

PRACTICING IN THE 'NEW NORMAL':

THE PRESERVATION OF
THE INDEPENDENT
DENTAL PRACTITIONER

PART II OF A SERIES

As we continue our series on the preservation of the independent dental practitioner, we examine how improving "clinical competency" can affect a practice's profitability. Clinical competency, meaning the improvement of clinical techniques and expansion of the scope of the practice, can have many positive effects. In this article, Tarun Agarwal, DDS, discusses the clinical and economic impact that CBCT can have for the independent dental practitioner. It is a tool that can help a practice stay competitive in the ever-changing dental world.

Enhancing 'clinical competency' with CBCT

Tarun Agarwal, DDS

There is no better time to be a dentist than the present, but gone are the days of simply being on the insurance list and having a line of patients ready to be treated. With the ever-increasing downward pressure on fees from insurance companies to the increasing competition from group practices, the private practice must innovate to thrive.

In my 16 years of practice, nothing has helped grow my practice like 3-D CBCT imaging. One of the most common questions I get is, "What exactly are the economics of owning 3-D CBCT and what can it do for my practice?"

Let's start with the first step, purchasing a machine. There are literally dozens of options available ranging in cost from \$75,000 to \$180,000. The cost depends on the brand and capabilities of the machine, but is also driven largely by the "field of view" (FOV). For simplicity, let's define our terms as follows:

- (A) Small FOV: Capturing a single jaw or segment of the jaws
- (B) Medium FOV: Typically the same area as a panorex
- (C) Large FOV: Capturing nearly the entire skull

In my practice, we are using the Orthophos SL (ORTHOPHOS SL, Sirona Dental Inc.). It's a medium field of view that is capable of imaging in both 2-D and 3-D. In the 3-D mode you can choose between 5cm x 5cm, 8cm x 8cm, and 11cm x 11cm FOVs. In the 2-D mode we take traditional panorex as well as extraoral bitewings.

Cone beam 3-D imaging literally has endless capabilities, but for this column I'd like to narrow my focus to implant dentistry.

Implant dentistry is one of the fastest (if not the fastest) growth segments in dentistry. By all accounts, we know that implant dentistry is expected to greatly expand in the coming years. It's also common knowledge that almost all implants restored at present are one to two units, and that patients are looking for more convenient treatment methods. This is a recipe for general dentists to play a much bigger role in implant dentistry, and 3-D imaging can help play a major role in making you, your dental team, and your patients more confident in realizing the potential of implant dentistry.

Let's start with the economics of getting started in implantology. On a basic level, you need to have an implant motor, surgical kit, and dental implants. The typical startup package costs between \$5,000 and \$10,000, depending on which system you choose. For this column, let's assume you will invest in a medium field of view CBCT around \$120,000. This makes your total startup cost approximately \$130,000 or about \$2,500 per month on a five-year loan.

For many, this can seem like a daunting number. It may scare you away from getting in the game. But take a closer look at the statistics and you will quickly realize the potential.

Let's begin with a common fear: Where will the patients come from? In the US, approximately 61 implants are placed for every 10,000 people.¹ If the

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TOTAL VISIBILITY FOR THE TOTAL PATIENT EXPERIENCE

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herently knew it was the right thing to do and I wanted to bring a unit to our practice. I told my dealer representative that I was ready to look at options.

I chose the OP300 Maxio for several reasons: We'd already been working with an OP100, so I had experience with Instrumentarium Dental, and it had worked well for us. The ease of use was also a big factor in my decision. We have a relatively large staff of 25 to 30 people, all of whom required training on the system. The OP300 Maxio is easy to use, offers an intuitive user interface with fewer settings, and delivers outstanding images. We couldn't find all these qualities in other brands.

Last, but certainly not least, was the Automated Dose Control product feature, which allows patient-specific exposure settings to be obtained automatically, providing me with the best image available at the optimum radiation dose to the patient. Questions about radiation come up pretty often, and we can confidently say we're using the optimized dose for the right image quality for each patient.



The intuitive graphical user interface (GUI) makes using features such as Automatic Dose Control as easy as pushing a button.

Now that we have the OP300 Maxio in our practice, it has immensely changed our workflow from a diagnostic standpoint. We waste less time and patients receive what we feel is the best care possible thanks to cone beam 3-D imaging. Questionable teeth (Is there a bone fracture? Bone loss?) are no longer questions. We see what we couldn't before, and

because of it, my treatment planning is more thorough and efficient and outcomes more predictable. It is also obvious to patients why the treatment is necessary; getting patients to agree to my recommended treatment is significantly easier once they've seen the cone beam 3-D image and I share my findings.

Finally, I would add that patients who have received a cone beam 3-D scan for implant or endodontic treatment would likely be disappointed if their next doctor didn't use this technology. They've come to expect it as a standard of care. **DE**



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typical dental practice has about 2,000 patients, that would mean every dentist has 12 implant patients already sitting in his or her practice. What most don't realize is that these 12 implants already sitting in practices pay for the implantology technology and the startup costs.

Let's dive deeper into the gross profit margin of a single implant. To simplify things, we'll use the patient fee of \$3,500 for a dental implant, abutment, and restoration.

The cost of materials includes the dental implant, the surgical guide, and the restoration. The dental implant averages \$350 per implant, but depending on the system used, it can be much less. Modern 3-D printing and milling has brought the costs of surgical guides down to the \$250 range. With ideal virtual planning, we are now able to avoid costly custom abutments. We can use the combination custom screw and retained implant restoration, which costs around \$350 to have fabricated. This puts our implant materials cost at around \$950. This leads to a gross profit margin of \$2,550.

If you combine 3-D CBCT with CAD/CAM, the economics and capabilities become even more resounding. As a CEREC and Orthophos SL owner (Sirona Dental Inc.), I have an integrated clinical and economic advantage. My surgical guide cost drops to \$56 (CEREC Guide 2) and my restoration cost drops to \$160 (TiBase and e.max abutment solutions). This brings my cost of materials per implant to \$566 or a gross profit margin of \$2,934 per case.

Since implementing 3-D CBCT imaging into my private practice,

we have seen the implant portion of our practice steadily grow year after year. We have gone from placing almost no implants to well over 100 annually. But the key fact is that this growth has been from patients *within* our practice *and* their referrals. We have done very little in the way of external marketing for dental implants.

The economics I have presented here are just implantology. They don't include the diagnostic benefits of being able to see and diagnose more needed care, the available medical billing benefits, additional disciplines that are enhanced, and the patient "wow" factor.

The bottom line: It is my strong belief that 3-D CBCT imaging can be the driver of massive growth for a dental practice—one just like yours. **DE**

REFERENCE

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