures involving laser technology.
       14. The exposure of radiographs without certification as provided by Rule 0460-04-.11 and Rule 0460-04-.08 (2).
       15. Expanded restorative or prosthetic functions without certification as provided by Rule 0460-04-.10 and Rule 0460-04-.08 (2).
    2. Dental assistants who perform procedures not delegable pursuant to this rule, or who perform procedures specifically prohibited by T.C.A. § 63-5-108, or who perform procedures without the direct supervision of a dentist, or who perform coronal polishing, application of sealants or nitrous oxide monitoring without the applicable certification or in violation of the rules governing those procedures, may be subject to disciplinary action pursuant to T.C.A. § 63-5- 116 (b).

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-108, 63-5-115, and 63-5-116.* ***Administrative***

***History:*** *Original rule certified June 7, 1974. Amendment filed August 26, 1980; effective December 1,*

*1980. Repeal and new rule filed December 11, 1991; effective January 25, 1992. Amendment filed May*

*15, 1996; effective September 27, 1996. Amendment filed September 17, 2003; effective December 1,*

*2003. Amendment filed August 3, 2005; effective October 17, 2005. Amendment filed October 12, 2007;*

*effective December 26, 2007. Amendment filed September 25, 2008; effective December 9, 2008.*

*Amendment filed September 30, 2014; effective December 29, 2014.*

**0460-04-.09 SEALANT APPLICATION CERTIFICATION.** A registered dental assistant with this certification may only practice sealant application under the direct supervision of a licensed dentist.

1. Definition - Sealant application shall mean the application of an organic polymer to the enamel surfaces of teeth.
2. Qualifications for Certification
   1. Registered dental assistants in good standing with the Tennessee Board of Dentistry, pursuant to Rule 0460-04-.02, are eligible to take a Board-approved sealant application certification course.
   2. Individuals enrolled in either an ADA-accredited or Board-approved dental assisting program, which has elected to include in its curriculum the Board-approved sealant application certification course, will be qualified to perform the application of sealants upon issuance of the certification. All such programs shall adhere to the requirements of Rule 0460-05-.03 (3).
   3. Registered dental assistants who have successfully completed a comparable assistant training program in another state in the application of sealants are eligible to apply directly to the Board of Dentistry for a sealant application certificate without additional training, provided the course is determined by the Board consultant to be equivalent to the Board-approved course in Tennessee. The information regarding content of the course and proof of completion must be sent directly from the course provider to the Board’s administrative office. If a certification or permit was issued by the other state, verification of the certificate or permit must be received directly from the other board.
   4. After successful completion of a Board-approved certification course, if required, and receipt of proper notification from the course/instructor, an applicant will be issued an initial approval letter. The applicant’s certification will be ratified at the next scheduled meeting of the Board.
3. Supervision
   1. Sealant application may only be performed under the direct supervision of a Tennessee licensed dentist.
   2. The dentist must examine the patient immediately before and after sealant application to determine the need for, and evaluate the results of, sealant application.
4. Retention of Certification - Certification in sealant application is only valid as long as the registered dental assistant has a current registration to practice registered dental assisting. If the registration expires or is retired, the certification is also considered expired or retired, and the dental assistant may not apply sealants until the registration is reinstated or reactivated.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-108, 63-5-115, and 63-5-116.* ***Administrative***

***History:*** *Original rule certified June 7, 1974. Amendment filed August 26, 1980; effective December 1,*

*1980. Repeal filed December 11, 1991; effective January 25, 1992. New rule filed September 17, 2003;*

*effective December 1, 2003. Amendment filed October 12, 2007; effective December 26, 2007.*

# 0460-04-.10 RESTORATIVE AND PROSTHETIC CERTIFICATIONS.

1. Dental assistants who have a minimum of two (2) years continuous full-time employment within the past three (3) years in a dental practice as a dental assistant are eligible for admission to a Board-approved certification course in restorative and/or prosthetic functions. A registered dental assistant must apply for and complete a Board-approved certification course in restorative or prosthetic functions and obtain the appropriate certification, issued by the Board, before he/she can perform expanded restorative or prosthetic functions on any patient.
2. Certification in restorative or prosthetic functions is only valid as long as the registered dental assistant has a current authorization to practice as a registered dental assistant. If the authorization expires or is retired, the certification is also considered expired or retired and the dental assistant may not perform restorative or prosthetic functions until the authorization to practice is reinstated or reactivated.
3. Registered dental assistants who possess a certification in restorative or prosthetic functions shall prominently display their current renewal certificate at their place of employment.
4. Registered dental assistants with certification in restorative or prosthetic functions may perform restorations or prosthetic functions only under the direct supervision and full responsibility of a licensed dentist.
5. Prohibited Procedures – The following procedures are prohibited for all dental assistants, including those who have certification in restorative or prosthetic functions:
   1. Restorative Functions
      1. Diagnosing of need for restorations;
      2. Preparation/Cutting of the tooth or soft tissue;
      3. Modifying existing structure;
      4. Removal of caries, bases and liners; and
      5. Use of high-speed handpieces intraorally.
   2. Prosthetic Functions
      1. Diagnosing need for any prosthetic appliance;
      2. Establishing vertical dimension of occlusion and interocclusal records;
      3. Delivering and/or adjusting appliance; and
      4. Use of high-speed handpieces intraorally.
6. Registered dental assistants, who have successfully completed a comparable assistant training program in another state in expanded restorative or prosthetic functions, are eligible to apply directly to the Board for an expanded functions certificate without additional training, provided the course is determined by the Board consultant to be equivalent to the Board- approved course in Tennessee. The information regarding content of the course and proof of

completion must be sent directly from the course provider to the Board’s administrative office. If a certification or permit was issued by the other state, verification of the certificate or permit must be received directly from the other board. If it is determined that the course is not equivalent, the registered dental assistant will be required to comply with the provisions of paragraph (1) before certification can be issued.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-108, and 63-5-115.* ***Administrative History:***

*Original rule certified June 7, 1974. Repeal filed December 11, 1991; effective January 25, 1992. Original*

*rule filed August 3, 2005; effective October 17, 2005. Amendment filed October 12, 2007; effective*

*December 26, 2007. Amendment filed September 30, 2014; effective December 29, 2014.*

**0460-04-.11 DENTAL RADIOLOGY CERTIFICATION.** Registered dental assistants with this certification may expose dental radiographs under the direct supervision of a licensed dentist.

1. A dental assistant must be currently registered, pursuant to Rule 0460-04-.02, by the Board before attending a certification course in dental radiology and/or qualifying for certification, except as follows:
   1. Dental assistants who are registered, pursuant to Rule 0460-04-.02, before the original effective date of this rule shall be issued dental radiology certification without having to complete the course required in paragraph (2).
   2. Registered dental assistants, who have successfully completed a comparable assistant training program in another state in dental radiology, are eligible to apply directly to the Board for dental radiology certification without having to complete the requirements of paragraph (2), provided the course is determined by the Board consultant to be equivalent to the Board-approved course in Tennessee. The information regarding content of the course and proof of completion must be sent directly from the course provider to the Board’s administrative office. If a certification or permit was issued by the other state, verification of the certificate or permit must be received directly from the other board. If it is determined that the course is not equivalent, the registered dental assistant will be required to comply with the provisions of paragraph (2) before certification can be issued.
   3. Assistants who have passed the radiology portion of the certified dental assistant examination given by the Dental Assisting National Boards, Inc. (DANB) or hold a current certification from DANB as a certified dental assistant are eligible to apply directly to the Board for dental radiology certification without having to complete the course required in paragraph (2). Proof of passage of the radiology portion of the DANB exam or proof of current DANB certification must be sent directly from the DANB to the Board’s administrative office.
2. To be eligible for certification, the registered dental assistant must successfully complete a Board-approved dental radiology training course or be currently enrolled in an ADA-accredited or Board-approved program which offers this course as part of their curriculum. Once eligible for certification, the registered dental assistant shall not expose dental radiographs until certification has been issued by the Board.
3. Dental radiology certification shall be added to the registration of the registered dental assistant, if the registered dental assistant has successfully completed a Board-approved certification course and notification of completion has been submitted to the Board's Administrative Office by the course director on a form provided by the Board.
4. Registered dental assistants with radiology certification shall prominently display their current registration certification, which is received upon registration and renewal, at their place of employment.
5. Certification in dental radiology is only valid as long as the registered dental assistant has a current registration. If the registration expires or is retired, the certification is also considered expired or retired and the dental assistant may not expose dental radiographs until the registration is reinstated or reactivated.
6. Application review and decisions required by this rule shall be governed by 0460-01-.04.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-108, and 63-5-115.* ***Administrative History:***

*Original rule certified June 7, 1974. Repeal filed December 11, 1991; effective January 25, 1992. Original*

*rule filed October 12, 2007; effective December 26, 2007. Amendments filed September 30, 2014;*

*effective December 29, 2014.*

# 0460-04-.12 THROUGH 0460-04-.14 REPEALED.

***Authority:*** *T.C.A. §§ 4-5-202 and 63-5-105(7).* ***Administrative History:*** *Original rule certified June 7, 1974. Repeal filed August 26, 1980; effective December 1, 1980.*

# RULES OF

**TENNESSEE BOARD OF DENTISTRY**

**CHAPTER 0460-05**

**GENERAL RULES GOVERNING SCHOOLS, PROGRAMS AND COURSES** **FOR DENTISTS, DENTAL HYGIENISTS, AND REGISTERED DENTAL ASSISTANTS**

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**0460-05-.01 SCHOOLS OF DENTISTRY.**

1. Reserved.
2. Reserved.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, and 63-5-108.* ***Administrative History:*** *Original rule*

*certified June 7, 1974. Amendment filed August 26, 1980; effective December 1, 1980. Repeal and new*

*rule filed December 11, 1991; effective January 25, 1992. Repeal filed February 12, 1996; effective April*

*27, 1996. New rule filed September 17, 2003; effective December 1, 2003.*

# 0460-05-.02 SCHOOLS, PROGRAMS AND COURSES FOR THE DENTAL HYGIENIST.

1. Dental Hygiene Schools.
   1. Reserved.
   2. Reserved.
2. Certification Course in Administration & Monitoring of Nitrous Oxide
   1. Application for Board Approval - The owner and/or director of a certification course in administration and monitoring of nitrous oxide shall make application for approval to operate that course of study on forms to be provided by the Board. The completed application must be received in the Board’s Office at least thirty (30) days prior to the next regularly scheduled Board meeting in order for the Board to review the application. The owner and/or director of the certification course will be notified in writing of the Board’s action(s). This section shall also apply to all dental hygiene schools.
   2. Retention of Approval.
      1. The certification course, whether offered independently or as a part of the curriculum taught by a dental hygiene school, shall maintain strict compliance with all minimum standards for admissions, facilities, instructor(s), equipment, and curriculum as set forth in this rule, as amended/may be amended, in order to obtain and/or retain Board approval.
      2. The certification course shall be subject to on-site inspections by representatives of the Board and/or required to complete such paper surveys, as requested.
      3. The Board shall be notified immediately of any changes made in the operation of the certification course, such as change of location, directorship, and/or

instructors. A new certificate of approval will be issued in the event of change in either ownership or directorship of the course.

* + 1. Certificates of approval shall be issued for one (1) year and shall expire on December 31st of any given year.
  1. Minimum Standards for Admissions, Facilities, Instructor(s), Equipment, and Curriculum.
     1. The certification course shall admit only those dental hygienists who are currently licensed, pursuant to Rule 0460-03-.01, .02, or .03, or are currently enrolled in an ADA-accredited dental hygiene program which offers this course as a part of its curriculum.
     2. The course shall be taught at an educational institution, defined as a school of dentistry, dental hygiene, or dental assisting, or a clinical facility approved by the Board which provides for proper patient care, including access to medication and equipment for the management of emergencies.
     3. The certification course shall be taught by a Tennessee licensed dentist or a licensed dental hygienist with administration and monitoring certification and a minimum of three (3) years clinical experience in utilizing administration of nitrous oxide and education in comprehensive pain and anxiety control. The instructor/dentist may employ and/or utilize anesthesiologists, pharmacologists, internists, and/or cardiologists who are licensed in Tennessee as instructors to assist the instructor/dentist in the teaching of the course.
     4. The clinical instructor-to-student ratio must be one (1) instructor to ten (10) students (1:10) with a class size no larger than fifty (50) students.
     5. The certification course shall consist of fourteen (14) hours of study over a two

1. day period. The course syllabus must be approved by the Board and meet the following requirements:
2. Didactic - The course shall be designed and conducted to provide the student with detailed knowledge of nitrous oxide – oxygen inhalation sedation, its use in dentistry, and the health hazards and abuse potential of nitrous oxide. The didactic portion of the course shall include instruction in all of the following subject matters:
   1. History, philosophy, psychology of nitrous oxide-oxygen inhalation sedation;
   2. Definitions and descriptions of the physiological and psychological aspects of pain and anxiety;
   3. Description of the stages of drug induced central nervous system depression, through all levels of consciousness and unconsciousness, with special emphasis on the difference between the conscious and unconscious state;
   4. Anatomy and physiology of respiration;
   5. Pharmacological and physiological effects of nitrous oxide, including physical properties, action, side effects, absorption, excretion, and toxicity;
   6. Advantages and disadvantages of inhalation sedation with nitrous oxide;
   7. Discuss and review pediatric and adult respiration;
   8. Discuss and review circulatory physiology and related anatomy for pediatric and adult patients;
   9. Management of reaction to, or complications with nitrous oxide;
   10. Taking and reviewing a thorough health history including:
       1. Taking and reviewing vital signs;
       2. Evaluating implications of the use of nitrous oxide based upon the patient’s health history;
       3. Reflexes related to consciousness;
       4. Possible reactions to nitrous oxide; and
       5. Instruction for post-operative care;
   11. Recognition, prevention and management of complications and life- threatening situations related to nitrous oxide;
   12. Description and use of inhalation sedation equipment and appropriate physiologic monitoring and administration equipment;
   13. Legal considerations of nitrous oxide use;
   14. Discussion of sexual phenomena and hallucinatory effects reported with nitrous oxide;
   15. Discussion of the potential for abuse of nitrous oxide;
   16. Recommended techniques for reducing occupational exposure to nitrous oxide; and
   17. An introduction of potential health hazards of trace anesthetics and proposed techniques for elimination thereof, including, but not limited to, recommendations and guidelines from the Centers for Disease Control (CDC) or the Occupational, Health, and Safety Administration (OSHA).
3. Clinical - The certification course shall afford participants with sufficient clinical experience to enable them to achieve competency. This experience must be provided under the supervision of qualified faculty, and the participants must be evaluated for competency. The clinical portion of the course shall be at least two (2) hours, including at least one (1) hour of

demonstration by an instructor and hands on participation by students. The clinical experience shall include all significant portions of the didactic instruction including:

* 1. Patient status assessment;
  2. Use of various equipment in the administration and monitoring of nitrous oxide;
  3. Introduction of sedation to a patient;
  4. Monitoring of the patient; and
  5. Post-operative care of the patient and provision of instruction to the patient.
  6. The instructor shall provide a copy of the syllabus to the student before or at the beginning of each course, setting forth the materials to be presented in the course and the evaluation criteria to be utilized by the clinical instructor to determine successful completion of the certification course.
  7. Upon completion of the course, students shall be evaluated by written examination. The examination shall cover the didactic portion of the course. The passing grade is set at 75%. If the student initially fails the written examination, the exam may be taken no more than two (2) additional times before the course must be retaken and the exam retaken. The examination shall be developed and administered by the course director/instructor in such a manner as to determine competency for the administration and monitoring of nitrous oxide.
  8. The director/instructor of the certification course shall, within thirty (30) days after course completion or upon graduation from the dental hygiene school, complete a form, provided by the Board, for each student to attest to the student’s successful completion of the course and the student’s examination grade. The completed forms shall be submitted directly to the Board’s Office by the Instructor/Director.
  9. The certification course, or dental hygiene school, will issue continuing education credit hours for the course.
  10. Failure to adhere to the rules governing the certification course or to provide access to inspection, pursuant to Rule 0460-05-.02 (2) (b), may subject the course provider and students to invalidation of the course results and withdrawal of course approval issued by the Board.

1. Certification Course in Restorative Functions
   1. Application for Board Approval – The director of a certification course in restorative functions shall make application for approval to operate that course of study on forms to be provided by the Board. The completed application must be received in the Board’s Office at least thirty (30) days prior to the next regularly scheduled Board meeting in order for the Board to review the application. The director of the certification course will be notified in writing of the Board’s action(s).
   2. Retention of Approval.
      1. The certification course must be taught at an educational institution as defined in part (3) (c) 2. of this rule and shall maintain strict compliance with all minimum standards for admissions, facilities, instructor(s), equipment, and curriculum as set forth in this rule, as amended/may be amended, in order to obtain and/or retain Board approval.
      2. The certification course shall be subject to on-site inspections by representatives of the Board and/or required to complete such paper surveys, as requested.
      3. The Board shall be notified immediately of any changes made in the operation of the certification course, such as change of location, directorship, and/or instructors. A new certificate of approval will be issued in the event of change in directorship of the course.
      4. Certificates of approval shall be issued for two (2) years and shall expire on December 31st every two (2) years.
   3. Minimum Standards for Admissions, Facilities, Instructor(s), Equipment, and Curriculum.
      1. The certification course shall admit only those dental hygienists who are currently licensed, pursuant to Rule 0460-03-.01, .02, or .03, and who submit proof of a minimum of two (2) years continuous full-time employment within the past three
2. years in a dental practice as a dental hygienist.
   * 1. The course shall be taught at an educational institution, defined as a school of dentistry or a school which offers a specialty program in a recognized specialty branch of dentistry.
     2. The certification course shall be taught by one (1) or more Tennessee licensed dentists who are faculty members at an accredited school of dentistry.
     3. The clinical instructor-to-student ratio must be one (1) instructor to eight (8) students (1:8).
     4. The certification course shall consist of a minimum of ninety-six (96) hours of study over a three (3) week period.
     5. The course syllabus shall be approved by the Board and the course shall be designed and conducted to provide the student with detailed knowledge of restorative functions. The clinical experience must be provided under the supervision of qualified faculty, and the students must be evaluated for competency. The didactic and clinical portions of the course shall include instruction in all of the following subject matters:
        1. First Week – The first (1st) week of the course must be a minimum of thirty-two (32) hours in length and a written and/or clinical competency examination is to be administered at the end of the week regarding:
           1. Dental morphology and occulusion;
           2. Dental materials, hazardous materials and product safety;

Amalgam;

Composite;

Glass Ionomer; and

Mercury.

* + - * 1. Principles of cavity preparation on anterior and posterior class I, II, III, IV, and V teeth;
        2. Instrumentation for all restorations;
        3. Liners and bases, types and placement;
      1. Second Week – The second (2nd) week of the course must be a minimum of thirty-two (32) hours in length and a written and/or clinical competency examination regarding items (I) through (V) is to be administered at the end of the week. No high-speed handpiece is to be used in the course, only a slow-speed handpiece:
         1. Isolation and rubber dam placement;
         2. Caries;
         3. Selection and placement of matrix retainers;
         4. Laboratory on insertion, packing and carving (finishing) of amalgam;
         5. Insertion, packing and carving (finishing) of amalgam;
      2. Third Week – The third (3rd) week of the course must be a minimum of thirty-two (32) hours in length and a written and/or clinical competency examination regarding items (I) through (III) is to be administered at the end of the week. No high-speed handpiece is to be used in the course, only a slow-speed handpiece:
         1. Insertion, packing and carving (finishing) of amalgam;
         2. Laboratory on insertion, packing and carving (finishing) of composite and glass ionomers;
         3. Insertion, packing and carving (finishing) of composite and glass ionomers;
      3. In addition to the weekly competency examinations required by subparts (i), (ii) and (iii), each student must pass a clinical examination regarding insertion, packing and carving (finishing) of amalgam prior to taking the comprehensive competency examination required by subpart (vi).
      4. Each student must pass the competency examination on the material covered each week before continuing to the material for the next week. Students who do not pass the competency examination may be offered remediation before the start of the next week.
      5. Passage of a comprehensive competency examination on all material covered in the course is required at the end of the course. This examination shall be both written and clinical.
  1. The instructor shall provide a copy of the syllabus to the student before or at the beginning of each course, setting forth the materials to be presented in the course and the evaluation criteria to be utilized by the clinical instructor to determine successful completion of the certification course.
  2. The passing grade on each competency examination is set at seventy-five percent (75%). If the student initially fails any competency examination, the exam may be taken no more than one (1) additional time before the entire course must be retaken and the exam retaken. The examination shall be developed and administered by the course instructors in such a manner as to determine competency for the restorative functions.
  3. The director/instructor of the certification course shall, within thirty (30) days after course completion, complete a form, provided by the Board, for each student to attest to the student’s successful completion of the course and the student’s examination grade. The completed forms shall be submitted directly to the Board’s Office by the director/instructor.
  4. The certification course will issue continuing education credit hours for the course.
  5. Failure to adhere to the rules governing the certification course or to provide access to inspection, pursuant to Rule 0460-05-.02 (3) (b), may subject the course provider and students to invalidation of the course results and withdrawal of course approval issued by the Board.

1. Certification Course in Prosthetic Functions
   1. Application for Board Approval – The director of a certification course in prosthetic functions shall make application for approval to operate that course of study on forms to be provided by the Board. The completed application must be received in the Board’s Office at least thirty (30) days prior to the next regularly scheduled Board meeting in order for the Board to review the application. The director of the certification course will be notified in writing of the Board’s action(s).
   2. Retention of Approval.
      1. The certification course must be taught at an educational institution as defined in part (4) (c) 2. of this rule and shall maintain strict compliance with all minimum standards for admissions, facilities, instructor(s), equipment, and curriculum as set forth in this rule, as amended/may be amended, in order to obtain and/or retain Board approval.
      2. The certification course shall be subject to on-site inspections by representatives of the Board and/or required to complete such paper surveys, as requested.
      3. The Board shall be notified immediately of any changes made in the operation of the certification course, such as change of location, directorship, and/or instructors. A new certificate of approval will be issued in the event of change in directorship of the course.
      4. Certificates of approval shall be issued for two (2) years and shall expire on December 31st every two (2) years.
   3. Minimum Standards for Admissions, Facilities, Instructor(s), Equipment, and Curriculum.
      1. The certification course shall admit only those dental hygienists who are currently licensed, pursuant to Rule 0460-03-.01, .02, or .03, and who submit proof of a minimum of two (2) years continuous full-time employment within the past three

(3) years in a dental practice as a dental hygienist.

* + 1. The course shall be taught at an educational institution, defined as a school of dentistry or a school which offers a specialty program in a recognized specialty branch of dentistry.
    2. The certification course shall be taught by one (1) or more Tennessee licensed dentists who are faculty members at an accredited school of dentistry.
    3. The clinical instructor-to-student ratio must be one (1) instructor to eight (8) students (1:8).
    4. The certification course shall consist of a minimum of sixty-four (64) hours of study over a two (2) week period.
    5. The course syllabus shall be approved by the Board and the course shall be designed and conducted to provide the student with detailed knowledge of prosthetic functions. The clinical experience must be provided under the supervision of qualified faculty, and the students must be evaluated for competency. The didactic and clinical portion of the course shall include instruction in all of the following subject matters:
       1. First Week – The first (1st) week of the course must be a minimum of thirty-two (32) hours in length and a competency examination is to be administered at the end of the week regarding:
          1. Anatomy and physiology;
          2. Dentulous soft tissue including the gingival sulcus and its management;
          3. Edentulous soft tissue;
          4. Physiologic function of these tissues and the principles of soft tissue management;
          5. Occlusion for fixed and removable appliances;
          6. Tray selection and impression materials of models;
          7. Border molding and master impressions, including a live patient experience;
          8. Tray selection;

Custom;

Stock;

Triple tray; and

Construction and fitting.

* + - * 1. Fixed prosthodontic impressions;

Full mouth;

Quadrant; and

Individual.

* + - 1. Second Week – The second (2nd) week of the course must be a minimum of thirty-two (32) hours in length and a competency examination is to be administered at the end of the week regarding:
         1. Gingival retraction;
         2. Mechanisms of gingival retraction;
         3. Types and size of cord;
         4. Pharmacology of medicaments used and the techniques for placement;
         5. Practice placement;
         6. Techniques of making impressions;
         7. Laboratory practice for fixed impressions including infection control;
         8. Temporary restorations and laboratory technique for each;

Aluminum;

Polycarbonate; and

Custom.

* + - * 1. Fabrication, polishing and placement of temporary restorations;

Anterior; and

Posterior.

* + - 1. Each student must pass the competency examination on the material covered before continuing to the material for the next week. Students who do not pass the competency examination may be offered remediation; and
      2. Passage of a comprehensive competency examination on all material covered in the course is required at the end of the course.
  1. The instructor shall provide a copy of the syllabus to the student before or at the beginning of each course, setting forth the materials to be presented in the course and the evaluation criteria to be utilized by the clinical instructor to determine successful completion of the certification course.
  2. The passing grade on each competency examination is set at seventy-five percent (75%). If the student initially fails any competency examination, the exam may be taken no more than one (1) additional time before the entire course must be retaken and the exam retaken. The examination shall be developed and administered by the course instructors in such a manner as to determine competency for the prosthetic functions.
  3. The director/instructor of the certification course shall, within thirty (30) days after course completion, complete a form, provided by the Board, for each student to attest to the student’s successful completion of the course and the student’s examination grade. The completed forms shall be submitted directly to the Board’s Office by the director/instructor.
  4. The certification course will issue continuing education credit hours for the course.
  5. Failure to adhere to the rules governing the certification course or to provide access to inspection, pursuant to Rule 0460-05-.02 (4) (b), may subject the course provider and students to invalidation of the course results and withdrawal of course approval issued by the Board.

1. Certification Course in Administration of Local Anesthesia
   1. Application for Board Approval – The director of a certification course in administration of local anesthesia shall make application for approval to operate that course of study on forms to be provided by the Board. The completed application must be received in the Board’s Office at least thirty (30) days prior to the next regularly scheduled Board meeting in order for the Board to review the application. The director of the certification course will be notified in writing of the Board’s action(s).
   2. Exemption from Board Approval – Dental hygiene programs accredited by the American Dental Association (ADA) Commission on Dental Accreditation which teach administration of local anesthesia to the level of clinical competency to the students enrolled in the associate, bachelor, or master degree program are exempt from obtaining Board approval.
      1. Students who complete a course taught within their associate, bachelor, or master degree program shall have the program send an original letter on school letterhead signed by the program director attesting to successful completion of the course to the level of clinical competency.
      2. Students shall submit the certification application and fee.
      3. The certification will not be issued until the required information is received and the dental hygiene license has been issued.
   3. Retention of Approval.
      1. The certification course must be taught at an educational institution and shall maintain strict compliance with all minimum standards for admissions, facilities, instructor(s), equipment, and curriculum as set forth in this rule, as amended/may be amended, in order to obtain and/or retain Board approval.
      2. The certification course shall be subject to on-site inspections by representatives of the Board and/or required to complete such paper surveys, as requested.
      3. The Board shall be notified immediately of any changes made in the operation of the certification course, such as change of location, directorship, and/or instructors. A new certificate of approval will be issued in the event of change in directorship of the course.
      4. Certificates of approval shall be issued for two (2) years and shall expire on December 31st every two (2) years.
   4. Minimum Standards for Admissions, Facilities, Instructor(s), Equipment, and Curriculum.
      1. The certification course shall admit only those dental hygienists who are currently licensed, pursuant to Rule 0460-03-.01, .02, or .03.
      2. The certification course may only be taught by:
         1. Tennessee licensed dentists who are faculty members at an accredited school of dentistry or dental hygiene and who have experience teaching the administration of local anesthesia; or
         2. Tennessee licensed dental hygienists with certification in the administration of local anesthesia who are faculty members at an accredited school of dentistry or dental hygiene and who have experience teaching the administration of local anesthesia. Such dental hygienist instructors may only teach the certification course while under the direct supervision of a qualified instructor-dentist.
      3. The clinical instructor-to-student ratio must be one (1) instructor to six (6) students (1:6).
      4. The certification course shall consist of a didactic section of twenty-four (24) hours and a clinical section of no less than eight (8) hours for a total of at least thirty-two (32) hours of study in administration of local anesthesia.
         1. Each student must pass a competency examination on the material covered in the didactic section before continuing to the clinical section of the course. Students who do not pass the competency examination may be offered remediation before the start of the clinical experience.
         2. Passage of a clinical competency examination, including satisfactorily performing injections.
         3. Upon successful completion of the course, the certification application and fee must be submitted by the student.
         4. The director/instructor of the certification course shall, within ten (10) days after course completion submit a letter, on school letterhead, for each student which attests to the student’s successful completion of the course and the student’s examination grades. The completed forms shall be submitted directly to the Board’s Administrative Office by the director/instructor.
         5. The student will be issued a temporary local anesthesia certification to complete a ninety (90) day extern in the office of the employer dentist(s). During the extern the following injections must be successfully completed:
            1. Minimum of fifteen (15) inferior alveolar blocks:
            2. Minimum of fifteen (15) posterior superior alveolar;
            3. Minimum of two (2) each of the following:

Middle superior alveolar;

Anterior superior alveolar;

Nasopalatine;

Greater palatine;

Long buccal;

Mental block; and

Lingual block.

* + - 1. The employer/supervising dentist(s) must submit, on a form provided by the board, proof of successful completion of the injections required by subpart (5) (d) 4 (v) of this rule.
      2. Upon receipt of proof of successful completion of the injections, the certification for administration of local anesthesia will be issued.
      3. Extensions of the ninety (90) day temporary permit will be considered on a case-by-case basis upon receipt of written documentation stating the reason an extension is requested. The board consultant has the authority to grant or deny the request.
    1. The course syllabus must be approved by the Board and meet the following requirements:
       1. Didactic Section - The didactic section shall be designed and conducted to provide the student with detailed knowledge of administration of local anesthesia, including didactic studies and clinical experience in the administration of posterior superior alveolar, middle superior alveolar, anterior superior alveolar, nasopalatine, greater palatine, long buccal, mental block, lingual block, inferior alveolar block and infiltration techniques, medical history and physical evaluation of the patient, and the prevention, diagnosis, and management of medical emergencies which

can be encountered in the dental patient. The didactic section of the course shall include instruction in all of the following subject matters:

* + - * 1. Medical history evaluation procedures;
        2. Physical evaluation;
        3. Understanding pharmacology of local anesthesia and vasoconstrictors;
        4. Anatomy of head, neck and oral cavity as it relates to administering local anesthetic agents;
        5. Indications and contraindications for administration of local anesthesia;
        6. Selection and preparation of the armamentaria and record keeping for administering various local anesthetic agents;
        7. Medical and legal management complications;
        8. Recognition and management of post-injection complications and management of reactions to injections;
        9. Proper infection control techniques with regard to local anesthesia and proper disposal of sharps;
        10. Methods of administering local anesthetic agents with emphasis on:

Technique;

Aspiration;

Slow injection; and

Minimum effective dosage;

* + - * 1. Medical emergency, prevention, diagnosis, and management;
        2. Instruction in the philosophy and psychology of the use of local anesthesia;
        3. A review of the physiology of nerve conduction;
        4. A review of regional anatomy;
        5. A survey of local anesthetic agents on nerve conduction;
        6. A review of the metabolism and excretion of local anesthetics;
        7. Instruction on toxicity of local anesthetic drugs;
        8. Instruction on the clinical manifestations of toxic reactions;
        9. Instruction on the treatment of toxic reactions;
        10. Instruction on allergic reactions to local anesthetic drugs;
        11. Instruction on the clinical manifestations of allergic reactions;
        12. Instruction on the treatment of allergic reactions to local anesthetics;
        13. Instruction regarding vasoconstrictor drugs used in local anesthetics;

(XXIV)Instruction on the clinical manifestations of toxic reactions to vasoconstrictor drugs used in local anesthesia;

1. Instruction on the treatment of toxic reactions to vasoconstrictors used in local anesthesia;
2. Instruction on drug interactions related to local anesthesia; (XXVII)Re-injecting when necessary; and

(XXVIII)Estimating the highest safe dosage of local anesthesia based upon the weight and/or age of the patient.

* + - 1. Clinical Section - The clinical section must be provided under the supervision of qualified faculty, and the students must be evaluated for competency. The clinical section of the course shall include instruction in all of the following subject matters:
         1. Evaluating the patient’s health status;
         2. Taking the patient’s vital signs;
         3. Administering local anesthetic infiltrations;
         4. Administering local anesthetic nerve blocks; and
         5. Monitoring the patient’s physical status while under the effects of local anesthetics.
  1. The instructor shall provide a copy of the syllabus to the student before or at the beginning of each course, setting forth the materials to be presented in the course and the evaluation criteria to be utilized by the clinical instructor to determine successful completion of the certification course.
  2. The passing grade on each competency examination is set at seventy per cent (70%). If the student initially fails any competency examination, the exam may be taken no more than one (1) additional time before the entire course must be retaken and the exam retaken. The examination shall be developed and administered by the course instructors in such a manner as to determine competency for the administration of local anesthesia.
  3. The certification course will issue continuing education credit hours for the course.
  4. Failure to adhere to the rules governing the certification course or to provide access to inspection, pursuant to subparagraph (5) (c) of this rule, may subject the course provider and students to invalidation of the course results and withdrawal of course approval issued by the Board.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-107, 63-5-108, 63-5-115, and 63-5-116.*

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*Repeal filed February 12, 1996; effective April 27, 1996. New rule filed September 17, 2003; effective*

*December 1, 2003. Amendments filed August 3, 2005; effective October 17, 2005. Amendment filed*

*October 12, 2007; effective December 26, 2007. Amendment filed September 25, 2008; effective*

*December 9, 2008. Amendments filed September 30, 2014; effective December 29, 2014.*

# 0460-05-.03 SCHOOLS, PROGRAMS AND COURSES FOR THE REGISTERED DENTAL ASSISTANT.

1. Registered Dental Assisting Programs.
   1. Approval and Re-approval of Program.
      1. The owner and/or director of a dental assistant program seeking board approval shall make application for approval to operate a program on forms provided by the Tennessee Board of Dentistry Administrative Office. The completed application along with program information required by this rule must be received by the Board office at least thirty days (30) days prior to the next regularly scheduled meeting in order for the Board to review the application. The owner and/or director of the program will be notified in writing of the Board’s action(s).
      2. The program shall be subject to on-site inspections by representatives of the Board and/or required to complete paper surveys, as requested.
      3. The Board shall be notified immediately of any changes made in the operation of the program, such as changes of location, directorship, and/or instructors.
      4. Approval granted by the Board of Dentistry is only valid for two (2) years from the date the approval is granted (ratified) by the Board.
      5. Should approval be removed by the Board or not renewed after the expiration of the two (2) year time period, the program shall cease using the language ‘board approved’ on all materials and advertisements.
      6. Resumes must be submitted on each instructor.
      7. The application must also include a detailed curriculum which lists the outline of the subjects covered in the program and the learning objectives for each subject.
      8. The program must inform the Board if the program will be taught in person or online. If any portion of the program is taught online, the subjects and number of hours taught online must be included with the application.
      9. In order to obtain and/or retain Board approval, the program shall maintain compliance with all minimum standards for admissions, facilities, instructor(s), equipment, and curriculum that are in effect upon application or re-application for approval.
   2. Minimum Standards for Admissions, Facilities, Instructor(s), Equipment and Curriculum.
      1. The curriculum must be structured on the basis of a minimum of 116 hours instructional hours and must include at least 14 hours in the subject of dental radiology.
      2. Instructional hours should include didactic and laboratory instruction.
      3. Students should generally be at least 18 years old before admittance to the program; however students must be 18 years old before any exposure to x-rays begins. Students must have high school diploma or equivalent.
      4. The program must demonstrate that student enrollment numbers are proportionate to the number of faculty, and to the availability of appropriate classroom, laboratory, and clinical facilities, equipment, instruments, and supplies. Student to instructor ratio should not exceed 10/1.
      5. A program must have access to dental operatories, sterilization equipment, x-ray machines (processing and/or digital equipment), and dental laboratory equipment.
      6. The students must be provided a program syllabus at the beginning of each program. The syllabus must include a program outline, learning objectives for each topic and the amount of time to be spent on each topic. A sample dental assistant registration applicant form must be included when applying for board approval.
      7. Program grading policies must be included in the information provided to each student.
      8. Skills assessments where needed must be performed.
      9. Students need to be informed that any conviction must be explained to the Board of Dentistry with their application for registration and that all court documents regarding any conviction must be submitted. The Board of Dentistry reviews all court documents required to be submitted with the application for registration and they may deny registration or require an appearance before the Board before deciding to issue or deny the registration.
      10. Suggested materials to be utilized in the course include but are not limited to, the most recent editions of the following:
          1. Modern Dental Assisting; Doni L. Bird, CDA, RDA, RDH, MA and Debbie

S. Robinson, CDA, MS

* + - 1. Tennessee Dental Practice Act – available at [http://tn.gov/health/article/Dentistry-statutes;](http://tn.gov/health/article/Dentistry-statutes%3B)
      2. Review of Dental Assisting; Betty Ladley Finkbeiner CDA Emeritus RDA BS MS
      3. The Dental Assisting Workbook; Doni L. Bird, CDA, RDA, RDH, MA and Debbie S. Robinson, CDA, MS
    1. The minimum of 14 hours in the subject of dental radiology required to be covered in the curriculum for the dental assistant registration must include, at a minimum, the same subjects as required for the dental radiology certification courses. (see Rule 0460-05-.03(7)(d)4.)
    2. The program syllabus must be approved by the Board and shall include instruction in all of the following subject matters:
       1. The dental health team;
       2. The dental office, including a review of equipment commonly found in treatment areas;
       3. Ethics and jurisprudence;
       4. Applied psychology and communication skills;
       5. A review of the teeth and supporting tissues;
       6. Assisting with soft tissue oral examination;
       7. Dental charting;
       8. Microbiology and oral pathology;
       9. Dental materials;
       10. Preventive dentistry;
       11. Disease transmission and infection control;
       12. Special and disabled patients;
       13. Medical emergencies;
       14. Pharmacology and pain control;
       15. Dental instruments;
       16. Delivering dental care and moisture control;
       17. The dental dam;
       18. Oral diagnosis and treatment planning;
       19. General dentistry and restorations;
       20. Pediatric dentistry;
       21. Orthodontics;
       22. Periodontics;
       23. Endodontics;
       24. Fixed prosthodontics;
       25. Removable prosthodontics; and
       26. Oral surgery.
    3. The curriculum content must include instruction in the following dental assisting skills and functions:
       1. Maintaining patient treatment records;
       2. Reviewing and recording medical and dental histories;
       3. Taking and recording vital signs;
       4. Seating and dismissing patients;
       5. Preparing tray set-ups for operative procedures;
       6. Managing infection and hazard control protocols consistent with current guidelines;
       7. Operating oral evacuation systems and air/water syringes;
       8. Maintaining a clear field of vision including various isolation techniques;
       9. Performing a variety of instrument transfers;
       10. Utilizing appropriate chairside assistant ergonomics;
       11. Providing patient preventive education and oral hygiene instruction;
       12. Identifying and responding to medical and dental emergencies;
       13. Providing pre and post-operative instructions prescribed by a dentist;
       14. Applying topical anesthetic and desensitizing agents;
       15. Placing and removing a rubber dental dam;
       16. Applying fluoride agents;
       17. Applying bases, liners, and bonding agents;
       18. Fabricating, placing and removing provisional restorations;
       19. Placing and selecting matrix retainers, matrix bands, and wedges;
       20. Removing of excess cement;
       21. Fabricating bleaching trays, mouth guards, and custom trays;
       22. Taking preliminary impressions (alginate impressions);
       23. Placing and removing retraction materials;
       24. Removing sutures;
       25. Performing pulp vitality tests;
       26. Placing and removing periodontal dressing; and
       27. Performing orthodontic functions as stated in Rule 0460-04-.08.
    4. Time and attendance records must be kept on each student. The student must make up any missed hours. Usually, each program has extra hours added to the 116 total hours to facilitate makeup lessons.
    5. Each program must have at least two (2) examinations during the program; one mid-term examination and a final examination.
    6. Examinations must have a passing score of at least 75%.
    7. Within thirty (30) days of program completion, the program director must certify in writing to the Board office that the student has completed all program requirements, including the requirements for the dental radiology certification.
    8. Within thirty (30) days of program completion, a list of students must be submitted to the Board office along with the program completion letter for each student.

1. Certification Course in Coronal Polishing
   1. Application for Board Approval – The owner and/or director of a certification course in coronal polishing shall make application for approval to operate that course of study on forms to be provided by the Board. The completed application must be received by the Board’s office at least thirty (30) days prior to the next regularly scheduled meeting of the Board in order for the Board to review the application. The owner and/or director of the certification course will be notified in writing of the Board’s action(s). This section shall also apply to ADA accredited dental assisting programs.
   2. Retention of Approval.
      1. In order to obtain and/or retain Board approval, the certification course shall maintain strict compliance with all minimum standards for admissions, facilities, instructor(s), equipment, and curriculum as set forth in the Board’s rules.
      2. The certification course shall be subject to on-site inspections by representatives of the Board and required to complete such paper surveys as requested.
      3. The Board shall be notified immediately of any changes made in the operation of the certification course, such as change of location, directorship, and/or instructors. A new certificate of approval will be issued in the event of change in either ownership or directorship of the course.
      4. Certificates of approval shall be issued for two (2) years and shall expire on December 31st.
      5. At least thirty (30) days prior to the commencement of the course, the approved course shall submit the name(s) of the Tennessee dentist(s) who will be directing the course, the date of the course, and the location of the course to the Board’s Administrative Office.
   3. Minimum Standards for Admissions, Facilities, Instructor(s), Equipment, and Curriculum.
      1. The course shall be taught at an educational institution, defined as a school of dentistry, dental hygiene, or dental assisting, or a clinical facility approved by the Board which provides for proper patient care, including access to medication and equipment for the management of emergencies.
      2. The course shall be directed in its entirety by a dentist who is licensed in good standing by the Tennessee Board of Dentistry. The dentist/clinical instructor may employ and/or utilize licensed dental hygienists or registered and certified dental assistants with a coronal polishing certification to teach and/or assist during the clinical portion of the course.
      3. The clinical instructor-to-student ratio must be no less than one instructor to six students (1:6) for the clinical portion of the course.
      4. The certification course shall consist of fourteen (14) hours of study over a two
2. day period. The course syllabus must be approved by the Board and meet the following requirements:
3. Didactic - The didactic portion of the course shall include instruction in all of the following subject matters:
   1. Principles of plaque and stain formation;
   2. The clinical appearance of plaque, intrinsic and extrinsic stains and calculus (removal of calculus and scaleable stains shall be accomplished only by a dentist or licensed dental hygienist);
   3. The clinical appearance of clean and polished teeth;
   4. Tooth morphology and the anatomy of the oral cavity as they relate to the retention of plaque, stain and polishing techniques;
   5. Principles of selecting abrasives and polishing agents and their effect on tooth structure and restorative materials;
   6. Principles of polishing, including the selection and care of the armamentarium, instrumentation techniques and precautions, including the care of the mouth with fixed or removable prostheses and/or orthodontic appliances;
   7. Principles of aseptic technique, including the sterilization of instruments, sanitation of equipment, and control of disease transmission;
   8. Principles of selecting and applying disclosing agents, including armamentarium, technique and precautions;
   9. Principles of the preparation of teeth and the oral cavity for fluoride application;
   10. The reaction of fluorides with tooth structure;
   11. Available fluoride agents;
   12. Principles of the preparation and storage of fluoride agents; and
   13. Principles of application techniques, including the selection and care of armamentarium, the isolation of teeth, adaptation of trays, techniques and precautions.
4. Clinical - The course provider shall conduct clinical experience of at least two (2) hours duration, which shall include at least a one-half (½) hour demonstration by an instructor. The clinical portion shall include all significant parts of the didactic portion and hands-on experience in the following:
   1. Identifying calculus, plaque, and intrinsic and extrinsic stains;
   2. Polishing exposed surfaces of teeth;
   3. Applying disclosing agents to the exposed surfaces of teeth;
   4. Evaluating the extent of plaque and stain removal;
   5. Maintaining the polishing armamentarium;
   6. Maintaining aseptic techniques;
   7. Applying various fluoride agents; and
   8. Applying various desensitizing agents.
5. The course shall include jurisprudence aspects, as follows:
   1. Limitations of the practice of dental assisting in accordance with the statutes and rules of the Board;
   2. Limitations on dental assistant services;
   3. Penalties for violation of the Dental Practice Act or Rules of the Board of Dentistry; and
   4. Mechanisms by which a person can report violations of statutes and/or rules of the Board of Dentistry.
   5. The clinical instructor shall provide a copy of the syllabus to the student before or at the beginning of each course. The syllabus shall set forth the materials to be presented in the course and the evaluation criteria to be utilized by the clinical instructor to determine successful completion of the certification course.
   6. Upon completion of the course, students shall be evaluated by both a written and a clinical examination. The written examination shall cover the didactic portion of the course. The clinical examination shall cover the clinical portion of the course. The passing grade for each examination is set at seventy-five percent (75%). A student who fails either examination may retake the examination two (2) additional times before having to repeat the course in order to retake the examination(s). The written and clinical examinations required in this subparagraph of the rule meet the examination requirement of T.C.A. § 63-5-108(d).
   7. A letter, attesting to successful completion of the course and test score(s) for each student, must be sent to the Board’s Administrative Office within thirty (30) days of completion of the certification course.
   8. The school offering the coronal polishing certification course will issue continuing education credit hours for the course.
   9. Failure to adhere to the rules governing the certification course or to provide access to inspection, pursuant to Rule 0460-05-.03 (2) (b), may subject the course provider and students to invalidation of course results and withdrawal of course approval by the Board.
6. Certification Course for Sealant Application
   1. Application of Rules - This section shall apply to both ADA accredited and board- approved dental assistant programs, as well as any other individual or entity which desires to establish such a certification course to admit and educate students who are currently registered as dental assistants. ADA accredited and board approved programs who are teaching students that are not currently registered as dental assistants must also comply with these rules but the students are not required to be a registered dental assistant until they have completed the program.
   2. All courses/entities (with the exception of dental assisting programs whose certification course is a part of their standard curriculum) shall have a procedure in place to ensure that the eligibility (current registration) of applicants is verified and documented, prior to allowing the applicant to attend the certification course.
   3. Application for Board Approval - The owner and/or director of a certification course in sealant application shall make application for approval to operate that course of study on forms to be provided by the Board. The completed application must be received by the Board’s Office at least thirty (30) days prior the next regularly scheduled Board meeting in order for the Board to review the application. The course provider will be notified in writing of the Board’s action(s). This section shall also apply to all dental assisting programs which choose to offer the certification course as a part of their curriculum.
   4. Retention of Approval.
      1. The certification course shall maintain strict compliance with all minimum standards for admissions, facilities, instructor(s), equipment and curriculum, as set forth in these rules and as they may from time to time be amended, in order to obtain and/or retain Board approval.
      2. The certification course shall be subject to on-site inspections by representatives of the Board and/or required to complete such paper surveys, as requested.
      3. The Board shall be notified immediately of any changes made in the operation of the certification course, such as change of location, directorship, and/or instructors. A new certificate of approval will be issued in the event of change in either ownership or directorship of the course.
      4. Certificates of approval shall be issued for one (1) year and shall expire on December 31st of any given year.
      5. At least thirty (30) days prior to the commencement of the course, the approved course shall submit the name(s) of the Tennessee dentist(s) who will be teaching the course, the date of the course, and the location of the course to the Board’s Administrative Office.
   5. Minimum Standards for Admissions, Facilities, Instructor(s), Equipment, and Curriculum.
      1. The certification course shall admit only those students who have been verified by the course as having a current registration issued by the Tennessee Board of Dentistry. Students in Board approved programs which have been approved by the Board to teach sealant application are not required to be registered before admittance to the dental assisting program/course but are required to be registered before the temporary sealant application certification will be issued.
      2. The course shall be taught at an educational institution, defined as a school of dentistry, dental hygiene, or dental assisting, or a clinical facility approved by the Board which provides for proper patient care, including access to medication and equipment for the management of emergencies. The course shall be directed by a dentist who is licensed in good standing by the Tennessee Board of Dentistry. The dentist/clinical instructor may employ and/or utilize licensed dental hygienists or registered dental assistants with sealant certification, either of which has two

(2) or more years of full-time experience in sealant application, to assist during the course.

* + 1. The class size shall be limited to forty (40) students, and the instructor-to student ratio must be one (1) instructor to ten (10) students (1:10) for the clinical portion of the course.
    2. The certification course shall consist of a minimum of six (6) hours of study of which at least four (4) hours must be clinical exercises. The course syllabus must be approved by the Board and meet the following requirements:
       1. Didactic - The didactic portion of the course shall include instruction in all of the following subject matters:
          1. Indication/contraindications for sealants;
          2. Preparation of teeth for sealants;
          3. Proper isolation and moisture control of teeth for sealants, including rubber dam, dri-angles, cotton rolls, and retractors;
          4. Education of patient and/or parent regarding sealants;
          5. Sealant materials, including light curing, self curing, and coloring;
          6. Acid etching, including proper use and negative aspects;
          7. Infection control;
          8. Tooth anatomy, including fossa, pit, fissure, groove, and occlusion; and
          9. Armamentarium.
       2. Clinical - The course provider/instructor shall conduct clinical exercises for a minimum of four (4) hours or until the clinical instructor determines clinical competency has been met. The clinical portion of the course shall include instruction in each of the following areas:
          1. Proper tooth isolation and preparation for sealants;
          2. Evaluation of proper technique in the placement of sealants;
          3. Evaluation by instructors of completed sealants; and
          4. Infection control.
  1. Each student must pass a competency examination on the material covered in the didactic section before continuing to the clinical exercises. The passing grade is set at seventy-five percent (75%). Students who do not pass the competency examination may be offered remediation before the start of the clinical exercises and attempt to pass the examination an additional two (2) times. In the event a student takes and fails the examination a total of three (3) times, the student shall be required to retake the course and retake the examination at a future date.
  2. During the clinical portion of the course, each student shall complete pit and fissure sealants on at least ten (10) sterile extracted and sealable teeth or until competency is determined by the instructor. Laboratory tooth models specifically designed for sealant placement may be substituted for some of the extracted teeth. Acceptance of teeth other than extracted teeth is to be determined by the dentist directing the course. All necessary materials and instruments shall be provided by the student. In working with the extracted teeth all OSHA personal protective equipment shall be utilized and the teeth disposed of in accordance with standard practices.

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* 1. Upon successful completion of the course, the certification application and fee must be submitted by the student.
  2. The director/instructor of the certification course shall, within thirty (30) days after course completion or upon graduation from a dental assisting program submit a letter for each student which attests to the student’s successful completion of the course and

the student’s examination grades. The completed forms shall be submitted directly to the Board’s Administrative Office by the director/instructor.

* 1. The student will be issued a temporary sealant application certification to complete a ninety (90) day externship in the office of the employer/supervising dentist(s). During the externship the following sealants must be successfully placed:
     1. A minimum of four (4) maxillary permanent molars;
     2. A minimum of four (4) mandibular permanent molars; and
     3. A minimum of two (2) premolars.
  2. The employer/supervising dentist(s) must submit, on a form provided by the Board, proof of successful completion of the sealants required by subparagraph (3) (j) of this rule.
  3. Upon receipt of proof of successful completion of the sealants, the certification for sealant application will be issued.
  4. Extensions of the ninety (90) day temporary sealant application certification will be considered on a case-by-case basis upon receipt of written documentation stating the reason an extension is requested. The Board consultant has the authority to grant or deny the request.
  5. The school offering the sealant application certification course will issue continuing education credit hours for the course.
  6. ADA accredited dental assisting programs who include sealant application in their curriculum shall adhere to these rules but their students shall be exempt from the externship requirements detailed in 3 (j) above. These students shall show full competency as determined by the program director. Within thirty (30) days of graduation from the ADA accredited dental assisting program, the students’ certification applications and fees shall be forwarded to the Board along with a letter from the director/instructor of the program attesting to each student’s successful completion of the course and the student’s examination grades. Upon receipt of this information, the certification for sealant application will be issued.
  7. Failure by the certification course to adhere to the rules governing the certification course or to provide access to inspection, pursuant to Rule 0460-05-.03 (3) (d), may subject the course provider and students to invalidation of course results and withdrawal of course approval by the Board.

1. Certification Course in Monitoring Nitrous Oxide
   1. Application of Rules - This section shall apply to both Tennessee ADA accredited and Board-approved dental assistant programs, as well as any other individual or entity which desires to establish such a certification course to admit and educate students who are currently registered dental assistants.
   2. Application for Board Approval - The owner and/or director of a certification course in monitoring nitrous oxide shall make application for approval to operate that course of study on forms to be provided by the Board. The completed application must be received in the Board’s Office at least thirty (30) days prior to the next regularly scheduled Board meeting in order for the Board to review the application. The owner

and/or director of the certification course will be notified in writing of the Board’s action. This section shall also apply to all ADA-accredited and board-approved dental assisting programs.

* 1. Retention of Approval.
     1. The certification course, whether offered independently or as a part of the curriculum taught by a dental assisting program, shall maintain strict compliance with all minimum standards for admissions, facilities, instructor(s), equipment, and curriculum as set forth in this rule, as amended/may be amended, in order to obtain and/or retain Board approval.
     2. The certification course shall be subject to on-site inspections by representatives of the Board and/or required to complete such paper surveys, as requested.
     3. The Board shall be notified immediately of any changes made in the operation of the certification course, such as change of location, directorship, and/or instructors. A new certificate of approval will be issued in the event of change in either ownership or directorship of the course.
     4. Certificates of approval shall be issued for one (1) year and shall expire on December 31st of any given year.
  2. Minimum Standards for Admissions, Facilities, Instructor(s), Equipment, and Curriculum.
     1. The certification course shall admit only those registered dental assistants who are currently registered, pursuant to Rule 0460-04-.01 (2), or are currently enrolled in an ADA-accredited or board approved program which offers this course as a part of their curriculum. It is the responsibility of the course owner/director to ensure that only currently registered dental assistants are admitted to the course.
     2. The certification course shall be taught by a Tennessee licensed dentist or a licensed dental hygienist with nitrous oxide administration certification and a minimum of three (3) years clinical experience in utilizing administration of nitrous oxide and education in comprehensive pain and anxiety control. The instructor/dentist may employ and/or utilize anesthesiologists, pharmacologists, internists, and/or cardiologists who are licensed in Tennessee as instructors to assist the instructor/dentist in the teaching of the course.
     3. The certification course shall consist of a minimum of five (5) hours of study. The course syllabus must be approved by the Board and this didactic course shall be designed and conducted to provide the student with detailed knowledge of nitrous oxide – oxygen inhalation sedation, its use in dentistry, and the health hazards and abuse potential of nitrous oxide. This didactic course shall include instruction in all of the following subject matters:
        1. The history, philosophy, psychology of nitrous oxide-oxygen inhalation sedation;
        2. Definitions and descriptions of the physiological and psychological aspects of pain and anxiety;
        3. Description of the stages of drug induced central nervous system depression, through all levels of consciousness and unconsciousness, with special emphasis on the difference between the conscious and unconscious state;
        4. Anatomy and physiology of respiration;
        5. Pharmacological and physiological effects of nitrous oxide, including physical properties, action, side effects, absorption, excretion, and toxicity;
        6. Advantages and disadvantages of inhalation sedation with nitrous oxide;
        7. Management of reaction to, or complications with nitrous oxide;
        8. Patient status assessment including:
           1. Taking and reviewing vital signs;
           2. Reflexes related to consciousness;
           3. Possible reactions to nitrous oxide;
        9. Instruction for post-operative care;
        10. Recognition, prevention and management of complications and life- threatening situations related to nitrous oxide;
        11. Demonstration and use of inhalation sedation equipment;
        12. Legal considerations of nitrous oxide use;
        13. Discussion of sexual phenomena and hallucinatory effects reported with nitrous oxide;
        14. Discussion of the potential for abuse of nitrous oxide;
        15. Recommended techniques for reducing occupational exposure to nitrous oxide; and
        16. Introduction of potential health hazards of trace anesthetics and proposed techniques for elimination thereof, including, but not limited to, recommendations and guidelines from the Centers for Disease Control (CDC) or the Occupational, Health, and Safety Administration (OSHA).
  3. Upon completion of the course, students shall be evaluated by written examination. The passing grade shall be seventy-five percent (75%). If the student initially fails the written examination, the exam may be taken no more than two (2) additional times before the course must be retaken and the exam retaken. The examination shall be developed and administered by the course director/instructor in such a manner as to determine competency for the monitoring of nitrous oxide.
  4. The certification course, or dental assisting school, will issue continuing education credit hours for the course.
  5. The director/instructor of the certification course or dental assisting program shall, within thirty (30) days after course completion or upon completion of the monitoring nitrous oxide portion of the ADA accredited or Board-approved dental assisting program, complete a form, provided by the Board, for each student to attest to the student's successful completion of the course or monitoring nitrous oxide portion and the student's examination grade. The completed forms shall be submitted directly to the Board's Office by the director/instructor.
  6. Failure to adhere to the rules governing the certification course or to provide access to inspection, pursuant to Rule 0460-05-.03 (4) (c), may subject the course provider and students to invalidation of the course results and withdrawal of course approval issued by the Board.

1. Certification Course in Expanded Restorative Functions
   1. Application for Board Approval – The director of a certification course in expanded restorative functions shall make application for approval to operate that course of study on forms to be provided by the Board. The completed application must be received in the Board’s administrative office at least thirty (30) days prior to the next regularly scheduled Board meeting in order for the Board to review the application. The director of the certification course will be notified in writing of the Board’s action(s).
   2. Retention of Approval.
      1. The certification course must be taught at an educational institution as defined in part (5) (c) 2. of this rule and shall maintain strict compliance with all minimum standards for admissions, facilities, instructor(s), equipment, and curriculum as set forth in this rule, as amended/may be amended, in order to obtain and/or retain Board approval.
      2. The certification course shall be subject to on-site inspections by representatives of the Board and/or required to complete such paper surveys, as requested.
      3. The Board shall be notified immediately of any changes made in the operation of the certification course, such as change of location, directorship, and/or instructors. A new certificate of approval will be issued in the event of change in directorship of the course.
      4. Certificates of approval shall be issued for two (2) years and shall expire on December 31st every two (2) years.
   3. Minimum Standards for Admissions, Facilities, Instructor(s), Equipment, and Curriculum.
      1. The certification course shall admit only those registered dental assistants who are currently registered, pursuant to Rule 0460-04-.02, and who submit proof of a minimum of two (2) years continuous full-time employment within the past three

(3) years in a dental practice as a registered dental assistant.

* + 1. The certification course shall be taught at an educational institution, defined as a school of dentistry or a school which offers a specialty program in a recognized specialty branch of dentistry. The course director must be a licensed dentist who is a faculty member of an accredited school of dentistry. The certification course shall be taught by a course director and one (1) or more Tennessee licensed

dentists and /or RDH/EFDA auxiliaries who are employed at an accredited school of dentistry.

* + 1. The certification course shall be taught by one (1) or more Tennessee licensed dentists who are faculty members at an accredited school of dentistry.
    2. The clinical instructor-to-student ratio must be one (1) instructor to eight (8) students (1:8).
    3. The certification course shall consist of a minimum of ninety-six (96) hours of study over a three (3) week period.
    4. The course syllabus shall be approved by the Board and the course shall be designed and conducted to provide the student with detailed knowledge of restorative functions. The clinical experience must be provided under the supervision of qualified faculty, and the students must be evaluated for competency. The didactic and clinical portion of the course shall include instruction in all of the following subject matters:
       1. First Week – The first (1st) week of the course must be a minimum of thirty-two (32) hours in length and a written and/or clinical competency examination is to be administered at the end of the week regarding:
          1. Dental morphology and occulusion;
          2. Dental materials, hazardous materials and product safety;

Amalgam;

Composite;

Glass Ionomer; and

Mercury.

* + - * 1. Principles of cavity preparation on anterior and posterior class I, II, III, IV, and V teeth;
        2. Instrumentation for all restorations;
        3. Liners and bases, types and placement;
      1. Second Week – The second (2nd) week of the course must be a minimum of thirty-two (32) hours in length and a written and/or clinical competency examination regarding items (I) through (V) is to be administered at the end of the week. No high-speed handpiece is to be used in the course, only a slow-speed handpiece:
         1. Isolation and rubber dam placement;
         2. Caries;
         3. Selection and placement of matrix retainers;
         4. Laboratory on insertion, packing and carving (finishing) of amalgam;
         5. Insertion, packing and carving (finishing) of amalgam;
      2. Third Week – The third (3rd) week of the course must be a minimum of thirty-two (32) hours in length and a written and/or clinical competency examination regarding items (I) through (III) is to be administered at the end of the week. No high-speed handpiece is to be used in the course, only a slow-speed handpiece:
         1. Insertion, packing and carving (finishing) of amalgam;
         2. Laboratory on insertion, packing and carving (finishing) of composite and glass ionomers;
         3. Insertion, packing and carving (finishing) of composite and glass ionomers;
      3. In addition to the weekly competency examinations required by subparts (i), (ii) and (iii), each student must pass a clinical examination regarding insertion, packing and carving (finishing) of amalgam prior to taking the comprehensive competency examination required by subpart (vi).
      4. Each student must pass the competency examination on the material covered each week before continuing to the material for the next week. Students who do not pass the competency examination may be offered remediation before the start of the next week.
      5. Passage of a comprehensive competency examination on all material covered in the course is required at the end of the course. This examination shall be both written and clinical.
  1. The instructor shall provide a copy of the syllabus to the student before or at the beginning of each course, setting forth the materials to be presented in the course and the evaluation criteria to be utilized by the clinical instructor to determine successful completion of the certification course.
  2. The passing grade on each competency examination is set at seventy-five percent (75%). If the student initially fails any competency examination, the exam may be taken no more than one (1) additional time before the entire course must be retaken and the exam retaken. The examination shall be developed and administered by the course instructors in such a manner as to determine competency for the restorative functions.
  3. The director/instructor of the certification course shall, within thirty (30) days after course completion, complete a form, provided by the Board, for each student to attest to the student’s successful completion of the course and the student’s examination grade. The completed forms shall be submitted directly to the Board’s Office by the director/instructor.
  4. The certification course will issue continuing education credit hours for the course.
  5. Failure to adhere to the rules governing the certification course or to provide access to inspection, pursuant to Rule 0460-05-.02 (5) (b), may subject the course provider and

students to invalidation of the course results and withdrawal of course approval issued by the Board.

1. Certification Course in Expanded Prosthetic Functions
   1. Application for Board Approval – The director of a certification course in expanded prosthetic functions shall make application for approval to operate that course of study on forms to be provided by the Board. The completed application must be received in the Board’s administrative office at least thirty (30) days prior to the next regularly scheduled Board meeting in order for the Board to review the application. The director of the certification course will be notified in writing of the Board’s action(s).
   2. Retention of Approval.
      1. The certification course must be taught at an educational institution as defined in part (6) (c) 2. of this rule and shall maintain strict compliance with all minimum standards for admissions, facilities, instructor(s), equipment, and curriculum as set forth in this rule, as amended/may be amended, in order to obtain and/or retain Board approval.
      2. The certification course shall be subject to on-site inspections by representatives of the Board and/or required to complete such paper surveys, as requested.
      3. The Board shall be notified immediately of any changes made in the operation of the certification course, such as change of location, directorship, and/or instructors. A new certificate of approval will be issued in the event of change in directorship of the course.
      4. Certificates of approval shall be issued for two (2) years and shall expire on December 31st every two (2) years.
   3. Minimum Standards for Admissions, Facilities, Instructor(s), Equipment, and Curriculum.
      1. The certification course shall admit only those registered dental assistants who are currently registered, pursuant to Rule 0460-04-.02, and who submit proof of a minimum of two (2) years continuous full-time employment within the past three

(3) years in a dental practice as a registered dental assistant.

* + 1. The certification course shall be taught at an educational institution, defined as a school of dentistry or a school which offers a specialty program in a recognized specialty branch of dentistry. The course director must be a licensed dentist who is a faculty member of an accredited school of dentistry. The certification course shall be taught by a course director and one (1) or more Tennessee licensed dentists and /or RDH/EFDA auxiliaries who are employed at an accredited school of dentistry.
    2. The clinical instructor-to-student ratio must be one (1) instructor to eight (8) students (1:8).
    3. The certification course shall consist of a minimum of sixty-four (64) hours of study over a two (2) week period.
    4. The course syllabus shall be approved by the Board and the course shall be designed and conducted to provide the student with detailed knowledge of prosthetic functions. The clinical experience must be provided under the supervision of qualified faculty, and the students must be evaluated for competency. The didactic and clinical portion of the course shall include instruction in all of the following subject matters:
       1. First Week – The first (1st) week of the course must be a minimum of thirty-two (32) hours in length and a competency examination is to be administered at the end of the week regarding:
          1. Anatomy and physiology;
          2. Dentulous soft tissue including the gingival sulcus and its management;
          3. Edentulous soft tissue;
          4. Physiologic function of these tissues and the principles of soft tissue management;
          5. Occlusion for fixed and removable appliances;
          6. Tray selection and impression materials of models;
          7. Border molding and master impressions, including a live patient experience;
          8. Tray selection;

Custom;

Stock;

Triple tray; and

Construction and fitting.

* + - * 1. Fixed prosthodontic impressions;

Full mouth;

Quadrant; and

Individual.

* + - 1. Second Week – The second (2nd) week of the course must be a minimum of thirty-two (32) hours in length and a competency examination is to be administered at the end of the week regarding:
         1. Gingival retraction;
         2. Mechanisms of gingival retraction;
         3. Types and size of cord;
         4. Pharmacology of medicaments used and the techniques for placement;
         5. Practice placement;
         6. Techniques of making impressions;
         7. Laboratory practice for fixed impressions including infection control;
         8. Temporary restorations and laboratory technique for each;

Aluminum;

Polycarbonate; and

Custom.

* + - * 1. Fabrication, polishing and placement of temporary restorations;

Anterior; and

Posterior.

* + - 1. Each student must pass the competency examination on the material covered before continuing to the material for the next week. Students who do not pass the competency examination may be offered remediation; and
      2. Passage of a comprehensive competency examination on all material covered in the course is required at the end of the course.
  1. The instructor shall provide a copy of the syllabus to the student before or at the beginning of each course, setting forth the materials to be presented in the course and the evaluation criteria to be utilized by the clinical instructor to determine successful completion of the certification course.
  2. The passing grade on each competency examination is set at seventy-five percent (75%). If the student initially fails any competency examination, the exam may be taken no more than one (1) additional time before the entire course must be retaken and the exam retaken. The examination shall be developed and administered by the course instructors in such a manner as to determine competency for the prosthetic functions.
  3. The director/instructor of the certification course shall, within thirty (30) days after course completion, complete a form, provided by the Board, for each student to attest to the student’s successful completion of the course and the student’s examination grade. The completed forms shall be submitted directly to the Board’s Office by the director/instructor.
  4. The certification course will issue continuing education credit hours for the course.
  5. Failure to adhere to the rules governing the certification course or to provide access to inspection, pursuant to Rule 0460-05-.03 (6) (b), may subject the course provider and

students to invalidation of the course results and withdrawal of course approval issued by the Board.

1. Certification Course in Dental Radiology
   1. Application of Rules – This section shall apply to both Tennessee ADA accredited and Board-approved dental assistant programs, as well as any other individual or entity which desires to establish such a certification course to admit and educate students who are currently registered dental assistants.
   2. Application for Board Approval – The owner and/or director of a certification course in dental radiology shall make application for approval to operate that course of study on forms to be provided by the Board. The completed application must be received in the Board's Office at least thirty (30) days prior to the next regularly scheduled Board meeting in order for the Board to review the application. The owner and/or director of the certification course will be notified in writing of the Board's action. This section shall not apply to ADA accredited and Board-approved dental assisting programs who provide dental radiology instruction in accordance with ADA accreditation standards or the Board-approved 116 hour dental assistant curriculum, with the exception of (e), (f) and (g) of this section.
   3. Retention of Approval.
      1. The certification course shall maintain strict compliance with all minimum standards for admissions, facilities, instructor(s), equipment, and curriculum as set forth in this rule, as amended/may be amended, in order to obtain and/or retain Board approval.
      2. The certification course shall be subject to on-site inspections by representatives of the Board and/or required to complete such paper surveys, as requested.
      3. The Board shall be notified immediately of any changes made in the operation of the certification course, such as change of location, directorship, and/or instructors. A new certificate of approval will be issued in the event of change in either ownership or directorship of the course.
      4. Certificates of approval shall be issued for one (1) year and shall expire on December 31st of any given year.
   4. Minimum Standards for Admissions, Facilities, Instructor(s), Equipment and Curriculum.
      1. The certification course shall admit only those registered dental assistants who are currently registered pursuant to Rule 0460-04-.01 (2). It is the responsibility of the course owner/director to ensure that only currently registered dental assistants are admitted to the course.
      2. The certification course shall be taught by a dentist who is licensed in good standing by the Tennessee Board of Dentistry. The dentist/clinical instructor may employ and/or utilize licensed dental hygienists or registered dental assistants certified in dental radiology to assist during the clinical portion of the course.
      3. The class shall be limited to forty (40) students and the clinical instructor-to- student ratio must be no less than one (1) instructor to eight (8) students (1:8) for the clinical portion of the course.
      4. The certification course shall consist of a minimum of fourteen (14) hours of study. The course syllabus must be approved by the Board and this didactic course shall be designed and conducted to provide the student with detailed knowledge of dental radiology including radiation health and safety and its application to dentistry. The course shall include instruction in all of the following subject matters:
         1. Expose and evaluate
            1. Select appropriate radiographic technique.
            2. Select appropriate radiographic film to examine, view, or survey conditions, teeth or landmarks.
            3. Select appropriate equipment for radiographic techniques.
            4. Select patient management techniques before, during and after radiographic exposures.
         2. Radiation Safety
            1. Patient.
            2. Operator.
         3. Quality Assurance
            1. Identify exposure errors and ways to avoid these errors in future exposures.
            2. Identify processing errors and ways to avoid these errors.
            3. Correctly mount and label radiographs for diagnostic assessment.
   5. Upon completion of the course, students shall be evaluated by written examination. The passing grade shall be seventy percent (70%). If the student initially fails the written examination, the exam may be taken no more than two (2) additional times before the course must be retaken and the exam retaken. The examination shall be developed and administered by the course director/instructor in such a manner as to determine competency in dental radiology. This also applies to ADA accredited and Board approved dental assisting programs that provide dental radiology instruction in accordance with ADA accreditation standards or the Board-approved 116 hour dental assistant curriculum.
   6. The certification course, or dental assisting school, will issue continuing education credit hours for the course.
   7. The director/instructor of the certification course or dental assisting program shall, within thirty (30) days after course completion or upon completion of the dental radiology portion of the ADA accredited or Board-approved dental assisting program,

complete a form, provided by the Board, for each student to attest to the student's successful completion of the course or dental radiology portion and the student's examination grade. The completed forms shall be submitted directly to the Board's office by the director/instructor.

* 1. Failure to adhere to the rules governing the certification course or to provide access to inspection, pursuant to Rule 0460-05-.03 (7) (c), may subject the course provider and students to invalidation of the course results and withdrawal of course approval issued by the Board.

***Authority:*** *T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-107, 63-5-108, 63-5-111, 63-5-115, and 63-5-*

*116.* ***Administrative History:*** *Original rule certified June 7, 1974. Amendment filed August 26, 1980; effective December 1, 1980. Repeal and new rule filed December 11, 1991; effective January 25, 1992. Repeal filed February 12, 1996; effective April 27, 1996. New rule filed September 17, 2003; effective December 1, 2003. Amendment filed August 3, 2005; effective October 17, 2005. Amendment filed October 12, 2007; effective December 26, 2007. Amendment filed September 25, 2008; effective December 9, 2008. Amendment filed October 22, 2010; effective January 20, 2011. Amendment filed December 20, 2011; effective March 19, 2012. Amendments filed September 30, 2014; effective December 29, 2014. Amendments filed January 31, 2017; effective May 1, 2017.*

**RULES OF TENNESSEE BOARD OF DENTISTRY**

**CHAPTER 0460-6 THROUGH CHAPTER 0460-14**

**REPEALED**

Policy Statement on the Anesthesia and Sedation Audit Requirements for Maintaining a Limited or Comprehensive Conscious Sedation or Deep Sedation/General Anesthesia Permit

Pursuant to Rule 0460-02-.07, in order to maintain a limited or comprehensive conscious sedation or deep sedation/general anesthesia permit a dentist must maintain the following:

* •Equipment and drugs on a list available from the Board and currently indicated for the treatment of the above listed emergency conditions must be present and readily available for use. A policy statement listing the required equipment and drugs is available on the Board’s website.
* •Proof of current certification in ACLS (a pediatric dentist may substitute PALS)
* •Obtain a minimum of four (4) hours of continuing education in the subject of anesthesia

and/or sedation as part of the required forty (40) hours of continuing education for dental licensure.

It is the position of the Board that a dentist must maintain these items even if you no longer provide sedation in your office and that any deficiency of these requirements will result in the dentist being turned over to the Office of Investigations and Office of General Counsel for formal disciplinary action and civil penalties.

A dentist may retire his/her sedation permit in lieu of formal disciplinary action by submitting a request in writing to the board office.

Adopted by the Board of Dentistry on April 27, 2017

Policy Statement on Dental Assisting Programs Maintaining Board Approval

Pursuant to Rule 0460-05-.03 (a) (9), in order to obtain and/or retain Board approval, the program shall maintain compliance with all minimum standards for admissions, facilities, instructor(s), equipment, and curriculum that are in effect upon application or re-application for approval.

It is the position of the Board that if a program is found to be noncompliant with any of the minimum standards for admissions, facilities, instructor(s), equipment and curriculum, the board consultant may withdraw the program’s board approval.

Adopted by the Board of Dentistry on April 27, 2017

TENNESSEE BOARD OF DENTISTRY PRACTITIONER PROFILE POLICY STATEMENT

The Board of Dentistry recognizes that ownership and practice location may change during the course of a dentist’s practice. The board staff has included a question on the application for licensure that seeks information on the ownership of the practice where the dentist intends to work, if known at the time of application.

To address deficiencies in practitioner profiles, board staff, utilizing the department’s e-notify, will remind licensees periodically of the requirement to maintain up to date profile information, and will include a statement reminding licensees that discipline can occur for failure to comply with state law.

Board staff is authorized to utilize agreed citations with a monetary penalty as a vehicle to address practitioners who refuse to update their profile within thirty days of being prompted by staff to do so.

As such, the Board has adopted the following monetary penalty for failure to update the practitioner profiled within 30 days of a change:

The Board will present to the licensee, an Agreed Citation which specifies payment of a fine in the amount of $100 per month for every month the practitioner profile has not been updated in excess of thirty (30) days from notification from the board that there is a profile deficiency.

The licensee shall be notified that all Agreed Citations prepared in accordance with this policy shall be reportable on the Department of Health’s website, its disciplinary action report issued in the month the action is taken and to all appropriate federal databanks including the National Practitioner Data Bank (NPDB).

If the licensee refuses to execute the Agreed Citation and/or remit the civil penalty described therein within sixty (60) days of the date the Agreed Citation is sent to the licensee, or if the licensee failed to update the practitioner profile for six (6) months or longer, the licensee shall be referred to the Office of Investigations and Office of General Counsel for formal disciplinary action. Upon a proven violation, the minimum disciplinary action for this violation shall be:

• A formal and reportable Reprimand on the license;

• Assessment of civil penalties in an amount to exceed $300 per month for every month in which the practitioner did not update the profile in excess of thirty (30) days from notification form the board of the deficiency;

• Assessment of costs associated with investigating and prosecuting the matter; and

• Any and all other remedies the Board deems appropriate.

RATIFIED BY THE BOARD OF DENTISTRY ON OCTOBER 13, 2016

Tennessee Chronic Pain Guidelines

Clinical Practice Guidelines for Outpatient Management of Chronic Non-Malignant Pain



2nd Edition





**DEPARTMENT OF HEALTH**

JOHN J. DREYZEHNER. MD, MPH

**COMM 1$$ 10 N€R**

BILL HASLAM

GOVERNOR

January 20 17

Dear f riends and Colleagues:

We are pleased to share with you the Tennessee Chronic Pain Gu ide lines for 2017.

In 2013, when Public Chapter 430 was enacted d irecting the develop ment of these guideli nes. there was widespread acknowledgeme nt that prescript ion d rug abuse and misuse, and opioid abuse specifically, was a real, observable public health threat to people in Ten nessee and across the country. Tennesseans had learned this fact the hard way: through the loss ofloved ones; the birth of drug-dependent babies; the ar rest and prosecution of drug seekers and pill mill opera tors and the **devastation of communities.**

We joined with other Te nnessee policymakersand healthexperts who heard these stories and took action, developing a comprehensive strategy to change the culture of prescription drug consumption in Tennessee and the Southeast. Education and awareness were at the hea rt of our strategy,as well as a deep understanding that a problem as com plex as this one will require collaboration and partnerships at every level. We have been humbled and inspired to find willi ng partners in every corner of the s1ate and across the country: healthcare practitioners,elec ted officials, comm unity

coal itions, concerned citizens, federal agenc ies, members of the media, all rallying around this ca use and the individuals struggling in their com munities.

We have begun to see our policymaking efforts yield some very hopeful results. Since these guidelines were finalized in 20 14, we have seen a 12 percent d rop in the total number of morphine

milligram equivalents prescribedin o ur Slate. T he number of pain clinics in Tennessee has decreased from 333 in 2014 to 188 in 2016. Howeve r, in spite of these successes, overdose deaths cont inue to rise ye.ar after year, as do insiancesof neonatal abstinencesyndrome, and we are just now developing an understanding of the adverse economic impact this epidemic has had on our state. It is clear much **work remani s.**

As we press on, we will need your co ntinuedpan nership. The re is perhaps no c lass ofi ndivid uals better positioned to stem the tide of this e pidemic than the healthcare providers practicing in ou r

state. Through conscientious and responsible prescribing,screen ing for substance use disorders and referral to substance use disorder treatment when indicated, providers can make a difference, and can do so without compromising quali ty of care. I recommend these guidelines to you in your pursuit of these goals.

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John J. Dreyzehner, MD, MPH, F - C

**Commissioner**

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#### TENNESSEE CLINICAL PRACTICE GUIDELINES

**FOR OUTPATIENT MANAGEMENT OF CHRONIC NON-MALIGNANT PAIN**

The purpose of these guidelines is to define appropriate treatment of chronic pain, a common and often serious condition. We want to foster timely and appropriate treatment for pain, which improves both the ability to function and quality of life. These guidelines are intended to be used to support clinicians in their treatment of patients with chronic pain with particular reference to the prescribing of opioid medications. We want to avoid addiction and adverse outcomes. Optimal treatment of chronic pain, defined as pain lasting longer than 90 days, is an interdisciplinary process that includes many interventions which do not always involve opioid pain medications.

The method used to formulate these guidelines included a review of national expert panel recommendations and state practice guidelines, multiple listening sessions with clinicians in Tennessee, oversight by a multidisciplinary steering committee and recommendations from an advisory committee with strong representation by clinicians with specialty training in pain medicine. Draft clinical guidelines were also circulated to a broader group of professional associations within Tennessee, including but not limited to mental health and substance abuse and workers’ compensation programs.

The importance of management of chronic pain is apparent by the following facts:

* In 2015, Tennessee had the second highest per capita prescription rate for opioids in the US.
* Unintentional overdose deaths increased more than 250% from 2001 to 2015, exceeding deaths due to motor vehicle accidents, homicide or suicide in 2015.
* The number of babies born dependent to drugs who suffered from Neonatal Abstinence Syndrome (NAS) grew ten-fold from 2001 to 2011.
* Worker’s compensation programs have seen the number of people treated for substance abuse increase five-fold in ten years.
* In the midst of this substance abuse epidemic, chronic pain is likewise a significant public health problem. At least 116 million US adults—more than the number affected by heart disease, diabetes and cancer combined—suffer from common chronic pain conditions.
* Acute and chronic pain are among the most common reasons for physician visits, for taking medications and are major causes of work disability. Severe chronic pain affects physical and mental functioning, quality of life and productivity.
* Acute pain may be spontaneous, surgical or due to an injury. The lowest dose for the shortest duration is recommended to avoid dependence and abuse. Long acting opioids should be avoided in the acute setting.

The long term goals of appropriate pain management are to improve symptoms, function and overall quality of life while minimizing adverse effects, addiction, overdose deaths and NAS. These guidelines can help providers reduce problems associated with prescription opiates while maintaining access to compassionate care and appropriate medications for patients living with chronic pain. These guidelines are organized into three sections and appendices contain additional tools and guidance.

***These guidelines are not applicable to end-of-life care, emergency room care or acute pain management. The guidelines apply to all healthcare providers. These guidelines would not apply to patients in a hospice program or in a palliative care setting with a life expectancy of six months or less. These guidelines do not apply to patients admitted to a hospital. These guidelines are not meant to dictate medical decision making. They are guidelines of generally accepted medical practice rather than absolutes. Providers still have flexibility to deal with exceptional cases. Occasional deviation from these guidelines for appropriate medical reasons is to be expected and documented.***

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# SECTION I:

## Prior to Initiating Opioid Therapy for Chronic Non-Malignant Pain

#### Key Principles Prior to Initiating Opioid Therapy

* 1. A patient having been prescribed opioids by a previous provider is not, in and of itself, a reason to continue opioids.
  2. Reasonable non-opioid treatments should be tried before opioids are initiated. Opioids should be initiated only after other reasonable, appropriate and available treatments for the pain condition have been considered.
  3. All newly pregnant women should have a urine drug test administered by the appropriate women’s health provider.
  4. The provider should discuss a birth control plan to prevent unintended pregnancy with every woman of child-bearing age who has reproductive capacity when opioids are initiated.
  5. The patient's medical history, physical examination, laboratory tests, imaging results, electro-physiologic testing, and other elements supporting the plan of care, should be documented in the medical record prior to initiating opioid therapy.
  6. Chronic pain shall not be treated by the use of controlled substances through telemedicine.

#### Initial Evaluation: Steps Prior to Initiating Trial of Opioid Therapy

* 1. A specific evaluation and history of the patient’s pain condition should be obtained. The examination should include the nature and intensity of the pain, past and current treatments for pain, any co-occurring disorders and the effect of the pain on the patient’s life functioning, including but not limited to work, relationships, recreation and sleep.
  2. The presence of important co-morbid medical conditions should be assessed and considered when deciding whether to initiate opioids. This includes age of the patient and medical conditions such as chronic obstructive pulmonary disease, sleep apnea, diabetes or congestive heart failure.
  3. An initial, condition-appropriate physical examination of the patient should be conducted. A systems review shall be conducted as well.
  4. The possible presence of co-occurring mental health disorders should be considered when deciding whether to initiate a trial of opioids. Screening should occur for disorders such as depression, anxiety and current or past substance abuse and, if present, these should be addressed in the creation of a treatment plan **(See Mental Health Appendix)**.
  5. A review of prior records directly related to the patient’s chronic pain condition is encouraged before opioids are prescribed.
  6. Women of child-bearing age who have reproductive capacity should be asked about the possibility of pregnancy at each visit. For women who wish to avoid unintended pregnancy, use of long-acting reversible contraceptives should be discussed, or referral to appropriate high-risk obstetrician made **(See Women of Child Bearing Age Appendix and Pregnant Women Appendix).**

#### Establishing a Diagnosis

There shall be the establishment of a current diagnosis that justifies a need for opioid medications.

#### Assessment of Risk for Abuse

* 1. The prescriber shall assess the patient’s risk for misuse, abuse, diversion and addiction using a validated risk assessment tool prior to initiating opioid therapy. **(See Risk Assessment Tools Appendix)**
  2. The prescriber should obtain a Urine Drug Test (UDT) (or a comparable test on oral fluids) prior to initiating opioid therapy. **(See Urine Drug Testing Appendix)**
  3. Based on the combined information of the validated risk assessment results, the Controlled Substances Monitoring Database (CSMD) results and the UDT results and past records, an initial assessment should be made about a patient’s risk of misuse, abuse or diversion of medications. The prescribing of opioids, if medically indicated, shall take this risk assessment information into account in the prescribing of opioids and the patient’s treatment plan. **(See CSMD Appendix)**

#### Goals for Treatment

* 1. The primary goal of treatment should be clinically significant improvement in function.
  2. A treatment plan should be developed at the onset of treatment and is expected to include other treatments or modalities beyond opioids, both non-pharmacological and pharmacological. The provider should make reasonable attempts to implement this treatment plan, allowing for barriers such as finances, accessibility and resource distribution.
  3. Treatment Plans should establish treatment goals with all patients, including realistic goals for pain and function. One widely used assessment is the 3- item PEG Assessment Scale
     + **P**ain average
     + Interference with **E**njoyment of life
     + Interference with **G**eneral Activity
  4. The patient should be counseled that the goal of chronic opioid therapy is to increase function and reduce pain, not to eliminate pain. Documentation of this discussion shall be included in the medical record.

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# SECTION II:

## Initiating Opioid Therapy for Chronic Non-

**Malignant Pain**

#### Key Principles When Considering Prescribing Opioids.

* 1. National data suggests risk of overdose death starts at 40 MEDD in opioid naive patients with the greatest risk in the population is in the first two weeks of treatment. The risk of overdose for all patient populations increases tenfold at 100 MEDD. Tennessee data suggests the tenfold risk may start closer to 81MEDD.
  2. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days in some instances is appropriate and shall be documented in the medical record.
  3. When starting opioid therapy as a primary care provider for chronic pain, clinicians should generally prescribe immediate-release opioids instead of extended-release or long acting opioids. Some deviations are expected and the reason should be documented.
  4. Any product containing buprenorphine, whether with or without naloxone, may only be prescribed for a use recognized by the federal food and drug administration. Unless there is a documented diagnosis of opiate addiction in medical record, the patient received treatment from a provider practicing under a 21 U.S.C. § 823(g)(2) and who is counted toward the total of number of patients set forth in that statute.
  5. Benzodiazepines should be generally avoided in combination with chronic opioid therapy. When the opioid dose reaches 120mg MEDD and the benzodiazepines are being used for mental health purposes, the provider shall refer to a mental health professional to assess necessity of benzodiazepine medication.
  6. Buprenorphine/naloxone combinations shall be avoided for the treatment of chronic pain.
  7. Should treatment deviate from recommended guidelines, the reasons shall be documented in the medical record.

#### Upon Initiating Opioid Therapy

* 1. The initiation of opioids should be presented to the patient as a therapeutic trial.
  2. When initiating opioid therapy, the lowest dose of opioids should be given to an opioid- naïve patient and then titrated to effect.
  3. Informed consent for the use of opioids in treating pain must be obtained prior to initiating treatment. Informed consent documents typically cover: potential risks and anticipated benefits of opioid therapy, potential side effects, likelihood of physical dependence, risk of over-sedation, pregnancy, risk of impaired motor skills, risk of addiction and death. **(See Sample Informed Consent Appendix)**
  4. A written treatment agreement should be used with the patient at the time opioids are first prescribed for chronic pain. Treatment agreements typically cover reasons, for which opioids may be discontinued, the practice policy on early refills, policy on lost prescriptions or medications, expectation for safe storage of medications, use of one pharmacy and expectations about periodic drug testing. The treatment agreement shall

include an expectation that a female patient will tell the provider if she wishes to avoid unintended pregnancy and if she becomes pregnant. **(See Sample Patient Agreement Appendix)**

* 1. As these new guidelines are implemented, practitioners may provide a bridge of opioids for up to six months while the assessment process is carried out. During this time a patient may be continued on a trial of opioids without a fully completed assessment. No provider is obligated to continue opioid therapy that has been initiated by another provider. If the initial evaluation of the patient does not support the need for opioids, a discussion about risks and possible treatment of withdrawal shall be included in the documentation of clinical reasoning for opioid cessation.
  2. Providers must continually monitor the patient for signs of abuse, misuse or diversion. An unannounced UDT (or a comparable oral fluids test) should be done twice a year at a minimum. **(See Urine Drug Testing Appendix)**

#### Women’s Health

* 1. The provider should discuss a method to prevent unintended pregnancy with every woman of child-bearing age who has reproductive capacity before opioids are initiated.
  2. The practitioner should obtain a signature indicating that any woman who wishes to become or is at risk to become pregnant has been educated about the risks and benefits of opioid treatment during her pregnancy.
  3. Women of child-bearing age who have reproductive capacity shall undergo a pregnancy test prior to the initiation of opioids.
  4. Women of child-bearing age who have reproductive capacity should be asked about the possibility of pregnancy at each visit. For women who wish to avoid unintended pregnancy, use of long acting reversible contraceptives should be discussed, or referral to appropriate high risk obstetrician made. **(See Women of Child Bearing Age Appendix and Pregnant Women Appendix**)

# SECTION III:

## Ongoing Opioid Therapy for Chronic Non-

**Malignant Pain**

#### Key Principles

* 1. All chronic opioid therapy should be handled by a single provider or practice and all prescriptions should be filled in a single pharmacy, unless the provider is informed and agrees that the patient can go to another pharmacy for a specific reason.
  2. Opioids should be used at the lowest effective dose.
  3. A provider should not use more than one short-acting opiate concurrently. If a provider deems it necessary to do so then the medical reasons shall be clearly documented.

Documentation of the discussion of the five A's (analgesia, activities of daily living, adverse side effects, aberrant drug-taking behaviors and affect) at initiation of chronic opioid therapy and at follow up visits shall be included in the medical record

#### Ongoing Therapy

* 1. Patients on opioid doses of 120mg MEDD or greater should be referred to a pain specialist for a consultation and/or management. If a provider cannot make the required consultation as outlined above, then he/she shall clearly document why not.
  2. Clinicians should review the patient’s history of controlled substance prescriptions using the Controlled Substance Monitoring Database (CSMD) data to determine whether the patients receiving opioid dosages or potentially dangerous combinations
  3. Providers must continually monitor the patient for signs of abuse, misuse or diversion. A UDT (or a comparable oral fluids screen or test) should be done twice a year at a minimum. **(See Urine Drug Testing Appendices)**
  4. Based on the combined information of patient behavior, collateral information, the CSMD results, the UDT (or Oral Fluids Test) results and past records, an ongoing risk assessment should be made about a patient’s risk of misuse, abuse or diversion of medications. The prescribing of opioids, if medically indicated, shall take this risk assessment information into account on an ongoing basis. Adjustments to the patient’s treatment should occur in a timely manner based on this information. Inconsistent results from the treatment plan should be addressed immediately and documented action taken as appropriate.
  5. Emergency department physicians should keep the specialist and the primary care provider informed about changes in a patient’s condition and any emergent incidents or conditions.
  6. Opioids are to be discontinued when the risks, side effects, lack of efficacy or presence of medication or aberrant behavior outweigh the benefits. Opioids sometimes have to be discontinued due to financial or third-party coverage issues. A taper of opioids may or may not be indicated, depending on the clinical situation. **(see Tapering Protocol Appendix)**
  7. Appropriate documentation of CSMD query should be included in the medical record. **(see CSMD Appendix)**
  8. Clinicians should offer or arrange evidence based treatment for patients with substance use disorder. Referral to an Addiction Specialist may be appropriate in some cases.

#### Women’s Health

* 1. The provider should discuss a method to prevent unintended pregnancy with every woman

of child-bearing age who has reproductive capacity when opioids are initiated. **(See Women of Child Bearing Age Appendix and Pregnant Women Appendix)**

* 1. The provider shall advise every woman of child-bearing potential on opioids that she be on a method to prevent unintended pregnancy specifically considering long acting contraceptive methods.
  2. The treatment agreement shall include an expectation that a female patient will tell the provider if she becomes pregnant or plans to become pregnant.
  3. If she plans to become or becomes pregnant she shall be referred to an obstetrician.
  4. When a UDT is performed, results must be documented in the medical record.

***The appendices that follow contain specific references from the guidelines as well as other pertinent information about the resources available in the State of Tennessee concerning substance abuse, the efforts to curb overdose death and other support systems centered around these topics.***

### PAIN MEDICINE SPECIALIST

Pain Medicine is the medical specialty dedicated to the prevention, evaluation and treatment of people with chronic pain. While most Physicians, Advanced Practice Nurses, and Physicians Assistants have training and experience in the management of chronic pain, Pain Medicine Specialists have fellowship training from ABMS, AOA, or additional training in pain medicine sufficient to obtain ABPM diplomat status. Current protocols regarding the delineation of prescribing authority to and supervision of Advanced Practice Nurses with certificate of fitness for prescribing and Physicians Assistants for prescribing to treat chronic pain continue to apply. Pain Medicine Specialists deal with patients being treated with more than 120 milligram morphine equivalents daily dose **because they are at least eleven times more likely to suffer an adverse effect including overdose death.**

The American Board of Medical Specialties (ABMS) and the American Osteopathic Association (AOA) are the primary physician certification organizations in the United States. The ABMS and the AOA assist 24 boards in granting certificates in 124 specialty and subspecialty areas. The AOA assists 18 boards in granting certificates in 57 specialty and subspecialty areas. The ABMS certifies pain medicine fellowship programs that result in subspecialty certification in Pain Medicine are under the Boards of Anesthesiology, Physical Medicine & Rehabilitation, Psychiatry and Neurology.

The American Board of Pain Medicine (ABPM) is not affiliated with the ABMS or the AOA and does not oversee fellowship training programs. The ABPM administers practice-related examination for Pain Medicine to qualified candidates who have achieved specified requirements in graduate medical education, licensure and controlled substances authorization, ABMS board certification (not necessarily in pain management), practice experience, continuing medical education, and adherence to ethical and professional standards. Diplomats of ABPM have certification in Pain Medicine.

### The State of Tennessee sets forth two tiers for the treatment of pain management:

#### Tier 1 Non-Pain Medicine Specialist:

1. All providers who wish to treat patients requiring less than 120 milligram morphine equivalent daily dose (MEDD) shall:
   1. Hold a valid Tennessee license issued by their respective board through the Department of Health and a current DEA certification.
   2. Attend Continuing Education pertinent to pain management as directed by their governing board.
   3. We recommend, but do not require, that providers have completed three years of residency training and be ABMS or AOA board eligible or board certified.
2. All providers wishing to treat patients requiring 120 MEDD or more shall consult with a Pain Medicine Specialist.
3. Providers treating patients with ongoing opioid therapy (prescribing of 120MEDD for more than six months in any calendar year) shall obtain at least one annual consultation with a Pain Medicine Specialist. Patients with more complicated cases may require more frequent consultation.

#### Tier 2 Pain Medicine Specialists:

A Pain Medicine Specialist is defined by T.C.A. § 63-1-301(9) as:

1. Has a subspecialty certification in pain medicine as accredited by the Accreditation Council for Graduate Medical Education (ACGME) through either the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA), or is eligible to sit for the board examination offered by ABMS or AOA;
   1. Holds an unencumbered Tennessee license; and
   2. Maintains the minimum number of continuing medical education (CME) hours in pain management to satisfy retention of ABMS or AOA certification. Any exceptions to this requirement shall be approved by the respective regulatory board;
2. Attains American Board of Pain Medicine (ABPM) diplomate status;
   1. Holds an unencumbered Tennessee license; and
   2. Maintains the minimum number of CME hours in pain management to satisfy retention of ABPM diplomate status. Any exceptions to this requirement shall be approved by the respective regulatory board;
3. Is board certified by the American Board of interventional Pain Physicians (ABIPP) by passing exam 1 on or before June 30, 2016, and holds an unencumbered Tennessee license and maintains the minimum number of CME hours in pain management to satisfy retention of ABIPP diplomate status; provided, that on and after July 1, 2016, a new applicant shall only qualify as a pain management specialist under this subdivision (9)(C) if the applicant is board certified by the American Board of Interventional Pain Physicians (ABIPP) by passing parts 1 and 2 of its examination, and holds an unencumbered Tennessee license and maintains the minimum number of CME hours in pain management to satisfy retention of ABIPP diplomate status; or
4. Has an active pain management practice in a clinic accredited in outpatient interdisciplinary pain rehabilitation by the commission on accreditation of rehabilitation facilities or any successor organization and holds an unencumbered Tennessee license.

It should be noted that should Tenn. Code Ann. § 63-1-301(9) change the law would render any part of these guidelines obsolete upon taking effect.

### MENTAL HEALTH ASSESSMENT TOOLS

There are several validated mental health screening and assessment tools available for use by physicians and healthcare professionals. Below are some names and links to these.

1. Patient Health Questionnaire – 2 (PHQ-2). This is a simple two-item screening tool. If it is positive on either item, the clinician should offer another more detailed questionnaire to better assess the presence or absence of a depressive disorder. One link to this screening tool: [http://www.cqaimh.org/pdf/tool\_phq2.pdf.](http://www.cqaimh.org/pdf/tool_phq2.pdf)
2. Patient Health Questionnaire – 9 (PHQ-9). This nine-item tool screens for a depressive disorder, and often is used as a follow-up to the PHQ-2. It’s easy to score and use. Here’s one link to a copy: [http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf.](http://www.integration.samhsa.gov/images/res/PHQ%2520-%2520Questions.pdf)
3. Zung Self-Rating Depression Scale (Zung). This is a 20-item written questionnaire. One copy is at [http://healthnet.umassmed.edu/mhealth/ZungSelfRatedDepressionScale.pdf.](http://healthnet.umassmed.edu/mhealth/ZungSelfRatedDepressionScale.pdf)
4. Hamilton Depression Rating Scale (Ham-D). This is 21-item screening questionnaire. Cutoff scores <7 is normal.

<http://img.medscape.com/pi/emed/ckb/psychiatry/79926-1889862-1859039-2124408.pdf>

1. A fairly comprehensive article on screening for depression in medical settings is [http://emedicine.medscape.com/article/1859039-overview.](http://emedicine.medscape.com/article/1859039-overview) This article reviews several scales.
2. Generalized Anxiety Disorder 7-item Scale (GAD-&). This is a 7-item scale to screen for generalized anxiety. One link is: [http://www.integration.samhsa.gov/clinical- practice/GAD708.19.08Cartwright.pdf.](http://www.integration.samhsa.gov/clinical-practice/GAD708.19.08Cartwright.pdf)
3. Primary Care PTSD (PC-PTSD). This is a four item screening test for Post-Traumatic Stress Disorder. One link is: [http://www.integration.samhsa.gov/clinical-practice/PC-PTSD.pdf.](http://www.integration.samhsa.gov/clinical-practice/PC-PTSD.pdf)
4. One excellent source for a number of screening tools for various mental health disorders is from the Substance Abuse and Mental Health Services Administration (SAMHSA), which is a branch of the U.S. Department of Health and Human Services. A link to a site that lists a number of tools is: [http://www.integration.samhsa.gov/clinical-practice/screening-tools.](http://www.integration.samhsa.gov/clinical-practice/screening-tools)
5. CAGE Questionnaire for Drug Use
   1. Have you ever felt you ought to cut down on your drinking or drug use?
   2. Have people annoyed you by criticizing your drinking or drug use?
   3. Have you felt bad or guilty about your drinking or drug use?
   4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

Scoring: Item responses on the CAGE questions are scored 0 for "no" and 1 for "yes" answers, with a higher score being an indication of alcohol problems. A total score of two or greater is considered clinically significant.

### MEDICATION ASSISTED TREATMENT PROGRAM

Methadone has been used in the treatment of opioid dependence for over 30 years. It has been found to be both effective and safe in long term administration. Medication Assisted Treatment (MAT) is the continual administering and dispensing of Methadone and other federally approved medications at relatively stable dosage levels, in conjunction with the provision of appropriate social, clinical, and medical services for an individual who is dependent on an opiate or morphine-like substance. An adequate individualized daily dose of methadone eliminates drug craving, prevents the onset of withdrawal, and blocks (through opiate cross-tolerance) the effects typical of other opiates, such as heroin or morphine. Efficacy of treatment is based on elimination of or reduction in illicit/inappropriate drug use, elimination or marked reduction in illegal activities, improved employment, pro-social behavior and improved general health. Patients taking stable doses of methadone are able to drive and operate heavy machinery in the same manner as individuals not taking methadone. Also methadone can be utilized when patients are pregnant (it is also monitored as needed and/or during every trimester). MAT is designed for an unknown and possibly indefinite period, according to the need of the individual. The only appropriate measure of time in treatment is how long it takes the individual to overcome a life of addiction.

All programmatic decisions regarding eligibility and admission criteria for MAT conform to regulations from the Dept. of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration (SAMHSA), and Tn. State Methadone Authority. Clinics offering MAT are accredited through CARF (Commission for Accreditation of Rehabilitation Facilities) or similar bodies.

Most patients are self-referred and must agree to coordination of care with their primary care physician and/or mental health practitioner. Dual enrollment in pain management is inappropriate and not allowed. Patients are subject to random bottle checks. Initially, all patients are required to visit the clinic daily for dosing. As patients establish a reliable track record (counseling, licit drug screens, absence of behavioral problems/criminal activity, gainful vocational, educational, or employment activity, safeguarding of medication), they gradually earn "take home" medication for self-administration. The most trustworthy patients come to the clinic once every 28 days. Typical methadone doses range from 60-120 mg daily.

Longstanding opiate abusers with high tolerance often do best staying on MAT with the supportive environment of the clinic staff. Younger patients or those with shorter abuse histories are more likely to be able to wean off methadone entirely.

Public Chapter 912 will be enacted on January 1, 2017. The act creates nonresidential office-based opiate treatment facilities. This will require any facility defined as a Nonresidential office-based opiate treatment facility to attain licensure as such by the Department of Mental Health & Substance Abuse Services. Nonresidential office-based opiate treatment facilities refers to facilities that are prescribing buprenorphine or products containing buprenorphine to 50% or more of its patients and to one hundred fifty patients or more. This legislation requires the TDMH&SAS to promulgate rules in consultation with the Department of Health.

### WOMEN’S ISSUES: WOMEN OF CHILD BEARING AGE

All women with reproductive capacity receiving a prescription for an opiate shall be educated about the risks of opiate use during pregnancy including the risk of physical dependence and addiction in the woman, the potential of physical dependence and withdrawal in the newborn, and possible long term consequences to the child.

1. Upon initiation of opioid therapy, the provider shall recommend reliable contraception such as long term reversible contraceptives and appropriate referrals should be made.
2. Any woman with reproductive capacity, who is presently under physician care for chronic pain management or medical replacement therapy, shall be counseled on the importance of reliable contraception such as long term reversible contraceptives. Appropriate referrals should be made.
3. The treatment plan shall include an expectation that a female patient will notify the provider if she becomes, or plans to become, pregnant.
4. The possibility of pregnancy should be assessed prior to initiation and continuation of any opioid or opioid replacement therapy. This risk should be assessed at each visit and prior to any refill for long-term therapies. A pregnancy test should be performed if there is any possibility of pregnancy. This should be documented in the medical record.
5. A woman who desires to become pregnant and is under physician treatment for chronic pain management and/or opioid replacement therapy shall be counseled on the potential risks of Intra-Uterine Drug Exposure. A referral for prenatal counseling should be made. Alternative treatment modalities should be discussed. Informed consent should be obtained prior to continuation of opioid or opioid replacement therapy.
6. Education shall include the potential risks of stopping her medications on her own during her pregnancy which include: the risk of relapse, risk of preterm delivery, intrauterine withdrawal, fetal distress, and fetal demise.
7. A woman on opioid therapy who becomes pregnant or desires to become pregnant shall be referred to or consult with an Obstetrician and appropriate Pain Management Specialist or Medical Replacement Treatment program.

### PREGNANT WOMEN

1. The OB and medical treatment physician should work together to encourage compliance with both chronic pain management or medical replacement therapy plan, and prenatal care.
2. A risk assessment, UDT, and CSMD check should be performed before initiating any opiate or benzodiazepine during pregnancy.
3. A UDT should be performed at intake to prenatal care. If positive, the mother should be referred to appropriate chronic pain management or replacement therapy specialists. The risks of Intra-Uterine Drug Exposure should be discussed, and documented, and random UDT should be performed during the prenatal course.
4. If a woman has a positive UDT on initial prenatal visit, A UDT should be performed upon admission for delivery to help identify the infant at risk for NAS.
5. Appropriate discontinuation has been shown to be safe for fetus during pregnancy. However, unintended consequences from tapering may outweigh benefits. *(Bell J, Towers CV, Hennessy MD, et al. Detoxification from opiate drugs during pregnancy.Am J Obstet Gynecol 2016)*

### RISK ASSESSMENT TOOLS

There are several validated risk assessment tools available to pain clinicians. Below is some information on the most commonly used tools and links so that they can be obtained. Some tools are copyrighted and some are not, and practitioners should adhere to legal guidelines in making and obtaining copies for their use.

1. **BRI** (Brief Risk Interview). This is a short (5-10 minutes) clinical interview that is a validated risk assessment tool (Jones & Moore, 2013). Questions are asked about such topics as past misuse of opioid medications, presence of mental health disorders, personal history of substance abuse and family history of substance abuse. It also incorporates information from UDT’s, past medical records and the CSMD. It classifies patients into risk categories of Low, Low Medium, Medium, Medium High, High and Very High. The scoring system and questions to be asked can be downloaded for free from [www.tedjonesresearch.com.](http://www.tedjonesresearch.com/) Interview information can also be scored on-line anonymously at that website.
2. **DIRE** (Diagnosis, Intractability, Risk, Efficacy score). This is a staff/interviewer rating scale that uses information about the patient’s diagnosis, engagement in treatment and psychiatric issues (Belgrade, Schamber and Lindgren, 2007). The numerical score categorizes patients into the categories of “not a suitable candidate for long-term opioid analgesia,” and “good candidate for long-term opioid analgesia.” Here is link to a pdf copy: [http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/maperc/online/ Documents/D.I.R.E.%20Score.pdf.](http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/maperc/online/Documents/D.I.R.E.%20Score.pdf)
3. **ORT** (Opioid Risk Tool). This is a brief ten-item patient-completed written questionnaire (Webster & Webster, 2005). It may be the most widely used risk assessment tool in the field. It asks for information such as personal and family history of substance abuse and psychiatric issues. It classifies patients into Low, Medium and High risk categories. One link to a copy is: [http://www.partnersagainstpain.com/printouts/Opioid\_Risk\_Tool.pdf.](http://www.partnersagainstpain.com/printouts/Opioid_Risk_Tool.pdf)
4. **PMQ** (Pain Medication Questionnaire). This is a 26-item patient-completed written risk questionnaire (Adams, Gatchel, Robinson, et. al., 2004). One study has shown that it is the best overall written risk assessment tool available.5 Questions include such topics as opinions about pain medication and pain treatment, obtaining pain medication, and past medication-aberrant behavior. A few items are reverse scored, making it just slightly more difficult for staff to score. It classifies patients into Low, Medium and High categories of risk. Here is one link to a copy: [http://www.opioidrisk.com/node/507.](http://www.opioidrisk.com/node/507)
5. **SOAPP** (Screener and Opioid Assessment for Patients with Pain). This is a 24-item patient- completed written risk assessment questionnaire (Butler, Budman, Fernandez, et. al., 2004). One study has shown that this questionnaire has the best sensitivity of any patient-completed questionnaire (best at identifying those patients which later engage in medication aberrant behavior).7 Items use a five-point rating scale and ask about such topics as impulsivity, cigarette smoking, overtaking medication and past substance abuse. It classifies patients into Low and

High risk (no Medium category). One link to a copy is: [http://www.painedu.org/soap.asp.](http://www.painedu.org/soap.asp) Please check with the authors about use and fees at [www.painedu.org/soapp.asp.](http://www.painedu.org/soapp.asp)

1. **SOAPP-R** (Screener and Opioid Assessment for Patients with Pain – Revised). This 24-item patient-completed questionnaire is a revision of the SOAPP (Butler, Fernandez, Benoit, et. al., 2008). The SOAPP-R is a widely used risk assessment tool. It uses a five-point rating scale in asking questions about such topics as impulsivity, legal problems, past substance abuse and past sexual abuse. It classifies patients in risk categories of Low and High risk (while it refers to a Medium category in the SOAPP-R manual, there has been no validation on the use of the Medium category). One link to a copy is: [http://www.opioidrisk.com/node/610.](http://www.opioidrisk.com/node/610) Please check with the authors about use and fees at [www.painedu.org/soapp.asp.](http://www.painedu.org/soapp.asp)
2. **BRQ** (Brief Risk Questionnaire). This is a 12-item patient-completed questionnaire (Jones, Lookatch and Moore, 2015)8. It asks patients about a wider range of variables than other risk assessment tools, asking about such issues as history of theft of medication, current help with medication storage, past incarceration and literacy. Patients are categorized into Low, Medium or High risk categories. It appears to be a more sensitive screening tool in identifying risk but may also tend to overrate a patient’s risk. It can be obtained on a free download from [www.tedjonesresearch.com.](http://www.tedjonesresearch.com/)

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### CSMD: CONTROLLED SUBSTANCE MONITORING DATABASE

#### Background

The Tennessee Controlled Substance Monitoring Database (CSMD) is a prescription monitoring program designed to provide healthcare practitioners with a comprehensive view of a patient’s controlled substance prescription history. The purpose of the CSMD is to assist in research, statistical analysis, criminal investigations, enforcement of state or federal laws involving controlled substances, and the education of health care practitioners concerning patients who, by virtue of their conduct in acquiring controlled substances, may require counseling or intervention for substance abuse, by collecting and maintaining data regarding all controlled substances dispensed in this state.

#### Access to Information

Information sent to, contained in, and reported from the database in any format is confidential, not public record and not subject to subpoena from any court and password access is made available only as provided for in Tennessee Code Annotated § 53-10-308 and to the following persons:

* + personnel of the committee specifically assigned to conduct analysis or research;
  + authorized committee, board, or department of health personnel or any designee appointed by the committee engaged in analysis of controlled substances prescription information as a part of the assigned duties and responsibilities of their employment;
  + a prescriber of controlled substances to the extent the information relates specifically to a current or bona fide prospective patient of the prescriber, to whom the prescriber has prescribed or dispensed, is prescribing or dispensing, or considering prescribing or dispensing any controlled substance; or a prescriber conducting medication history reviews who is actively involved in the care of the patient; a prescriber or supervising physician of the prescriber conducting a review of all medications dispensed by prescription attributed to that prescriber;
  + a dispenser or pharmacist of controlled substances to the extent the information relates specifically to a current or a bona fide prospective patient to whom that dispenser has dispensed, is dispensing, or considering dispensing any controlled substance; or a dispenser not authorized to dispense controlled substances conducting drug utilization or medication history reviews who is actively involved in the care of the patient;
  + the state chief medical examiner, deputy chief medical examiner or a county medical examiner appointed pursuant to T.C.A. § 38-7-104 when acting in an official capacity as established in § 38-7-109; provided, any access to information from the database shall be subject to the confidentiality provisions of this part except where information obtained from the database is appropriately included in any official report of the county medical examiners, toxicological reports or autopsy reports issued by the county medical examiner under T.C.A. § 38-7-110(c);
  + personnel of the following entities actively engaged in analysis of controlled substances prescription information as a part of their assigned duties and responsibilities related directly to TennCare:
    - the Office of Inspector General;
    - the Medicaid Fraud Control Unit;
    - the Bureau of TennCare's chief medical officer, associate chief medical directors, director of quality oversight, and associate director of pharmacy.
  + Personnel of the bureau of TennCare who request aggregate controlled substances prescribing information from the database which does not contain personally identifiable data but only on request by the following personnel of the bureau:
    - The chief medical officer
    - Associate chief medical directors
    - Director of quality oversight and
    - Directors of pharmacy
  + a quality improvement committee as defined in § 68-11-272 of a hospital licensed under title 68 or title 33, as part of the committee's confidential and privileged activities under § 68-11-272(b)(4) with respect to the evaluation, supervision or discipline of a healthcare provider employed by the hospital or any of its affiliates or subsidiaries, who is known or suspected by the hospital's administrator to be prescribing controlled substances for the prescriber's personal use;
  + a healthcare practitioner extender, who is acting under the direction and supervision of a prescriber or dispenser, and only to the extent the information relates specifically to a current or bona fide prospective patient to whom the prescriber or dispenser has prescribed or dispensed, is prescribing or dispensing, or considering prescribing or dispensing any controlled substance;
  + The judge of a drug court treatment program, created under the Drug Court Treatment Act of 2003, compiled in title 16, chapter 22, and pursuant to this part to the extent the information relates specifically to a current participant in the drug court treatment program.
  + the following personnel of the department of mental health and substance abuse services actively engaged in analysis of controlled substances prescription information as a part of their assigned duties and responsibilities shall have access to the database for controlled substances prescription information for specific patients:
    - The chief pharmacist;
    - The state opioid treatment authority (SOTA) or SOTA designee; and
    - The medical director.
  + aggregate controlled substances prescribing information from the database may be provided upon request by the following personnel of the department of mental health and substance abuse services, who are actively engaged in analysis of controlled substances prescription information as provided in this subsection (*l*), and may be shared with other personnel of the department of mental health and

substance abuse services as needed to fulfill assigned duties and responsibilities: o The chief pharmacist;

* + - The SOTA; or
    - The medical director.
* Authorized committee, board, or department personnel and any designee appointed by the committee engaged in analysis of controlled substances prescription information as a part of the assigned duties and responsibilities of their employment may publish, or otherwise make available to healthcare practitioners and to the general public, aggregate unidentifiable personal data contained in or derived from the database for the purpose of educational outreach.

#### CSMD DATA

The CSMD contains prescription information from all dispensers of controlled substances in Tennessee and also those dispensers who ship to a patient residing in Tennessee. This includes mail-order pharmacies and some Veteran’s Affairs pharmacies as well. The CSMD collects and maintains dispensing data regarding all controlled substances in Schedules II, III and IV, and Schedule V controlled substances identified by the controlled substance database advisory committee as demonstrating a potential for abuse. Data is to be submitted at least once every seven

1. days for all the controlled substances dispensed during the preceding seven-day period. The following information is required to be submitted for each dispensing in ASAP 2009 (4.1) format:
   * Prescriber DEA number;
   * Dispensing date;
   * Patient identifier,
   * Controlled substance NDC number;
   * Quantity dispensed;
   * Strength of controlled substance;
   * Estimated day supply;
   * Dispenser DEA number;
   * Date the prescription was written;
   * Whether the prescription was new or a refill;
   * Source of payment.

All data in the CSMD is reported as submitted to the data collection website by the dispenser. Therefore, if there are any questions about the data a practitioner should contact the dispenser identified within the report. The dispenser can, in turn, correct any errant information by coordinating with the state’s data collection vendor. Neither the data collection vendor nor the Department of Health can edit prescription information found in the CSMD.

#### Registration

All prescribers and dispensers of controlled substances in Tennessee must register for access to the CSMD. Healthcare practitioners wishing to register with the CSMD to access prescription information are required to navigate to [www.TNCSMD.com](http://www.tncsmd.com/) and choose the “register” link. A registration form will appear requesting information used to validate a healthcare provider’s statutory authority to access CSMD data. A username and password will be sent to the approved registrant after validation and processing by CSMD administration. All passwords are case-sensitive, must be at least eight characters long and must contain an upper and lowercase letter, at least one number and one special character.

A healthcare provider may also choose to allow licensed and up to two unlicensed extenders per practice location to register with the CSMD in order to retrieve prescription information on the prescriber or dispenser’s behalf. The extender should navigate to [www.TNCSMD.com](http://www.tncsmd.com/) and register for a separate account. In addition to supplying self-identifying information, the extender must provide information which identifies the supervisor permitting access to the CSMD. After validation by CSMD administrative staff, the supervisor must login to his/her account to approve

the registrant as their extender. Once this process is complete, the extender may access CSMD information. All access by any user leaves an audit trail that can be monitored and accessed as needed. A supervisor may revoke CSMD access of their extender at any time if necessary.

Law enforcement personnel engaged in an official investigation or enforcement of state or federal laws involving controlled substances wishing to request information must follow a distinct process outlined in T.C.A. § 53-10-306 (a) (6) in order to request information from CSMD administration.

#### CSMD Reports Patient Report

A patient’s CSMD report contains a variety of information related to the prescriber or dispenser of controlled substances. After entering the search criteria, a box of potential patient matches appears to consider incorporating into the report. Please note that many patients may have a similar name or date of birth as another patient in the CSMD and it is possible for erroneous information to be incorporated into the patient report if inappropriate patients are selected during this process.

Once the report is generated, a CSMD user will see a list of all patients incorporated into the report along with address information. The user will also see a list of all prescriptions attributed to the selected patient(s) in reverse chronologic order. On the right side of the first page is an estimated morphine equivalent dose that the patient is currently taking. For further explanation of the morphine equivalent dose, see (Morphine Equivalent Dose Appendix.) At the end of the report there is a listing of all prescribers and dispensers associated with the patient’s selected prescription history, as well as additional information used to calculate the morphine equivalent dose.

#### Prescriber Self-Lookup

A prescriber can utilize the prescriber self-lookup report for multiple purposes. The report is useful for identifying potential prescription fraud, i.e. a stolen prescription pad or phoned-in prescriptions. It is also a useful snapshot of a prescriber’s patient population and the prescriptions attributed to the prescriber. All data in the CSMD is reported as submitted to the data collection website by the dispenser. Therefore, if there are any questions about the data a practitioner should contact the dispenser identified within the report. The dispenser can, in turn, correct any errant information by coordinating with the state’s data collection vendor. Neither the data collection vendor nor the Department of Health can edit prescription information found in the CSMD.

#### Future Enhancements

The CSMD Committee and Department of Health are committed to utilizing the CSMD to protect patient health and prevent prescription drug abuse and diversion. As resources become available, enhancements will be incorporated into the CMSD to further this mission. Enhancements such as real-time reporting by dispensers and incorporation of the CSMD into electronic health records are being investigated as well as further sharing of data between states as laws allow. Any suggested improvements can be sent to [csmd.admin@tn.gov](mailto:csmd.admin@tn.gov) for consideration.

#### Operational and Legal Resources

The statute governing the operation of the CSMD is found under T.C.A. § 53-10 Part 3 and the supporting rules are 1140-11. Current Federal Regulations (42 CFR Part II) protect the confidentiality of patients in a federally recognized substance abuse treatment facility and thus their dispensed medications are not included in the CSMD. The statute making doctor shopping illegal is

found under T.C.A. § 53-11-402 and § 71-5-2601. The statute requiring reporting of a doctor shopper to law enforcement can be found at T.C.A. § 53-11-309.

A form to report a potential doctor shopper to law enforcement is available at: [http://health.state.tn.us/boards/Controlledsubstance/PDFs/PH-4152.pdf.](http://health.state.tn.us/boards/Controlledsubstance/PDFs/PH-4152.pdf)

Please send the form to your local law enforcement or contact the Tennessee Meth and Pharmaceutical Task Force at 423-752-1479 to obtain the appropriate fax number.

Additional information about the CSMD can be obtained at: <http://health.state.tn.us/Boards/ControlledSubstance/index.shtml>

### SAMPLE INFORMED CONSENT: Controlled Substance Agreement

Please read the information below carefully and ask your provider if you have any questions relating to the medication prescribed to you.

#### Using Controlled Medications to Treat Pain

1. These medications are used to treat moderate-to-severe pain of any type, and to treat anxiety and stress associated with moderate-to-severe pain.
2. These medications are best understood as potentially effective tools that can help reduce pain, improve function, and improve quality of life
3. Using these medications requires that both the physician and patient work together in a responsible way to ensure the best outcome, lowest side effects, and least complications

#### How Do Opioids work?

1. Opioid medications work at the injury site, the spinal cord, and the brain
2. They dampen pain, but do not treat the underlying injury
3. They may help to prevent acute pain from becoming persistent chronic pain
4. These medications may work differently on different people because of a number of factors.
5. Side effects and complications will also individually vary

#### How do Benzodiazepines work?

1. The benzodiazepines are a class of drugs with varying properties, which act by slowing down the central nervous system.
2. Benzodiazepines are useful in treating anxiety, insomnia, agitation, seizures, and muscle spasms. While Benzodiazepines do not treat acute or chronic pain, they are taken by patients with pain for other issues (such as anxiety or muscle spasms).
3. These medications may work differently on different people because of a number of factors.
4. Side effects and complications will also individually vary

#### What to Expect When You Take Controlled Medications for Pain and Related Conditions

1. Pain relief
2. Reduction of anxiety and stress caused by pain
3. Side effects

#### What Should Not Be Expected From Treatment with Controlled Medications

1. Cure of the underlying injury
2. Total elimination of pain, anxiety, and stress
3. Loss of ability to feel other physical pain

#### Negative Effects of Controlled Medications Vary in Different People

1. Opioid Side effects
   1. Common effects include: Constipation, dry mouth, sweating, nausea, drowsiness, euphoria, forgetfulness, difficulty urinating, and itching
   2. Uncommon effects include: Confusion, hallucinations, shortness of breath, depression, lack of motivation
2. Benzodiazepines Side effects
   1. The most common side effects include: Clumsiness or unsteadiness, dizziness or lightheadedness and drowsiness; slurred speech
   2. Less common side effects include: Anxiety; confusion (may be more common in the elderly); fast, pounding, or irregular heartbeat; mental depression; abdominal or stomach cramps or pain; blurred vision or other changes in vision; changes in sexual desire or ability; constipation; diarrhea; dryness of mouth or increased thirst; false sense of well- being; headache; increased bronchial secretions or watering of mouth; muscle spasm; nausea or vomiting; problems with urination; trembling or shaking; unusual tiredness or weakness
3. Physical dependency
   1. Opioid medications will cause a physical dependency marked by abstinence syndrome when they are stopped abruptly. If these medications are stopped or rapidly decreased the patient will experience chills, goose bumps, profuse sweating, increased pain, irritability, anxiety, agitation, and diarrhea. The medicines will not cause these symptoms if taken as prescribed and any decision to stop these medications should be done under the supervision of your physician in a slow downward taper.
   2. Benzodiazepines may be habit-forming (causing mental or physical dependence), especially when taken for a long time or in high doses. Some signs of dependence on benzodiazepines are: A strong desire or need to continue taking the medicine; a need to increase the dose to receive the effects of the medicine. Withdrawal effects occurring; for example, irritability, nervousness, trouble in sleeping, abdominal or stomach cramps, trembling or shaking.
4. Misuse of medications: Addiction

This is a psychological condition of use of a substance despite self- harm. Between six and ten percent of the population of the United States have problems with substance abuse and addiction. Controlled medications are likely to activate addictive behavior in this group of people

1. Diversion:

It is illegal to share your controlled medications with other people. It is illegal to provide false information to a prescriber in an attempt to obtain controlled medication. It is illegal to doctor shop, or visit multiple doctors in attempt to obtain controlled medications. Federal and state laws exist to address diversion problems. It is critical that you safeguard your controlled medications and use them only as prescribed by your doctor.

1. Driving

Studies of patients with chronic pain demonstrate improved driving skills when taking certain controlled medications, but individuals may have problems driving and need to realistically assess their own skills, as well as listen to others who drive with them to determine if they should be driving while taking these medications. You should consult the State Department of Transportation if you have questions about driving and taking

controlled medications. This is especially important if your work involves driving, making important decisions that affect others, etc.

#### Common Sense Rules for Using Controlled Medications

* 1. Follow your doctor’s recommendations
  2. Do not take more or less pills than prescribed without discussing this first with your physician and receiving permission to do so
  3. Do not share medications with family or friends
  4. Do not take medications from family or friends
  5. Do not stop these medications abruptly. Dose reductions need to be discussed and cleared by your physician. This is important no matter which controlled medication you take.
  6. Do not sell medications
  7. Do not take medications in any manner other than prescribed. For example do not chew or inject your medications
  8. Keep all medications out of reach of children
  9. Do not leave your prescriptions or controlled medications lying around unprotected for others to steal and abuse them
  10. Do not operate a motor vehicle if you feel mentally impaired using controlled medications. You are responsible for exhibiting good judgment in your daily affairs, including your use of controlled medications.
  11. Alcohol use should be curtailed when using controlled medications

Continued Use of Controlled Medication is based on your physician’s judgment and a determination of whether the benefits to you of using controlled medications outweigh the risks of using them.

Your physician may discontinue treating you at his or her discretion. Your physician may require a consultation with an addiction specialist. Your physician may require more frequent visits.

We believe in treating your pain and we recognize the value of controlled medications in this process. When used properly, controlled medications can help restore comfort, function, and quality of life. However, as stated above, controlled medications may also have serious side effects and are highly controlled because of their potential for misuse and abuse. It is important to work with your physician and communicate openly and honestly with him or her about your pain control needs. By doing so, medications can be used safely and successfully.

By your signature below, you are acknowledging that you have read and reviewed these matters with your physician and that you have sufficient information to make a decision to use the controlled medications prescribed.

You should NOT sign this form if you do not believe you have enough information to make an informed decision about your use of controlled medications and how they fit in to your pain management treatment plan.

Patient Name: Physician Signature:

Patient Signature: Date:

**SAMPLE PATIENT AGREEMENT: Controlled Substance Treatment** PATIENT NAME: PRIMARY CARE PHYSICIAN/SITE:

I understand that this agreement between myself; and (insert name of medical office/group)

is intended to clarify the manner in which chronic (long- term) controlled substances will be used to manage my chronic pain. Chronic controlled substance therapy for patients who do not suffer from cancer pain is a controversial issue.

I understand that there are side effects to this therapy; these include, but are not limited to, allergic reactions, depression, sedation, decreased mental ability, itching, difficulty in urinating, nausea and vomiting, loss of energy, decreased balance and falling, constipation, decreased sexual desire and function, potential for overdose and death. Care should be take when operating machinery or driving a car while taking these medications. When controlled substances are used long-term, some particular concerns include the development of physical dependence and addiction. I understand these risks and have had my questions answered by my physician.

I understand that my (insert name of medical group) physician will prescribe controlled substances only if the following rules are adhered to:

* All controlled substance prescriptions must be obtained from your (insert name of medical group) primary care physician. If a new condition develops, such as trauma or surgery, then the physician caring for that problem may prescribe narcotics for the increase in pain that may be expected. I will notify my primary care physician within 48-hours of my receiving a narcotic or any other controlled substance from any other physician or other licensed medical provider. For females only: If I become pregnant while taking this medicine, I will immediately inform my obstetrician and obtain counseling on risks to the baby.
* I will submit urine and/or blood on request for testing at any time without prior notification to detect the use of non-prescribed drugs and medications and confirm the use of prescribed ones. I will submit to pill counts without notice as per physician’s request. I will pay any portion of the costs associated with urine and blood testing that is not covered by my insurance.
* All requests for refills must be made by contacting my (insert name of medical group) primary care physician during business hours at least 3-workdays in advance of the anticipated need for the refill. All prescriptions must be filled at the same pharmacy, which is authorized to release a record of my medications to this office upon request. A copy of this agreement will be sent to my pharmacy.
* Pharmacy name/address/telephone:
* The daily dose may not be changed without my (insert name of medical group) primary care physician’s consent. This includes either increasing or decreasing the daily dose.
* Prescription refills will not be given prior to the planned refill date determined by the dose and quantity prescribed. I will accept generic medications.
* Accidental destruction, loss of medications or prescriptions will not be a reason to refill medications or rewrite prescriptions early. I will safeguard my controlled substance medications from use by family members, children or other unauthorized persons.
* You may be referred to an appropriate specialist to evaluate your physical condition.
* You may be asked to have an evaluation by either a psychiatrist or psychologist to help manage your medication needs.
* If your physician determines that you are not a good candidate to continue with the medication, you may be referred to a detoxification program or evaluation by a pain management center.
* These medications may be discontinued or adjusted at your physician’s discretion.
* I understand that it is my physician’s policy that all appointments must be kept or cancelled at least 2-working days in advance. I understand that the original bottle of each prescribed controlled substance medication must be brought to every visit.

I understand that I am responsible for meeting the terms of this agreement and that failure to do so will/may result in my discharge as a patient of (insert name of medical group). Grounds for dismissal from (insert name of medical group) include, but are not limited to: Evidence of recreational drug use, of drug diversion, of altering scripts (this may result in criminal prosecution), of obtaining controlled substance prescriptions from other doctors without notifying this office, abusive language toward staff, development of progressive tolerance, use of alcohol or intoxicants, engagement in criminal activities, etc.

Patient’s Signature Witness’ Signature

Date Date

### URINE DRUG TESTING

Drug testing of patients receiving chronic opioid therapy (COT) is recommended by numerous entities, including the American Pain Society (APS), the American Academy of Pain Medicine (AAPM), American Society of Interventional Pain Physicians (ASIPP), the Institute of Medicine (IOM) and the Drug Enforcement Administration (DEA).1-18 The purpose of drug testing is to identify the presence of expected and unexpected prescribed medications and identify the use of illicit substances to enhance patient safety and promote public health and welfare. Therefore, testing should target common drugs of abuse, both prescription and illicit. Unexpected urine drug test (UDT) results are seen frequently, with one study showing 27% of patients with no behavioral signs presenting with unexpected positive UDT results.6 A study in a pain management program at an urban teaching hospital reported a 45% rate of unexpected toxicology results. The prevalence of illicit drugs in UDT results of pain management patients has been reported between 10.9 and 24%.5,19,20 Given these circumstances, a consistent approach to UDT based on validated risk models and clinical evaluation is advised (**See Risk Assessment Tools Appendix).**

Historically, most urine drug testing performed for compliance assessment purposes incorporated two steps: screening and conﬁrmation. This screen and confirm testing paradigm was developed for the workplace setting due to its ease of use and lower costs. However, this approach presents many pitfalls for use in the clinical setting.

Immunoassay (IA) is the most common method used for screening, and is frequently employed by on- site, point- of-care testing (POCT) in outpatient clinics and hospital laboratories. The most frequently used definitive or confirmatory methods include gas chromatography/mass spectrometry (GC/MS) and liquid chromatography/tandem mass spectrometry (LC/MS/MS). Depending on how LC/MS/MS is performed, it may also be used as a screening method.21

IA tests are qualitative in nature and detect the presence or absence of a drug class and provide the advantage rapid results. However, IA tests have significant cross-reactivity with other substances, resulting in lower sensitivity and specificity when compared to confirmation testing. Studies of presumptive positive IA tests show high rates of false-positive results when sent for confirmatory testing

Table 1

|  |  |  |
| --- | --- | --- |
| **Table 1. Reported rates of presumptive positive results which did not confirm (false positives)22-23** | | |
| **Immunoassay** | **Manchikanti, et al (2011)** | **Kirsh, et al (2015)** |
| **Amphetamines** | 52.9% | 21.4% |
| **Barbiturates** | Not tested | 21.5% |
| **Benzodiazepines** | Not tested | 11.4% |
| **Cocaine** | 0.0% | 12.3% |
| **Marijuana** | 38.7% | 21.3% |
| **Methadone** | 18.3% | 45.3% |
| **Opiates** | 3.6% | 22.4% |
| **Oxycodone** | 38.8% | 41.3% |
| **MDMA/Methamphetamine** | 85.7% | 99.5% |
| **PCP** | Not tested | 100% |
| **Tricyclic Antidepressants** | Not tested | 76.2% |

Table 2. Partial list of drugs which can cause a false-positive IA result.

|  |  |  |  |
| --- | --- | --- | --- |
| **Table 2: Cross-Reacting Compounds on Immunoassay (IA)21** | | | |
| **IA Test** | **Potential Drugs Causing a False Positive Result** | |  |
| **Buprenorphine** | Codeine  Dihydrocodeine | Morphine  Methadone |  |
| **Fentanyl** | Trazodone | Risperidone |  |
| **Methadone** | Chlorpromazine Clomipramine Cyamemazine  Diphenhydramine | Doxylamine Phenothiazine compounds Olanzapine  Quetiapine | Tapentadol Thioridazine Verapamil |
| **Opiates** | Dextromethorphan Diphenhydramine Doxylamine  Heroin\* | Poppy seeds\* Procaine  Quinine (tonic water)  Quinolone antibiotics | Ranitidine Rifampin Tolmetin  Verapamil |

\*These products either contain or metabolize to morphine, and are therefore a “true” positive result

A true negative test result means that at the time of collection, the concentration of drug/metabolite fell below the test cutoff, or threshold. Due to different rates of metabolism and excretion and interpatient variability in a drug’s period of detection, a true negative result may occur because the specimen was collected beyond the expected window of detection. A false negative result occurs when a drug/metabolite was present in the specimen, but was not detected by the testing method used. Reasons identified as possible causes of false negative immunoassay results include the following:

* Lack of cross-reactivity-Opiate immunoassays are targeted for natural opioids such as codeine and morphine and may not reliably detect synthetic or semi-synthetic opioids, such as hydrocodone, oxycodone or oxymorphone. Rates of false negatives have ranged from 30- 72%.23-24
* Drugs not included in testing-Commonly abused prescription drugs may not be included in the immunoassay including drugs such as: carisoprodol, methadone, buprenorphine and tramadol.
* Metabolites do not react to immunoassay-Most immunoassays only detect parent drug. For instance, most immunoassays are cross-reactive to opioid normetabolites at a rate of 0.1%. However, many patients excrete only opioid normetabolites, ranging from 2.2-53.1%, depending on drug.25-26
* Thresholds are too high-Most immunoassay screens were developed for workplace drug testing where thresholds are typically higher than in clinical settings. False negatives for illicit drugs are common with immunoassay screening when higher thresholds are used.
* Dilute specimen-The most common attempt to beat a drug test is to ingest excess water, which can be effective in producing a false negative result. Specimen validity testing, performed as part of confirmatory testing, is effective in identifying dilution attempts.
* Adulterated or substituted specimens-Adulterants may be added to a specimen to mask the presence of illicit drugs. Specimen validity testing, performed as part of confirmatory testing, is effective in identifying adulteration attempts.

Due to high rates of false positive and negative results, consideration should be given to performing confirmatory testing when making treatment decisions.

Oral fluid confirmation testing is a widely acceptable and growing alternative to UDT in pain management patients, especially in cases of shy bladder, severe renal impairment or suspected urine specimen tampering/substitution. Oral fluid testing is increasingly used due to ease of collection, limited invasiveness and opportunity for direct observation. Most prescription drugs of interest in pain management and illicit drugs are readily detectable in oral fluid when proper collection procedures are followed.27-28 One notable difference between oral fluid and urine is that the disposition of parent drug and metabolites is reversed. While metabolite concentrations typically exceed parent drug in urine, parent drugs are generally more readily detectable than metabolites in oral fluid. This may be relevant for patients with impaired or absent metabolism due to pharmacogenetics or drug-drug interactions, especially for drugs that are extensively metabolized and only detected by metabolite presence in urine. The increased detection of parent drugs in oral fluid may be useful to assess compliance in these circumstances, particularly when urine specimen adulteration or tampering is suspected.21,29

Frequency of drug testing is left to the prescriber’s discretion, but general guidelines can be discussed, based on the relative risk for addiction or death of the patient. As detailed elsewhere in these guidelines confirmation testing is required prior to the outset of COT and at least twice per year for all patients on COT. Lower risk patients would typically be maintained on this frequency. Moderate risk patients would be tested 3-4 times per year. Higher risk patients and those over 100mg MEDD should be tested 4-5 times per year. Instances of aberrant behavior such as lost or stolen medication may also prompt additional screening. Higher risk patients may also need routine confirmation testing because certain aberrant behaviors will appear normal with office-based (POCT). Unexpected results from POCT should be sent for confirmatory testing. It is important to note that a patient’s level of risk may change over time30 and therefore risk should be reassessed periodically to determine if more or less frequent testing is warranted. When conducting testing, a prescriber should inform the patient of the reason for testing and the potential consequences of the results. Ideally, testing should be performed at random intervals when possible to maximize effect on compliance.

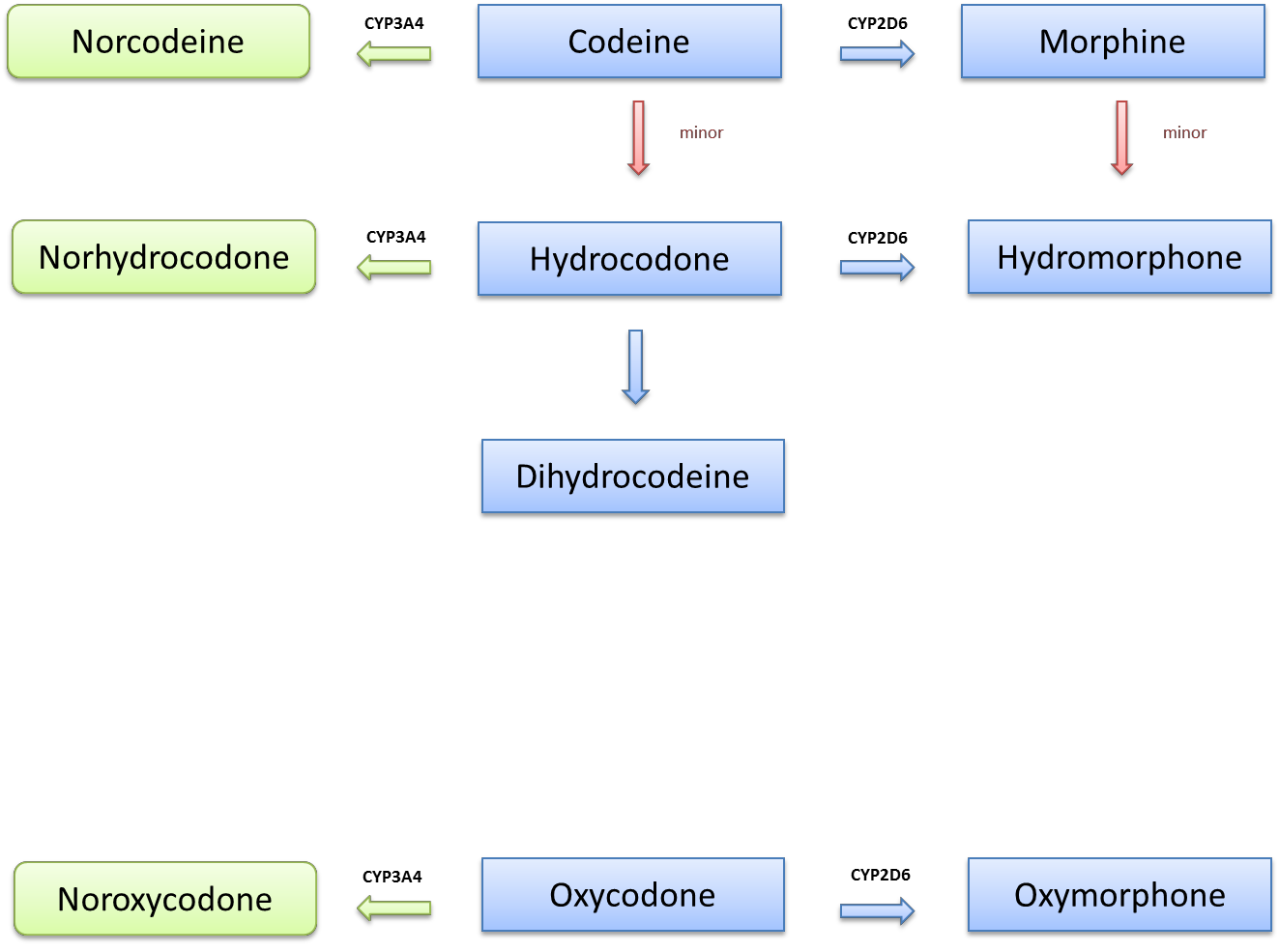
Interpretation of UDT results can be difficult, as opioids undergo extensive metabolism after ingestion; the metabolism is affected by pharmacogenetics, drug-drug and drug-food interactions.31-32 Many prescription opioids are metabolized to other commercially available opioids, which can complicate interpretation. (A metabolism chart for codeine, hydrocodone and oxycodone is included at the end of this appendix-Figure 1). Pharmaceutical impurities can be another source of unexpected results, which have been described as occurring in up to 1% of the label medication quantities. The following impurities have been described in literature:33-36

* Hydrocodone in oxycodone;
* Oxycodone in oxymorphone;
* Morphine and hydrocodone in hydromorphone; and
* Codeine in morphine.

In some instances, metabolites may be present in the absence of parent drug. Normetabolites are products of CYP3A4 metabolism, which is subject to induction and inhibition by drug-drug and drug- food interactions. Morphine, hydromorphone and oxymorphone are pharmacologically active metabolites which are products of CYP2D6 metabolism, which is subject to drug inhibition and pharmacogenetic variability. Additionally, minor metabolism can produce other metabolites. For example, small amounts of hydromorphone are possible after morphine use and small amounts of hydrocodone are possible after codeine use. The enzymes responsible for this metabolism have not been identified and metabolism may not take place in all patients.21 In confirmation testing, unexpected sources of a detected metabolite should be considered; a table of potential causes of unexpected positive results is included in Table 3.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Table 3: Possible sources of unexpected positive opioid markers** | | | | | |
| **Drug Identified** | **Comments on Alternative Sources** | | | | |
| **Codeine** | * **Pharmaceutical impurity in morphine (up to 0.5%).33** * **Pharmaceutical impurity in hydrocodone (up to 0.15%).33** * **Codeine may be present after use of heroin.37** * **Codeine is a component in several prescription and OTC cough suppressants.** * **Codeine may be present after ingestion of poppy seeds, typically at lower concentrations thanmorphine.12** * **Products containing opium may result in positive findings primarily for morphine, with codeine at lesser concentrations.** | | | | |
| **Dihydrocodeine** | * **Dihydrocodeine is a component in several prescription coughsuppressants.** | | | | |
| **Heroin** | * **Heroin-specific markers acetylcodeine.** * **Other metabolites which hydromorphone.** | **include**  **may be** | **parent**  **present** | **heroin,**  **include** | **6-acetylmorphine (6AM), and 6-**  **codeine, morphine, and sometimes** |
| **Hydrocodone** | * **Minor metabolite of codeine: hydrocodone concentrations in urine should be under 5% of the codeine concentration.38** * **Pharmaceutical impurity in hydromorphone (up to 0.1%).33** * **Pharmaceutical impurity in oxycodone (most notably OxyContin®, up to 1%).33** * **Hydrocodone is a component of several prescription cough suppressants (e.g., Tussionex®, Hycodan®).** | | | | |
| **Hydromorphone** | * **Minor metabolite of morphine: hydromorphone concentrations in urine are usually under 6% of the morphine concentration.39-43** * **Hydromorphone sometimes appears as a metabolite of morphine after heroin ingestion.** * **Pharmaceutical impurity in oxymorphone (up to 0.15%).33** | | | | |
| **Morphine** | * **Poppy seeds in food products (bagels, salad dressings, etc) may result in morphine concentrations in urine up to 2,000 ng/mL.12 In rare instances, poppy seeds have resulted in higher morphine concentrations, but these occurrences areconsidered exceptions.44-49** * **Codeine concentrations are typically less than half the morphine concentration (or lower) after poppy seed ingestion.49-50** * **Poppy seeds are unlikely to cause a positive morphine result in oral ﬂuid or blood.12,50-51** * **Pharmaceutical impurity in hydromorphone (up to 0.15%).33** * **Products containing opium may result in positive findings primarily for morphine, with codeine at lesser concentrations.** | | | | |
| **Oxycodone** | * **Pharmaceutical impurity in oxymorphone (up to 0.5%)33** | | | | |

Due to interpatient variability, a broad range of observed patterns of parent drug and metabolites is possible. If a provider has questions about interpretation of toxicology results, they should contact the laboratory director, toxicologist, or local Medical Review Officer.



### TAPERING PROTOCOL

There are many reasons to discontinue chronic opiate therapy. Any time the risks of the continued opiate use outweigh its potential benefit, the therapy should be discontinued. Violation of the controlled substances could be another reason to discontinue opiates.

1. Opiate discontinuation does pose the potential for withdrawal syndrome. This typically consists of nausea, vomiting, myalgia, headaches, abdominal pain, and sweating. These symptoms are not usually serious, and while not fatal, opiate withdrawal can cause discomfort. It should be noted, however, that benzodiazepine withdrawal does have the potential to be life threatening.
2. Low dose opiates may not require weaning at all. If the decision is made to discontinue opiates, steps should be taken to minimize the impact of opiate withdrawal syndrome. It is the responsibility of the current prescribing provider to address this issue.
3. There are several different weaning protocols outlined by various sources. A conservative approach recommends a 10% reduction in the original dose per week. Other sources state that a 25% reduction every 4 days should avoid withdrawal syndrome. The more rapid protocols recommend for a daily reduction of 25-50% of the previous days dose. The Tennessee Department of Health does not recommend any one specific weaning protocol.
4. There are also several different medications that can help alleviate the symptoms of opiate withdrawal. Clonidine can diminish some of the symptoms of opiate withdrawal. Clonidine can be administered 0.1- 0.2mg orally every 6 hours or with a transdermal patch at 0.1mg/24hours. Hypotension and anticholinergic side effects may be encountered with clonidine. Weaning opiates is not always indicated when they are to be discontinued. If recent urine drug screening has shown that opiates are not present in the patient’s system, then a weaning protocol would not be necessary.
5. If drug diversion were suspected then prescribing additional opiates would not be indicated. In any circumstance where prescribing additional opiates to a patient is thought to constitute more risk to the patient or to the community than the potential for withdrawal syndrome, no additional opiates should be prescribed.

### MORPHINE EQUIVALENT DOSE

Morphine equivalent dose (MED) is the equipotent dose of any opioid in terms of morphine. Morphine is widely regarded as the “standard” for the treatment of moderate to severe pain and is used as the reference point. As MED increases, the likelihood of an adverse effect increases, therefore identifying at-risk patients is a crucial first step towards improving patient safety. Various MED charts are available for use in clinical practice, for instance, the Tennessee Controlled Substance Monitoring Database (CSMD) utilizes a chart of conversion factors created by the US Centers for Disease Control and Prevention. The conversion factor is entered into the following formula:

### MED Conversion Formula:

(Drug Strength) \* (Drug Quantity) \* (Morphine Equivalent Multiplier)

MED=

(Day Supply)

CDC guidance states that fentanyl and buprenorphine patches are exceptions to using the above formula to compute MEDs. This exception only applies to the transdermal patch formulation, not the other dosage forms of either drug. A calculation of MED for these transdermal patch formulations must incorporate the frequency of patch rotation, which may vary depending upon the prescriber’s directions. Therefore, even though the duration of use of each patch may be less than the typical number of days, the quantity of drug that a patient receives each day remains constant because of the continuous release rate of active ingredient from the patch. Due to its complex pharmacokinetic properties, methadone exhibits an exponential increase in MED as dose increases above approximately 30 to 40 milligrams of methadone per day. Particular caution is warranted when methadone therapy approaches or exceeds these daily doses, or when a concomitant medication may inhibit methadone metabolism through the cytochrome CYP450 system.

No MED chart can adequately account for the patient-specific responses to a particular agent as risk of adverse events from taking any opioid can be dose-independent and may begin at low doses. Some of the variables include: age, gender, genetic variability in drug metabolism, drug-drug interactions, opioid tolerance and organ dysfunction such as renal and hepatic impairment, adrenal insufficiency, hypothyroidism, and abnormal levels of protein binding. Therefore, any conversion chart should only be used as a guide when formulating treatment plan. Dosing should be individualized and begun at conservative doses, based on assessment of risk.

|  |  |  |
| --- | --- | --- |
| **TABLE OF FREQUENTLY PRESCRIBED PAIN MEDICATIONS** | | |
| **Short-Acting Opioids** | **DEA**  **Schedule** | **Available Strengths\*** |
| Acetaminophen/ Caffeine/Dihydrocodeine Cap and Tab | (C-III) | 356.4/30/16 |
| Acetaminophen/Butalbital/Caffeine/Codeine Capsule | (C-III) | 325 (also as 300)/50/40/30mg |
| Aspirin/Butalbital/Caffeine/Codeine Capsule | (C-III) | 325/50/40/30mg |
| Acetaminophen/Codeine Tablet | (C-III) | 300/15, 30, 60mg |
| Acetaminophen/Codeine Solution/Suspension | (C-V) | 120/12mg /5ml |
| Codeine sulfate Tablets | (C-II) | 15, 30, 60mg |
| Fentanyl citrate Oral lozenge | (C-II) | 200, 400, 600, 800, 1200, 1600mcg |
| Fentanyl citrate Oral spray | 100, 300, 400 mcg |
| Fentanyl Oral spray | 100, 200, 400, 600, 800, 1200,  1600 mcg |
| Fentanyl citrate Oral effervescent tab | 100, 200, 400, 600, 800 mcg |
| Fentanyl citrate Oral sublingual tab | 100, 200, 400, 400, 600, 800 mcg |
| Hydrocodone/Acetaminophen | (C-II) | 2.5/325, 5/300, 5/325, 7.5/300,  7.5/325, 10/300, 10/325mg |
| Hydrocodone/Ibuprofen Tablet | (C-II) | 2.5, 5, 7.5, 10/200mg |
| Hydromorphone HCl Tablet | (C-II) | 2, 4, 8mg |
| Hydromorphone HCl liquid | 1mg/ml |
| Levorphanol tartrate Tablet | (C-II) | 2mg |
| Morphine sulfate Solution | (C-II) | 10, 20, 100mg/5ml |
| Morphine sulfate Tablet | 15, 30 mg |
| Oxycodone HCl/Acetaminophen Tablet | (C-II) | 2.5/325, 5/300, 5/325, 7.5/300,  7.5/325, 10/300, 10/325 mg |
| Oxycodone HCl/Ibuprofen Tablet | (C-II) | 5/400mg |
| Oxycodone/Oxycodone terephthalate/Aspirin Tablet | (C-II) | 4.5/0.38/325 mg |
| Oxycodone HCl Capsule or Tablet | (C-II) | 5, 7.5, 10, 15, 20, 30 mg |
| Oxycodone HCl Solution | 5mg/5ml, 20mg/ml |
| Oxymorphone Tablet | (C-II) | 5, 10mg |
| Meperidine HCl Solution | (C-II) | 50mg/5ml |
| Meperidine HCL Tablet | 50, 100 mg |
| Tapentadol Tablet | (C-II) | 50, 75, 100mg |
| Butorphanol tartrate Spray | (C-III) | 10mg/ml |
| Pentazocine HCl/Naloxone HCl Tablet | (C-III) | 50/0.5mg |

|  |  |  |
| --- | --- | --- |
| **TABLE OF FREQUENTLY PRESCRIBED PAIN MEDICATIONS** | | |
| **Long-Acting Opioids** | **DEA Schedule** | **Available Strengths\*** |
| Buprenorphine Patch | (C-III) | 5, 7.5, 10, 15, 20mcg/hr |
| Buprenorphine HCl Film | (C-III) | 75, 150, 300, 450, 600, 750, 900mcg |
| Fentanyl Patch | (C-II) | 12, 25, 37.5, 50, 62.5, 75, 87.5  100mcg/hr |
| Hydromorphone ER Tablet | (C-II) | 8, 12, 16, 32mg |
| Hydrocodone Bitartrate ER (12 hour) Capsule | (C-II) | 10, 15, 20, 30, 40, 50mg |
| Hydrocodone Bitartrate ER (24 hour) Tablet | (C-II) | 20, 30, 40, 60, 80, 100, 120mg |
| Methadone Tablet | (C-II) | 5, 10mg |
| Morphine Sulfate ER Capsule or Tablet | (C-II) | 10, 15, 20, 30, 45, 50, 60, 75, 80, 90,  100, 120, 200mg |
| Morphine Sulfate/Naltrexone ER Capsule | (C-II) | 30/1.2, 50/2, 60/2.4, 80/3.2,  100/4mg |
| Oxycodone ER Tablet | (C-II) | 10, 15, 20, 30, 40, 60, 80mg |
| Oxycodone Myristate Capsule | (C-II) | 9, 14.5, 18, 27, 36mg |
| Oxymorphone ER Tablet | (C-II) | 5, 7.5, 10, 15, 20, 30, 40mg |
| Tapentadol ER Tablet | (C-II) | 50, 100, 150, 200, 250mg |
| **Benzodiazepines** | **DEA Schedule** | **Available Strengths\*** |
| Alprazolam Tablet or Oral-Dissolving Tablet | (C-IV) | 0.25, 0.5, 1 or 2 mg |
| Alprazolam ER Tablet | 0.5, 1, 2, 3mg |
| Clonazepam Tablet or Oral-Dissolving Tablet | (C-IV) | 0.125, 0.25, 0.5, 1, 2mg |
| Diazepam Tablet | (C-IV) | 2, 5, 10 mg |
| Lorazepam Tablet | (C-IV) | 0.5, 1, 2 mg |
| **Muscle Relaxant** | **DEA Schedule** | **Available Strengths\*** |
| Carisoprodol Tablet | (C-IV) | 250, 350mg |
| Carisoprodol/Aspirin Tablet | (C-IV) | 325/200mg |
| Carisoprodol/Aspirin/Codeine Tablet | (C-III) | 325/200/16mg |
| **Other Pharmacotherapeutic Options** | **DEA Schedule** | **Available Strengths\*** |
| Selective Serotonin Reuptake Inhibitors |  |  |
| Tricyclic Antidepressants |  |  |
| Tramadol ER Capsule or Tablet | (C-IV) | 100, 150, 200, 300mg |
| Tramadol Tablet | (C-IV) | 50mg |
| Tramadol/Acetaminophen Tablet | (C-IV) | 37.5/325mg |
| Dronabinol Gelcap | (C-III) | 2.5, 5, 10 mg |
| Aspirin/Butalbital/Caffeine Capsule | (C-III) | 325/50/40mg |
| \*Strengths are not intended to be exhaustive. | | |

### TERMS/DEFINITIONS

**Acute Pain:** pain of sudden onset usually from a single, “fixable” event commonly seen with surgery, accidental injury or inflammation, however, can be from unknown cause; short duration from days to less than 3-6 months as associated with healing; considered our biological red flag that sends warning signals through the nervous system that something is either wrong within the body or that a hurtful activity should be avoided to prevent further or repeat damage.

**ABAM:** American Board of Addiction Medicine. The American Board of Addiction Medicine, Inc. (ABAM) is a not-for-profit 501 (c)(6) organization whose mission is to examine and certify diplomats. It was founded in 2007 following conferences of committees appointed by the American Society of Addiction Medicine. This action was taken as a method of identifying the qualified specialists in Addiction Medicine. ABAM offers a rigorous certifying examination that was developed by an expert panel and the National Board of Medical Examiners, as well as maintenance of certification examination to ensure that ABAM- certified physicians maintain life- long competence in Addiction Medicine. (From ABAM Web Site.)

**ABMS**: American Board of Medical Specialties. The ABMS is comprised of 24 medical specialty Member Boards.

**AOA:** American Osteopathic Association. The AOA serves as the professional family for more than 104,000 osteopathic physicians (DOs) and osteopathic medical students. The AOA promotes public health and encourages scientific research. In addition to serving as the primary certifying body for DOs, the AOA is the accrediting agency for all osteopathic medical schools and has federal authority to accredit hospitals and other health care facilities.

**ASAM:** American Society of Addiction Medicine. American Society of Addiction Medicine is a professional society representing over 3,000 physicians and associated professionals dedicated to increasing access and improving the quality of addiction treatment; educating physicians, other medical professionals and the public; supporting research and prevention; and promoting the appropriate role of physicians in the care of patients with addictions. (From ASAM Web Site.)

**Allodynia:** pain caused by a stimulus or action that does not normally cause pain, like light touch, pressure or a gentle breeze on skin.

**Chronic Pain:** pain lasting longer than expected healing time, may last for many months, years or a lifetime, may be constant or in intervals; cause may be unknown or result of recent or previous acute pain episode; may be related to another chronic disorder, such as arthritis, peripheral vascular disease, diabetes, or cancer.

**Hyperalgesia:** an increased response to a stimulus that normally would induce a mild discomfort.

**MME:** Morphine Milligram Equivalents

**Neuropathic Pain:** chronic pain caused by the nervous system.

**Nociceptive Pain:** acute pain as a response to a noxious stimulus.

**Opioid Naïve:** patients who are not chronically receiving opioid analgesics on a daily basis.

**Opioid Tolerant:** patients who are chronically receiving opioid analgesics on a daily basis.

**Pain:** is an unpleasant sensory and emotional experience associated with actual or potential tissue damage. Pain is personal and subjective.

**Pain Medicine Specialist:** Pain Medicine is the medical specialty dedicated to the prevention, evaluation and treatment of people with chronic pain. Additionally (See Pain Medicine Specialist Appendix)

**Somatic Pain:** pain originating from the muscles and/or bones.

**Visceral Pain:** pain originating from within internal organs.

### SAFETY NET

#### Tennessee’s Substance Abuse System

* 1. Substance abuse is a pervasive public health issue that has roots in individual, family, peer, and community conditions. Substance abuse negatively impacts families and children, increases crime, threatens public safety, and imposes tremendous social and economic costs to every community. Not surprisingly, it also prompts a wide range of responses across the public and private institutional systems.
  2. The National Survey of Substance Abuse Treatment Services (N-SSATS) examines facilities providing substance abuse treatment services conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA). N-SSATS collects data on the location, characteristics, services, and number of clients in treatment at alcohol and drug abuse treatment facilities (both public and private) throughout the 50 states, the District of Columbia, and other U.S. jurisdictions. It looks at 208 facilities in Tennessee:
  3. Along with these numbers, N-SSATS found that 81.7% of Tennessee’s substance abuse treatment providers offer outpatient treatment services, 32.7% offer residential services, and 6.7% offer hospital inpatient services.
  4. The Tennessee Department of Mental Health and Substance Abuse Services, Division of Substance Abuse Services (TDMHSAS-DSAS), serves as the single state authority for receiving and administering federal block grant funding from the U.S. Department of Health and Human Services/SAMHSA and state funding to serve indigent uninsured individuals around the state who have a substance use disorder. The mission of TDMHSAS-DSAS is to improve the quality of life of Tennesseans by providing an integrated network of comprehensive substance abuse treatment services, fostering self-sufficiency and protecting those who are at risk of substance abuse, dependence and addiction.
  5. TDMHSAS licenses organizations to provide a continuum of substance abuse treatment services throughout the state. Services include outpatient, intensive outpatient, partial hospitalization, residential treatment, clinical halfway house, social detoxification, medically monitored detoxification, medically managed detoxification, and opioid treatment. All treatment providers use an assessment tool to determine the severity of a person’s substance use disorder and the most appropriate service for the individual. Many of these agencies accept commercial insurance, TennCare, and self-pay.
  6. To locate a substance abuse treatment facility in your community, visit [www.samhsa.gov/treatment.](http://www.samhsa.gov/treatment)

### PRESCRIPTION DRUG DISPOSAL

#### Proper Disposal

Unwanted, unused or expired prescription drugs present substantial risks to communities through the potential for abusive use or by damaging the environment as a result of improper disposal. Residential supplies of pharmaceutically controlled substances, those found in home medicine cabinets, have become the supply source of choice for many young people and individuals abusing substance. According to the 2011 Substance Abuse and Mental Health Services Administration’s National Survey on Drug Use and Health (NSDUH), more than 70 percent of people abusing prescription pain relievers got them through friends or relatives, a statistic that includes raiding the medicine cabinets of family and friends. Easy access to prescription drugs is one factor leading to the prescription drug epidemic and an effective method to control access is development of mechanisms for safe, convenient, and responsible disposal. The State of Tennessee has been actively engaged in two types of disposal activities: **Take-Back Events and Permanent Prescription Collection Boxes**.

Take-back events are one-day events where the public is encouraged to discard their unused, unwanted, and expired medications including prescription drugs from their homes. In addition to removing prescription drugs from the community these events are intended to increase awareness of the prescription drug epidemic, inform the public about the need for safely disposing of prescription drugs, and raise awareness of local permanent disposal sites available year round.

Prescription drug collection boxes are established as permanent disposal sites located within law enforcement agencies where community members can safely deposit prescription drugs in a secure container. To be compliant with Drug Enforcement Administration (DEA) regulations, drug collection boxes must be located with a law enforcement entity to ensure access to prescription drugs is carefully controlled and that substances are properly destroyed once collected. Since the beginning of 2012, the number of permanent prescription drug collection boxes has more than doubled from 36 to 82 boxes. This achievement would not have been possible without the Tennessee Department of Mental Health and Substance Abuse Services, the Tennessee Department of Environment and Conservation, and the Tennessee Department of Health working together to ensure the availability of disposal boxes and working with law enforcement agencies to identify and establish safe prescription drug disposal sites. One of the goals of this multi-agency collaboration is to establish at least one permanent prescription drug collection box in all 95 counties of the state. Establishing permanent prescription drug collection boxes as the method for Tennessee citizens’ to routinely dispose of medications will require continued public education concerning their use and ease of access, thereby increasing their use and reducing the amount of substances available for abuse and increase home and community safety. Locations of permanent drug collection boxes may be found at [http://www.tn.gov/mental/publications/Permanent%20Drug%20Take-](http://www.tn.gov/mental/publications/Permanent%2520Drug%2520Take-Back%2520Boxes.pdf) [Back%20Boxes.pdf.](http://www.tn.gov/mental/publications/Permanent%2520Drug%2520Take-Back%2520Boxes.pdf)

### USE OF OPIOIDS IN WORKERS’ COMPENSATION MEDICAL CLAIMS

The use of opioids in Workers’ Compensation is a significant component of the medical care of injured workers, not only in Tennessee but across the United States. Injuries to the back, knees, and shoulders are among the most frequently occurring workers’ compensation injuries. These injuries frequently result in the injured worker experiencing chronic pain and the use of opioids has become a routine practice in the medical care for this type of injury.

A recent study by NCCI for the state of Tennessee found that 11% of workers’ compensation medical costs nationwide were attributable to drugs. In Tennessee the percentage is even higher, 16%. Of the top ten drugs prescribed for workers’ compensation patients in Tennessee, 22.5 % were opioids (Hydrocodone-Acetaminophen – 16.0 %, Tramadol – 4.3%, Oxycodone HCI- Acetaminophen – 2.2%).

The number of deaths attributable to accidental overdose is not tracked in Tennessee or most other states. It has been estimated that the number of deaths countrywide is in excess of 200, but that estimate may be low as the number of deaths in the two states that track opioid use would account for 25% of that estimate. 1

These statistics are cause for concern and were a consideration in Public Chapter 289 passed by the General Assembly in 2013 that included a provision mandating the adoption of medical treatment guidelines to be effective January 1, 2016. Pain management will be the first guideline developed.

Tennessee is one of many states that are undertaking the development of guidelines for pain management with the goal of promoting the optimum use of opioids. The table below lists the states with pain management medical treatment guidelines and the basis of those guidelines.

1 Reducing Inappropriate Opioid Use in Treatment of Injured Workers: A Policy Guide. International Association of Industrial Accident Boards and Commissions. September 5, 2013. Found

at: [http://www.iaiabc.org/i4a/pages/index.cfm?pageID=416](https://mail.tn.gov/owa/redir.aspx?C=TpL0pxPKV065r5S7HEDOVbbmnjxPs9AIwBRkQgCVg0fIeUYfLxfGXe_NAq8POy6FoYgEtLRSzVA.&amp;amp%3BURL=http%253a%252f%252fwww.iaiabc.org%252fi4a%252fpages%252findex.cfm%253fpageID%253d4169)9

### MEDICAL TREATMENT GUIDELINES FOR PAIN MANAGEMENT FOR WORKERS' COMPENSATION

|  |  |  |
| --- | --- | --- |
| **State** | **Guideline type** | **Website, if available** |
| California | ODG | proprietary |
| Colorado | state specific | [http://www.colorado.gov/cs/Satellite/CDLE-](http://www.colorado.gov/cs/Satellite/CDLE-WorkComp/CDLE/12480953116866) [WorkComp/CDLE/12480953116866](http://www.colorado.gov/cs/Satellite/CDLE-WorkComp/CDLE/12480953116866) |
| Connecticut | state specific | <http://wcc.state.ct.us/download/acrobat/protocols.pdf> |
| Delaware | state specific | <http://dowc.ingenix.com/info.asp?page=pracguid> |
| Hawaii | ODG | Proprietary |
| Kansas | ODG | Proprietary |
| Louisiana | state specific modeled on Colorado, ODG | <http://www.laworks.net/WorkersComp/OWC_MedicalGuid> elines.asp |
| Massachusetts | state specific | <http://www.mass.gov/lwd/workers-compensation/hcsb/tg/> |
| Minnesota | state specific | <http://www.dli.mn.gov/wc/TpToc.asp> |
| Montana | state specific, Colorado model, ACOEM | [www.mtguidelines.com](http://www.mtguidelines.com/) |
| New Mexico | ODG | proprietary |
| New York | state specific, adopted from Colorado model, ACOEM | [http://www.wcb.ny.gov/content/main/hcpp/MedicalTreatm](http://www.wcb.ny.gov/content/main/hcpp/MedicalTreatmentGuidelines/2010TreatGuide.jsp) [entGuidelines/2010TreatGuide.jsp](http://www.wcb.ny.gov/content/main/hcpp/MedicalTreatmentGuidelines/2010TreatGuide.jsp) |
| North Dakota | ODG, ACOEM et  al professional organization guidelines | proprietary |
| Ohio | ODG | proprietary |
| Oklahoma | ODG | proprietary |
| Rhode Island | state specific | [http://www.courts.ri.gov/Courts/workerscompensationcourt](http://www.courts.ri.gov/Courts/workerscompensationcourt/Medical%20%20%20%20AdvisoryBoard/Pages/Protocols.aspx)  [/Medical AdvisoryBoard/Pages/Protocols.aspx](http://www.courts.ri.gov/Courts/workerscompensationcourt/Medical%20%20%20%20AdvisoryBoard/Pages/Protocols.aspx) |
| Texas | ODG | proprietary |
| Washington | state specific | [http://www.lni.wa.gov/claimsins/providers/treatingpatients/](http://www.lni.wa.gov/claimsins/providers/treatingpatients/treatguide)  [treatguide](http://www.lni.wa.gov/claimsins/providers/treatingpatients/treatguide) |
| Wisconsin | state specific | N/A |
| Wyoming | ODG | proprietary |
| ODG: Official Disability Guidelines for Treatment in Workers' Compensation, published by Work  Loss Data Institute | | |
| ACOEM: American College of Occupational and Environmental Medicine, Occupational Medicine  Practice Guidelines, 3rd Ed | | |

### NALOXONE

* + 1. 63-1-156 allows licensed healthcare providers to prescribe an opioid antagonist (Naloxone) when acting in good faith and exercising reasonable care via a direct or standing order for the following individuals:
       1. A person at risk of experiencing an opiate related overdose, or
       2. A family member, friend, or other person in a position to assist a person at risk of experiencing an opiate-related overdose

The chief medical officer of the department of health is authorized to implement a state-wide collaborative pharmacy practice agreement for opioid antagonist therapy with pharmacists. A collaborative practice is an agreement where a physician and a pharmacist enter into a contract allowing the pharmacist to dispense a medication in certain circumstances much like a standing order.

Evidence of the use of reasonable care in administering the drug shall include the receipt of basic instruction and information on how to administer the opioid antagonist, including successful completion of the online overdose prevention education program offered by the Department of Health as evidenced by a certificate of completion.

Naloxone is a pure opioid antagonist, reversing the effects of opioids including respiratory depression, sedation, and hypotension. The onset of action is within 2 minutes when given IV, however, nasal and IM administrations have been documented in the literature. Because of variability in response, an individual may still experience withdrawal symptoms after administration.

The commissioner of health or the commissioner’s designee, in consultation with other state, federal or local government personnel, including contractors, shall create and maintain an online education program with the goal of educating laypersons and the general public about the administration of opioid antagonists and appropriate techniques and follow-up procedures for dealing with opioid- related drug overdose.

The following individuals are immune from civil liability in the absence of gross negligence or willful misconduct for actions authorized by this section:

1. Any licensed healthcare practitioner who prescribes or dispenses an opioid antagonist pursuant to subsection (c); and
2. Any person who administers an opioid antagonist pursuant to subsection (e).

Any person who in good faith seeks medical assistance for a person experiencing or believed to be experiencing a drug overdose shall not be arrested, charged, or prosecuted for a drug violation if the evidence for the arrest, charge, or prosecution of the drug violation resulted from seeking such medical assistance. Any person who is experiencing a drug overdose and who in good faith seeks medical assistance for or is the subject of a request for medical assistance shall not be arrested, charged, or prosecuted for a drug violation if the evidence for the arrest, charge, or prosecution of the drug violation resulted from seeking such medical assistance.

This immunity from being arrested, charged, or prosecuted shall apply to the person experiencing a drug overdose only on the person's first such drug overdose. Also any such person experiencing their first over dose if seeking medical assistance shall be immune from:

1. Penalties for a violation of a permanent or temporary protective order or restraining order; or
2. Sanctions for a violation of a condition of pretrial release, condition of probation, or condition of parole based on a drug violation.

The act of providing first aid or other medical assistance to someone who is experiencing a drug overdose may be used as a mitigating factor in a criminal prosecution for which immunity, set out in subsection (b), is not provided.

The duration of action of some opioids may exceed that of naloxone. Depending on a patient’s age and route of administration of naloxone, the duration of action may vary from minutes to hours. The patient must be watched closely until stabilized in the appropriate healthcare facility. A repeat dose or doses may be necessary before patient reaches a healthcare facility.

Intranasal administration via atomizer is considered a safe and effective alternative to traditional administration routes for naloxone. Advantages include elimination of the risk of needle exposure. Institution of a collaborative agreement may allow dispensing of naloxone by a pharmacist. The FDA has approved Intranasal Naloxone.

The chief medical officer of the department of health has implemented a state-wide collaborative pharmacy practice agreement for opioid antagonist therapy with pharmacists. The agreement can be found online at [http://www.tn.gov/assets/entities/health/attachments/TDH\_Naloxone\_Collaborative\_practice.pdf.](http://www.tn.gov/assets/entities/health/attachments/TDH_Naloxone_Collaborative_practice.pdf)

### CHRONIC PAIN GUIDELINE ALGORITHM WOMEN’S HEALTH

**WOMEN’S HEALTH**

**Women of Childbearing Age With Reproductive Capability**

**Pain Diagnosis Supported by Clinical Findings**

**Non-Opioid Treatment Plan (Physical Therapy, Acupuncture, Massage**

**Therapy, etc.)**

\*Successful

Unsuccessful

**Continue Non-Opioid Treatment**

Negative

**Pregnancy Test**

Positive

**Consider Opioid Treatment Plan**

**Refer to High Risk OB for consideration of opioid therapy**

**Adjust Non-Opioid Treatment Plan as needed**

No Yes

**Adjust Opioid Treatment Plan as needed**

***(Section 2; pg. 3 of the guidelines)***

**ANNNOTATIONS**

1. **Controlled Substance Monitoring Database (CSMD); Urine Drug Test (UDT)**
2. **High Risk Obstetrician**

***\*Function improved to permit (ADL Terminology)***

**Check CSMD, UDT and Re-evaluation**

**On-Going Management**

**Patient treated by High Risk OB throughout pregnancy**

### CHRONIC PAIN GUIDELINE ALGORITHM OPIOID THERAPY

**CANDIDATE FOR OPIOID THERAPY**

**Pain Diagnosis Supported by Clinical Findings**

Function Not Improved

Function Improved

**Development of treatment plan first trying non-opioid therapy (Physical Therapy, Acupuncture, Massage Therapy, etc.)**

Expected Results

**Check CSMD, UDT, and Risk Assessment**

Unexpected Results

**Continue non-opioid treatment**

**Informed Consent**

Expected Results

**Confirmatory UDT Results by GCMS or LCMS**

Unexpected Results

**High risk avoid opioids and refer to substance abuse counselor or mental health professional**

**Initiate opioid therapy and repeat UDT and check CSMD (frequency schedule according to risk level)**

**Evaluate effectiveness of therapy**

**On going therapy and re-evaluation**

<120 MEDD

**UDT and CSMD**

**Report as needed**

≥120 MEDD

**ANNOTATIONS**

* 1. **History and Physical, Old Records, Laboratory Test, Imaging Results**
  2. **Women of childbearing age should have pregnancy test before starting opioids (see Women Health Algorithm)**
  3. **Avoid benzodiazepines**
  4. **Single pharmacy, single prescriber, single and lowest effective dose**
  5. **Consider mental health referral**
  6. **5 A’s Analgesia, ADL, Adverse side effects, Aberrant behavior, and Affect**
  7. **Urine Drug Test (UDT); Gas chromatography–mass spectrometry (GCMS); Liquid chromatography–mass spectrometry (LCMS)**

**Consult Pain Medicine Specialists**

**Recommendation to primary physician**

**Assume clinical care of chronic pain patient**

### NON-OPIOID THERAPIES

Guideline:

“Non-opioid treatments should be tried before opioids are initiated. Opioids should be used only after all other appropriate and available treatments for the pain condition have been exhausted.”

Supporting rationale:

Modern pain medicine is a multi-disciplinary practice. When considering opioids for therapy, a practitioner should try a variety of appropriate non-opioid treatments for chronic pain prior to the initiation of narcotics, and use opioids only as a last resort. A thorough work up to support a diagnosis for opioids should include a history and physical, psychological screening, functional assessment, diagnostic studies, and specialist opinions. After an appropriate diagnosis for narcotics is found then the primary care provider can initiate nonnarcotic treatment such as:

1. Non-opioid medications
2. Functional treatments
3. Psychological treatments
4. Coordinated care with specialists
5. Injection therapy
6. Complimentary therapeutics

A variety of non-opioid medications are used in pain medicine. Anti-inflammatories are a first line medication used in arthritic pain and other mild to moderate chronic pain conditions. Anti-spasmodics and muscle relaxants are useful adjuvants for patients with chronic musculoskeletal pain conditions like chronic spasticity, myofascial pain. Antidepressants and anti-neuroleptics are commonly used neuroadjuvants used for fibromyalgia, peripheral neuropathy, radiculopathies, and myofascial pain.

Antidepressants can also have an added benefit of relieving symptoms of anxiety and depression that are commonly associated with chronic pain patients. Any of the aforementioned medication that can cause sedation should be used with care if they are initiated prior to or in conjunction with narcotics.

Functional treatments are restorative modalities that can help patients to improve their general mobility and strength while improving pain. Early in a chronic pain condition a patient should be referred to a physical therapist or occupational therapist for an assessment and treatment of a chronic pain patient’s disability. Manual manipulation, strengthening exercises, land based therapies, aquatic therapy, electro- stimulation treatments, home exercise programs, bracing, ultrasound are part of the functional treatment armamentarium for chronic pain patients. Additionally, periodic functional assessments are encouraged to demonstrate the efficacy of treatment prior to and after the initiation of narcotics.

Often times patients will have a primary diagnosis that’s best treated by a specialist while receiving concomitant chronic pain treatment. A specialist referral prior to the initiation of narcotic treatment is encouraged especially if the etiology of the chronic pain condition can be treated without narcotics and can be attenuated or cured with alternative pharmaceuticals or surgery. It is also helpful to get a specialist opinion on whether certain conditions constitute a chronic pain condition and whether that condition is best treated with narcotics.

Mental health referral for a chronic pain condition is helpful early in the treatment process. Recognition of anxiety disorders, depression, post-traumatic stress disorder, and other mental health disorders at the beginning in the treatment of pain is important. Chronic pain is a significant stressor and providing coping mechanisms and other strategies may reduce maladaptive behaviors in patients such as

overtaking pain medications and obtaining medications not prescribed to the patient. Relaxation techniques, biofeedback, individual and group sessions, and other skills are all useful adjunctive treatments in the chronic pain patient population.

Simple injections for pain including joint injections trigger point injections, and botulinum injections have a role in the primary care providers’ non-opioid treatment plan. There are some injections that are best performed by a specialist and a referral to these specialists early in a patient’s care is encouraged prior to the initiation of narcotics.

Also for consideration for primary care providers treating pain are other non-Allopathic treatments for pain. Chiropractic treatments, exercise, massage, alternative supplements and medications may all have a role in treating chronic pain conditions. Treatments like yoga, tai chi, acupuncture, and mindfulness meditation can attenuate pain and restore/ preserve function for some people.

### TENNESSEE EMERGENCY DEPARTMENT OPIOID PRESCRIBING GUIDELINES

1. One medical provider should provide all opioids to treat a patient’s chronic pain.
2. The administration of intravenous and intramuscular opioids in the ED for the relief of acute exacerbations of chronic pain is discouraged.
3. Emergency medical providers should not provide replacement prescriptions for controlled substances that were lost, destroyed, or stolen.
4. Emergency medical providers should not provide replacement doses of methadone for patients in a methadone treatment program.
5. Long-acting or controlled – release opioids (such as OxyContin®, fentanyl patches, and methadone) should not be prescribed from the ED. Exceptions may include terminal care and cancer-related pain.
6. ED providers are encouraged to review the Tennessee Controlled Substance Monitoring Database prior to writing prescriptions for controlled substances in the ED.
7. Physicians may send patient pain agreements to local EDs and work to include a plan for pain treatment in the ED.
8. EDs should coordinate the care of patients who frequently visit the ED using an ED care coordination program.
9. EDs should maintain a list of clinics that provide primary care for patients for all payer types.
10. EDs should perform screening, brief interventions and treatment referrals for patients with suspected prescription opiate abuse problems.
11. The administration of Demerol (Meperidine) is the ED is discouraged.
12. For exacerbations of chronic pain, the emergency medical provider may contact the patient’s primary opioid prescriber. The emergency medical provider should only prescribe enough pills to last until the office of the patient’s primary opioid prescriber opens.
13. Prescriptions for opioid pain medication from the ED for acute injuries, such as fractured bones, in most cases should not exceed seven days.
14. ED patients should be screened for substance abuse prior to prescribing opioid medication for acute pain.
15. The emergency physician is required by law to evaluate an ED patient who reports pain. The law allows the emergency physician to use their clinical judgement when treating pain and does not require the use of opioids.

Tennessee Chronic Pain Guidelines

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This document was produced by the Tennessee Department of Health and the Chronic Pain Guidelines Steering Committee and Expert Panel.

**Policy Statement Clarifying ACLS and PALS Course Requirements**

Pursuant to Rule 0460-02-.07 (1) (a), Advanced Cardiac Life Support (ACLS) is a certification that means a person has successfully completed an advanced cardiac life support course offered by a recognized accrediting organization. To be recognized as an accredited organization, the course must include an in person skill set assessment.

Pursuant to Rule 0460-02-.07 (1) (l), Pediatric Advanced Life Support (PALS) is a certification that means a person has successfully completed an pediatric advanced life support course offered by a recognized accrediting organization. To be recognized as an accredited organization, the course must include an in person skill set assessment.

Adopted by the Board of Dentistry on July 9, 2015.

**Policy Statement on Controlled Substance Continuing Education Requirement**

Pursuant to T. C. A. § 63-1-402, on or after July 1, 2014, all prescribers who hold a current federal drug enforcement administration (DEA) license and who prescribe controlled substances shall be required to complete a minimum of two (2) hours of continuing education related to controlled substance prescribing biennially to count toward the licensees’ mandatory continuing education.

The continuing education must include instruction in the department’s treatment guidelines on opioids, benzodiazepines, barbiturates, and carisoprodol, and may include such other topics as medicine addiction, risk management tools, and other topics as it pertains to dentistry.

The two (2) hours of continuing education required by this law will count for the two (2) hours of continuing education pertaining to chemical dependency as required by Rule 0460-01-.05.

Adopted by the Board of Dentistry on March 27, 2015.

Policy Statement on Tobacco Meeting Chemical Dependency Continuing Education Requirement

Continuing Education courses pertaining to the use of tobacco do not meet the two (2) hour chemical dependency requirement as listed in Rule 0460-01-.05.

Adopted by the Board of Dentistry on January 9, 2015

Equipment and Drugs List  
as Required by Rules 0460-2-.07(6)(b)6(iv) and (7)(b)6(v)

Rules 0460-2-.07(6)(b)6 and (7)(b)6 cover the training, protocols and equipment required for the treatment of emergencies. It also requires equipment and drugs to be present and readily available for use. At a minimum, the following equipment and drugs must be available for treatment of emergency conditions when using Limited or Comprehensive Conscious Sedation or Deep Sedation and General Anesthesia:

Limited and Comprehensive Conscious Sedation

Written protocols must be established by the dentist to manage emergencies related to conscious sedation including but not limited to laryngospasm, bronchospasm, emesis and aspiration, airway occlusion by foreign body, angina pectoris, myocardial infarction, hypertension, hypotension, allergic and toxic reactions, convulsions, hyperventilation and hypoventilation.

(1) The following emergency equipment for adults and for pediatric patients, if pediatric patients are treated, must be present and easily accessible from the operatory and recovery room:

(a)  A positive pressure oxygen delivery system, including full face mask for adults and for pediatric patients, if pediatric patients are treated;

(b)  Oral and nasal airways of various sizes for adults and for pediatric patients, if pediatric patients are treated;

(c)  Blood pressure cuff and stethoscope for adults and for pediatric patients, if pediatric patients are treated (automatic pressure devices accepted);

(d)  Cardiac defibrillator or automated external defibrillator (AED);

(e)  Laryngoscope with current batteries;

(f)  Intubation forceps and endotracheal tubes;

(g)  Tonsillarsuctiontips;

(h)  A back-up suction device and an emergency lighting system;

(i)  Appropriate syringes;

(j)  Pulse oximeter to provide continuous monitoring of heart rate and oxygen saturation.

(2) The following drugs or type of drugs with a current shelf life must be maintained, insofar as possible given national drug availability, and easily accessible from the operatory and recovery room:

(a)  Epinephrine;

(b)  Atropine;

(c)  Lidocaine;

(d)  An antihistamine;

(e)  A bronchodilator;

(f)  An antihypoglycemic agent;

(g)  A vasopressor;

(h)  A corticosteroid;

(i)  An anticonvulsant;

(j)  A narcotic and benzodiazepine antagonist;

(k)  Nitroglycerine; and

(l) Aspirin.



Deep Sedation/General Anesthesia



Written protocols must be established by the dentist to manage emergencies related to deep sedation/general anesthesia including but not limited to laryngospasm, bronchospasm, emesis and aspiration, airway occlusion by foreign body, angina pectoris, myocardial infarction, hypertension, hypotension, allergic and toxic reactions, convulsions, hyperventilation and hypoventilation.

(1) The following emergency equipment for adults and for pediatric patients, if pediatric patients are treated, must be present and easily accessible from the operatory and recovery room:

(a)  A positive pressure oxygen delivery system, including full face mask for adults and for pediatric patients, if pediatric patients are treated;

(b)  Oral and nasal airways of various sizes for adults and for pediatric patients, if pediatric patients are treated;

(c)  Blood pressure cuff and stethoscope for adults and for pediatric patients, if pediatric patients are treated (automatic pressure devices accepted);

(d)  Cardiac defibrillator or automated external defibrillator (AED);

(e)  I.V. set-up, including appropriate hardware and fluids;

(f)  Laryngoscope with current batteries;

(g)  Intubation forceps and endotracheal tubes;

(h)  Tonsillarsuctiontips;

(i)  A back-up suction device and an emergency lighting system;

(j)  Appropriate syringes;

(k)  Tourniquet and tape;

(l)  Pulse oximeter to provide continuous monitoring of heart rate and oxygen saturation;

(m)  ET CO2 monitor.

(2) The following drugs or type of drugs with a current shelf life must be maintained, insofar as possible given national drug availability, and easily accessible from the operatory and recovery room:

(a)  Epinephrine;

(b)  Atropine;

(c)  Lidocaine;

(d)  An antihistamine;

(e)  A vasodilator;

(f)  A bronchodilator;

(g)  An antihypoglycemic agent;

(h)  A vasopressor;

(i)  A corticosteroid;

(j)  An anticonvulsant;

(k)  A narcotic and benzodiazepine antagonist;

(l)  An appropriate antiarrhythmic medication;

(m) Nitroglycerine;

(n)  Dantrolene (only necessary if agents (i.e. volatile agents) used have the potential for malignant hyperthermia. Use of succinylcholine as an emergency agent only does not require the practitioner to have dantrolene on hand.);

(o)  Succinylcholine;

(p)  Adenosine; and

(q)  Aspirin.

Rev. April 2018

**Policy Statement on Falsely Attesting To The Attendance and Completion of Required Continuing Education Hours and/or The CPR Training Requirement**

Pursuant to Tenn. Comp. R. & Regs., 0460-01-.05 (7) (a), any dentist, dental hygienist, or dental assistant who falsely attests to attendance and completion of the required hours of continuing education and/or the CPR training requirement may be subject to disciplinary action.

As such, upon notification to the Board that a dentist, dental hygienist or dental assistant is in violation of this rule, the licensee will be required to make up the hours in which they are deficient, be assessed one (1) Type C civil penalty for each continuing education hour forged and/or CPR training requirement forged and receive a reprimand. A reprimand is formal discipline and is reportable to the National Practitioners Database.

**Adopted by the Board on September 18, 2014**

**Policy Statement Regarding the Minimum Requirements Necessary for Sedation Course Approval**

Applications for sedation course approval should include as a minimum the following:

1. Complete faculty list with full formal CV of each faculty member
2. Complete course breakdown including teaching and lecture assignments as well as clinical teaching assignments of all faculties and the time spent in each activity.
3. Current and previous state licensure of all faculty
4. Complete list of malpractice and disciplinary actions for all faculty in all current and prior states in which licensed.
5. How much sedation does each participant perform?
6. Does the participant perform the dentistry as well on the sedated patient?
7. What agents are taught?
8. What is the student –instructor ratio in the course?
9. Who is the primary educational director in charge of and responsible for determining that a participant has been trained to competence?
10. Is the teaching course under the auspices of an ADA-recognized educational institution? If so, provide certification to that effect from the parent organization.
11. Where exactly is the course conducted? In what facility?

**Adopted by the Board of Dentistry on January 31, 2013**

**Policy Statement on Registered Dental Assistants Exposing Radiographs**

Pursuant to 0460-04-.11 of the Tennessee Board of Dentistry Rules and Regulations, a registered dental assistant shall not expose dental radiographs until certification has been issued by the Board.

If the licensed dentist(s) who is supervising a registered dental assistant, allows the dental assistant to expose dental radiographs without the proper certification, both the supervising dentist and registered dental assistant will be in violation of the Tennessee Dental Practice Act for unlicensed practice.

Upon notification to the Board that a supervising dentist(s) has allowed the registered dental assistant to expose radiographs, a complaint will be opened in the Office of Investigations for review by the board consultant and the board’s attorney.

Upon review of the complaint, the registered dental assistant will receive a Letter of Warning from the board’s consultant and the supervising dentist(s) will receive a reprimand and $500.00 civil penalty for each registered dental assistant found to be exposing radiographs without the proper certification. A reprimand is formal discipline and is reportable to the National Practitioners Database.

**Adopted by the Board of Dentistry on January 31, 2013**

**TENNESSEE BOARD OF DENTISTRY**

POLICY STATEMENT ON USE OF LASERS FOR DEBRIDEMENT AND BACTERIAL REDUCTION BY DENTAL HYGIENISTS

The position of the Tennessee Board of Dentistry is that the use of lasers for debridement and bacterial reduction by licensed dental hygienists is permitted after successful completion of a course which should include didactic and hands-on training.

Adopted by the Board of Dentistry on September 9, 2011. Amended by the Board of Dentistry on June 20, 2014.

**TENNESSEE BOARD OF DENTISTRY**

POLICY STATEMENT ON ACCEPTANCE OF THE AMERICAN BOARD OF DENTAL EXAMINERS, INC. (ADEX) EXAMINATION

The Tennessee Board of Dentistry has determined that the American Board of Dental Examiners, Inc. (ADEX) examination is closely aligned to the examination given by the Southern Regional Testing Agency (SRTA).

For licensure credentialing the candidate must have passed the ADEX exam administered by SRTA, NERB or CITA. In addition, the WREB and CRDTS exam will also be accepted.

Accordingly, it is the Board’s policy that any applicant for licensure by examination who relies on ADEX scores must have successfully completed such examination in order to meet the requirements for licensure by examination.

Adopted by the Board of Dentistry on May 18, 2012. Amended by the Board of Dentistry on June 20, 2014.

**TENNESSEE BOARD OF DENTISTRY POLICY STATEMENT**

PRACTICE OF DENTAL HYGIENE BY STUDENTS IN VOLUNTEER SETTINGS

The position of the Tennessee Board of Dentistry is to allow dental hygiene students enrolled in American Dental Association accredited programs to perform dental hygiene services including local anesthesia in volunteer settings under the direct supervision of an instructor.

Adopted by the Tennessee Board of Dentistry on June 10, 2010.

POLICY STATEMENT TENNESSEE BOARD OF DENTISTRY

LAPSED LICENSE POLICY

The Board of Dentistry recognizes that an individual may inadvertently allow his/her license to lapse/expire. However, applicable law prohibits an individual from working as a dentist, dental hygienist, or registered dental assistant unless he/she has an active and unrestricted license. The statute also prohibits a dentist from allowing a dental hygienist or registered dental assistant under that dentist’s supervision to perform any acts or services which require licensure or registration without an active and unrestricted license. While the Board and Committee do not condone an individual working on an expired license, the Board recognizes that the inadvertent lapses can occur. As such, the Board has adopted the following procedures for reinstatement of an expired license.

1. Immediately upon recognition that his/her license has expired, the individual must stop practicing and contact the Board’s Administrative Office to request a reinstatement application.
2. Upon receipt of the reinstatement application, the individual is to complete the application in its entirety, providing a detailed work history, including duties performed since the license expiration date. The application is to be signed, notarized, and returned to the Board’s Administrative Office along with any additional information required for the application.
3. Upon receipt of a completed renewal application and the applicant’s payment of all fees, the Board Administrator may renew a license which is less than sixty (60) calendar days past the expiration date
4. If the reinstatement application received reflects in the work history that the individual has worked in excess of ninety (90) calendar days, on an expired license, the Board will present to the licensee, an Agreed Citation which specifies payment of a fine in the amount of $100 per month for a dentist, $75.00 per month for a dental hygienist, and $50.00 per month for registered dental assistants for every month worked in excess of ninety (90)days from the expiration in addition to the required reinstatement fees. If the reinstatement application received reflects in the work history that the individual has worked in excess of ninety (90) days on an expired license, the Board will also present to the supervising dentist(s), if applicable, a Letter of Concern for the first offense, a Letter of Warning for the second offense, and official notice which specifies payment of a civil penalty in the amount of $1,000.00 for the third offense of allowing a license under supervision to work in excess of the ninety calendar days for expiration date. The individual’s license will not be reinstated unless and until the Agreed Citation is executed by the licensee and payment of the fine remitted to the Board’s Administrative Office.

A. The licensee shall be notified that all Agreed Citations prepared in accordance with this policy shall be reportable on the Department of Health’s website, its disciplinary action report issued in the month the action is taken and to all appropriate federal databanks including the National Practitioner Data Bank (NPDB).



B. This remedy is only available to those licensees who have practiced on a lapsed license for less than six (6) months from the date the license went into expired status.

1. If the licensee refuses to execute the Agreed Citation and/or remit the civil penalty described therein within sixty (60) days of the date the Agreed Citation is sent to the licensee, or if the licensee practiced on a lapsed license for six (6) months or longer, the licensee shall be referred to the Office of Investigations and Office of General Counsel for formal disciplinary action. Upon a proven violation, the minimum disciplinary action for this violation shall be:

A. A formal and reportable Reprimand on the license;

* 1. Assessment of civil penalties in an amount to exceed $300 per month for every month in which the individual has worked at least one day beyond the sixty (60) calendar day grace period;
  2. Assessment of costs associated with investigating and prosecuting the matter; and
  3. Any and all other remedies the Board deems appropriate.

1. In the event the matter is referred to the Office of Investigations and Office of General Counsel for formal disciplinary action, the Board’s Administrative Office shall be permitted to reinstate those applicants for whom they have received a completed reinstatement application, supporting documentation (including any required proof of continuing education), and the applicant’s payment of all fees, subject to further action on the license as described in paragraph five (5) above. Though the Board’s Administrator may reinstate such a license upon approval from the Board’s consultant, preferential treatment will not be given to these applicants. These applications will be reviewed in the order in which they are received. For those applicants who have declined an Agreed Citation, their application will be deemed received sixty (60) days from the date the Agreed Citation was sent.

RATIFIED BY THE BOARD OF DENTISTRY ON THE \_\_\_\_\_\_\_DAY OF \_\_\_\_\_\_\_\_\_\_.

**TENNESSEE BOARD OF DENTISTRY**

**POLICY ON UNREADABLE FINGERPRINTS TAKEN FOR CRIMINAL BACKGROUND CHECK**

Health care consumers are dependent upon professional licensing boards to conduct appropriate screening of applicants. The Board of Dentistry has the responsibility of protecting the health, safety and welfare of the citizens of the State of Tennessee and to that end has a duty to exclude individuals who pose a risk to the public health, safety and welfare. One means of predicting future behavior is to look at past behavior. Checking whether applicants for licensure or registration have a criminal history and examining the nature of that history can provide significant information for boards to use in making licensure decisions. To that end, the Board of Dentistry asks all new applicants to obtain a criminal background check and have the results transmitted to the Board for examination. In most cases, the fingerprints are clear and easily readable. However, some individuals cannot get readable fingerprints. For applicants with unreadable prints, the Board of Dentistry adopts the following policy relative to unreadable fingerprints:

In all cases where an applicant’s fingerprint cards are unreadable, the applicant shall be required to come to the State of Tennessee and submit to a FBI/TBI fingerprint **scan** through the State of Tennessee’s approved vendor or its equivalent as determined by the board.

1. **For applicants not licensed in any other jurisdiction:**

**The board shall require the applicant to submit to an FBI/TBI fingerprint scan through the State of Tennessee’s approved vendor or its equivalent as determined by the board or its equivalent in the state in which the applicant is located.**

1. **For applicants licensed in other jurisdictions:**

**The board shall require the applicant to submit to an FBI/TBI fingerprint scan through the State of Tennessee’s approved vendor or its equivalent as determined by the board or its equivalent in the state in which the applicant is located.**

**Adopted by the Board of Dentistry on the 13th day of September, 2007**

**BOARD OF DENTISTRY POLICY STATEMENT ON DISCIPLINING CONTINUING EDUCATION DEFICIENCIES**

DENTIST

Should a licensed Tennessee dentist fail to obtain the required amount of continuing education during a biennial CE cycle, the following shall occur:

1. The licensee must pay a civil penalty in the amount of $600 within thirty days of notification from the Board; and

2. The licensee must make up the amount of hours he or she is deficient. All deficient hours must be made up within ninety days of notification from the Board. If a licensee is deficient in hours for a particular category of required CE (i.e., chemical dependency hours or CPR hours), the licensee must make up the hours required for that particular category. If a licensee is deficient in CPR hours, such licensee must also provide proof within ninety days that he or she is currently certified in CPR.

CE make-up hours do not count toward the hour requirement for any CE cycle other than the one which was found to be deficient.

In the event a licensed Tennessee dentist fails for a second time to obtain the required amount of continuing education during a biennial CE cycle, such licensee must pay a $1,200 civil penalty, and must also meet the requirements of number 2, above.

DENTAL HYGIENIST

Should a licensed Tennessee dental hygienist fail to obtain the required amount of continuing education during a biennial CE cycle, the following shall occur:

1. The licensee must pay a civil penalty in the amount of $300 within thirty days of notification from the Board; and

2. The licensee must make up the amount of hours he or she is deficient. All deficient hours must be made up within ninety days of notification from the Board. If a licensee is deficient in hours for a particular category of required CE (i.e., chemical dependency hours or CPR hours), the licensee must make up the hours required for that particular category. If a licensee is deficient in CPR hours, such licensee must also provide proof within ninety days that he or she is currently certified in CPR.

CE make-up hours do not count toward the hour requirement for any CE cycle other than the one which was found to be deficient.

In the event a licensed Tennessee dental hygienist fails for a second time to obtain the required amount of continuing education during a biennial CE cycle, such licensee must pay a $600 civil penalty, and must also meet the requirements of number 2, above.

REGISTERED DENTAL ASSISTANT

Should a registered Tennessee dental assistant fail to obtain the required amount of continuing education during a biennial CE cycle, the following shall occur:

1. The licensee must pay a civil penalty in the amount of $150 within thirty days of notification from the Board; and

2. The licensee must make up the amount of hours he or she is deficient. All deficient hours must be made up within ninety days of notification from the Board. If a licensee is deficient in hours for a particular category of required CE (i.e., chemical dependency hours or CPR hours), the licensee must make up the hours required for that particular category. If a licensee is deficient in CPR hours, such licensee must also provide proof within ninety days that he or she is currently certified in CPR.

CE make-up hours do not count toward the hour requirement for any CE cycle other than the one which was found to be deficient.

In the event a registered Tennessee dental assistant fails for a second time to obtain the required amount of continuing education during a biennial CE cycle, such licensee must pay a $300 civil penalty, and must also meet the requirements of number 2, above.

**Adopted by the Board of Dentistry on the 13th day of September, 2007**

**Policy Statement**

It is the policy of the Tennessee Board of Dentistry to accept, as proof of continuing education, transcripts from the organizations listed at board rule 0460-1-.05(3)(d), so long as such transcripts list courses attended and the number of credit hours.

**Adopted by the Board of Dentistry on the 21st day of September, 2006.**

Policy Statement

The position of the Tennessee Board of Dentistry is that since acupuncture is not a specialty recognized by the Tennessee Board of Dentistry or the American Dental Association, there are no licensing procedures or guidelines regarding the use of acupuncture in the statutes and rules of the Tennessee Board of Dentistry.

However, the Tennessee Board of Medical Examiners Advisory Committee for Acupuncture does regulate and issue certification for the practice of acupuncture. The Tennessee Board of Dentistry can neither endorse nor encourage the use of this technique in the practice of dentistry but if a dentist does utilize this treatment in their practice, they must obtain certification from the Tennessee Board of Medical Examiners Advisory Committee for Acupuncture before utilization of this technique.

Adopted by the Board of Dentistry on the 26th day of January, 2006.

**POLICY STATEMENT TENNESSEE STATE BOARD OF DENTISTRY**

**POLICY: MANAGEMENT OF PRESCRIBING WITH EMPHASIS ON ADDICTIVE OR DEPENDENCE-PRODUCING DRUGS**

The Tennessee Board of Dentistry is charged by the General Assembly to protect the citizens of the State from harmful dentist management. A significant number of dentists who are asked to appear before the Board are required to do so because of their lack of information about the management and responsibilities involved in prescribing controlled substances. Frequently, the inadvertent offender is a dentist with a warm heart and a desire to relieve pain and misery, who is always pressed for time and finds himself or herself prescribing controlled drugs on demand over prolonged periods without adequate documentation. The purpose of the Board of Dentistry in presenting the following information is to help licensed dentists in Tennessee consider and reevaluate their prescribing practice of controlled substances. Practicing dentists have often mentioned the abrupt education they received in their own prescribing patterns. Moreover, there have been many requests to the Board from dentists requesting detailed information on prescribing in certain specific situations.

*It is not what you prescribe, but how well you manage the patient's care, and document that care in legible form, that is important.*

The prescribing matters that come before the Board are almost always related to the prescription of controlled substances. We feel that a majority of instances where dentists have been disciplined by the Board for prescribing practices could have been avoided completely if they had followed the steps that are being outlined here. To prevent any misunderstanding, it is necessary to state what the Board **does not** have.

It **does not** have a list of "bad" or "disallowed" drugs, but the substances prescribed must be rational to the practice of dentistry. All drugs are good if prescribed and administered when properly indicated. Conversely, all drugs are ineffective, dangerous, or even lethal when used inappropriately.

It **does not** have some magic formula for determining the dosage and duration of administration for any drug. These are aspects of prescribing that must be determined within the confines of the individual clinical case, and continued under proper monitoring. What is good for one patient may be insufficient or fatal for another.

What the Board **does** have is the expectation that dentists will create a record that shows: - Proper indication for the use of drug or other therapy;  
- Monitoring of the patient where necessary;  
- The patient's response to therapy based on follow-up visits; and

- All rationale for continuing or modifying the therapy.

**STEP ONE**

First and foremost, before you prescribe anything, start with a diagnosis which is supported by history and physical findings, and by the results of any appropriate tests. Too many times a dentist is asked why he or she prescribed a particular drug, and the response is, "Because the patient was in pain." Then the dentist is asked "How did you determine that?", and the answer is, "Because that's what the patient complained of." Nothing in the record or in the dentist's recollection supports the diagnosis except the patient's assertion. **Do a workup sufficient to support a diagnosis,** including all necessary tests.

**STEP TWO**

Create a treatment plan which includes the use of appropriate non-addictive modalities, and make referrals to appropriate specialists, when indicated. The result of the referral should be included in the patient's chart.

**STEP THREE**

Before beginning a regimen of controlled drugs, make a determination through trial or through a documented history that **non-addictive modalities are not appropriate or they do not work**. A finding of intolerance or allergy to NSAIDs is one thing, but the assertion of the patient that, "Gosh, Doc, nothing seems to work like that Percodan stuff!" is quite another. Too many of the dentists the Board has seen have started a treatment program with powerful controlled substances without ever considering other forms of treatment.

**STEP FOUR  
Make sure you are not dealing with a drug-seeking patient**. If you know the patient, review the prescription records in the patient's chart and discuss the patient's chemical history before prescribing a controlled drug. If the patient is new or otherwise unknown to you, at a minimum obtain a drug history, and discuss chemical use and family chemical history with the patient.

**STEP FIVE**

It is a good idea to obtain the informed consent of the patient before using a drug that has the potential to cause dependency problems. **Take the time to explain the relative risks and benefits of the drug and record in the chart the fact that this was done**. When embarking on what appears to be the long-term use of a potentially addictive substance, it may be wise to hold a family conference and explain the relative risks of dependency or addiction and what that may mean to the patient and to the patient's family. Refusal of the patient to permit a family conference may be significant information.

**STEP SIX**

Maintain regular monitoring of the patient, including frequent physical monitoring. If the regimen is for a prolonged drug use, it is very important to monitor the patient for the root condition which necessitates the drug **and** for the side effects of the drug itself. This is true no matter what type of controlled substance is used or what schedule it belongs to. Also, remember that with certain conditions, drug holidays are appropriate. This allows you to check to see whether the original symptoms recur when the drug is not given - indicating a continuing legitimate need for the drug or whether withdrawal symptoms occur - indicating drug dependence.

**STEP SEVEN**

Make sure YOU are in control of the supply of the drug. To do this, at a minimum you must keep detailed records of the type, dose, and amount of the drug prescribed. You must also monitor, record and personally control all refills. Do not authorize your office personnel to refill prescriptions without consulting you. **One good way to accomplish this is to require the patient to return to obtain refill authorization, at least part of the time**. Records of the cumulative dosage and average daily dosage are especially valuable. A thumbnail sketch of three hypothetical cases will illustrate our point here. In the first case, a dentist prescribed hydrocodone and soma for a dentally related condition. The patient was also obtaining the same drugs from two physicians. In the second case, a dentist prescribes, Tylenol 3's to a patient for slightly more than a year at the average daily rate of 30 per day! The third case is very similar, except that it was Tylenol 4's at the rate of 20 per day. Some quick observations:

- No dentist who was aware of that kind of prescribing would have continued with it.  
- Few, if any, patients could have been consuming that much Tylenol with codeine unless addicted or reselling it.  
Another important part of controlling the supply of drugs is to check on whether the patient is obtaining drugs from other health care professionals. Checking with pharmacies and pharmacy chains and other health care providers may tell you whether a patient is obtaining extra drugs or the patient is doctor shopping. If you are aware it is occurring, contact other dentists and health professionals in your area.

**STEP EIGHT**

Maintaining regular contact with the patient's family is a valuable source of information on the patient's response to the therapy regimen, and may be much more accurate and objective than feedback from the patient alone. The family is a much better source of information on behavioral changes, especially dysfunctional behavior, than is the patient. Dysfunctional changes may be observable when the patient is taking the drug, or when the drug is withdrawn. These changes, at either time, may be a symptom of dependency or addiction. The family is also a good source of information on whether the patient is obtaining drugs from other sources, or is self-medicating with other drugs or alcohol.

**STEP NINE**

To reiterate, one of the most frequent problems faced by a dentist when he or she comes before the Board or other outside review bodies is **inadequate records**. It is entirely possible that the dentist did everything correctly in managing a case, but without records which reflect all the steps that went into the process, the job of demonstrating it to any outside reviewer becomes many times more difficult. Luckily, this is a problem which is solvable.

**Adopted by the Tennessee Board of Dentistry on this the 21st day of September, 2005.**

Note: The above policy was taken almost verbatim from the practice statement issued by the Board of Medical Examiners of the State of North Carolina in February of 1991 to all its licensees. We express our appreciation to them, and the Minnesota Board of Medical Examiners who originally distributed this information in 1990, and acknowledge the authorship by those two Boards of this nine step process. This policy was taken almost verbatim from the policy statement issued by the Tennessee Board of Medical Examiners in September of 1995.

**Policy Statement**

It is the position of the Tennessee Board of Dentistry that the requirement of CPR certification found in T.C.A. 63-5-107(c)(1) and Rule 0460-1-.05(4) for dentist is met by submission of certification of either the ACLS or PALS certification. The Board determines that CPR basic life support training is included in the ACLS and PALS training.

**Adopted by the Board of Dentistry on the 12th day of May, 2005. Amended by the Board of Dentistry on the 20th day of June, 2014.**

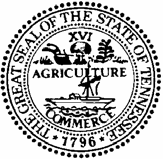
**Policy Statement**

The position of the Tennessee Board of Dentistry is the payment of lapse license penalty fees, civil penalty fees and cost assessment fees is to be paid within thirty (30) days of notice that the fees are due. In cases that the licensee or individual is unable to pay all fees due within thirty (30) days, the Board will allow the licensee or individual to make arrangements with Health Related Boards (HRB) to pay monthly or twice a month for up to twelve (12) months as long as a payment is made each month.

If a licensee or individual is paying a civil penalty or cost assessment to satisfy an order from the Board, then the licensee or individual will not be in compliance with the order until all fees due are received. If the licensee or individual does not pay all fees due under the terms of the agreement with HRB, then they will be in violation of the order of the Board and such action or inaction could result in additional disciplinary action by the Board.

If the licensee is paying a lapse license penalty resulting from practicing on a lapsed license, then the licensee will not be reinstated until all fees are paid. If the fees due are not paid under the terms of the agreement with HRB or the licensee practices as either a dentist, dental hygienist or registered dental assistant before the license is reinstated, the licensee may be disciplined by the Board and/or assessed additional penalty fees.

**Adopted by the Board of Dentistry on the 19th day of May, 2004.**



State of Tennessee Department of Health

**Division of Health Related Boards Administrative Policies and Procedures**

**Subject: Renewal for Licensees File No: 404.02 Called to Active Military Duty**

# Approved by: Effective Date: 04/10/03

Robbie H. Bell, Director

**PURPOSE:** To protect licensees who are active in military service, who have been deployed for action and are not available to renew their licenses or to obtain required continuing education in a timely manner.

**POLICY:** The Division shall allow special consideration for renewal of the licenses of military personnel who were called to active duty, and were unable to obtain required continuing education or to renew their license timely.

# PROCEDURES:

1. Any licensee who held an active license with Health Related Boards at the time he/she was called to active duty in the military of the United States, and was unable to renew that license while on active duty, shall notify the appropriate board office in writing.
   1. The licensee shall submit a letter stating the reason for non-renewal of the license was active duty in the U.S. Military.
   2. Dates and proof of service shall be submitted to the office by the licensee.
2. Upon receipt of notification and proof of active service, the licensee shall be allowed to renew the license with no late renewal or penalty fees added to the cost of renewal.
   1. A copy of all documentation regarding notification and proof of active service shall be included in the permanent licensure file of the licensee.
3. A licensee whose license has been expired for one year or less shall not be required to complete required continuing education for renewal of the license at that time.
4. A licensee whose license has been expired for more than one year shall be required to obtain one-half of the required continuing education in order to have the license renewed.

LL/G3033114/BDS

Page 1 Effective Date: 04/10/03 File No.: 404.02