How Does Your Orthodontic Practice Stack Up?

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What separates super-achieving orthodontists' practices from those of their colleagues? Successful practices keep financial statistics on a monthly basis, monitor them against established benchmarks, and take steps to correct any deficiencies. In this article, we will discuss key orthodontic statistical benchmarks gathered from our consulting experience, so that you can determine how your practice compares.

Fee Benchmarks

The average child case fee increased to $4,474 in 2001 for our clients, up approximately 3% from the year earlier. Adult case fees averaged $4,956 last year, up approximately 4% from 2000. While there were wide local and regional variations in these fees, typically the adult case fee should be set at least $400 above the average child fee because of the increased difficulty in dealing with and treating adults.

Records fees averaged $244 for our clients last year, up from $214 in 2000. Approximately half of our clients charged this fee in addition to the child fee, while the remainder included the records costs as part of the treatment fee. We believe the records fee should be charged in addition to the treatment fee. Thus, if prospective patients do not accept treatment, they will at least pay for the cost of the records.

This raises another question: Should the doctor offer to tell the family whether the patient needs treatment, without incurring a fee? Doing so may indeed increase the number of prospective patient appointments and thus new patients.

The average fee for Phase I cases among our clients was $2,567 in 2001, up approximately 3% from a year earlier, while Phase II fees averaged $3,182, up 4% from a year earlier. We have long recommended that the Phase I fee be set at roughly 50% of the combined Phase I and Phase II fees for treatment, in order to adequately recognize the value of diagnosis and treatment planning on the front end of the case. This step should also improve conversion rates from Phase I to Phase II, which were below 50% in some practices. While the average Phase I fee was still below that of Phase II, the difference has narrowed over the past few years.

Over the past few years, there has been a marked decrease in the number of Phase I cases started. Recent studies have indicated no significant clinical difference in the outcome for children receiving early treatment, and two-phase treatment is quite inefficient for the doctor due to the increased number of visits required. As a result, most high-performing orthodontic practices have limited the percentage of Phase I and limited treatment starts to less than 15% of their total starts for the year.

Many practices have had success charging a single comprehensive fee for two-phase treatment rather than charging separately, to avoid a second treatment conference and the possibility of losing Phase I patients who don't convert to Phase II (parents who say, "She looks good enough, I think we will skip the second phase"). In these practices, the comprehensive fee was about 115% of the normal child fee, recognizing the increased treatment time, number of visits, and difficulty associated with two-phase treatment.

Another important advantage of using the "comprehensive" treatment program is the continuity of monthly payments during the period while waiting for the cuspids to erupt. Thus, there will be no reluctance to remove the appliances when tooth movement is completed early, just because part of the fee remains unpaid.

While the above fees may represent the "average" fee charged for each case, in fact most practices charge a range of fees, based upon degree of difficulty and/or estimated treatment time. As treatment modalities and materials have

improved, orthodontists are treating cases in shorter periods of time. Since many doctors have based the fee charged on the estimated treatment time, in many cases the average fee has declined as their treatment efficiency has improved. Since the orthodontist is being compensated for the result achieved, rather than for the "chairtime used", this makes no sense.

Accordingly, we recommend that doctors tighten their fee ranges to control against charging less for a better result in a shorter treatment time. For example, a doctor charging a child fee of $4,474 may have a lower limit of $4,074 for the easiest case and an upper limit of $4,874 for the most difficult case, so that the average fee should fall at or near the $4,474 average.

Furthermore, we recommend that doctors track their average fee charged for all new case starts (Phase I and full treatment starts) each year. This average is determined by adding the total fees charged for all Phase I and full treatment starts for the year, and then dividing the total by the total number of Phase I and full case starts for the year. The average case fee thus calculated was $3,918 for our clients last year, up from $3,777 a year earlier. This increase of almost 4% was attributable to the combination of higher fees, tighter fee ranges, and a declining percentage of Phase I and limited treatment starts for these practices.

Efficiency Monitors

The average orthodontic practice with whom we consulted produced approximately $1,700,000 last year, with the doctor working 170 days, for a daily production of just over $10,000. The average doctor was seeing approximately 70 patients per day, and each chairside treatment assistant was averaging 17 patients a day.

We have long recommended that doctors maximize efficiency in their orthodontic practices by utilizing the "one-appointment consultation" technique, and more practices are seizing this opportunity. By providing the new-patient exam, taking records, and placing separators at the initial appointment, doctors are able to minimize required patient visits, thus maximizing treatment efficiency. Forty-nine percent of doctors with whom we consulted were utilizing the one-appointment records/consultation technique, up from 41% the year before.

Most well-run orthodontic practices have achieved tremendous efficiencies over the past five years through reduced treatment times and increased intervals between required patient visits. The average treatment time for child cases has dropped from 24 months to 20-22 months in recent years, and the average interval between patient visits has increased to eight weeks.

We further recommend that doctors track the total number of visits required to complete treatment (including retention) for cases as they deband. The total number of visits required for treatment completion dropped to 24 last year from 25 in the preceding year, thus showing that doctors are making gains in treatment efficiency. These visits were broken down over the course of treatment as follows: two visits for entry completion, two for banding, 16 for the tooth-movement phase, and four for retention.

Retention visits have typically suffered from a broken-appointment rate three times the average incurred during active treatment. Accordingly, doctors have reduced their emphasis on scheduled retention visits by reducing the number to four visits over the 24-month period following debanding, down from five scheduled visits during the 25-month period following debanding the prior year.

One key efficiency statistic that each doctor should track is income per visit. This is calculated simply by taking the total collections for the period and dividing it by the total number of actual patient visits. Well-run orthodontic practices were averaging approximately $125 per visit, up from $122 the prior year. While some high-efficiency, higher-fee practices were averaging $200 or more, other low-fee, low-efficiency practices were averaging no more than $80 per visit.

Marketing

The practices with whom we've consulted showed a 6% increase in new patients last year, up from 4% in the prior year. While most of these new patients were doctor-referred (55%), the percentage of patient-referred patients continued to increase, and now stands at 38%. The remaining 7% of new patients came from various sources, including insurance/managed-care plans, direct mail, and other forms of advertising.

More doctors are actively seeking referrals from the staffs of referring doctors—a strategy we recommended some time ago. As general dentists have become busier by offering a wider array of services to their ever-growing patient bases, they are less inclined to look for patients who may need orthodontic treatment. Many successful orthodontists have been very effective in targeting hygienists through continuing education programs, luncheons with their staff members, and other methods to encourage them to suggest orthodontic treatment to the doctor or directly to the patient. Seventy-three percent of the orthodontic practices with whom we consulted sought referrals from hygienists, up significantly from prior years.

Well-run orthodontic practices have not only benefitted from an increasing number of new patients, but also from a higher treatment acceptance (conversion) rate. The treatment acceptance rate is defined as the percentage of patients who accept treatment when treatment is actually recommended. For children, the average conversion rate increased to 80% last year, up from 78% the year before. Adults showed an even larger gain, with a conversion rate of 64% last year, up from 58% the year before. This increasing conversion rate is a result of increased training for treatment coordinators and more flexible payment arrangements.

Most well-run orthodontic practices offer a significant discount (7%) for cash payment in full at the beginning of treatment, and approximately 6% of their patients paid by this method. Another 15% paid using Orthodontists Fee Plan, up significantly from prior years. We continue to highly recommend the use of OFP to separate "the money from the medicine", and as a means to improve case acceptance, increase cash flow, reduce bad debt, and increase treatment efficiency. Not surprisingly, the practices that showed the highest percentages of patients who paid in full at the beginning of treatment, either by cash or through OFP, also had the lowest broken-appointment rates and the best treatment efficiency, measured in visits required to complete treatment. Sixty-four percent of new patients paid using the traditional method (25% down, with the balance financed interest-free over the remaining treatment term), while the remaining 15% paid either by automatic debit to credit cards on a monthly basis, automatic bank draft, or some other method.

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