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## WESTERN STATES PRESIDENTS' CONFERENCE



**Robert A. Neill, DDS**

*article by Dr. Rob Neill  
MDA President-Elect*

The MDA's President Dr. Andy Hyams, Trustee Dr. Roger Kiesling, Executive Director Mary McCue and I attended the Western States Presidents' Conference. The two-day meeting was held July 30 and 31<sup>st</sup> at Lake Tahoe, Nevada, and included participants from the Dental Associations of Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming. Many important topics were discussed.

In Arizona and New Mexico the dental associations and the American Indian tribes are working together on a Native American Oral Health Care Project to improve the oral health of Native Americans. The United States has a fiduciary responsibility for health care and other services and benefits in exchange for land and resources taken from tribes. The Indian Health Service (IHS) alone has been ineffective in attaining good oral health for Native populations in Arizona and New Mexico. One in four native elders is without natural teeth and 20% of those do not have dentures. Sixty percent of children have severe early caries. Of great concern is the very high caries rate as the sugar in the diet of the tribal members negates any fluoride consumption. Of interest, members also have a very high rate of diabetes.

This project is committed to:

1. acknowledging the sovereignty of the tribes
2. honoring and respecting the interests and priorities of tribal leaders and communities
3. improving access to quality oral health care.

What is being done? The associations and tribes have developed a Community Dental Health Coordinator (CDHC) Pilot Program. Candidates for the CDHC program are generally chosen from their locale, trained as CDHCs and then work in their home communities. So far the program looks promising and North and South Dakota are looking into implementing this program.

An interesting note – one particular tribal Chief declined the Indian Health Service program and was able to get the money allocated for his own program where he hires private practice dentists to come into his communities. This has been very successful.

Utah is using case managers to help with improving health care on their Indian reservations.

A summary of the ADA Workforce Summit indicated most dentists do not support a new provider position. Some wondered who came up with the terminology for a new position (i.e.; midlevel) and felt it should be called “low level provider” instead. Most states in our western region oppose a new provider position although Washington is being forced to support an advanced hygiene model who would work only in community clinics because legislation is already started and they thought this was their only option.

Non-covered services: some insurance companies have been dictating what dentists charge for non-covered services. Legislation blocking that practice has recently passed in Idaho, Arizona, Washington, Alaska, and California. Wyoming and Utah are pursuing the legislation. It has failed to pass in Hawaii. The ADA is pushing for national ERISA plan reform at the federal level to block this practice in all states.

Hawaii, California, and Utah have programs for mentoring young dentists and leadership development.

New Mexico is pursuing tort reform.

*continued on page 14*

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Montana Dental Association



# Across the Big Sky



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## Dentistry and the Law...

*This column is offered to answer some of the queries frequently posed of MDA executive director/legal counsel Mary McCue about practice issues involving legal questions. If you have a legal question, e-mail MDA at mda@mt.net or call 800/257-4988.*

**Question:** What can I do if a negative comment about my dental practice is posted on a website?

**Answer:** Although your first inclination may be to file a lawsuit, you should carefully consider taking any legal action. You may wish to consult an attorney with expertise in Internet-related law to learn whether there is a legal basis for filing a lawsuit, for example if the content defames you and your practice and you have suffered harm due to the inflammatory material. But filing a lawsuit is costly and time-consuming. There may be significant costs in trying to find the Internet user who authorized the comments. There also may be limited potential for damages. It is often difficult to prove that a negative comment has harmed your dental practice.

The website itself may be immune from legal liability under the federal Communications Decency Act of 1996. If the website simply posts content from a third person, it may be protected by the federal law. The law does not protect the user who created the content.

Perhaps the best way to respond to a negative posting is to review the website guidelines. If the negative comment violates the guidelines you should follow the website's procedure for reporting and removing the offending material. Although most websites allow you to respond to a negative review, remember to follow confidentiality and privacy laws, including HIPAA if you are a HIPAA-covered entity. You can also determine how much traffic the website gets. If the site appears low in a search of your name when you perform an Internet search this may mean that people are unlikely to read the negative comments. You can also encourage satisfied patients to post positive comments or reviews.

One of the best ways to prevent these kinds of negative reviews or comments is to ensure that your patients leave the office satisfied with the services they have received. Try to become aware of valid patient concerns and address them at their source.

### Letters to the Editor

MDA News invites feedback from our readers on material contained in the newsletter or otherwise of interest to dentists. Any communication intended for publication should be addressed to: Mary McCue, Montana Dental Association, PO Box 1154, Helena, Montana 59624.

### It Start With Me

will be hosting several **flu shot clinics** around the state from late **September through October**.

No need to preregister and the cost is only \$20, which is cheaper than most. Currently, the standard cost can range from \$25 to \$30 - depending on the provider.

Some preservative free vaccines (no mercury) will be available for \$25.

#### Check these dates:

**Helena - Capital Hill Mall**

**October 20-21-22 7am-6pm**

**Missoula - City Life Community Center**

*just off of Russell Street near the fairgrounds*

**October 14-15-16 7am-6pm**

**Butte - One day only - TBD**

More than likely September 30 or October 1

# MESSAGE FROM YOUR PRESIDENT, DR. ANDY HYAMS



Andrew C. Hyams, DDS

## Tough Issues Facing Dentistry

As a kid, I enjoyed playing basketball. The game of basketball in the 60's and 70's was a far different game than it is now. Roles were clearly defined. You needed two ball handling guards, two medium size forwards and a big aircraft carrier center to play around the basket. There was no three-point line, no shot clock, no possession arrows, so when the ball was tied up, there were many jump balls. Unfortunately for my game, I grew tall precociously. I was six feet by the time I was in 8<sup>th</sup> grade. That pigeon holed me into the center position and I never developed good ball handling and shooting skills. The problem compounded when I stopped growing as a high school sophomore at 6'2". In high school, I was an undersized center and got stuffed more often than a Butterball turkey. Today, the game has been changed radically by the three point line, shot clocks and possession arrows. Speed and athletic ability outweigh height and brawn. The old game is gone forever. Truly, basketball has seen a paradigm shift.

When I first got into dentistry twenty-five years ago, the profession was aware, that in any year, we were only seeing about half of the population. At the time, we weren't satisfied with that situation but there was really no concerted effort made to study

this group with any sophisticated analysis. Programs like Medicaid, Head Start, CHIP, Community Health Centers (CHCs) and charities like Give Kids A Smile (GKAS), Breakfast Exchange, Donated Dental Service, PLUK, and many other private charities were developed for the poor and disadvantaged to access care. These numerous programs, while having some degree of success, have been insufficient in meeting the challenge of serving this population for a variety of reasons. Increasingly in the last decade, there has been great effort in analyzing this population group that does not access dental care in the traditional manner.

The health care system in the U.S. has changed dramatically in the last twenty five years. The private fee for service system has largely been replaced by the corporate system we have today that is run and managed like any large industrial organization. This system is financed primarily by private employers through employee health benefits and by the government through Medicare and Medicaid. Very little is actually financed through out of pocket expenses by patients. Benefits are channeled in the system in a "Robin Hood" fashion that redistributes the health care dollars based on need over value.

In contrast, dentistry has remained the poor step-child of the U.S. health care system. The dental care system is largely a private, fee for service model that largely remains a "cottage" industry of small independent practitioners. Most of the costs are financed directly by our patients or by their employer prepaid benefit programs (dental insurance). There is very little facility in our system to redistribute the dental care dollars without regard to those who pay for that care. Although dentists are among the most charitable of all health care providers, individual charity cannot redistribute dental health care adequately.

Politics have also changed in the last twenty five years. Personal responsibility has been de-emphasized. People are no longer responsible for the outcomes in their lives. Society has become more egalitarian. Inequality in outcomes has become taboo. Health care and access to that care have been packaged as a right of citizenship. If you don't believe it, take a look at the 2010 Healthcare Reform Act, all 2500 pages.

Like it or not, dentistry is along for the ride. Saying no is not an option. Alternate systems for the delivery of dental care are already out of the gate. We must be at the table as the future of dentistry is debated. Just like basketball, dentistry is witnessing a paradigm shift. The old game and the politics that accompanied it are gone. It's time to seek new partners for the future of dentistry. Older practitioners like me will probably be all right but younger practitioners need to get involved. It's your future, don't be left out.

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# MPCA, CHCs, AND HEALTH CARE REFORM: WHAT'S IT ALL MEAN?



Kurt S.  
Lindemann,  
DDS

by Dr. Kurt Lindemann,  
MDA Vice President

Maybe you have heard of the Montana Primary Care Association (MPCA), but are not really familiar with what they do. Their website states “The MPCA is a non-profit membership organization whose members are ambulatory health care providers serving Montana’s medically underserved and underserved residents without financial or other discrimination”.

The website goes on to state seven main objectives of the organization: 1) Improve access to quality primary care for all Montanans, 2) Develop a diverse membership of primary care providers, 3) Provide a forum for information sharing, discussion and development of strategies for addressing statewide primary care issues, 4) Encourage and support new and existing providers in area of shortages, 5) Assist communities in attracting and retaining primary care providers, 6) Strengthen the viability and stability of primary care practices in underserved areas, and 7) Assist Montana residents that encounter difficulties in obtaining affordable, accessible health care.

The membership of the MPCA is made up of Community Health Centers, Certified Rural Health Clinics, Urban and Tribal Indian providers, National Health Service Corps Clinics, and private primary health clinics throughout Montana. The services provided may include medical, mental health, and dental. There are currently 15 health center dental clinics in Montana.

Mary Beth Frideres, RN of the Montana Primary Care Association gave a presentation at the August 27<sup>th</sup>, 2010 MDA board of directors meeting in Helena. She is the former director of the Helena CHC and has a son in his first year of dental school at OHSU. She gave an overview of the MPCA objectives, how CHCs run, and discussed how national health care reform would affect Community Health Centers (CHCs) in the coming years.

CHCs are started in communities based on a designation as a health professional shortage area. The acronym HPSA (Health Professional Shortage Area) has been applied to the dental services in two ways. There are specific federal guidelines in determining a HPSA. These two main designations are by low income and geographic location. The formulas can be a little complex and have some variables, but in a nutshell it goes something like this. The first method is based on the percent of the population below 200% of poverty level for a given county. The second is the dentist to population ratio (1:5000) for a given geographic area. There are different ratios for primary medical and mental health services. Communities that qualify under these guidelines can apply for grant money to start a CHC. These grants typically are in the \$400-650K range and are

continued indefinitely over time as long as the clinic runs within federal guidelines. Expansion grants are also available.

The Primary Care Office (PCO) as part of the Department of Public Health and Human Services (DPHHS) sends out a workforce survey to each dentist. The data collected on these surveys is used to make a determination of a HPSA for a particular part of our state. Again the HPSA designation is used in funding new CHCs. All new CHCs are required to provide dental services. If you do not fill out these surveys there may be the impression that your community is underserved when it may in reality have ample providers to service the need. PLEASE FILL OUT THE SURVEYS.

You probably didn’t know that August 8<sup>th</sup>- 14<sup>th</sup> was national health center week. I sure didn’t until I decided to go home for lunch, flipped on the TV and was channel surfing and came across a program by the Center for American Progress on C-SPAN about the future of CHCs in relation to national health care reform. Wow, what a wake-up call for me! There are 11 billion dollars earmarked for the CHC program. Representatives from the National Association of Community Health Centers (NACHC) put up a graph that showed the direct and indirect employment and economic impact that CHCs will have by 2016. Nearly 280,000 individuals will work at a CHC. 460,000 will be deriving their employment directly or indirectly from CHC operations. The fiscal impact to the economy will be roughly \$52 billion dollars both direct and indirectly. That means that one out of every 650 people in the U.S. will at least indirectly derive their employment from CHCs!

Ms. Frideres also discussed the \$11 billion that is slated for the CHC program. She stated that currently 20 million patients are served and the program is funded at \$2.2 billion annually. “The intent is for existing CHCs to expand and new health centers to ramp up over the next 5 years to provide access to primary (medical, oral, and behavioral health services) care for 32 million people, previously uninsured, who will be seeking care when the new insurance reform starts in 2014”. Ms. Frideres also stated that there will be approximately 70,000 new patients covered under Medicaid in Montana in the coming years.

Other changes brought about by health care reform include requiring private insurers to contract with CHCs and in addition pay the health centers no less than their Prospective Payment System (PPS) per visit rate. PPS is a cost-based reimbursement system mandated by the federal government. It is only meant to cover the cost of delivering care, not to make a profit. The reform act also funds new programs for health center-based residency programs.

*continued on page 11*

# REPORT FROM BUTTE DENTIST DR. DAN O'NEILL SERVING AS A DENTIST IN AFGHANISTAN

*As a member of the Montana National Guard, MDA member and Past President, Dr. Dan O'Neill is currently serving as a dentist for the U.S. Armed Forces in Afghanistan.*



August, 2010

**Camp Phoenix  
Kabul, Afghanistan**

Hello folks,

Thought I would give everyone an update on the happenings at Camp Phoenix, both from the soldier's perspective and the dentist perspective. In the past there was more freedom of movement "outside the wire" or off post, but those opportunities were withdrawn early this year. I'm not sure if the mission changed, in other words using a humanitarian program of providing medical care to the local population, winning the hearts and minds of the indigent Afghani, rather than with guns and bullets.

There are a series of garrisons or posts in and around Kabul, called the Kabul cluster, where the level of medical care may be emergency treatment only, to surgical care in a coalition hospital. More serious injuries are medically evacuated out of the country to Germany, usually on Air Force aircraft. The medical providers and staff here at Camp Phoenix train for a mass casualty event, which would be the extreme situation we would see. Hopefully, it won't happen, but if it does I will know what to do, and when to do it.

The physicians, nurses, and PAs, as well as the technicians are a combination of active duty Army, Reserve, and National Guard. At this time most of the personnel at Camp Phoenix are National Guard components from Vermont and South Dakota, up to 2000 soldiers. In addition, I believe there are an additional force of contractors, private citizens, many with prior military

service, who manage the food service, new building construction, and general camp maintenance. In addition, there appears to be a large group of Afghani nationals who contribute to a number of services on Phoenix.

Again Camp Phoenix is a miniature version of a small town in America, with a few minor exceptions. There is a U.S. post office, gym, basketball court, racquetball court, chapel, fire department, restaurant (dining facility), motel (Lego Land), courthouse (headquarters), county attorney (JAG), Fed Ex office, telephone company (IO Global-internet), hardware store (self- help warehouse), Wendy's (barbecue shack), Wal-Mart (PX), Starbuck's (Green Bean), county fair (Afghani Friday Bizarre), and library. Movies are shown in a studio next to the library every evening and there is an outdoor cinema on Freedom Square every Friday evening, with fresh

popcorn served. An interesting environment when an occasional Air Force cargo plane would land at nearby Kabul International Airport or a Blackhawk helicopter land on the pad, a stone's throw away.

There are no bars and alcohol is strictly forbidden. Everyone is carrying a weapon, 9mm pistol, or M4/M16, or bigger. The weapon is your friend and is required equipment to be worn at all times; the only exception, in the gym. There are different levels of "alert" with our current status, AMBER; therefore a full magazine is loaded into the weapon. In the event a change occurred, GREEN, the magazine would be out of the weapon and RED would be with the weapon locked and loaded. Reflecting, it definitely would not be my average day in Butte, Montana.

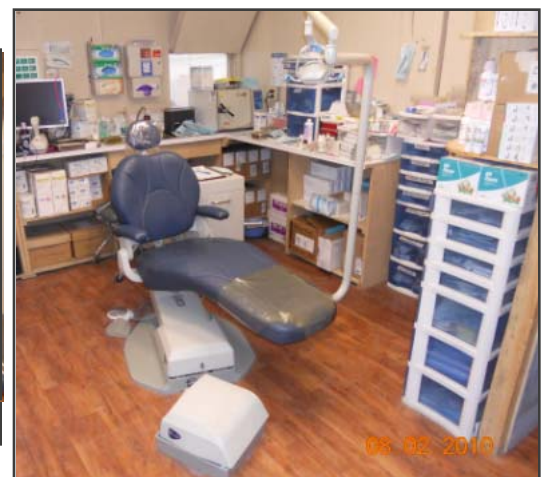
Met some great folks here.

Best Wishes,

Dr. Dan O'Neill



**Operatories at Camp Phoenix.**



# ORTHODONTIC MINISCREWS USED TO RESTORE CONGENITALLY MISSING TEETH 7 AND 10

*Article submitted by Dr. Kevin Miltko of Missoula, MDA Immediate Past President.*

This case study is just one example of the miniscrew possibilities. Special thanks to Dr. Troy Shaw for the great orthodontic treatment. Miniscrews and temporization by Dr. Kevin Miltko. Credit also to miniscrew guru Dr. Christian Kenworthy for his inspiration and support.

A common problem is the temporary restoration of congenitally missing teeth 7 and 10 post orthodontic treatment. In this case study, a fifteen year old girl is one year post orthodontic completion with retainers made by her orthodontist. She has two retainers for her maxillary arch and one for her mandibular arch. One of the maxillary retainers has teeth 7 and 10 incorporated in the retainer and is meant for daytime wear only as the wires and baseplate to restore the teeth interfere with occlusion. The other retainer is meant for nighttime wear. Unfortunately, over the one year post - ortho, the patient has selected to only wear the daytime retainer as she always wants to have teeth in the 7 and 10 position. The result is that the retainer wires have opened the occlusion and created diastemas distal to teeth 6 and 11. Teeth 7 and 10 will eventually be restored via implants once her growth has stopped, after age 18. In the meantime, a different solution to temporize 7 and 10 will be used to allow for restoration of her occlusion.

Orthodontic miniscrews have been used to anchor orthodontic movement and are more than capable of supporting single tooth temporary restorations. Miniscrew placement has also been shown to support bone levels in an edentulous area much like an implant. In this case,

profound topical anesthetic was used to numb the gingiva. Then 10 mm IMTEC orthodontic miniscrews were placed in the edentulous areas of 7 and 10. Radiographs were taken of the miniscrews in place to ensure their proper placement. The nice thing about miniscrews is that they can easily be unscrewed and redirected if a different angulation is desired. Denture teeth were then hollowed out and bonded to the miniscrew with composite. The patient has been given special oral hygiene instruction to floss around the restorations as keeping these areas clean is essential to their success. She was placed on Peridex rinses twice daily for fourteen days immediately post treatment. She is now ready to return to the orthodontist for new retainers to restore her teeth back to the proper occlusion that had originally been present post - ortho. Now that the occlusion is free of retainer interferences, this occlusion will be able to be maintained until it is time to restore with implants.

Orthodontic miniscrews have an incredible potential to change not only what we thought were the previous limits of orthodontic care, but also provides another excellent option to temporarily restore edentulous areas.



**removable retainer restoring teeth 7 and 10**



**retainer restoring teeth 7 and 10**



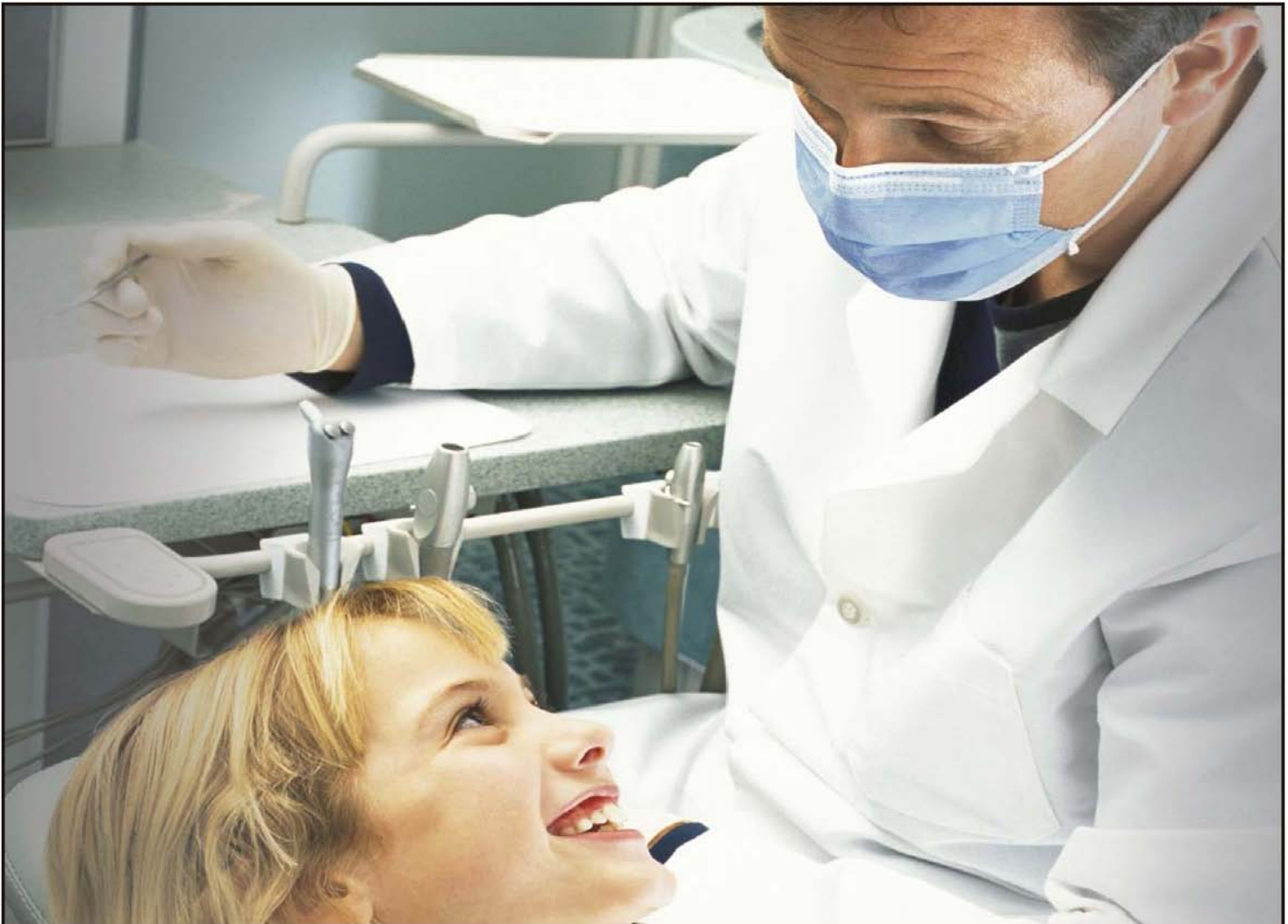
**retainer wires interfering with occlusion**



**Congenitally missing teeth 7 and 10 post orthodontic treatment.**



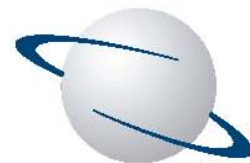
**Miniscrews in place for teeth 7 and 10**



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# HEALTHCARE REFORM HITS CLOSE TO HOME



by *Richard Miltenberger*  
*Mountain West Benefits*

During the healthcare reform debates of 2009, the American Dental Association was successful in keeping the practice of dentistry isolated from the new legislation. However, as employers, dentists will still need to consider the effects of the reform bill (called “PPACA”) on their business.

In theory, the legislation allows an employer to keep the same coverage in place with few changes, so long as nothing in the policy or employee contribution level changes. In practice, this would be difficult for a small employer to implement, so the consensus of opinion is to advise that the new mandates be implemented, regardless of changes in the insurance contract. The PPACA mandates a very robust preventative benefit, which will add expense to most policies. This may not be a bad thing, as preventive care has been shown to save dollars in the long run. In the short run, it will add cost, and we will see many small employers reducing other benefits to make room for the additional cost. There are some other policy limits that need to be eliminated (limits on physical therapy, rehab, etc) and all of these add cost as well.

There is a tax credit available to employers with fewer than 25 employees, and that credit takes effect this year. Not everyone will qualify, but be sure to ask your tax advisor about the health insurance tax credit to see if your policy qualifies.

Another change that you will want to pay close attention to is how much you contribute to your employees’ premium. Many small business owners will pay a higher proportion of the insurance premium for key employees or owners. This practice is not allowed after your next insurance renewal. The penalties are severe, so be careful on this issue. Going forward, you may want to gross up salary to make up the shortfall.

Children of employees can stay on the plan (even if married) up until their 26<sup>th</sup> birthday starting next year (their spouses or children cannot be insured). Another change requires that employer contributions be shown on the W-2 forms starting with the 2011 tax year. The benefits are not taxable, and perhaps employees will get a better idea of how much they are actually being paid—the “hidden paycheck”.

The effects of the long range elements of the PPACA are still not clear--the 2400 page law is actually fairly sketchy on detail, and regulations (expected to reach 10,000 pages) need to be written before we know exactly what the impact will be. By 2014, there will be a health insurance “Exchange”, which has been compared to “Travelocity”—

each state will have one, run by a board of directors, which will mandate a variety of details as to coverage, pricing, etc. The good news is that those who are deemed “sick” by insurers cannot be charged more than those who are healthy. Those who are healthier might pay more than they pay today, so there is a trade off.

The effects of the 2014 changes on our MDA health insurance plan are simply not yet known. We have always been challenged in that our Trust has been playing by these new rules for years---we give the same rate increase to the sickest dentist as to the dentist with no claims; and we do not “cherry pick” dentists who apply for coverage. As a result, some new dentists have been surprised to see that the MDA plan is not the least expensive they could find---the reason being that we do not turn down every third dentist, or rate up the ones who have actually used the plan.

That means our rates tiers are much “flatter” than those available from a commercial carrier (we still charge less--or more--based upon age, and 260 Montana dentists have found the program to be the right choice). So, in that sense, we might find the new world of healthcare reform a more level playing field in 2014. Or we might be regulated out of existence; it will be two to three years before we know what direction things will take, but we will stay on top of events as they develop, and keep you informed at each step.

*Richard Miltenberger is a partner in Mountain West Benefits, advisors to the MDA Health Insurance Trust. If you have specific questions regarding this topic, feel free to call or e-mail Richard at 406-443-1060 or [rmiltenberger@mwbs-insurance.com](mailto:rmiltenberger@mwbs-insurance.com)*



## *Topical Medications continued from back cover*

In addition to the above formula we also compound the following topical preparations specifically for the treatment of TMJ/TMD:

Keto-Flex – Ketoprofen 10% / Cyclobenzaprine 1% in DIPL – Diclofenac 4% / Ibuprofen 2% / Pentylene glycol 3% / Lidocaine 2%

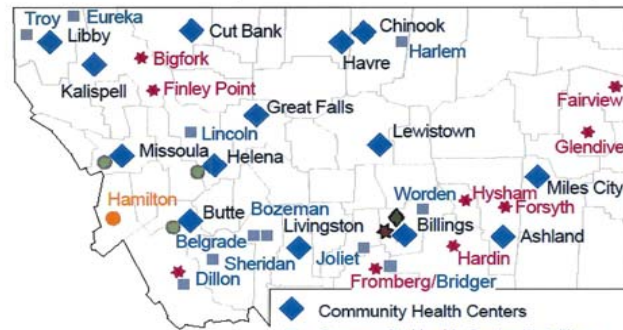
*Juro's Home Medical - Pharmacy, located in Billings, Montana has been compounding medications for over thirteen years. Juro's has supported the District 9 Winter Meeting, the MDA Annual Meeting as well as the MDHA Annual Session this year.*

*What's It All Mean? continued from page 5*

Moving forward the MPCA supports the efforts of your Montana Dental Association to reach out to provide more oral health care to those in need. MPCA would support an effort to see dental Medicaid reimbursement rates increased (so your overhead is covered) and expanded coverage for adults. "The Montana Primary Care Association would like to work with the MDA on oral health issues. You guys are doing a great job, just there is a greater need" says Ms. Frideres.

Health care reform and dentistry, what does the future hold for those of us in private practice? I would say an opportunity to guide the ultimate direction of how oral health is delivered 20 years from now. Whether or not you like them is irrelevant, public health dental clinics are here to stay and will only grow in number. Most CHC dentists in Montana are members of the MDA, and many transition into private practice. Most dental schools today require students to go through a CHC rotation. Why not look at models that can increase the productivity of the existing dental work force, without bringing in a so called mid-level provider? Every dentist 55 and younger should be well read in the politics of oral health care. It is important to build coalitions with other health care stakeholders as we move forward. Those of you 55 and older who want to transition your practice in the next 10 years need to be vigilant as well. It will affect your practice, your family, and your patients. Will you pledge to give a day or two a year to keep your profession, "Dentistry, Healthcare that Works" viable? Attend a Board of Dentistry meeting, meet with your local state representatives, and go to your district meetings. I truly think that the times require strength in numbers, not the apathy of "I paid my MDA dues, let someone else fight my profession's battles". I ask that you take 15 minutes to bring a colleague up to speed who may have "misplaced his or her newsletter".

## Montana Community Health Centers - January 2010



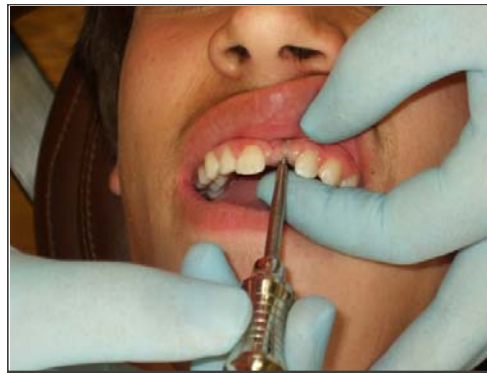
Calendar Year 2009  
**90,448 patients**  
 (unduplicated)



## ANOTHER ORTHODONTIC MINISCREW CASE STUDY

*This case study is submitted by Dr. Christian Kenworthy who is a Missoula Orthodontist*

Dr. Kenworthy is demonstrating in these photos the temporization of tooth #9 in an adolescent male via IMTEC orthodontic miniscrew. Profound topical is placed on the gingiva and the miniscrew is placed with the driver. The tooth is then restored with a denture tooth and composite. This will stay in place until the adolescent is old enough for implant restoration.





# In Memoriam

## Dr. George Robert Dachs

Long-time MDA member, Dr. George Robert Dachs passed away on February 15 of natural causes. George was born on June 13, 1918, in Deer Lodge to Lukas and Anna Rotzinger Dachs. He attended schools in Deer Lodge and graduated from Powell County High School in 1937.

He then went to work for the Montana Highway Patrol in Helena, serving as bookkeeper and performing other office duties. In 1941, George joined the U.S. Naval Reserve on active duty and served in various posts, including Pearl Harbor.

On Dec. 29, 1945, he married Helen Liming, who was also serving in the Navy, in Memphis, Tennessee. After their discharge from the Navy, they returned to Deer Lodge where George worked for the Milwaukee Railroad as a fireman and engineer. In September 1948, he enrolled at the University of Nebraska Arts and Sciences College. In 1954 he graduated from the University of Nebraska Dental College, having been selected for the dental honorary fraternity, OKU.

George practiced dentistry in Kalispell from 1954 until his retirement in 1982. He enjoyed many summers at Swan Lake where he built a log cabin for the family. He cut trees for the logs and made his own shakes for the roof. According to his family, he was very proud of that cabin.

George was preceded in death by his wife, Helen, in 2007, following 61 years of marriage; son, Terry, and infant daughter, Kathleen; two brothers and two sisters. He is survived by daughters: Cherie Shevlin and Joe, of Helena, and Nancy Posivio, and Bill, of Ronan; and son, Dave, and Maureen, of Cascade. He is also survived by 16 grandchildren and 11 great-grandchildren; one sister, LaVona Schrieber, of Missoula and several nieces and nephews.

## Dr. R.M. "Manny" O'Neal

On September 3, 2010, former MDA member and Board of Directors member, Ruben Manuel "Manny" O'Neal died. He was born on February 20, 1950, to Sybil and Alvin O'Neal and had two sisters, Jennifer and Peggy. Dr. O'Neal was an educated professional, receiving his DDS from Louisiana State University.

He served one tour of duty as point man in Vietnam. For his service he received the Purple Heart, two Silver Stars and a Bronze Medal. He returned to his home in Louisiana and became the proud father of his firstborn, son Ruben Manuel O'Neal III, known as Trey.

His passion for dentistry and the mountains led him to Missoula, where he opened his own practice, O'Neal Dental Clinic, and served his community as a dentist for 26 years. He loved all that Montana offered and excelled at skiing and hunting big game.

He met the love of his life in 1985, a born and bred Montana girl, Teresa CeCelle Zimmerer. On August 17 of this year, Teresa and Manny celebrated their 25th wedding anniversary. They had two sons, Kellan Patrick and Jeffrey Nicholas. Manny loved his family, which grew to include his daughter-in-law Gina (in-law only by name, truly his daughter in his heart), and his cherished grandchildren Taylor, McKenzie, and Savannah. He is also survived by his parents-in-law Frank and Mae Zimmerer, 13 brothers and sisters-in-law, and numerous nieces and nephews and grandnieces and grandnephews.

To extend online condolences to the O'Neal family, please visit [www.hixsonbrothers.com](http://www.hixsonbrothers.com).

*Photos from restoring teeth 7 and 10 continued from page 9*



Teeth 7 and 10 restored via mini screws



radiograph of miniscrew in place



## People We Know...

### Former Great Falls Dentist Still Golfing at Age 100

Retired dentist Dr. Maurice Avery of Great Falls may be one of the world's oldest golfers. Dr. Avery turned 100 in April and is in remarkably good shape, physically and mentally. He lives in his own home and still drives a car. He attends church services regularly and goes out to lunch with old friends. With his son, Dr. John Avery, Dr. Maurice still plays golf at Meadow Lark Country Club, the course where they meet at least once a week when the weather is good. Dr. Maurice, a retired dentist who spent almost 50 years in the profession, no longer keeps score. Once you've broken 100 you no longer need to break 100! "I was never very good at golf," says Dr. Maurice. "I think the lowest handicap I ever had was 21."

But he's been around the game a long, long time. He started caddying at the Gary, Indiana Country Club, where his father was a member, when he was 10. That was in 1920. "Back then golfers only had four or five, maybe six clubs at the most in their bags. We used to carry two bags," recalls Dr. Maurice. He played golf sporadically during his life, which was spent mostly in the Chicago area.

Dr. Avery began coming to Montana because his wife's family owned property near Roscoe, a small town south of Red Lodge. They built a cabin there in the early 1970's and spent up to three months each summer there. Dr. Avery played a lot of golf in Arizona after he retired almost 30 years ago. "I played nine holes a day about six days a week," he recalls. It is heartening to see someone of Dr. Avery's age with such vigor and still enjoying the golf links.



Photo courtesy of the Great Falls Tribune.

## AFTCO NATIONWIDE



**Ed Butcher, MA**  
Senior Consultant

*Ed has 20 years  
experience  
assisting Montana  
dentists select:  
the right practice,  
the right partners,  
or the right purchaser.*

### Largest Dental Transition Company in the United States

- \* New dentists can maximize profits with proper planning - first year dentists "take home" \$150,000 to \$250,000 after debt service and operating overhead.
- \* Established dentists can increase income while working less - AFTCO can create over 100 transition programs.
- \* Funding your retirement with the practice equity while continuing to practice.
- \* Planning an "exit strategy" 5 to 10 years before retirement in the "First Step".
- \* Reduce your work schedule from 4 days to 2 days while maintaining the same income.
- \* Enjoy a 4 week vacation instead of a 2 week vacation!

### AFTCO IS THE "BUSINESS" AND "QUALITY OF LIFE" COMPANY

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*Western States Presidents Conference continued from front cover*

California is proposing a resolution to allow ADA members to pay their dues over 12 months in an installment plan rather than in just one payment.

Some states require their members to pay political contributions. In the Montana Dental Association it is an option although we highly recommend supporting our political PAC.

New dental schools are to be built in Utah and New Mexico

Ms. Deb Gonzales, Chief Strategy Officer of the California State Dental Association, gave an overview of the National Healthcare Reform Bill. It will impact the insurance market, the oral healthcare system, and you as a dentist and as an employer and individual.

Thirty-two million more people will be covered through coverage mandates and the expansion of Medicaid. The original cost estimate was 938 billion dollars, but in June the CBO (Congressional Budget Office) increased this number to ONE TRILLION (a billion here, a billion there and pretty soon, you're talking real money!!).

The bill will be phased in over eight years. Major funding begins in 2013, employer and individual mandates in 2014, taxing Cadillac plans in 2018. Now (2010) - no insurance rescissions (revoking) allowed in existing plans and insurance companies must allow coverage of children up to age 26 on their parents' plan.

The plan will prohibit insurers from denying coverage for children with pre-existing conditions and bars insurance companies from putting a lifetime limit on the dollar amount of coverage and cancelling policies (except for fraud).

Potential impact on dentists: The Good: you won't be subject to employer mandates (to provide health coverage for employees) or associated penalties and there will be added coverage for children by increasing CHIP funding by 23%.

The Bad: It imposes a 2.3 billion dollar annual fee on drug makers that will no doubt be passed on to buyers in 2011, imposes an excise tax and a 2.3% sales tax on medical devices, a hospital insurance tax, a 3.8% unearned income tax, increases Medicare payroll taxes and a 3.8% tax on income from investments, all in 2013. It also starts taxes on tanning businesses, pharmaceutical, and insurance companies. It also reduces the cap on employee contributions to flexible spending accounts from \$3K to \$2.5K and disallows their use for over-the-counter medications. The secretary of HHS (Health & Human Services) will establish procedures to monitor providers and will develop provider level outcome measures. Medicaid will also be expanded.

Tax credits will be available to small businesses with fewer than 25 employees for providing health insurance to

these employees in 2010. You must disclose on a W2 the value of such insurance coverage provided in 2011.

Mandates: All US citizens will be required to have health coverage. Parents must cover themselves and their children. Some exemptions will apply and there will be penalties for non-compliance starting in 2014.

States must form insurance exchanges by 2014. Some insurance plans will be grandfathered. You will need to work with your insurer to find out how you stand with your plan.

Prevention is a priority. There will be a five-year public information campaign promoting oral health. Grants will be available for prevention, wellness, school based health centers, and oral health services and dental caries management. The bill requires that all states receive grants for school-based sealant programs and infrastructure grants for CDS and 11 billion dollars for federally qualified health clinics (FQHCs).

Some recent congressional signals are that some of these provisions and grants may not get funding, but, gives priority to school-based care and supports states efforts for advanced dental hygiene practitioners. There also will be some loan repayment or forgiveness programs.

Workforce grants for Alternative Dental Providers (any proposed now or deemed by the Secretary of HHS) will be available.

The enormity and complexity of this legislation is breathtaking. My personal opinion is that they should chuck the whole bill in its entirety and start over, discussing and changing what truly needs fixing in our health care system, rather than having to deal with the monster they created that nobody got a chance to read before the bill was passed. We will need to continue to monitor this law as it relates to dentistry and our membership. The MDA and ADA will try to keep you posted, but please consult with your personal advisers.

The Western Regional meeting was informative. It was good to converse with leadership from our Western states and realize Montana is not alone as we wrestle with important issues.



# Classifieds

## Practice Opportunities

### Practice for Sale

**Northwest** - Practice for Sale: Experience mountains, rivers and a beautiful valley. This is a quality, fee for service, Family Practice. It is committed to excellence and provides all facets of patient centered care including fixed and removable Prosthetics, Surgery, Endodontics, Pediatric Dentistry and a quality Hygiene program. The growing, active community, has excellent schools, a hospital and is close to a University and International airport. Hunting, fishing and floating provide a recreational paradise. Contact: Dr. Don Hanson (406) 862-6260  
www.qualitytransitionsdds.com

**Western Montana** - A great opportunity in the surrounding beauty of the Rocky Mountains. This family Practice offers a wide cross section of dental care plus a well trained, versatile staff with many years of experience. A perfect setting for the outdoor enthusiast (rafting, hiking, hunting, fishing and golfing nearby). The community has excellent schools, hospital, museum and public library. East, Interstate drive to a large University, international airport, cultural and sporting events. Reply in confidence to Dr. Don Hanson (406) 862-6260  
www.qualitytransitionsdds.com

**Helena** - Associate wanted in well-established very active, six operator practice in new facility. Accepting curriculum vitae of dentist to associate with intention to buy. Helena, located in Western Montana, is home to some of Montana's finest outdoor sports, including fishing, skiing, and hiking. It is a great family-oriented community with excellent schools. Contact Dr. Eddy Crowley at 406-459-6141 or 406-442-0282. Email maryc@bresnan.net.

**Southwest** - New Listing in area of high demand. Solo practice is collecting \$600,000 and has 3 ops with room for 4. The atmosphere is fun and friendly, with a highly cohesive staff and a high number of new patients each month. Owner refers out very little and has computerized ops and digital radiography. Walk away sale – available immediately. For detailed information contact Wendy Hirai at Consani Seims Limited – 866.348.3820.

**Bridger Dental Care - U.S. Bankruptcy Auction** - Internet Only Bidding - Open For Bidding June 14th and Closes For Bidding July 1 @ 10AM MDT, 822 Stoneridge Drive, Ste 3 - Bozeman Montana. **Most inventory is 2006 or newer:** (3) Dental chairs, X-RAY SYSTEMS Gendex Orthoralix 8500 Panoramic • (2) Progeny JB-70 Intra-Oral • Acuray 071A Belmont • DenOptix Gendex Digital Imaging System; Midmark MII Ultra Clave, Midmark Soniclean Ultrasonic Cleaner; Midmark track ceiling • Ritter 354/355 minor surgery ceiling • Zoom Advanced power; LAB Harvest Smart Prep PRPI • Handler Mdl Trimmer, The Machine III Precision vacuum former, PROLAB Basic lab control; WORKSTATIONS & CARTS Midmark Treatment Console w/Dell Optiplex computer, w/Asepsis 21 cart, Assistant cart, (2) Optima MX Bien Air's • Midmark Integrated Treatment Console, Midmark Storage Cabinet & Counter, (2) Midmark 6065 Mobile Treatment cabinets, Hygenist's Cart, Midmark "The Rock" Compressor • Apollo "Gold Series" Vacuum; ACCESSORIES And More. Visit [www.mbauction.com](http://www.mbauction.com) for Complete Info & Bidding Information. Musser Bros. Inc (406) 652-2266  
[memusser@mbauction.com](mailto:memusser@mbauction.com)

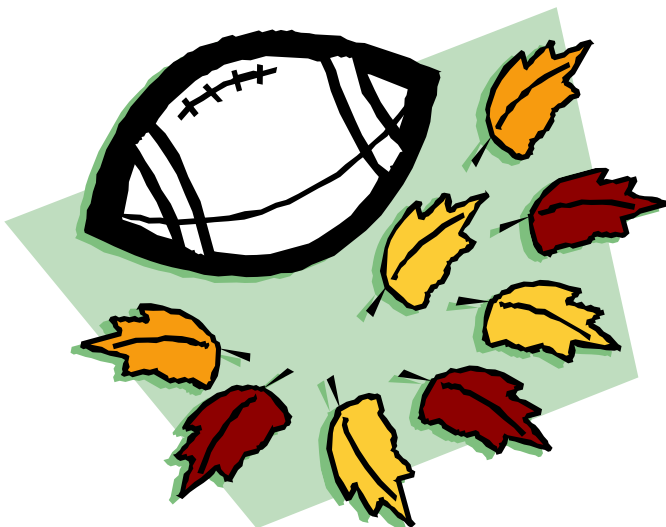
**South Dakota** - Excellent opportunity to JOIN or PURCHASE general practice in northeastern South Dakota. Great hunting and fishing area, excellent school system, small town atmosphere with a large drawing area. General practice performing nearly all aspects of dentistry. 6 ops w/ expansion space. 1.2 M Gross. Confidential. Email: dentalopportunity@iw.net.

### Temporary Coverage of Your Dental Practice

I am semi-retired in Bozeman, and provide locum tenens or "fill in" dental services. Whether it is an illness, military commitment, extended vacation, or just assisting during a transition, I can help. Contact Ron DeArmond at 406/579-8103, 406/586-1768  
[ron\\_dearmond@hotmail.com](mailto:ron_dearmond@hotmail.com).

### Equipment

**For Sale:** Kodak digital 8000 panoramic machine. Manufactured May 2006. Works flawlessly. Crated and ready to ship. \$15,000. Phone 406/234-2926, Dr. Eric Hogan.



# TOPICAL MEDICATIONS FOR OROFACIAL NEUROPATHIC PAIN

## Article submitted by Juro's Compounding Pharmacy

The primary advantage of the treatment modalities discussed in this article is the potential to provide relief of neuropathic pain without the associated side effects of systemic therapies. By working closely with a dental practitioner to help formulate the best pharmaceutical therapy for patients, the compounding pharmacist has become an essential member of the healthcare team for practicing dentists.

The Department of Diagnostic Sciences, Division of Orofacial Pain, University of Medicine and Dentistry of New Jersey, Newark, conducted a study to evaluate the effect of topical medications alone or in combination with systemic medications in the treatment of orofacial neuropathic pain conditions. A retrospective chart review was performed for 39 patients who were diagnosed with a neuropathic pain condition such as deafferentation pain, traumatic neuroma, or trigeminal or glossopharyngeal neuralgia, and were treated for orofacial neuropathic pain at the Orofacial Pain Clinic.

The review concluded that topical medication as single treatment or in combination with systemic medications can reduce orofacial neuropathic pain severity.

"The topical medication can be ordered from a compounding pharmacy where it can be formulated to contain carbamazepine 4%, lidocaine 1%, ketoprofen 4%, ketamine 4%, and gabapentin 4%. Carbamazepine and gabapentin...act by suppressing paroxysmal discharges and reducing neuronal hyperexcitability. Lidocaine, which is a local anesthetic, acts by blocking sodium channels, preventing nerve depolarization. Ketoprofen has anti-inflammatory activity. Last, ketamine blocks N-methyl-D-aspartate (NMDA) receptors, whose hyperactivity contributes to maintenance of neuropathic pain." The topical preparation should utilize penetration enhancers such as anhydrous gel base and bio-adhesive copolymers. These are used to carry the medication transdermally and transmucosally."

Oral Surg Oral Med Oral Pathol Oral Radiol Endod. 2008 Apr;105(4):466-9

*continued on page 10*



## Dental Datebook

### 2010

#### October

9-13 ADA Annual Session, Orlando, Florida

#### December

17 Montana Board of Dentistry Meeting

### 2011

#### January

13-14 Billings Mid-Winter meeting. Thurs. Dr. Lorne Lavine and Fri. Dr. Duane Shafer

#### March

4 Montana Board of Dentistry Meeting

25 MDA sponsored CDE, Dr. Bill Costerton, "Biofilm", Bozeman (tentative)

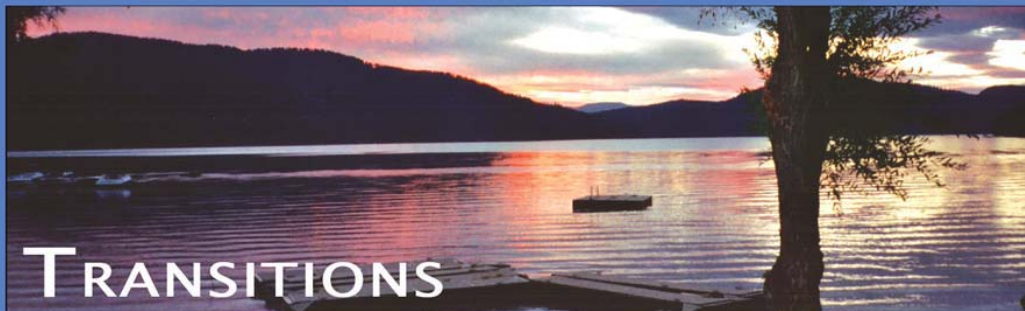
### May

5-6 MDA annual meeting, Helena, Red Lion Colonial Hotel, Featured Speaker, Dr. Stanley Malamed, "Medical Emergencies in Dental Practice". Further details TBD.

### 2012

#### April

25-27 Montana Dental Association annual meeting. Missoula, Montana. Thursday, April 26 - Dr. Gordon Christensen "The Christensen Bottom Line"



# TRANSITIONS

Donald G. Hanson, DDS, PC.: 406.862.6260  
[www.qualitytransitionsdds.com](http://www.qualitytransitionsdds.com)

Do  
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a  
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## Keeping You in Touch with Dentistry in Montana