Dentists are Still Doing Way Too Many Three-Unit Bridges

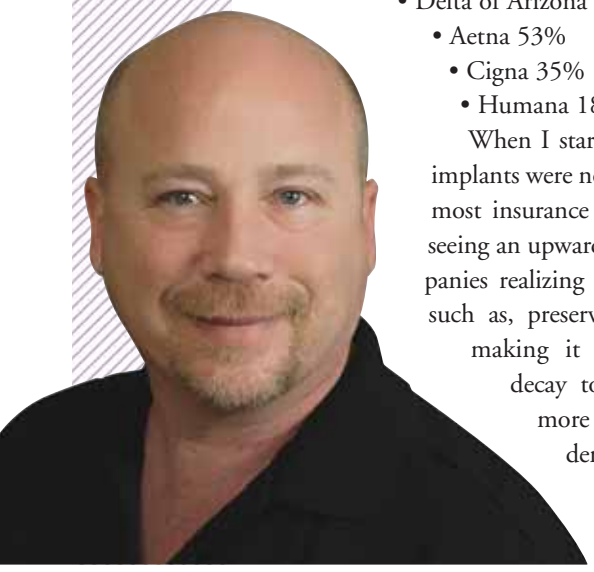
by Howard Farran, DDS, MBA, Publisher, *Dentaltown Magazine*

Dr. Carl Misch, who is regarded by many as the number-one implantologist in the world today, (and who just filmed a series of four awesome online CE courses for Dentaltown.com), wrote in his book *Dental Implant Prosthetics* that the 15 year survival rate of implant restorations is 95 percent and for a three-unit bridge the survival rate is 74 percent. In this day and age, dentists really have to ask themselves, "If an implant and crown has a 21 percent higher success rate over a three-unit bridge, why are we doing so many three-unit bridges?"

Insurance Coverage?

Is it because insurance still doesn't cover implants? We all know that's not true! Twenty-five years ago, when I opened my Phoenix, Arizona, dental practice – Today's Dental – almost zero insurance companies offered any coverage of dental implants. Today, based on the insurance plans that we have verified and have in our system at my practice, we have come up with the following percent of insurance plans that have implant coverage:

- Delta of California 86%
- Metlife 76%
- Delta of Arizona 74%
- Aetna 53%
- Cigna 35%
- Humana 18%



When I started my practice in 1987, implants were not a covered benefit under most insurance plans, but today, we are seeing an upward trend in insurance companies realizing the benefits of implants; such as, preserving tooth structure and making it virtually impossible for decay to form. With more and more insurance plans covering dental implants, it can't possibly be a good enough reason to not be placing implants.

Pricing and Presentation?

Here's another reason why we might be placing way too many three-unit bridges: price breakdown and case presentation. When I graduated from dental school in 1987, I argued with a lot of local Medicaid plans because coverage of an extraction was $2 cheaper than a filling. Moms in lower socioeconomic brackets had the economic incentive to pull their babies' teeth instead of fixing them, just because it was cheaper. I always thought the extraction should cost $2 *more* than an amalgam filling, because when it comes to certain procedures for certain patients, affordability was always the key decision maker.

The same thing is happening with bridges vs. implants. Most dentists will offer their patients an exact flat fee for a bridge, and they'll say they can prep it today and cement it in two weeks. Then when the patient asks about an implant, most dentists break it down to something like, "Well, um, it's $1,500 for the implant and it's $1,000 for the crown, but then we might have to do a bone graft, and we might have to do a gum procedure, and I won't really know what we're looking at until I pull the tooth to know how long this will take…" It's a total confusing quagmire! The implant is the better option, but you make it so difficult for the patient to understand. I mean, I'm a dentist with an MBA and an MAGD and because of the way you present a bridge vs. an implant *even I would opt for the bridge!*

You need to figure out a way to explain that the cost of an implant is the same as the cost of a bridge. If you charge $3,000 for a bridge, then an implant should be $3,000 as well. Now, whether or not you have to do a bone graft or something more, that's just the cost of doing business. Obviously some cases will be easier than others, but that's life. It's also the way everybody else does business. When you take your car in to fix your radiator, they're going to do it at a flat fee. I guarantee some radiators are easier to fix than others – you're not going

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to get nickel and dimed because your radiator was harder to fix than the last one they worked on.

You know what would help you place more implants in your practice? If your implants cost *less* than a bridge! They have a 21 percent better success rate, after all! You need to take the economic incentive to do the cheaper but less effective option out of the equation. If you tell your patients it's cheaper to do an implant and a crown than it is to do a bridge, you're going to be placing a ton more implants, doc!

"It's time to change the way we think about implants and the way we present this incredible option to our patients – the future of the dentistry we provide depends on it!"

Specialists?

I recently spoke about this issue with Dr. August de Oliveira, the author of *Implants Made Easy*, and he brought up a survey conducted by Straumann, which indicated the United States of America currently ranks fifth in total implants placed. More than 85 percent of general dentists in South Korea place implants, more than 50 percent of all general dentists in Europe place implants, and the most implants placed in the world is Israel. When I asked August why he thinks so many dentists still do bridges over implants he said, "It's a loss in production if general dentists send out the implant case. Rather than learning how to do implants themselves, they do bridges and send out an occasional implant. That is changing as patients are getting educated on the benefits of an implant crown vs. a three-unit bridge."

In America, culturally, we got into this groove where oral surgeons and periodontists place implants. GPs don't want to do implants because it's inconvenient, it's a loss of revenue to send out, and you have to work with a specialist. If you're not going to place implants yourself, you need to work with a specialist who will agree with your vision of a flat fee for all implants placed. If you charge $3,000 for a bridge, you're going to charge $3,000 for an implant whether you place it or the specialist does. You want the safety of being able to tell your patients that they're going to go to another doctor who will place the implant, it will be the same fee, and there will be no nickel and diming. If your specialist cannot work with the laws of averages like every other service industry does, then find another specialist! Either that or learn how to place implants. Too hard, you say?

Implants Are Hard? Really? In 2013?

I learned how to place implants early on in my dental career. I earned my Diplomat in the International Congress of Oral Implantologists (DICOI) and my fellowship at the Misch Institute. In 1987 placing an implant was hard. You had 2D X-rays, panos and PAs, and you never truly knew what was going on until you laid a flap. Today, with 3D cone beam computed tomography (CBCT), diagnosis is twice as easy – heck, even the software that's been developed for these systems will tell you how long and wide the implant can be to place in your particular patient. You almost don't need to think about it. Oh, and anatomical features that scared us to death back in the day, like the inferior alveolar nerve and the sinus, are all spelled out for you in a 3D image. You know exactly what you're looking at before you even pick up an intrument. This harkens back to my May 2013 column "Is Dentistry Getting Too Easy?" It's twice as easy to do a root canal today (with high-speed handpiece-driven NiTi files), and it's just as easy to place an implant with the help of 3D CBCT.

It's time we all sit back and rethink placing implants. Placing an implant today is so much easier than pulling a wisdom tooth – yet I know more dentists who pull 10 to 30 percent of their wisdom teeth but don't place a single implant. I think that's completely backward (and bizarre)! That's like saying you can repair your car but can't fix the chain on your bicycle. You need more skill to pull a wisdom tooth than to place an implant. With the technological advancements we have at our fingertips today, it just doesn't make any sense why dentists don't place more implants.

Remember the 4,000lb Gorilla in the Room

When it comes to the dentistry we do, nobody likes to talk about the 4,000lb gorilla in the room – mortality. The average man dies at age 74, and the average woman dies at almost 80. When grandma and grandpa go into the nursing home to live out their remaining days, all the dentistry we've per-

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formed over their lifetime crumbles and rots after 18 months. I've been a huge proponent of there being less inert and more bacteriostatic restorative materials in the dental market – and dental implants fit that bill. When I visit nursing homes, it's sad to say that the lucky ones are the people who have dentures and implant-supported prosthetics. The people who have their mouths full of $20,000 worth of root canals and crowns are the most unlucky, because their teeth turn to mush from root surface decay. These people are too old and brittle to do any extractions or full-mouth restorative, and their home care is essentially nonexistent. You really need to start asking yourselves, especially by the time a patient turns 60 years old, are we really going to do a root canal buildup, a crown and a three-unit bridge instead of titanium implants, which the *Streptococcus mutans* won't eat? Think about it.

In Summary

While I was wrapping my head around this issue, I talked to longtime Townie, Dr. Jay B. Reznick, oral surgeon at the Southern California Center for Oral & Facial Surgery, in Tarzana, California, and founder of OnlineOralSurgery.com. He sent me an e-mail that summed up the issue of why dentists don't place implants more than bridges quite nicely. Jay says:

"A dental implant is designed to be 'permanent,' however there are a lot of factors, such as hygiene, patient general health and nutrition, systemic disease, local factors, age, implant positioning, prosthetic stresses and individual variation that will reduce the longevity. I always tell my patients, 'Dental implants are as permanent as their "permanent" teeth,' so they understand that even what nature gave them is not always perfect and can fail under the right set of conditions. A three-unit bridge is also meant to last a long time, but dental insurance companies will pay to replace a bridge after five to 10 years (depending on the policy), so that should tell you a lot.

"There are a number of reasons why dentists may choose to do a bridge over an implant. I think the biggest is still the misconception, especially in the older practitioners, that implant dentistry is too complicated. They also feel the bridge will be delivered sooner than in the case of an implant, where the extraction site needs to heal and the implant needs time to integrate. Right behind that is the economic desire to keep all the revenue within their practice, rather than sharing the case with a surgical specialist. Of course, that model is changing rapidly, as more and more general dentists are becoming trained and placing their own implant fixtures and then restoring them.

"We are seeing an increase in the number of dental insurance carriers that are covering implant treatment. They are usually the more expensive plans for the patient or employer, and reimburse at a substantially reduced rate from usual, customary and reasonable (UCR) charges.

"The only advantage a bridge has over an implant is that it is faster. The implant helps preserve bone and soft tissue architecture, is easier for the patient to maintain, and leaves a one-tooth problem as a one-tooth problem, rather than creating a three-tooth problem (which will become a four-tooth problem, and eventually a denture)."

It's time to change the way we think about implants and the way we present this incredible option to our patients – the future of the dentistry we provide depends on it! ■

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Howard Farran, DDS, MBA, is an international speaker who has written dozens of published articles. To schedule Howard to speak to your next national, state or local dental meeting, e-mail jenna@farranmedia.com.

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