THE READERS' CORNER

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(Editor's Note: The Readers' Corner is a quarterly feature of JCO in which orthodontists share their experiences and opinions about treatment and practice management. Pairs of questions are mailed periodically to JCO subscribers selected at random, and the responses are summarized in this column.)

1. How do you decide on a fee for a case?

More than 96% of the respondents based their fees on two criteria: length and complexity of treatment. Additional consideration was then given to any auxiliaries needed, such as functional appliances, protraction facemasks, palatal expanders, or lip bumpers. Other factors included cooperation of patients and parents, maximum amounts paid by insurance companies, and dollar-per-hour multipliers (usually $200-300/hour) for the time projected on a particular case.

Some individual comments were:

- "There are multiple variables to contend with, including anticipated treatment time, full appliances vs. partial appliances, overall complexities, and a difficult-patient factor."
- "My fee is based on the type of malocclusion, the number of problems on the problem list, the severity of the skeletal or dental problem, and the attitude of the patient or parent."

What are your usual payment arrangements?

Practically all the clinicians offered a fixed fee, with down payments ranging from 20-30% and the balance to be paid within 18-24 months. Only two respondents used open-ended fee arrangements.

About 20% of the practices checked prospective patients' credit references and adjusted their down payments accordingly. Most respondents offered 5-10% discounts for paying the entire fee at the start of treatment. Six percent used finance companies, such as Orthodontists Fee Plan, that pay the entire 10%-discounted fee up front. One orthodontist reported using automatic bank drafts for monthly payments.

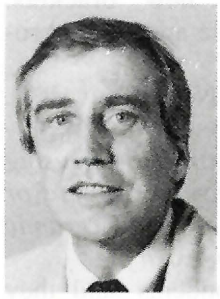
If you perform two-phase treatment, how do you usually structure the fee?

Nearly all of the respondents divided payment of two-phase treatment fees into two segments—usually 40-50% for the first phase, with the remainder paid during the second phase. Some said they reduced the second-phase fee if unexpected corrections were obtained in the first phase. Conversely, second-phase fees were often increased if the anticipated Phase I corrections did not occur due to biomechanical difficulties or poor cooperation.

How often do you raise fees? If not on a regular schedule, what is your basis for making a fee increase?

Most of the clinicians reviewed their fees annually and raised them every year or two. The average annual increase was about 4-5%; some practices raised fees 2.5% every six months. A few respondents said their fee increases were limited by the reimbursement provided under insurance plans.

Fee adjustments were usually based on the cost of living and expenses for professional sup-



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plies. Other references included the biennial JCO Orthodontic Practice Study and the Dental Price Index.

Specific comments included:

• "I raise fees every 1-1.5 years based on the immediate surrounding area competitiveness and my overhead."

• "I raised fees annually until last year. Inflation was flat last year, and the economy in my area is in a severe slump, so there was no fee increase."

• "I increase fees when it seems appropriate. This is getting to be more difficult due to the control insurance companies are exerting, especially Delta Dental."

• "I can no longer raise fees, as 90% of my patients have Delta Dental Plan. Therefore, I can only charge to the 80th percentile of stated fees. However, when I did raise fees, I used the Consumer Price Index published by the Department of Commerce."

How do you deal with non-payment?

When a delinquency occurred, 86% of the respondents said they contacted the patient by phone and followed up with a letter requesting payment, or offered to refinance the current balance on a different payment schedule. If more stringent collections were necessary, 23% used collection agencies, 27% terminated treatment, and most of the rest contacted attorneys. Only two clinicians were willing to write off debts without resorting to some method of collection other than letters or phone calls.

Some individual comments:

• "I use letters, then calls, then an attorney gets it and sends letters, which usually get a response. When that fails, the attorney puts a lien on the patient's property."

• "When phone calls and standard collection letters are not effective, we send a letter (example given by the AAO) pertaining to discontinuing treatment, or recommending that the patient seek the services of another orthodontist."

• "My collection rate is 98.73%. The key is prevention, prevention, prevention. Use a credit report, and when it's a lost cause, write the debt off in 90 days."

• "One staff member is responsible for late-fee collection, and she has to stay on top of it to make sure that no one gets so far behind that it's impossible to catch up. Since each case is different, the staff member and I discuss the problems and decide whether to rework the arrangements, put the patient's treatment on hold (never more than two months), or terminate treatment."

What kinds of cases do you treat pro bono?

Nearly all the respondents said they didn't charge fees to referring doctors, family of referring doctors, or staff members. Two-thirds did not charge the family of staff members, and the remainder reduced these fees. Most also granted full or partial fee reductions to staff of referring dentists. A few said they treated children of close friends and some relatives pro bono.

Most of the clinicians did not routinely grant pro bono status to patients unable to pay for treatment, but these responses were occasionally modified by "sometimes" or "it all depends on the circumstances". Two-thirds of the orthodontists said they would not charge patients with severe dentofacial problems who were unable to pay, and another 8% said they would not charge these patients if requested by the referral sources.

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2. Do you recycle metal brackets through an outside company? Do you recycle in-house?

The overwhelming majority of respondents did not use recycled brackets in any form. Only one practice used recycled brackets routinely.

Comments included:

• "I don't use recycled brackets, but sell used brackets to a recycler."

• "All patients start with new brackets. However, if one or two of these are lost or broken, I'll use recycled brackets."

• "I'll never use them. Never! Never! Never!"

Do you normally charge an extra fee for using ceramic brackets? Do you recycle ceramic or plastic brackets? If you use recycled ceramic brackets, do you still charge an extra fee?

Fully 82% of the respondents said they

charged additional fees for ceramic brackets, and another 8% did not use them at all. Only one respondent used recycled ceramic brackets, and did not charge an extra fee.

Some individual responses were:

- "I do not use ceramics any longer. After I took the last ones off, six or seven years ago, I had a staff dinner to celebrate and swore never to do it again."
- "I pass the extra cost of ceramics on to the consumer. That's the American way."
- "It's not only the extra cost of ceramics, but the elastic ties discolor and are much more noticeable. It takes extra visits to change them to keep the appliance looking clean. That's justification enough to charge an extra fee."

Have you experienced a higher incidence of bond failure with recycled brackets? Have you noticed any mechanical degradation of recycled brackets?

Since only a few respondents used recycled brackets, it was impossible to draw any definitive conclusions. It was interesting to note, however, that the only clinician who routinely used recycled brackets reported a higher incidence of bond failure. He also noted that he had to use a magnifying glass to identify the recycled bracket markings. There were no reports of mechanical degradation.

If patients ask you about recycling, how do you respond?

The vast majority of practitioners said they informed their patients that they did not use, or no longer used, recycled brackets. Sixteen percent of these further noted that they saw no detrimental effects of recycled brackets, but that they simply preferred to use new appliances.

Replies included:

- "I tell the patient as part of our commitment to the delivery of only the highest quality orthodontic care, we have never used recycled or reconditioned brackets."
- "We tell them that we prefer new appliances, but recycled brackets are safe from a sterilization standpoint. We just choose not to use them."

Do you believe informing patients of the intent to use recycled brackets is a professional responsibility?

There was a fairly even split in the responses to this question. Fifty-one percent felt it was the orthodontist's responsibility to inform the patient, 45% believed it was not, and 4% were not sure.

Some specific responses:

- "Patients should know what they are being treated with. I am not opposed to recycling, but it's unfair to mislead a patient, even if indirectly. Patients, of course, assume their brackets are not used."
- "There is no evidence that the use of recycled brackets is detrimental to treatment. Why create a problem by disclosure?"
- "Does the proctologist tell you the scope has been used and sterilized?"
- "There's a legal standard called reasonable presumption. It's reasonable to presume that operating instruments or tableware have been cleaned prior to reuse. It's unreasonable to assume that your contact lenses, hearing aids, partial dentures, or braces have been recycled. That's why you have to inform your patients. When you do, no problem. When you don't, sleepless nights."

Do you believe recycling should be a concern to your patients?

Nearly three-fourths of the clinicians did not see any significant technical or infection-related concerns pertaining to recycled appliances. Others cited factors such as an increased proclivity to bond failure or to distortion in the recycled brackets. There was more emphasis on ethical, rather than mechanical, concerns that would be relevant to patients.

If you once recycled brackets and have stopped, what were your reasons?

Fifteen percent of the respondents indicated that they once used recycled brackets. Their reasons for no longer using them included:

- "I stopped over 10 years ago because I anticipated what a negative impact it could have on my

practice if the word got out."
• "We once used recycled brackets for the financial benefit, but that proved minimal, so we use new brackets now."
• "Public concern generated by a television expose. I thought it was a non-issue, but I believe patients might think it a substantial issue. I decided not to argue the point."

If you have never recycled brackets, what are your reasons?

Only 22% of the total respondents answered this question, but their replies centered around quality, cost, and patient concerns. Specific comments included:
• "I think patients might equate second-hand brackets with second-hand treatment."
• "I just never started. Also, brackets are usually damaged during removal beyond what I think would be reparable."
• "I don't want the responsibility of monitoring for the few distorted brackets that may slip through the screening process. I find it simpler to use new brackets. However, I reserve the right to change my mind."
• "In my office, I have never used, and will never use, recycled brackets for the following reasons: it's not worth risking my reputation; I wouldn't want my child in recycled brackets; treating to the ideal is difficult enough without this variable thrown in."

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