Client name	Randy Mc Henry
Form	Montana Licensing Reform Task Force
Matter	Randy McHenry - Rules
Sent	April 10, 2026 at 8:58 AM
Due	
Submitted	April 10, 2026 at 8:58 AM

Randy McHenry

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Montana Licensing Reform Task Force

This Task Force was created pursuant to Executive Order 1-2026 on January 29, 2026.

Purpose of the Licensing Reform Task Force

The Task Force shall provide the Governor with recommendations and strategies for the State of Montana to reform the professional occupational licensing system for the purposes of:

• identifying and removing burdens and barriers faced by licensees that are not necessary to protect the public; and
• improving access to and availability of professional services for citizens across Montana, including rural communities.

In developing recommendations and strategies, the Task Force shall seek input from Montana citizens, legislators, Montana associations whose members are licensed occupational professionals, professional licensing boards, relevant state agencies, advisory groups and researchers focused on occupational licensing, and other appropriate stakeholders as determined by the Task Force.

Public Record

Please note that all information received through this form is public record.

Which committee would you like to receive your comment?

Health Care Subcommittee
Barriers Subcommittee
Sunset Review Subcommittee

We want to hear from you!

We would like to receive any comments you would like the Task Force, or one of its subcommittees, to review. In addition, we are specifically looking for feedback for:

1. Specific topics a committee or the task force should consider, and
2. Specific people or organizations you think the task force should hear from.

Do you have a general comment or a specific person or topic for the Task Force to hear from?

Specific person or topic

What are your comments?

Formal Submission to the Licensing Reform Advisory Council
Regarding Denturist Scope of Practice Reform in Montana
Submitted in response to:
Executive Order 1-2026 issued by Greg Gianforte

I. Purpose of Submission
This submission provides recommendations for the reform and modernization of denturist licensure and scope of practice in the State of Montana. These recommendations are offered in direct alignment with the objectives outlined in Executive Order 1-2026, specifically:
• Removal of unnecessary regulatory barriers
• Expansion of workforce capacity
• Improvement of access to care, particularly in rural communities
• Reduction of unnecessary cost burdens to patients
• Ensuring that licensure requirements remain narrowly tailored to public health and safety

---

II. Foundational Principle: Education-Based Scope of Practice
A central and governing principle of this submission is as follows:
Scope of practice for denturists must be determined by recognized, accredited education, training, and demonstrated competency in prosthetic care—not by artificial, outdated, or protectionist limitations.
Where a procedure, service, or responsibility is:
• Taught within accredited denturist education programs,
• Supported by nationally or internationally recognized training standards, and
• Demonstrated through competency-based evaluation,
…it should be included within the lawful scope of practice.
Failure to align scope with education creates:
• Artificial workforce constraints
• Reduced access to care
• Increased costs to patients
• Regulatory inconsistency with the intent of Executive Order 1-2026

III. Key Recommendations
1. Alignment of Scope with Recognized Education and Training
Montana should formally align denturist scope of practice with:
• Nationally accredited educational standards
• Established clinical competencies in prosthetic care
This includes recognition of competencies in:
• Removable prosthetics
• Implant-supported prosthetics (including full-arch restorations)
• Digital denture workflows
• Non-diagnostic patient assessment within prosthetic care
Rationale:
Executive Order 1-2026 requires that licensure qualifications be justified and narrowly tailored. Education and competency provide that justification.

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2. Removal of Unnecessary Supervision and Gatekeeping Requirements
Requirements for dentist supervision or mandatory referral—when not clinically necessary—should be eliminated.
Licensed denturists should be permitted to provide:
• Direct-to-patient prosthetic care
• Independent clinical services within their education and training
Rationale:
Such requirements represent unnecessary barriers that reduce competition, increase cost, and restrict access without improving patient safety.

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3. Protection of Independent Regulatory Oversight
Denturist regulation should remain independent and not be consolidated under dental boards.
Rationale:
Executive Order 1-2026 explicitly recognizes that existing licensed professions may impose barriers that restrict competition. Independent oversight ensures that scope is evaluated based on competency—not competitive influence.

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4. Expansion of Implant Prosthetic Scope (Including Abutments)
Denturists should be authorized to:
• Restore implant-supported prosthetics
• Perform prosthetic conversions and maintenance
• Place abutments and torque implants within prosthetic protocols

This authority is already recognized in jurisdictions such as Washington.
Rationale:
These procedures are prosthetic—not surgical—in nature and are included in advanced denturist training pathways. Aligning with existing state models demonstrates both safety and effectiveness.

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5. Interstate Licensure Reciprocity and Scope Portability
Montana should adopt:
• Licensure reciprocity or endorsement pathways
• Scope recognition parity with other states where broader authority is granted based on equivalent training
Rationale:
Executive Order 1-2026 specifically calls for licensure portability to expand access. Restricting trained professionals below their demonstrated competency limits workforce mobility and patient access.

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6. Recognition of Denturists as Primary Prosthetic Providers
Denturists should be statutorily recognized as:
• Independent providers of removable prosthetics
• Providers of implant-supported prosthetic restorations
Rationale:
This clarification eliminates ambiguity and aligns regulatory structure with actual training and practice.

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7. Removal of Unnecessary Clinical Restrictions
Montana should eliminate restrictions on:
• Immediate dentures
• Post-operative prosthetic care
• Disproportionate regulatory burdens unique to denturists
Rationale:
These services are low-risk, education-based procedures. Restrictions increase cost and reduce access without improving safety.

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8. Radiology Endorsement for Denturists (Critical Patient Safety Issue)
A radiology endorsement should be established allowing denturists to:
• Take panoramic radiographs
• Perform basic radiographic assessment
• Refer patients appropriately for further evaluation
Clinical Justification:
The edentulous population frequently does not receive routine radiographic screening. This creates a significant and documented risk of:
• Undiagnosed pathology
• Delayed diagnosis
• Increased morbidity and cost of care
This issue is particularly pronounced in rural communities.
Based on direct clinical experience, this gap has resulted in missed pathology that could have been identified earlier with routine imaging.
Rationale:
This recommendation:
• Improves early detection of disease
• Enhances patient safety
• Reduces downstream healthcare costs
• Aligns with rural healthcare access priorities
Radiographic competency can be safely implemented through structured education and endorsement.

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9. Cost Reduction and Market Competition
Denturists should be allowed to operate without structural suppression from competing regulatory frameworks.
Rationale:
Increased competition reduces consumer costs and improves access—explicit goals of Executive Order 1-2026.

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10. Sunset Review of Restrictive Regulations
All statutes and regulations governing denturists should undergo review to remove:
• Outdated provisions
o Denturist must give no questions asked refund for up to 2 years. No other licensed dental professional is required to do this.
o Current education requirements based on years and not academic credit hours for denturists only. All licensed dental professionals in Montana are based on credit hours and not time specific requirements to months or years in their specific academic programs.
• Requirements not tied to measurable safety outcomes
Rationale:
This aligns directly with the Executive Order's directive for comprehensive review.

---

11. Clarification of Permitted Clinical Activities
Statutory language should clearly authorize denturists to:
• Perform non-diagnostic patient assessments
• Provide post-operative care
• Manage prosthetic complications within scope
Rationale:
Clear definitions reduce regulatory ambiguity and enforcement inconsistency.

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12. Integration into State Healthcare Strategy
Denturists should be included in:
• Medicaid planning
• Rural healthcare delivery systems
• Workforce expansion initiatives
Rationale:
Denturists are a critical component of accessible, cost-effective oral healthcare delivery.

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13. Elimination of Redundant Licensing and Overregulation
Montana should remove:
• Duplicate oversight
• Unnecessary compliance burdens
Rationale:
This reduces administrative cost and increases efficiency without compromising safety.

IV. Conclusion
Denturists are uniquely positioned to:
• Expand access to care
• Reduce cost to patients
• Strengthen the healthcare workforce
• Address critical gaps in rural healthcare delivery
When scope of practice is aligned with recognized education and demonstrated competency, these outcomes can be achieved without compromising public health or safety.
These recommendations are fully consistent with the intent and directives of Executive Order 1-2026 and represent a necessary step toward modernizing Montana's healthcare licensing and scope of practice framework.

THIS NEXT SECTION IS THE SAME RESPONSE WITH SOME PROPOSED DRAFTED LANGUAGE

Formal Submission to the Licensing Reform Advisory Council
Regarding Denturist Scope of Practice Reform in Montana

I. Purpose of Submission
This submission provides recommendations for modernization of denturist licensure and scope of practice in Montana consistent with Executive Order 1-2026, including:
• Removal of unnecessary regulatory barriers
• Expansion of workforce capacity
• Increased access to care, especially in rural communities
• Reduction in patient cost
• Ensuring licensure remains narrowly tailored to public safety

---

II. Foundational Principle: Education-Based Scope of Practice
Scope of practice for denturists shall be determined by recognized, accredited education, training, and demonstrated competency in prosthetic care.

III. Key Recommendations with Statutory Language

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1. Education-Based Scope Alignment
Proposed Statutory Language:
Section X-1. Scope of Practice Determination
(1) A licensed denturist may perform any procedure, service, or function that:
(a) is included within an accredited denturist education program or recognized continuing education program; and
(b) the denturist has demonstrated competency to perform.
(2) The scope of practice may not be restricted by requirements not directly related to demonstrated education, training, and competency.

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2. Removal of Supervision Requirements

Proposed Statutory Language:
Section X-2. Independent Practice Authority
(1) A licensed denturist may provide prosthetic oral healthcare services directly to patients without supervision by a dentist or other licensed professional.
(2) A referral to a dentist or physician shall only be required when clinical findings exceed the denturist's defined scope of practice.

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3. Independent Regulatory Oversight
Proposed Statutory Language:
Section X-3. Regulatory Authority
(1) Denturists shall be regulated under an independent board or regulatory structure that reflects their distinct scope of practice.
(2) No regulatory authority composed primarily of another profession may restrict denturist scope beyond education-based competency standards.

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4. Implant Prosthetic Scope Including Abutments
Proposed Statutory Language:
Section X-4. Implant Prosthetic Services
(1) A licensed denturist may perform prosthetic procedures related to dental implants, including:
(a) placement and removal of abutments;
(b) torquing of implant components in accordance with manufacturer specifications;
(c) restoration, maintenance, and adjustment of implant-supported prosthetics.
(2) Procedures authorized under this section are defined as prosthetic, not surgical, in nature.

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5. Interstate Reciprocity and Scope Recognition
Proposed Statutory Language:
Section X-5. Licensure Reciprocity and Scope Parity
(1) The State shall grant licensure by endorsement to denturists licensed in another jurisdiction with substantially equivalent education and training requirements.
(2) A denturist licensed under this section may perform procedures authorized in the originating jurisdiction, provided such procedures are supported by documented education and competency.

---

6. Recognition as Primary Prosthetic Providers
Proposed Statutory Language:
Section X-6. Provider Classification
Denturists are recognized as independent healthcare providers for removable and implant-supported prosthetic services and shall not be classified as auxiliary to dentistry.

---

7. Removal of Restrictive Provisions
Proposed Statutory Language:
Section X-7. Elimination of Unnecessary Restrictions
(1) The following restrictions are repealed unless directly tied to documented patient safety outcomes:
(a) limitations on immediate denture services;
(b) limitations on post-prosthetic care;
(c) profession-specific financial or refund requirements not applied to comparable licensed professions.

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8. Radiology Endorsement (Critical Patient Safety Provision)
Proposed Statutory Language:
Section X-8. Radiology Endorsement
(1) The Board shall establish a radiology endorsement for licensed denturists.
(2) A denturist holding this endorsement may:
(a) expose and process panoramic radiographs;
(b) perform basic radiographic assessment for the purpose of identifying abnormalities;
(c) refer patients to a dentist or physician for diagnosis and treatment.
(3) Radiographic interpretation under this section shall not constitute a medical or dental diagnosis.

---

9. Market Competition and Cost Reduction
Proposed Statutory Language:
Section X-9. Competitive Practice Protections
No rule or regulation may be adopted that has the primary effect of restricting market competition unless it is demonstrably necessary to protect public health and safety.

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10. Sunset Review Requirement
Proposed Statutory Language:
Section X-10. Regulatory Review
All statutes and administrative rules governing denturists shall be subject to periodic review to ensure alignment with current education standards, workforce needs, and public safety data.

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11. Clarification of Clinical Activities
Proposed Statutory Language:
Section X-11. Authorized Clinical Functions
A licensed denturist may:
(a) perform non-diagnostic patient assessments;
(b) provide post-prosthetic care;
(c) manage prosthetic complications within their scope of practice.

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12. Integration into Healthcare Systems
Proposed Statutory Language:
Section X-12. Healthcare System Inclusion
Denturists shall be recognized as eligible providers within state healthcare programs, including Medicaid and rural health initiatives.

---

13. Reduction of Redundant Regulation
Proposed Statutory Language:
Section X-13. Regulatory Efficiency
The State shall eliminate duplicative or unnecessary regulatory requirements that do not directly contribute to patient safety.

IV. Conclusion
Denturists provide a critical, cost-effective, and accessible component of Montana's healthcare system.
Aligning scope of practice with recognized education and demonstrated competency:
• Expands access to care
• Reduces cost to patients
• Strengthens the rural workforce
• Maintains appropriate patient safety standards
These reforms are fully consistent with the intent and directives of Executive Order 1-2026 and represent a necessary modernization of Montana's licensing framework.

I feel the task force should consider reaching out to the state associations, National association and American Denturist college for information pertaining to questions as they may arise. I have several dental specialists I can add to the list if needed.

I sincerely appreciate everyone hard work to help out the underserved communities and professionals in our great state!

Take care,
Randy McHenry LD BTSc
President NDA

Client name	Malcolm Horn
Form	Montana Licensing Reform Task Force
Matter	Malcolm Horn - Rules
Sent	April 9, 2026 at 4:22 PM
Due	
Submitted	April 9, 2026 at 4:22 PM

Malcolm Horn

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Other phone	14066965040		

Montana Licensing Reform Task Force

This Task Force was created pursuant to Executive Order 1-2026 on January 29, 2026.

Purpose of the Licensing Reform Task Force

The Task Force shall provide the Governor with recommendations and strategies for the State of Montana to reform the professional occupational licensing system for the purposes of:

• identifying and removing burdens and barriers faced by licensees that are not necessary to protect the public; and
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Barriers Subcommittee

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Specific person or topic

What are your comments?

Dear Esteemed members of the Barriers and Health Care Task Forces,

I am submitting my public comments after years of conversations with the Board of Behavioral Health (BBH), educators in our State University system and other behavioral health providers. Our current rules and statutes pertaining to the Licensed Addiction Counselor (LAC) is not only woefully behind the national standards, it leaves the public at risk of inadvertent harm. I have two key goals in my request:

GOAL 1: Reduce barriers for master's level clinicians to work as Licensed Addiction Counselors (LAC).

GOAL 2: Reduce unnecessary education requirements for any potential LAC candidate (Gambling Disorder, Co-Occurring Disorder, Behavioral Pharmacology).

In order to understand the intention of these goals, one must be aware of the LAC requirements in Montana:

A qualified degree meeting specific requirements in counseling, human behavior and abnormal disorders

285 "addiction-specific" education hours (these span from understanding the American society of Addiction Medicine (ASAM) patient placement criteria; counseling skills; behavioral pharmacology; gambling disorder; cultural competence; ethics; treatment planning and documentation; alcohol & drug studies

1,000 hours of supervision by a qualified license holder in an approved setting

These requirements are the same regardless of current license status (i.e. someone that is currently licensed as a Master's level LCSW or LCPC), education or work experience.

GOAL 1: Reduce barriers for master's level clinicians to work as Licensed Addiction Counselors (LAC).

LAC rules in Montana allow for those with an Associates degree (minimal education and experience) and a Master's degree (high level of education, experience and hands-on training) to be licensed through the same education & supervision requirements. This means that those with only two years of education (an Associates degree) are allowed the same level of practice scope and reimbursement as those with a Master's degree (6 plus years of education—includes their Bachelor's degree—and hands on internship and practicum experiences). Not only does this skew our perceived competencies (an Associates level LAC is assumed to have the same level of proficiency and scope of practice as someone with a Master's degree) they are also reimbursed the same. Not only does this limit the motivation to pursue higher education (why attain a higher degree if I am reimbursed the same?) but also leaves the public at risk: a consumer may not know that their Associates level LAC does not have the experience and practice as someone with a Master's degree. This also limits us in two additional ways:

Portability: because our licensure standards are less than other states and does not align with the National standards, the Montana LAC is not portable. Our threshold is less than the standard of licensure nationally, thus, other states will not accept our license.

Reimbursement: Third party reimbursement structures (from private insurance companies to Medicaid) pay an Associates level clinician the same as a Master's level clinician. Historically, Blue Cross Blue Shield has objective to this; as they should: why reimburse a Master's level clinician the same as an Associates?

Individuals who already hold an LCSW or LCPC license have demonstrated competency in core counseling skills, clinical documentation, ethical practice, and related professional standards. In addition, they have completed 3,000 hours of supervised practice under a qualified, licensed professional. Requiring these licensees to complete additional education requirements and accrue an additional 1,000 hours of supervision in order to obtain LAC licensure is duplicative and unnecessary, and it further limits the entry of qualified counselors into the addiction counseling workforce. Logically, if someone already has an LCSW or LCPC under the BBH requirements, they should not need additional education and 1,000 hours of supervision (that they likely need to pay out-of-pocket for) in order to practice as an LAC; they may need some education on (ASAM) patient placement but forcing them to seek/demonstrate 285 addiction-specific education hours and

1,000 of supervision is superfluous. The additional education and supervision requirements for those already licensed as Master's level practitioners prevent current, qualified individuals from practicing as an addiction counselor.

Suggested Resolution: ask the BBH to create a reduced education & supervision "pathway" for those already licensed as an LCPC or LCSW. All components of the 285 hours (with the exception of the Gambling Disorder requirement) are covered in their education; they may need additional knowledge on ASAM placement criteria, but the other education requirements are redundant. They have already completed 3,000 hours of supervision in order to be licensed as an LCPC/LCSW; an additional 1,000 hours is onerous. Those already holding and LCPC or LCSW should be exempted from the 1,000 hours of supervision.

GOAL 2: Reduce unnecessary education requirements for any potential LAC candidate (Gambling Disorder, Co-Occurring Disorder, Behavioral Pharmacology).

The state of Montana has education requirements for the LAC that are not only incongruent with national standards, they do not align with the scope of practice for an LAC. Currently, all applicants for an LAC are required to attain education in the following areas: 15 hours of Gambling Disorder; 15 hours of Co-Occurring Disorders (such as depression and anxiety); 15 hours of Behavioral Pharmacology. Two important facts:

No other state requires their addiction counselors to have gambling education. We have created an unnecessary barrier that has no clinical or national relevance.

An LAC is not required to have specialized knowledge of methamphetamine, opioid, cannabis or any other of the abusable substances. Specifying Gambling is illogical and, again, does not align with national LAC education standards.

No other states include this education requirement, including the 2 states highest in gambling availability (Nevada and New Jersey)

Many LCPC and LCSW clinicians have also note taken a course on gambling, creating a further barrier for currently licensed individuals.

An LAC in Montana cannot diagnose, treat or medicate any mental health disorder. Forcing them to attain 30 hours (15 hours of Co-Occurring Disorders and 15 hours Behavioral Pharmacology) creates an arbitrary burden and barrier for those applying for an LAC.

An LAC is prohibited by scope of practice from engaging in mental health-related services. Requiring them to attain educational components for areas outside their scope leaves them vulnerable to malpractice and the potential to overstep their scope and harm clients.

While it may be salient for an LAC to know about co-occurring issues and medications, this is already captured in the required education component of "Addiction Assessment" where a potential licensee must know about the American Society for Addiction Medicine (ASAM) patient placement requirements; this is 60 hours of the 285 hours required by the BBH.

Insisting on this requirement creates barriers to interstate licensure mobility. Counseling and social work are currently engaged in compact initiatives specifically aimed at standardizing training requirements to facilitate license portability. These efforts reflect the realities of a mobile workforce and the expanding use of telehealth, which enables continuity of care when providers or clients relocate. Establishing specialized training requirements unique to Montana runs counter to these initiatives and reduces the availability of counselors seeking to transfer their licenses into the state. At a time when the goal is to attract qualified professionals to the state—both to strengthen the workforce and contribute to the tax base—and to encourage current residents and LCPC/LCSW licensees to pursue LAC licensure, these rules appear counterproductive to that objective.

Suggested Resolution: eliminate the requirement of Co-Occurring Disorders and 15 hours Behavioral Pharmacology as requirements for the LAC. Follow national counselor requirements (can be found at naadac.org).

In summation:

At a time when the behavioral health workforce is under significant strain, it is critical that licensure education standards balance rigor with practicality; this must be balanced with public safety and welfare or persons' served. Consistency with other states supports licensure portability, facilitates participation in interstate compacts, and ultimately expands access to qualified addiction counselors—including through telehealth—without compromising public safety or quality of care. I respectfully encourage continued review of licensure education rules with attention to national standards, workforce impact, and the distinction between minimum competency and post-licensure specialty training. Maintaining clear, equitable, and portable education requirements will strengthen the profession and better serve individuals and families affected by substance use

disorder. Thank you for your time and consideration.

Respectfully,

F. Malcolm Horn, Ph.D., LCSW, LAC

Chief Behavioral Health Officer

Rimrock Foundation

Client name	Cindy Patterson
Form	Montana Licensing Reform Task Force
Matter	Cindy Patterson - Rules
Sent	April 9, 2026 at 1:43 AM
Due	
Submitted	April 9, 2026 at 1:43 AM

Cindy Patterson

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Montana Licensing Reform Task Force

This Task Force was created pursuant to Executive Order 1-2026 on January 29, 2026.

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Health Care Subcommittee
Barriers Subcommittee
Sunset Review Subcommittee

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1. Specific topics a committee or the task force should consider, and
2. Specific people or organizations you think the task force should hear from.

Do you have a general comment or a specific person or topic for the Task Force to hear from?

General comment

What are your comments?

This submission includes evidence for the April 13 Full Task Force meeting and is relevant to the Health Care, Barriers, and Sunset Review subcommittees.

In March, I testified before the EAIC regarding the Montana Board of Behavioral Health's handling of the cross-complaints filed by both myself and my former therapist against my husband.

As a vulnerable client with complex PTSD, I spent five years in counseling before entering a romantic relationship with my therapist and marrying him only 14 months after termination. Under ARM 24.219.2301(2)(b)(iii), sexual or romantic involvement within two years of termination is prohibited, and after two years the licensee must demonstrate that no exploitation occurred based on factors such as the client's personal history, mental status, and likelihood of adverse impact. My circumstances met multiple exploitation factors, yet the Board did not apply its own rule.

Before the marriage, my husband's own PhD therapist became involved in my case in ways that shaped the conditions for the exploitation. He reframed my distress over the relationship as "attachment issues," influencing my decision to proceed with the marriage. After the marriage, he provided concurrent individual counseling to both myself and my spouse, which the Board's own compliance officer identified as an unethical dual relationship. This dual role skewed his objectivity and obscured my abuse, and he later used his professional title to attempt to influence the licensing decision in West Virginia, where my husband also held a license, in a manner falling under the rule prohibiting exploitation of professional relationships (ARM 24.219.2301(2)(e)).

In Wyoming, multiple violations were alleged against my spouse, and the pattern was serious enough to warrant revocation. Montana, however, declined reciprocal discipline and dismissed the complaints against both clinicians. Montana also ignored my husband's claim to West Virginia that my counselor accused him of filming 'live porn' in our basement—an allegation showing clear mental instability.

These outcomes were not the result of one person's decision—they reflect structural weaknesses in Montana's disciplinary framework. To prevent similar failures, I am requesting statutory reforms in three areas:

1. Ban therapist-client romantic relationships.
Montana's current two-year rule allows sexual or romantic involvement after termination. The power imbalance does not end at termination, and true consent is not possible. A complete ban is needed.

2. Require mandatory reciprocal discipline.
Montana accepts out-of-state licenses under reciprocity and should likewise honor out-of-state disciplinary actions. Optional reciprocity allowed the Board to disregard Wyoming's findings.

3. Reform Board procedures to increase transparency and consistency.
To address screening-panel secrecy and inconsistent dismissals, the following changes are needed:

• Knowledge Presumption: Because the rules are written as prohibitions that presume prior knowledge, licensees are presumed to know all regulations and must seek written Board clarification (compliance officer) for any uncertainty, rather than relying on peers, supervisors, or private counsel to skirt responsibility.

• Public Disciplinary Labels: Any Board action—educational, advisory, corrective, etc.—should be designated as discipline and made public to prevent the use of soft language that obscures outcomes.

• Transparent Dismissals: The Board should provide written explanations for all dismissals, including their interpretation of any rule raised or implicated.

Supporting documents are provided through the secure link below. The files are set to "anyone with the link can view" so staff can download and print them for the April 13 meeting packet.

Document folder:
https://drive.google.com/drive/folders/1dqOXuKH4NUiVcNqj1y6DJ5o9eTddoAmT?usp=sharing

Thank you,
Cindy Patterson
(304) 618-3482

Client name	Kaylynn Sheldon
Form	Montana Licensing Reform Task Force
Matter	Kaylynn Sheldon - Rules
Sent	April 10, 2026 at 11:09 AM
Due	
Submitted	April 10, 2026 at 11:09 AM

Kaylynn Sheldon

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Work phone	408981744		

Montana Licensing Reform Task Force

This Task Force was created pursuant to Executive Order 1-2026 on January 29, 2026.

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Specific person or topic

What are your comments?

Dear Members of the Task Force Council,

I am writing to respectfully request consideration for expanding the scope of practice for Licensed Denturists in the state of Montana to include the ability to take radiographs within private practice settings.

Denturists are formally educated and clinically trained in oral anatomy, pathology recognition, and prosthodontic care. However, current regulatory limitations prevent them from utilizing radiographic tools that are already consistent with their training. Aligning scope of practice with education is a practical, evidence-based policy approach that ensures the healthcare workforce is used to its full capacity.

Access to oral healthcare remains a measurable challenge in Montana, particularly in rural and frontier communities. Many areas experience shortages of dental providers, resulting in delayed diagnoses and limited access to timely care. Expanding the scope of denturists would immediately increase the number of providers capable of performing thorough assessments and identifying conditions that require referral.

Radiographs are a foundational diagnostic tool in modern oral healthcare. A significant portion of oral disease—including cysts, tumors, infections, and bone abnormalities—may not be detectable through visual examination alone. Early detection through radiographic imaging is directly associated with improved patient outcomes, reduced treatment costs, and decreased burden on the broader healthcare system.

I would like to share a recent clinical experience that highlights the importance of expanding diagnostic capacity. I was treating a patient who had been directly referred from a dental office just days prior. Upon evaluation, I identified a large, slow-growing lesion located on the right retromolar pad. The growth was purple in color and soft in texture—features that warranted further investigation.

I contacted the referring dentist to discuss whether there were plans for removal and biopsy. The dentist indicated they were not aware of the presence of this growth. To ensure the patient received appropriate care, I offered to refer the patient to a maxillofacial surgeon for further evaluation, removal, and biopsy. The dentist and patient were grateful for the collaboration and attention to detail. It is my opinion that dental specialists and general dentists should unite to form a highly trained team of dental providers that will only serve as a benefit to patients within the community.

This experience is not shared to highlight an oversight by a colleague, but rather to underscore an important reality in healthcare: patient safety is strengthened when more trained professionals are equipped with the tools necessary to fully evaluate and identify potential pathology. Each additional qualified provider who can assess, detect, and refer contributes to a stronger safety net for the people of Montana.

By authorizing denturists to take radiographs, Montana would effectively increase its diagnostic capacity without requiring the training of new providers. This is a cost-effective workforce solution that enhances early detection and timely referral, particularly in underserved areas.

From a public safety perspective, increasing the number of trained professionals who can recognize abnormalities—both clinically and radiographically—reduces the likelihood of undiagnosed or late-stage disease. In rural communities especially, where patients may have infrequent access to care, maximizing each patient interaction is critical.

This expansion would not replace the role of dentists, but rather complement the existing healthcare system. Denturists would continue to work within a collaborative model, ensuring that patients requiring advanced care are directed to the appropriate providers.

In summary, expanding the scope of practice for Licensed Denturists to mirror education and training, which includes radiographic imaging would:
Increase access to care, particularly in underserved and rural communities
Improve early detection of oral disease and pathology
Enhance patient safety through broader diagnostic coverage
Reduce overall healthcare costs through earlier intervention
Better align regulatory policy with existing education and training

I respectfully urge the Council to consider this evidence-based policy change. Empowering denturists to practice to the full extent of their training will strengthen Montana's oral healthcare system and provide meaningful benefits to the public.

Thank you for your time, consideration, and dedication to improving healthcare access and safety across our state.

Sincerely,
Kaylynn Sheldon L.D