TECHNOLOGY LIST FOR THE OPTIMIZED PERIODONTAL PROGRAM

CHARLES BLAIR, D. D. S.

BASICS: New Patient Baseline is required for malpractice, state board (standard of care), and insurance documentation. It is absolutely foolish not to have this technology for protection of the doctor's license.

1. Digital Camera
2. Intraoral Camera
3. Study models, only where indicated (complex/ortho case)
4. X-rays, ideally digital x-rays (full series or panoramic plus BWX)
5. Presentation of treatment options (particularly complex treatment) plus informed consent for the procedure treatment planned.

ESSENTIAL SOFTWARE: Must have, no choice not to.

1. Patient contact software (DemandForce; www.demandforce.com)
2. Patient education software (Guru; www.howdoyouguru.com)
3. PreViser (www.previser.com)

BASIC HYGIENE EQUIPMENT/SUPPLIES: Essential for every practice. If you don't have this equipment, it negatively affects productivity.

1. Piezoelectric Scaler
2. Voice Entry Software (www.dentrix.com) **or** Automated Foot Pedal (www.dentalrat.com)
3. Local anesthetic by Hygienist; where permitted by state law.
4. Oraqix® /other topical anesthetic
5. Nitrous Oxide; where permitted by state law.
6. Basic Shade Guide **or** Electronic Shade Guide
7. Caries and Calculus Detector, Spectra, and SOPROLIFE.
8. VELscope
9. Indentify 3000 (Trimira)
10. Isolation (dry field for sealants)
11. Patient Study Models (bridge, implant, space maintainer, etc.)

ADVANCED HYGIENE & DOCTOR EQUIPMENT: Essential for optimizing revenues.

1. Unbooked Operatory; used by both hygienist and doctor.
2. Digital Panoramic X-Ray (8 seconds); it pays for itself and is super efficient.

OPTIONAL EQUIPMENT:

1. Soft Tissue Laser; where permitted by law.
2. Magnification Optics
3. Prophy Jet

DR. BLAIR'S COMMENT: If the technology is used as outlined, plus good practice management techniques, the hygienist will produce three times their W-2. Underutilized technologies will diminish the monetary output of the hygiene department.

MATHEMATICS OF THE DENTIST'S BUSYNESS

Most dentists think a lack of busyness is a lack of new patients. That's partly true, but the mathematics of busyness is far more complicated. Dentists with busyness problems routinely focus on advertising or joining discount (PPO) plans to increase new patient flow. The route they travel is the most expensive approach to generating new patients and not always effective. They aren't aware of, or won't consider, the other methods to increase dentist busyness.

INQUIRY CONVERSION RATE

The source of new patient flow is derived from both internal and external marketing methods. Internal methods are much cheaper but require attention to detail and time, such as "asking" for referrals. External methods such as direct mail, yellow pages, advertised promotions, and the internet demand a substantial cash outlay.

With the exception of a few shoppers, most potential patients already have a favorable impression of the practice through referrals or advertising. It's imperative that the business staff intimately knows all the services offered and have the requisite telephone skills to convert inquires to appointments. The first step is for the doctor to tape record calls, listen, and see if the call dialog meets the dentist's expectation. Special care and extra time must be taken if the practice does not participate with Delta Dental or other PPO plans. Dentists spend on advertising and technology while neglecting staff training expense. Don't forget the importance of staff training which will increase the call conversion rate.

NEW PATIENT FLOW

Once patients call the office a certain percentage (phone call conversion rate) will elect to come in for an exam. We call this string of new patients entering the practice for an initial evaluation (exam) the "new patient flow". The new patient flow required by a practice is directly related to the productive capacity of the dentist. A million dollar producer would require twice the new patient flow of a $500,000 producer. Thus, there is a direct correlation of new patient flow requirements as to the production level of the dentist.

Now, with the development of PracticeBooster® (see www.practicebooster.com) and its database, we have identified and developed several mathematical algorithms to quantify several of the components that contribute to the dentist's busyness. For instance, in a general practice a value of $4,500 per new patient *ratio* will roughly predict the new patient count required for adequate busyness. Adequate busyness is defined as the dentist is solidly booked 1½ to 2 weeks ahead. For instance, a $900,000 practice will need about 200 new patients per year for adequate doctor busyness (See Figure 2 calculation). Likewise, a smaller $450,000 practice would need about 100 new patients a year for adequate dentist busyness. If the practice has a high percentage of children, add 10% to the calculation; if the practice has above 20% PPO revenues, add 10% to the new patient calculation. This is a simple calculation which can determine new patient requirements. This rule-of-thumb equation applies as long as the dentist does a decent job of diagnosing, provides a fairly wide service mix, patients reasonably accept treatment, and checks an adequate size hygiene patient base is available.

HYGIENE DEPARTMENT SIZE

The next component of dentist busyness is the size of the hygiene department (hygiene check count available). Through PracticeBooster's research model, we have found that a practice with average fees will need a hygiene day per week for each $115,000 of doctor related production. Our statistical model converts a practice's fee to a "standardized fee" for even closer refinement of this ratio. Thus, a higher producing dentist needs a bigger hygiene department to feed him/her. For instance, an average $600,000 practice generally has one hygienist working 4-4½ days per week. For easy math, assume the dentist produces about $460,000 of individual production, requiring four days of hygiene for adequate busyness. See Figure 3 for calculating the hygiene days required for adequate doctor busyness. The larger $800,000 to $1,000,000 practice generally would require 1½-2 full time hygienists working 4-4½ days. Thus, the hygiene to doctor day ratio is critical for adequate busyness. One of the reasons for associate busyness problems is an inadequate hygiene base or the inability to ratchet up the hygiene day count.

CLINICAL SERVICE MIX BREADTH

The next component of doctor busyness is the breadth of the clinical service mix. Broadly, we classify dentists as a Refer-O-Dontist, Typical, or Decathlon Dentist. PracticeBooster's database indicates that the Refer-O-Dontist generates about 60 discrete office procedures; the Average Dentist about 90, and the Decathlon Dentist about 120 discrete procedures. These procedure counts include all hygiene procedures. The service mix breadth can easily be determined by running an office procedure report listing the procedures by ADA code for a twelve month time line. To make this determination, simply count all the procedures for which there is any activity.

The dentist that does a "little bit of everything" can be busier and even thrive with less new patient flow. The Refer-O-Dontist needs greater new patient flow due to a restricted service mix. With the current economic problems and the profession's rapid shift to PPO's, there is a much greater need to provide a greater spectrum of services to maintain busyness. The pool of full-fee patients is greatly diminishing with everyone chasing them. Many older (and not so old) dentists have developed a sense of entitlement over the years to restrict procedures to only what they enjoy, or has no hassles. Times are changing and this group is rapidly losing their practice!

CLINICAL TREATMENT INTENSITY

The next component of busyness is the Clinical Treatment Intensity (CTI) rate of the dentist. For instance, how many sealants are generated per 100 child prophys? How many crowns, fillings, surgical extractions, core buildups under crowns, etc. per 100 prophys are done? With missing teeth, does the dentist treatment plan a partial denture, fixed bridgework, an implant, or nothing at all? PracticeBooster's analysis shows that the treatment variation among dentists is astounding!

Some insurance companies have tracked a few of the procedure intensity levels and have written dentists (particularly those in network) that they are performing *too many* crowns, core buildups, SRP, etc. per 100 prophys submitted and that they are "outliers". Thus, they may be placed on a "watch" list or other scrutiny. Interestingly, we've never seen a letter sent to a dentist charging them with under treatment! Until PracticeBooster's development, the dentist has never had any comprehensive treatment intensity data for comparison by peer percentile. Naturally the more aggressive the treatment intensity per patient base, the less new patient flow and hygiene base requirements.

CASE ACCEPTANCE RATE

The last component of dentist busyness is the patient's acceptance of care. The patient acceptance rate is a function of the patient's financial wherewithal, effective use of intraoral camera and digital x-rays, third party financing availability, and effective communication of the dentist and staff. Thus, a higher case acceptance rate lowers the new patient flow requirements for adequate busyness.

SUM OF THE COMPONENTS

Since dentist busyness is derived from the sum of the five components presented here, each discrete component may be a stronger or weaker contribution to the overall composite. For instance, a weaker new patient flow may be offset by higher than average clinical treatment intensity, more extensive procedure mix, or higher case acceptance. The bottom line is that the dentist's schedule be booked solid for about 1½ to 2 weeks. Less than a week out puts extra pressure on the business staff to shift patients forward and involves extra time. Booking beyond two weeks results in patient inconvenience, staff stress, and indicates the dentist has a pent up demand for his/her services.

Before you take the knee-jerk reaction of spending money on external marketing or joining PPO's which increase write-offs, work hard to optimize the various components of busyness as presented in this article Forget that sense of entitlement if you have it, focus within the practice to increase busyness, and face the reality of a vastly changing shift in the marketplace.

DENTIST BUSYNESS ANALYSIS

I. DENTIST BUSYNESS STATUS: The **dentist busyness status** is measured by the number of work days on the dentist's schedule with patients booked solid. This variable can be as low as a few days (0.2-0.3 week) or up to eight weeks or more. Remember, a broken appointment problem (last minute cancellations and no-shows on today's schedule) is a totally different problem and has nothing to do with busyness. There are three broad categories of doctor busyness:

1. Less than one week of busyness places extra effort on the front desk moving patients around, which is stressful and inefficient. Thus, solid bookings of only a few days out (a true dentist busyness problem) may indicate one or more of the following problem areas affecting dentist busyness:
    a) Inadequate new patient flow
    b) Low Clinical Treatment Intensity treatment planning, on the part of the dentist.
    c) Narrow clinical procedure service mix offerings by the dentist.
    d) Inadequate hygiene work day to doctor work day ratio to support dentist busyness.
    e) Poor patient case acceptance, not directly measured in this report.
2. Equilibrium is a balance of doctor work demand coupled with a given production and *optimum* dentist busyness is considered to be about 1.5-2 weeks booked solid.
3. Doctor busyness beyond three weeks indicates that there is more dentistry demand than the dentist(s) can, or is willing, to produce. Excessive busyness offers:
    a) Increasing fees more aggressively.
    b) Getting out of some current PPO plans, if applicable.
    c) The possibility of a one or two day part-time associate. If an associate day is added, another hygiene day will be needed to be added long term for adequate doctor busyness.
    d) Possibility of a future partnership.

DOCTOR BUSYNESS STATUS: _____WEEKS

The dentist's busyness status is based on four contributing factors in *addition* to the new patient flow. The four other major factors affecting **dentist busyness status** are:

1. The count of hygiene doctor exams (finding treatment) measured as hygiene days per week.
2. Clinical Treatment Intensity, which is the quality of the doctor's exam and subsequent amount of dentistry done on the patient base.
3. Clinical service mix breadth of the dentist.
4. Case acceptance. PracticeBooster®, in this report, directly measures all aspects of doctor busyness **except** for case acceptance.

The "knee-jerk" reaction of the dentist with busyness problems is immediately to join PPO's and market externally (killing the bottom line) to solve the problem through increasing new patient flow ONLY. Rather, time and effort needs to be spent on the multitude of strategies as outlined by this PracticeBooster® report and use the proven business strategies to improve productivity and busyness.

II. FORECASTED NEW PATIENT AVAILABILITY: This Calculator forecasts the specific new patient flow required for adequate doctor busyness. The total production of the practice divided by a value of $4,500 yields the forecasted requirements for new patient flow. This $4,500 value utilized does not mean that a new patient has a clinical or lifetime value of $4,500. Instead, this $4,500 value is a mathematical calculator that was derived from examining thousands of practice.

$$\frac{\text{Gross Collections}}{\$4{,}500} = \frac{\$\_\_\_\_\_}{\$4{,}500} = \_\_\_\_\_ \text{ \# New Patients Required}$$

If the practice has a high percentage of children, add 10% to the calculation; if the practice has above 20% PPO revenues, add 10% to the new patient calculation.

NEW PATIENT FLOW COMES FROM:

1. **INQUIRY CONVERSION RATE:** This measures the new patient's telephone/internet inquiry rate for conversion into a new patient appointment. Exceptional telephone skills are required to convert PPO patients into a non-participating office.
2. **TELEPHONE ANSWERING HOURS**: Not answering the phone during lunch or days closed hurts the new patient flow. With a recording, a percentage of new patient go elsewhere.
3. **BUSINESS HOURS:** Restricted business hours availability (evenings, Friday's, Saturday's) decrease new patient flow.
4. **INTERNAL MARKETING:** Patient of record referrals. Patients should be "trained" to refer with exceptional scripting and rewards of small gifts and thank-you notes.
5. **EXTERNAL MARKETING:** Internet, direct mail, yellow pages, radio, newspapers, etc.
6. **PPO PLAN PARTICIPATION:** The discount write-offs (to gain new patients) are a real-dollar marketing expense.
7. **ACQUIRE PATIENT RECORDS:** Often the lowest cost overall method to gain new patient flow.

Remember, new patient flow is just *one* of the five major factors contributing to the dentist's busyness.

Deficiencies in the new patient flow of a practice can be offset by:

1. A higher hygiene to doctor day ratio, more patient exams to check.
2. A more expanded service mix.
3. An increased doctor's Clinical Treatment Intensity level.
4. An increased case acceptance.

III. **FORECASTED RDH DAYS AVAILABILITY:** This calculator measures the number of forecasted hygiene days as required by the doctor's productivity level. The higher the dentist's production level, the greater the need for more hygiene days. These are some basic rules to follow in computing the number of hygiene days required to support doctor busyness:

1. A productive doctor (higher producing) will need additional hygiene flow for adequate doctor busyness. A rough rule of thumb is one hygiene day per week is required per $115,000 of annual doctor production.
2. Hygiene day to doctor day ratios are critical because:
    a) Higher hygiene day to doctor day ratios are generally more desirable since more treatment can be found on the increased patient base.
    b) A low hygiene day ratio coupled with doctor busyness problems indicates there are not enough hygiene work days to support the doctor's production level.
3. If the hygienists are treating periodontal needs (hence, less prophy slots available), then additional hygiene work days will be required to be added for adequate doctor busyness.
4. *Deficiencies* in the hygiene day requirements for adequate doctor busyness can be offset by:
    a) Higher new patient counts
    b) A more expanded service mix
    c) An increased Clinical Treatment Intensity
    d) Increased case acceptance.

$$\frac{\text{Doctor (Only) Collections}}{\$115{,}000} = \frac{\$690{,}000}{\$115{,}000} + \text{1 Day}$$

$$\frac{\text{Actual Hygiene Days/Week}}{\text{Forecasted Hygiene Days/Week}} = \frac{7 \text{ Days/Week}}{7 \text{ Days/Week}} = \text{100\% Hygiene Day Availability for Doctor Checks}$$

*Includes doctor evaluations (exams)

IV. **ACTIVE CLINICAL PROCEDURE MIX BREADTH:** The average practice, at the 50th percentile, performs 93 discrete procedures. There are many ways to practice dentistry, procedure-mix wise. Some practitioners perform a narrow scope of procedures (refer-o-dontist) while others offer a wide service mix (decathlon-o-dontist). The *wider* the scope of the service-procedure mix, the *less* patient flow required for a given production level with adequate dentist busyness. A *wider scope* of procedures can help offset:

1. Inadequate new patient flow.
2. Shortage of hygiene days to doctor day's ratio.
3. Clinical Treatment Intensity deficiencies.
4. Case acceptance deficiencies.

V. **Clinical Treatment Intensity℠ (CTI℠):** The Clinical Treatment Intensity℠ of the hygienist and dentist directly affects the doctor and hygienist busyness. Increased overall treatment translates into increased practice busyness.

VI. **Case Acceptance:** Bottom line, the patient must accept treatment for busyness to occur. Use of digital x-rays, study models, GURU patient Education, scripting, and third-party financing will increase case acceptance.

HYGIENE DEPARTMENT BUSYNESS ANALYSIS

NEW PATIENTS: New patients are required to keep the doctor busy and to replenish hygiene patients leaving the practice (out the back door).

HYGIENE BUSYNESS STATUS: There are three broad levels of hygiene busyness:

1. **OPEN SLOTS** indicates the hygiene schedule has "holes" in it, particularly for the next few days. We are not talking about appointment changes or a last minute collapse of the schedule - that's a broken appointment problem. Also, open slots due to block scheduling for new patients and SRP don't count if they are not filled after the current week - that's the purpose of block scheduling. **Open slots** indicates inadequate hygiene busyness, and more visit "slots" are available than patient counts to fill them.
2. **BOOKED SOLID** indicates the number of hygiene slots available roughly match the patient base needing hygiene services. **BOOKED SOLID** indicates there are little, or no openings for the next 7-10 business days or greater except for last-minute cancellations and schedule changes over the next few days.
3. **OVERFLOWING** indicates no openings for greater than three weeks. Therefore, it is very hard to get patients into hygiene, with a fairly large waiting list. An **OVERFLOWING** status can indicate:

Note: If half the patients are a no-show today, that is a broken appointment problem, NOT a busyness problem.

Things that could happen for the slots available if an influx of new patient flow is entering the practice for hygiene services, particularly perio:

1. The dentist could be under-treating patients and requiring excessive new patient flow, without enough hygiene slots available.
2. A highly effective preventative re-care system coupled with too few hygiene days available
3. A highly effective diagnosis and acceptance of periodontal therapy (SRP) program with too few hygiene days available to accommodate the SRP treatment requirements.

HYGIENE DEPARTMENT BUSYNESS STATUS: _____ (open slots, booked solid, or overflowing)

REPLENISHMENT RATE CALCULATION:

$$\frac{\text{New Patients* (D0150/D0180)}}{\text{All Prophys + D4910/2}} = \_\_\_\_\_ = \_\_\_\_\_\% \text{ Replenishment Rate}$$

*Also includes consultation (D9310) if used for new patients.

HYGIENE DEPARTMENT REPLENISHMENT RATE: This Calculator measures the new patient count size replenishing the hygiene department as a percentage of the existing hygiene base. Practices lose hygiene patients (requiring two visits each year) due to inadequacies of the recall system, moving, death, apathy, and changing dentists. If the practice location is rural usually the hygiene loss rate is less while an urban location, with more turnovers, will be higher. An older patient population is less mobile (and more loyal) so the loss rate is lower in the more mature practice. The loss rate is much higher when the office has poor contact with the patient base. As listed in the Table below, a low (<7%) replenishment rate percentage indicates the hygiene base is probably declining and open slots are a problem, or will be in the future. A minimum (8%-9%) replenishment rate indicates the hygiene base size should be static and in equilibrium. An excessive (>10%) replenishment rate in the front door

indicates a high flow of patients is running or is crowded out the back door. Thus, there are generally no slots available for perio treatment (SRP).

REPLENISHMENT PERCENTAGE	HYGIENE DEPARTMENT STATUS	YOUR DEPARTMENT STATUS
< 6%	Declining Replenishment*	
7% - 9%	Moderate Replenishment/Static**	
10% - 19%	Excessive Replenishment***	
> 20%	Grossly Excessive Replenishment***	

***DECLINING HYGIENE REPLENISHMENT:** Indicates that the Hygiene base size should be declining or barely static. In some cases the doctor is busy enough but the hygiene base is declining. This is seen commonly with the older doctor.

****MODERATE/STATIC HYGIENE REPLENISHMENT:** Indicates that the Hygiene base should be Static

*****EXCESSIVE OR GROSSLY EXCESSIVE HYGIENE REPLENISHMENT:** Indicates one or more of the following:

1. Growing practice, and has the ability to add hygiene day(s) and operatory
2. Overflowing-inadequate slots to treat perio (SRP), and has the ability to add hygiene day(s) and operatory.
3. Recall system problems-excess patients going out the back door if there are **open slots**. There is plenty of new patient flow, but a recall problem creates the **open slots**.

OVERALL RECOMMENDATIONS (DEPENDING ON THE PRACTICE SITUATION):

1. The primary purpose of adding additional hygiene days is to:
    a) *Increase* doctor busyness, because it is needed or an associate has been hired.
    b) *Add SRP capacity* to the hygiene department.
    c) *Increase hygiene days* (capacity) and operatory in anticipation of an associate.
2. With a higher replenishment rate, additional hygiene days may be added over the longer term for increasing doctor busyness or adding associate day(s) for proper hygiene day ratio.
3. Patient contact software (DemandForce) is essential to maintain optimum relationships with the patient base through appointment reminders, electronic newsletters, birthday greetings, patient surveys, Google ranking, etc.

The Unbooked Operatory
By: Dr. Charles Blair

Many dental offices have an extra plumbed, but not equipped, operatory. When the dentist is queried as to its non-use, here is the *logical* routine:

> Typical Doctor's Answer: The hygienist works one operatory, with one patient at a time. She wouldn't use an extra operatory much. The dentist uses primarily one operatory and the second to a lesser degree. The dentists really only needs two. Thus, the obvious conclusion: <u>The unbooked operatory would not be used enough to offset its acquisition cost.</u>

While the scenario outlined above is logical and "cost-based," it neglects to address the powerful incentives to equip another operatory.

Wouldn't every practitioner like to increase productivity, lower stress and enhance customer service? The alternate or "unbooked" operatory (interchangeable for doctor or hygienist) is the ideal solution.

Since provider clinical time is extremely valuable, with the doctor's time worth $3 to $7 per minute (or $180 - $420 per hour) and the hygienist's time is worth $1.25 to $1.75 per minute (or $75 - $105 per hour), optimizing the clinical workflow should be every practice's number one goal. To achieve maximum clinical productivity with minimum stress, the overall goal should be both high production dollars *per hour* and high dollars *per visit* (based of course on the diagnosed needs of each patient).

The benefits that can be gained by having an unbooked operatory are numerous. First, it provides an extra chair for patients, whose "work-in" appointments take just a few minutes - removing sutures, checking sore spots for a partial denture, taking X-rays, etc. Without this extra operatory, these types of appointments can ruin on-time performance and the scheduled flow for the day in existing operatories. The shuffling of patients from one operatory to another is inefficient and puts unnecessary stress on the entire team. Emergency appointments can also be scheduled in the unbooked operatory by discussing the appropriate time opportunities at the morning huddle.

Secondly, if the doctor or hygienist has fallen off schedule, the unbooked operatory may be utilized seating the next patient for his/her scheduled appointment. This allows the hygienist to proceed on time with her next patient or if the doctor is running behind, he/she can take a brief break to give "on-time" anesthesia, keeping the patient waiting no more than 10 minutes in the reception area.

Outstanding customer service is the goal for each and every patient. Today's patient is more educated, thus has higher expectations and demands not only for high quality dentistry, but also on-time performance and top-notch treatment from a customer service prospective. Consistent, on-time performance lowers the broken appointments rate since patients perceive that they are expected to show up and that the office doesn't "overbook."

Chair conversion provides benefits from a customer service standpoint and is a key to a high efficiency, productive practice. To increase efficiency while also boosting productivity, simple operative-surgical procedures, i.e. air abrasion or simple restorative, may be performed on the current hygiene patient if the doctor has extra time in his/her schedule, allowing the next hygiene patient to be seated in the extra operatory. There is little profit in rebooking the patient, meeting and greeting, filing an insurance form, etc., for simple, low-level procedures. Tooth whitening is an example of an "impulse buy" and the impression should be taken <u>today</u>, not at a subsequent appointment for greatest efficiency. Since the variable costs of supplies and lab are 15%-20% of practice expenses, there is an 80% profit margin or more for "working in" the *extra* procedure within the constraints of current staff and other operating expenses. The following example illustrates profit potential for only an extra procedure or two per day, above and beyond the current schedule:

If the doctor is working with only one assistant, the unbooked operatory can be utilized if the assistant is running behind and may not have time to clean and turn over the current operatory. This extra operatory also maximizes the efficiency of a "rover" who works both the front desk and clinical areas. It allows the rover time to turn the operatory for the doctor or hygienist, take a necessary x-ray, etc.

Occasionally doctors will hire a part-time hygienist or utilize an assistant to facilitate "accelerated" hygiene if hygiene backlog becomes excessive. Again, the unbooked operatory is available for this function or for a part-time associate doctor. Where appropriate, in some cases a dental specialist or podiatrist might use this additional operatory on the days the practice wasn't seeing patients. When equipment malfunctions, the unbooked operatory will be there to save the day.

Too often, doctors have an extra operatory that is plumbed, but not equipped—what a shame! The extra operatory *decreases*, not *increases* stress, as described above. It is important to realize the cost of equipping this extra operatory will more than pay for itself in a very short time, through the increased opportunity for additional production, since it is only $30 per day. Unfortunately many dentists are "cost-oriented" rather than revenue savvy. They are overly concerned with "cost", rather than seeing the benefits of a greater net, lower stress, improved productivity, and increased levels of customer service.

Labor expense is costly, comprising 65% to 75% of the total expense of running a dental practice (including team and doctor compensation) while amortized equipment/high tech capital expenditures are much less in comparison. Doctors should focus on improving labor efficiency through continuing education, proper scheduling, and wise equipment purchases to enhance overall productivity. Appropriate expenditures for equipment in all operatories, including the unbooked operatory, along with practice management consulting will pay high dividends increasing productivity while decreasing stress. As a bonus, Uncle Sam provides some nice tax breaks and incentives. Bottom line - - after taxes, the extra operatory costs only a few dollars a day.

Use of the Section 179 expense election:

$30,000	New operatory expense
<30,000>	Section 179 expense election ($250,000 limit)
- 0 -	
	$ 30,000 total write-off in one year!
	($10,500 in taxes is saved at the 35% tax bracket!)

In summary, doctors often have an extra operatory that is plumbed, but not equipped - - what a shame! The extra operatory *decreases* not increases stress, as described above. It is important to realize the cost of equipping this extra operatory will more than pay for itself in a very short time through the increased opportunity for additional production, since it is only $30 per day. Unfortunately many dentists are "cost-oriented" rather than "revenue savvy." They are overly concerned with "cost", rather than seeing the benefits of a greater net, lower stress, improved productivity, on-time performance, and increased levels of customer service.

DR. JOHN DOE SAMPLE CLINICAL PROTOCOLS FOR NEW AND RECALL PATIENTS

(STOP LEAVING MONEY-ON-THE-TABLE WITH POOR/NO PROTOCOLS)

NEW PATIENT PROTOCOLS

A. New Patient: Five Evaluation Coding Choices:*

1. D0145: Under three Evaluation with counseling, $50 (lowest fee)
2. D0150A Comprehensive Oral Evaluation: Three years and up to 17 yrs, $60 (mid-level fee)
3. D0150B Comprehensive Oral Evaluation: 18 years and up, $69 (higher fee)
4. D0180 Comprehensive Periodontal Evaluation: May be used if new patient exhibits signs and symptoms of periodontal disease or has risk factors for perio such as diabetes or heart disease. In addition, full mouth probing and charting is mandatory. UCR for D0180 is often higher than D0150. However, many practices charge the same fee for the D0150 and D0180.
5. D9310 Consultation: May be used only if the new patient is referred to the office by a dentist or physician. Often, the consultation (D9310) is subject to the "two evaluations a year rule". However, sometimes a "third" evaluation is paid if to a specialist. This code can be reported by either the GP or specialist.

NOTE: Never use D0120 for a new patient child to hold down the fee. Simply charge a lower fee for D0150, D0150A, and D0150B illustrate a method to charge less for a child new patient evaluation.

*Fees shown are for illustration only and do not reflect any particular zip code.

B. New Patient: Four X-ray Coding Choices:

1. Under six years, take either two occlusals (D0240) or 2BWX (D0272). Payors generally limit reimbursement to a full-series UCR amount.
2. Ages 6 years and up, take a Pan (D0330) plus 2BWX (D0272) or 4BWX (D0274), if no perio or crown and dental bridge issues are present.
3. If an adult perio or extensive crown and bridge patient, always take a full series (D0210).
4. Vertical Bitewings 7-8 (D0277) may be taken for a new patient but is not as good as a full series (D0210). Also, many payors "count" D0277 as a full series (D0210) toward the x-ray 3-5 year limitation.

C. New Patient Fluoride Treatment (Consider fluoride varnish for all fluoride procedures): Three Coding Choices:

1. Match D1203 with child prophy (D1120) for low risk patients. Any type of fluoride is ok, including varnish.
2. Match D1204 with Adult prophy (D1110) for low risk patients. Any type of fluoride is ok, including varnish.
3. Match D1206 with either child or adult prophy if the patient: wears braces, has moderate-to high caries risk, has potential for root caries, or has extensive crown and bridge. D1206 is only for moderate-to-high caries risk patients and requires fluoride varnish application.

Note: D1204 and D1206 are generally reimbursed up to 18years of age.

D. New Patient Treatment Protocol Sequences:

Assumes evaluation (D0150 or D0180) CAN be performed at first visit. Four treatment choices:

1. One prophy visit if clean, non-perio month.
2. Two separate prophy visits if heavy calculus, but non-perio issues (no attachment or bone loss) mouth.
3. SRP if at least 4-5mm probing depths, bleeding-on-probing (BOP), with some attachment and bone loss present.
4. If extensive perio patient (7mm pockets), then refer to periodontist.

OR

Assumes evaluation (D0150 or D0180) CANNOT be performed at first visit.

1. First visit; do gross debridement to enable comprehensive evaluation (D4355), if reimbursement is available. Only 30% of policies reimburse D4355. Otherwise, palliative (D9110) could be considered (only if patient says they have discomfort). X-rays (a pan, BWX, or full series) can be done at the first visit without a problem.
2. Second visit; the evaluation (D0150 or D0180) is now completed. X-rays can also be taken (or completed) at the second visit, 4BWX (D0274), panoramic (D0330), or full series (D0210) to complete any baseline x-ray requirements. Then, the dentist orders one of three treatment choices:
    a) A final prophy (D1110) to complete the patient's treatment
    b) SRP if at least 4-5mm probing depths, bleeding-on-probing (BOP), with some attachment and bone loss present.
    c) If extensive perio patient (7mm pockets), then refer to periodontist.

E. New Patient Perio Treatment Sequence:

1. First, start treatment with SRP visits.
2. Next, a 6 week recall visit is scheduled (optional).
3. Finally, follow-up D4910 recall visits are scheduled every 90 days thereafter.
   Notes:
    a) Use D4341 for quad and D4342 for 1-3 teeth per quad SRP treatment.
    b) Six week recall is often no charge; some charge a prophy (D1110) at the six week evaluation. This works sometimes but some payors will deny any subsequent D4910 visits, if a prophy is reported. Arestin® (D4381) could be reported and possibly paid. D0180 could be reported (if the doctor examines the patient) but probably not reimbursed. Probing and charting (D4999) by the hygienist and D4910 could be reported at the six week recall, with generally no reimbursement. So, reimbursement for any procedure (except Arestin®) at the six week re-evaluation is spotty at best.
    c) The D4910 visit is 90 days after the last SRP visit if there is no prophy (D1110) charged at the six week re-evaluation. If a prophy (D1110) is charged at the six week re-evaluation, then the D4910 visit would be 90 days after the six week re-evaluation prophy visit.

RECALL PATIENT PROTOCOL

A. Check-Up Evaluation: Six Coding Choices:

1. Use recall evaluation (D0120) once a year for perio and non-perio patients (plans generally limit to two evaluations per year).
2. Use recall evaluation (D0120) twice a year for perio and non-perio patients (plans generally limit to two evaluations per year).
3. For perio recall patients (D4910) alternate every six months the periodic (D0120) and comprehensive periodontal evaluation D0180 (plans generally limit to two evaluations per year). However, plans may down code D0180 to D0120.
4. Use D0180 four times a year (insurance will generally limit to two evaluations (of any type) per year and probably down code to D0120) in many cases.
5. If an extended amount of doctor time is spent on a problem – focused recall situation, use code D0140 sparingly. D0140 is a higher UCR than D0120.
6. If a patient of record has "disappeared" for several years consider using D0140 for a more extensive evaluation instead of using D0150 (which probably will be downgraded to a D0120 by the payor if reported in the past).

B. Check-Up X-ray: Three Coding Choices:

1. Pan and BWX combination x-rays or full series taken on an every 3 or 5 year basis.
2. 2 BWX, 1st molars only; 4 BWX after second molars have erupted. 4BWX not generally age-limited. BWX may be taken annually, if clinically justified.

3. Generally don't consider reporting 7-8 vertical bitewings (D0277) and use this code due to reimbursement issues. D0277 may be upgraded by some payors to a full series or downgraded to 4BWX for payment, not a good result. Sometimes 4 BWX verticals are taken annually and alternated front and back each year for perio patients, which may work best.

C. Check-up Fluoride Treatment (Fluoride varnish for all fluoride procedures is recommended): Three Coding Choices:

1. Match D1203 with child prophy (D1120) for low risk patients (any type of fluoride is OK, including fluoride varnish).
2. Match D1204 with Adult prophy (D1110) for low risk patients (any type of fluoride is OK, including fluoride varnish).
3. Match D1206 with either child prophy or adult prophy if the patient: wears braces, has moderate-to high caries risk, has potential for root caries, or has extensive crown and bridge. D1206 is to be reported only for moderate-to-high risk patients and requires fluoride varnish application.

OTHER CODES AT RECALL APPOINTMENTS

A. Desensitizer (Sensitive tooth/teeth)

1. If sensitive tooth at checkup/operative visit report D9910, no charge or up to $20 if done in conjunction with a checkup or operative visit. D9910 reports desensitizing up to a "whole mouth".
2. If sensitive tooth at emergency visit, use palliative D9110 fee $65.
3. Some offices charge a whole mouth desensitizer (D9910) in conjunction with SRP. The desensitizer is generally not reimbursed and many PPO's require the charge to be written off as it is considered integral to the procedure.

B. Irrigation

1. There is no specific code for irrigation so use D4999, unspecified procedure. Irrigation is not reimbursed as many PPO's require the charge to be written off as it is considered *integral* to the prophy or SRP procedure.

C. Chlorhexidine

1. There is no specific for chlorhexidine so use D4999, unspecified procedure, if used in the office. Chlorhexidine is generally not reimbursed and many PPO's require the charge to be written-off, as it is considered integral to the prophy or SRP procedure.
2. If chlorhexidine is dispensed for home use, report D9630 (which will not be reimbursed).

EMERGENCY VISIT CODING CHOICES

Four Emergency Visit Procedure Choices:

1. Definitive Treatment (filling, extraction, root canal, etc.)

OR

2. Palliative (D9110)* (use more often, use D0140 less)**

OR

3. Gross Pulpal Debridement (D3221)-Open and refer to endodontist/different office.

OR

4. Pulp Vitality Test (D0460)-Not used in conjunction with evaluation (D0140). Use when Palliative (D9110) cannot be justified.

*Other treatment (except x-rays) cannot be reported in conjunction with the Palliative (emergency) visit.

**Some practices only perform one recall exam per year. If so, D0140 can be used at one emergency visit without affecting the (one) recall exam per year. If the practice does two recall exams a year, generally avoid D0140 at the emergency visit, because of the evaluation frequency limitation.

Three Emergency Visit X-Ray Choices:

1. Two Periapicals (D0220/D0230) taken at different clinical angles

OR

2. Panographic (D0330) taken on a standalone basis

OR

3. 4BWX (D0274) taken on a standalone basis

FLUORIDE CODE TABLE

Topical Fluoride Code	Patient Status	Caries Risk	Any Type of Fluoride?	Fluoride Varnish
D1203	Child Prophy	Low Risk	Yes	Yes
D1204	Adult Prophy	Low Risk	Yes	Yes
D1206	Child or Adult Prophy	Medium-High Risk	Varnish Only	Mandatory

MAKING THE DECISION TO PARTICIPATE OR DROP OUT OF A PPO NETWORK

The decision to participate or drop out of a provider PPO network is a complex decision for the dentist and team. Rather than make an emotional decision either way, why not approach this decision from a business standpoint? Here are some suggested steps to evaluate and make an informed decision:

1. Closely analyze your practice's current production revenues for each insurance company for the past six or twelve month time frame. Run a production report for each of the plans and calculate the market share percentage for each plan. For participating plans, compute the percentage of write-offs for each plan and the amount of money involved.

2. Select the same time frame as #1 and examine only the new patient flow counts of each plan and calculate each plan's revenue percentage. Compare the new patient evaluation (D0150/D0180) percentage to the current market share percentage by revenues. Then compare the percentage market share of each plan for the practice and the percentage share of the new patient flow. Is the new patient percentage for the PPO plan higher than the PPO plan's current market share of the practice? If so, the practice overall is moving deeper into discounted dentistry (PPO participation) with that particular plan.

   So, is a particular PPO plan dominating a higher percentage of your new patient flow over time? Have other dentists dropped the under-funded (low fee) PPO plan in your area as you have ignored the poor fee reimbursement and remained aboard? Have you checked the plan's website to confirm the level of provider participation in your area and plotted the providers within a fifteen mile radius compared with other plans? Are those PPO plan patients now crowding out your new patient capacity? Thus, new patient percentages for a recent timeline are the early warnings for the positive or negative direction of the practice's PPO participation in a given plan.

3. Next, examine the quality of the patient base and their historical acceptance of covered and non-covered procedures. In selecting a plan for termination, fees may be similar but the patient base quality of one over the other will select the winner.

4. Finally, examine the processing policies and "hassles" administratively of each PPO plan. For instance, core buildups for crowns may be questioned extensively or excluded. Is there a high denial rate for crowns and bridges, or are the perio recall benefits poor?

5. Are non-covered procedure fees controlled by the plan? What is their benefit level? Examine the fee structure to see if you can afford to provide those non-covered services and still participate in that plan. Also, check if your full fee schedule will prevail above the plan limitation (typically $1,500 per year), or if the PPO plan controls.

6. What is the market share of the plan you are considering dropping? If the plan is 40% of your practice it may be unwise to do so unless you can replace a large portion of the loss. If the plan compromises a small portion of the practice, say five percent, the effect of a termination will be small.

7. Ask the professional relations representative of each plan for a copy of the current provider contract and operating procedure manual, to be sure you have the current versions. Review each contract. Read it, as most dentists never take the time to read or examine a plan's processing policies, rules, and regulations. The ADA's or AGD's Contract Analysis

Service is available to their members to analyze the various contract provisions and clauses. However, it will be a factual report and will make no recommendations or encouragement as to participation or non-participation in a given plan.

8. Contact each plan to see if they will raise their fee reimbursement prior to making a final decision. If they need you for their network (because of low dentist participation), they will likely increase reimbursement levels. Sometimes they will raise the fees for ten of your most-reported procedures. You may be called upon to identify them.

9. With many plans, you can resign with only 30 days notice-DON'T! Upon your resignation, many plans will immediately contact your patients to encourage them to go elsewhere to in-network dentists who will offer the PPO's lower fee schedule. Talk with your patients prior to dropping the plan and let them know you plan to terminate the plan in the future, but not them. Encourage them to stay and offer third party financing for easy payment. If they say they are still leaving, let them know they are welcome to come back at any time. In addition, tell them that you are still available for any major work, like crowns. Then drop the plan with proper notification, according to your contract obligations.

10. When you hear that a given company is "going PPO", don't panic and immediately join. Wait and see what the level of "out of network fees" will be, as selected by the employer. Sometimes the employees going out of network pays little out of pocket so check and see what the reimbursement levels really are. If so, let the patients know that they can remain with your practice with only a small, additional out-of-pocket cost.

11. Examine your average doctor busyness level – the ideal is 1½ - 2 weeks solidly booked out, on average. The doctor busyness level will fluctuate somewhat throughout the year, plus and minus. Doctor busyness is determined by these five major factors: the number of new patients, the amount of hygiene days checked compared to the productivity of the doctor, the breadth of the clinical procedure mix (average practice performs 90 different clinical procedures), the level of the clinical treatment intensity (do you see a watch, filling or crown), and case acceptance. If the doctor is solidly booked less than 3-4 days in advance, then it is critical to take action to increase busyness. Advertising or joining PPO's may be a consideration, if all the other factors mentioned have been considered.

12. Take into consideration numbers 1-11 above, and make your own personal decision to act or not to act. Be sure to have your attorney examine the specific contract provisions to determine which restrictions might apply to the aforementioned exit strategies. It's important to do this prior to taking any of the outlined actions.

Finally, always submit the practice's unrestricted, full fee on all claim forms, not the PPO's fee for at least four reasons:

1. Sends the practice's unrestricted fees through the system to set or influence the UCR.
2. Write-offs for each plan can be tracked and compared.
3. For those patients with primary and secondary insurance coverage, the unrestricted fee schedule should be listed on each form for proper reimbursement.
4. By filing the practice's full unrestricted fee, any PPO increase in reimbursement level will be picked up immediately with the EOB.

Take into consideration all of the aforementioned actions. Remember, deciding to participate or drop a plan is always an individual, not a collective action. Look at all the facts and circumstances and approach the decision in a business-like manner. Make this your own personal decision.

ANTI-TRUST WARNING -There are antitrust issues even for two or more dentists who collude to boycott or drop a given PPO plan. Do not discuss, in any respect, dropping plans in concert with anyone or any entity. The ADA and AGD, along with state and local constituencies, can only provide information and education to its members in the many issues of managed care– they must stay neutral due to anti-trust laws. Remember, the decision to retain or drop any given plan is purely an individual decision. Act for yourself. Every dentist should read the ADA's excellent publication, "Anti-Trust Laws in Dentistry: A Primer of Do's, Don'ts, and How-To's for the Dentist and Dental Societies". This is a roadmap to keep your personal professional conduct proper and to stay out of harm's way. The ADA publication is available for download to member dentists at www.ada.org

Dr. Charles Blair is the CEO of Dr. Charles Blair & Associates, Inc., in North Carolina. His Revenue Enhancement Program includes fee consulting and proper insurance coding guidance. Thousands of offices have gone through the program. Call 866.858.7596 or contact Dr. Charles Blair and Associates, Inc. by email at info@drcharlesblair.com for further information on his unique programs.

For further information on the insurance coding manual, ***Coding with Confidence: The Go-To Dental Insurance Guide****, please contact our office at 866.858.7596 or by email at info@drcharlesblair.com.*

For further information on the ***Insurance Solutions Newsletter****, please call 888.825.0298 or email amds@ncfweb.net.*

PracticeBooster®

PERCENTILER

PERIO %

Total adult prophylaxis revenues	$113,750		70%
Total periodontal therapy revenues		$49,530	30%
			100%

Percentiler℠

Higher is Better

30%

3%	5%	12%	20%	29%	40%	54%
10th	20th	35th	50th	65th	80th	90th

SRP %

$\frac{\text{Total SRP/year}}{\text{4 quads/patient}} = \frac{128}{4} =$ **32 patients treated annually for active periodontal treatment (SRP)**

$\frac{\text{SRP Patients/Year}}{\text{New Patients/Year}} = \frac{32}{184} =$ **17.4% of new patients treated with SRP***

* Assumes that all SRP was done on new patients for this illustration.
If anything, this value is overstated.

Percentiler℠

Higher is Better

17.4%

1.3%	3.4%	6.1%	9.1%	12.8%	18.1%	27.1%
10th	20th	35th	50th	65th	80th	90th

D4910 %

ADA Code	Clinical Procedure	Fee	Count	Percentage
D1110	Adult Prophylaxis	$91	1,250	87.41%
D4910	Perio Maintenance	$114 *	180	**12.59%**
			1,430	100.00%

Percentiler℠

Higher is Better

12.59%

0.00%	0.22%	1.63%	4.82%	8.93%	16.92%	25.59%
10th	20th	35th	50th	65th	80th	90th