Dealing with Patient Transfers

I had a talk with a client about a complicated situation regarding a transfer patient into his practice. The case and situation was difficult and he wanted to discuss the best way to approach the patient/family at their upcoming consult visit. In discussing this case, it became obvious to me that what every orthodontist needs, is a consistent way to "view" transfer-in cases. What I mean by view is the view I have when discussing such cases from "outside the orthodontic box", which is different from the view most doctors have from "inside the orthodontic box". Inside the box is where the details of each case are typically viewed and outside the box is the manner in which all cases should be viewed for the peace of mind of all involved.

Most doctors view a transfer-in case as "a continuation of the previous orthodontist's treatment", which is impossible since they are not that orthodontist—only he/she can continue *their* treatment. You can only provide *your* treatment, based on what you find in the mouth, using *your* unique philosophies and mechanics (yes, every doctor's treatment mechanics and philosophies are unique). Thus, you have a choice between thinking in terms of "continuing *their* treatment" or in terms of "providing *your* treatment".

The pitfalls of "continuing *their* treatment" are that:

- You continue with *their* diagnosis (extraction or non-extraction, surgical or non-surgical, single or multiple phase, etc.) instead of your own.
- You continue with *their* mechanics as best you can or make modifications in their strap-up.
- You continue with *their* timetable, although it typically is increased due to loss of treatment time, etc.
- You continue with *their* fees, although they usually overpay the previous orthodontist and even though you recalculate the fee as you are supposed to, you usually give them a substantial break.
- In essence, you continue treatment on *their* patient, instead of *your* patient.
- Now, if the patient just needs Retention Tx, it is not a problem unless, you fail to get a release indicating that you are not responsible for whatever happens in the retention of that other orthodontist's active treatment.

The satisfaction of "providing *your* treatment" is that:

- You provide *your* diagnosis, which you are comfortable with and can base a sound treatment plan on.
- You provide *your* mechanics, which you are comfortable with and know what they will produce, even if you have to redo some or all of their strap-up.
- You provide *your* timetable, which you can accurately predict, even if it is much more or less time than the previous orthodontist's.
- You can calculate *your* fees, based on the work you will do, which is fair to all involved. The only consideration is whether the patient has siblings that also need treatment.
- In essence, it is *your* new patient, not someone else's.

There is one more level of thinking that must be addressed, that of professional courtesy. If your treatment differs substantially from previous doctors, it has nothing to do with you or them; you have your way of doing things and they have theirs, neither is right or wrong, only different. This must be

fully communicated to the patient/family or else they will feel taken advantage of by either you or the previous doctor or both. Addressing the previous doctor overpayment is difficult and is best avoided.

For your own peace of mind, at current fees of about $5,000/case, a transfer in *or* transfer out patient fee is typically about $1,000 for the deband and retention, plus about $100/month of treatment left to do, plus $50 per 10-minute unit of additional brackets or bands yet to be cemented. If your fees are for example, 20% higher or lower, so are the above $ amounts. Of course, if the transfer-in patient has siblings that need treatment, a substantial reduction in the patient's fee might be warranted.

A final comment is that the patient ultimately decides what to do since you can only provide them with options. In the case that prompted this pearl, the patient wanted to transfer to that practice because they now had insurance that the practice accepted and the previous practice didn't. It also turned out that the case was being treated non-extraction and my client diagnosed a 30-month full skeletal class-II requiring extractions/surgery and a new strap-up. This fact did not make the previous orthodontist wrong; he may well have suggested extractions/surgery with the family, with them accepting a compromised treatment to avoid the surgery. The patient thus has a choice to: 1) accept a 30-month skeletal treatment at a full fee with some insurance coverage, 2) go to another practice that has insurance coverage and possibly be treated non-extraction, or, 3) continue with their present orthodontist and not receive insurance benefits. This example is not uncommon, but the manner in which you handle a transfer case should be common—that is, fair to you and the patient.

I hope that this article helps you to view your transfer-in and transfer-out patients in a better light.