Ep #8: Why Your Practice Needs Cone Beam Computed Tomography

Full Episode Transcript

With Your Host

Dr. Tarun Agarwal

T-Bone Speaks with Dr. Tarun Agarwal

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Welcome to *T-Bone Speaks* with Dr. Tarun Agarwal where our goal is to change the way you practice dentistry by helping you achieve clinical, financial, and personal balance. Now, here's your host, T-Bone.

T-Bone: Hello, everyone. Welcome back for another episode of *T-Bone Speaks*. I'm Tarun Agarwal, better known as T-Bone. I'm sitting here with my cohost.

Chuck: Hey, this is Chuck McKee.

T-Bone: Not on Facebook yet, still. So Chuck, I know every time we talk about doing 30, 35 minute episodes and they end up being 45 to 55 minutes, then I'll get somebody to email me and complain about it. Then I just tell them, "Don't listen." I mean, I'm just quite frank with people. If you don't like what I'm doing, don't listen. It's like the kind of people that were complaining that I was cursing at the beginning, although I've stopped doing that by the way.

Chuck: I think it's just people who love you, they like us, and they're just trying to give you a little tough love.

T-Bone: I just think it's people that just want to give me a hard time quite honestly but I deserve it because I give a lot of people a hard time.

Chuck: And it's easy.

T-Bone: It is easy. You know what's on my mind today, Chuck?

Chuck: What's going on?

T-Bone: What's on my mind is I do a lot of speaking on cone beam. It's an important part of my practice. I just for the

life of me don't understand why more people don't invest and dive into cone beam.

One of the most common things I see, I don't hear it, but I see it because I can see it in their eyes is that people are scared of cone beam. The general dentist is scared of cone beam. So let's talk about that. Let's talk about what they're scared of, let's try to debunk some myths. Let's go into this concept. Let's really do a good job of staying at the 35 minute mark for today.

Chuck: That comes up often. It's interesting, about 50 percent of my clients use cone beam and they're general dentists. My oral surgeons obviously use cone beam.

T-Bone: Obviously, but it's not obviously, not all oral surgeons are using cone beam.

Chuck: But it's funny that you say that. Everyone I think 100 percent of the time has been nervous about it. But it's one of things—we've sold a lot of technology through the years. It's one thing at that $100,000 price point that for whatever reason, it's the easiest technology we sell to integrate into an office. Folks seem to enjoy that more than anything I've ever sold them.

I always thought it would be CEREC first because it's fun, it's easy, it's a simple ROI. The math is there. It's an awesome experience for the patient. But for whatever reason, I've never seen anything integrate like cone beam does. However, you're 100 percent right, a lot of people, everybody, 100 percent of the time, they're intimidated by it.

That's something, again, not being a doctor, I've never understood but I think the biggest thing is the liability. That is something for four, five, six years now, if I take an image, I'm responsible for it. I think people are more nervous about, they don't know what they're seeing, and they're not trained to see that. So I think when people are scared of it, it's that. It's the liability term. I think also we have imaging centers that you see that have done a great job.

T-Bone: Yeah, but they're dying. Imaging centers are going away.

Chuck: I think, you know, you've seen that in the past where imaging centers have maybe scared general dentists. Is that fair to say?

T-Bone: Yeah, but that's like the argument that specialists are scaring, like the oral surgeons scare dentists off taking out teeth and the orthodontists scare general dentists from doing braces, things like that. I think that's an unfair thing to look at. Imaging centers are going away, bottom line. That business model is going to go away.

Chuck: I will tell you, what I love about cone beam and what it's doing for general dentistry is we all know that it's getting harder and harder to grow as a general dentist. We're seeing decreased fees, like we've talked about. How many times do we have people send us an email, "I'm working harder than I've ever worked in my life and I'm making the same or less money."

What I personally love about cone beam, it gives you a way as a dentist to provide conservative treatment before you even do anything. It allows you to be more efficient,

ultimately more conservative, and it really is the wow factor for the patients. I think that it is something that you guys take for granted. I really think that is something. It is something that is so mundane that you guys do every day, something as simple as an x-ray. It's overwhelming to a patient. They don't know what they're looking at.

T-Bone: It's interesting, when we do training on cone beam one of the first things I ask everybody is how many of us are imaging the majority of our patients and it just shocks me—very few hands go up. I say, "How many of you when you first saw your cone beam image at a seminar or whatever were wowed by it?" Everybody's hand raised up. "So you don't want your patients to be wowed?" It's unbelievable.

Let's dive into this. The first thing that comes out of my head is why does a GP need CBCT? I would probably say ten years ago cone beam was a specialist product. I would say today, I don't know the exact math, but I would say 80 to 85 percent of all cone beam sales are going to GPs.

The market can't be that wrong is what I always say. It would be one thing if you're the outlier, you're the one out of 20 people that are buying cone beams that fall into that category. But when 8 out of 10 sales are going to general dentists, there's got to be something good there. So why does a GP need cone beam?

Chuck: Let's go back a minute, let's talk about my first cone beam order. I'm not going to say sell because I didn't sell you your cone beam. Do you remember my response to you?

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T-Bone: "Why do you need this?"

Chuck: When you told me, "I'm going to order this from you," what did I tell you?

T-Bone: That I'm nuts.

Chuck: I went, "Why? Why do you need it? You're doing great. You're crushing it with your CEREC. You're doing great with your speaking. What are you going to gain from this?"

T-Bone: Oh, god.

Chuck: You remember what you told me?

T-Bone: I don't remember.

Chuck: You told me, "Trust me."

T-Bone: Trust me.

Chuck: Trust me. So anyway, why do you guys need it? I mean it's so easy now looking back but you know a lot of the people listening don't have this.

T-Bone: Here's what I would tell you. Why does a GP need cone beam? The first thing that comes into my mind is you need a shot in the arm. If you look at yourself and you look at your practice and you say to yourself, "Hey, I'm not achieving the professional satisfaction. I'm not excited to go to work. I'm hitting a plateau or I'm stagnant." Then I say you need cone beam because what cone beam will bring to your office is excitement.

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Number one, you'll diagnose unbelievably better because when you can see things in three dimension and when you can communicate to patients in the three dimension. So one of the side benefits I talk about with cone beam is that it allows the doctor to shut up. When you can just put an image on the screen and say, "This is what I'm seeing," and that's all you've got to do, it makes things easier for you.

The other thing it does is add procedures. Very specifically, implants. So for the average GP, we know that about 15 to 18 percent of GPs are doing implants, surgically placing. That means 80 to 85 percent are not. I believe that we should as an industry be shooting for about a 50 to 60 percent of GPs placing implants. The number one reason that GPs don't place them is that they're afraid. They're afraid of what may happen.

What I tell everybody about cone beam is cone beam takes away this fear and allows you to have x-ray vision like Superman. It allows you to see what's going on. Where is the nerve? Where are things going on? So that you can virtually plan an implant and then use guided surgery to place the implant. We can dive in deeper to implants in a second but I also want to keep going. What are the other things we see?

Chuck: I want to touch on that. In the last few years, we've really just seen a catapult of people integrating this technology. One of my favorite things, I love to tell dentists this, you folks are ultra-conservative and you like to justify everything you do because sometimes it feels like you guys feel guilty for what you have to charge. Is that fair to

say? I mean how often do we hear people say, “Gosh, it’s just so expensive.” So you guys over talk everything.

T-Bone: We over talk, no question. Dentists talk too much.

Chuck: I love this analogy and I knocked this off from someone, I say, so the patient comes in, we’re going to start doing implants. “Mrs. Jones, we’re going to do virtual surgery today. I’m going to go ahead and place your implants. It’s going to take me about three minutes to plan this out and I’m going to tell you whether or not we can do it and what kind of pain medicine you're going to need based on how easy this case is going to be.

“So Mrs. Jones, this is my stud finder. There’s two things I’m looking for when I use this x-ray. Let’s think about this as a stud finder. We’re going to make sure we have enough wood to put this big screw in here. The second thing is I want to make sure I’m not going to hit any power cables. It’s just like at home, Mrs. Smith. Whenever we’re going to hang a picture on the wall, we’ve got to make sure we have somewhere to hang it and we’re not going to hit any pipes or any electrical stuff.” I love that.

T-Bone: It’s a good analogy.

Chuck: It’s simple, right?

T-Bone: Back to the implants. So you can do implants. Why else does a GP need cone beam? If you're not doing implants, that’s a great reason to get that. What about endo? Here’s what we know with cone beam: we can diagnose better, we can see better, then we can know how many canals we have.

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I can't tell you how many times I look at an endo case on a 2D PA and it looks like nothing is going on. Then we take a look at in 3D and we can see all kinds of stuff going on. We can see infection before it shows up on a 2D x-ray. We know for example that for a PA, a periapical lesion to show up on a 2D x-ray, it has to have eaten through the cortical plate or significant damage has had to have been done and typically even through the cortical plate.

What we'll see on cone beams is we can slice through, slice by slice, we can see it much earlier. So with endo you can diagnose better. You can also predict how many canals they have and you can learn the anatomy of the canals better.

The other area is diagnostics, the ability to show your patients and see the infections, to see the sinus issues, to see all of those things. It's invaluable to what you can diagnose with it.

The other area that we're using cone beam is in sleep medicine. That's a new area of cone beam and it's not diagnostic for sleep apnea but it is unbelievably communicative for sleep apnea. I don't even know if communicative—it's like George Bush—strategery. I don't know if communicative is a word but it's unbelievably able to communicate what you're seeing.

I love it when I walk into my hygiene room and my hygienist has segmented the airway and everything looks great there. Or I walk into my sleep coordinator has segmented the airway and we can see and the patient

just sees that thing in color and we can see where it is. It's awesome. It's unbelievable there.

Chuck: Let's talk about this. So this is a significant investment for a doctor or any practice, especially for the solo practitioner. I hear this often, "I think I'll wait. It's getting better and better and better." There's a lot of ROI pressure. You're on your second machine now.

T-Bone: Yes.

Chuck: So it has gotten better. Do you feel that ROI pressure?

T-Bone: I don't feel it today but it's unfair, eight years in, I can't say because it's Monday morning quarterbacking for me.

Chuck: Okay.

T-Bone: I can look back and say it was easy but I'll tell you this, I felt a lot of pressure when I bought it. Number one, when I first bought cone beam it was in the midst of the Great Recession, we were going down. I said, "Hey, if I'm going down, I might as well go down burning" from that perspective.

But I had to convince my wife because she's seen me buy some crazy things in dentistry or crazy things in life. Google Glasses come to mind that we don't use. Granted, Google Glasses were only a couple of thousand dollars where as a cone beam unit is in the six-figure category or can be in the six-figure category. So I felt that pressure. But here's what I'm going to say to everybody, if you think cone beam is the savior of your practice and you need this to save your practice, probably not a good decision. You should never do anything out of desperation.

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Chuck: Absolutely.

T-Bone: That's usually a bad decision. But, if you say, "Hey, listen, I can make this work." Here's what I tell everybody when I'm speaking, if you have half a personality, cone beam makes all the sense for you. if you have zero personality, cone beam is not going to make you have personality. If you can get out of the way of your team and your team has personality, then cone beam can help your team members make things better for you.

Let me turn things backwards a little bit, Chuck, who is not a candidate for cone beam technology? I would say the person who is infinitely struggling and putting this kind of note on them would create pressure to diagnose unnecessarily. Would create them to potentially bankrupt. I don't believe that you should do that. I firmly don't believe that.

The other area where I see as not a candidate for cone beam, I would probably say the practitioner starting out is not a candidate for cone beam. Now I can make the case that you can start a practice with cone beam and do unbelievably well but it's probably not a good point, a place to start for them.

I would say the mature practice, I would say a practice doing at least $500,000, $600,000 a year is ripe for cone beam. Ripe for cone beam because it's a practice that is paying the bills, making some money. It's a practice that has a reasonable patient base and that practice is dying for a kick in the pants.

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Chuck: Let's talk about that. How do we get paid for this? Listen, we talk about the wow factor. It's hard to have when we say the wow factor and we talk about case acceptance, that's just intangible. But how do we get paid? Because I've always told people for years, "Give away the cone beam in hopes the patient and the case acceptance will go up with implant planning."

T-Bone: Let me go through the gamut of how we can get paid for this thing. Number one, you can ask your patient to pay. I'm not necessarily a fan of that. I think it creates a barrier. I think there's unbelievable diagnostic value in showing this to the patient, that your case acceptance will go up. So I'm personally not a big believer in having your patients pay for this x-ray. Number one, they're not used to it. In dentistry we have a hard time asking a patient to pay for a PA much less a cone beam scan. So option number one is have your patient pay for it.

Option number two is to give it away. Listen, that's not a bad thing to do. In fact, that's what I did for five or six years of having cone beam. I just gave it away because I knew it as a quote\unquote "bread in a grocery store". It was a loss leader. It was gasoline for a few pennies of margin to get somebody to come inside.

So what cone beam did for me in giving it away was that it allowed me to have diagnosis, it allowed me to have a conversation, it allowed me to get a relationship with the patient, and let the patient see what was going on. Now also on that, the thing I say to everybody is, "Listen, when you buy this machine, you pay for it whether you take one scan, zero scans, or 100 scans per month."

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There is zero reason not to take radiographs, cone beam, of the vast majority of your patients. I would say, in my opinion, and this is not legally binding, in my opinion, it's standard of care in our practice. We can't diagnose, we can't really do the things that are possible without cone beam.

Number three, I would refer everybody back to our previous episode where we talked about medical billing with Mr. Hootan Shahidi and I would say that medical billing is the hottest topic in cone beam dentistry right now. The ability to get paid through medical insurance for medically necessary cone beam CTs is probably the easiest and most logical and likely way to get paid for this.

In fact, I would not say that it's about getting paid. I would say it's the likeliest and easiest way to actually pay for the machine. A practice doing $600,000 a year—typically that would be one and a half hygienist, probably?

Chuck: Absolutely.

T-Bone: That practice will produce, should be producing, enough from cone beam through medical insurance alone to more than pay for the machine. So medical insurance is the most logical way to get paid for the machine.

Chuck: I had an email that came across last week about this. This was actually from a rep. It said, "You know, I've got a lot of doctors, I'm in a pretty big metro area that no one really has cone beam." We're talking two or three percent. He sent me a question about, he said, "My dentists are scared. Can you address that?" I was like, "What does

that mean?" I sent him an email back. He said, "They're scared to death of the liability of cone beam."

T-Bone: Let's talk about liability. Let's just get to it.

Chuck: Yeah, let's jump into that.

T-Bone: What is the liability? Number one, this is a tough area to define because number one the cone beam is relatively new technology in the sense that we don't have a lot of case law on it. We don't have a lot of dental boards ruling on it. We don't have a lot of consensus on what should be done.

For example, in some countries it's required that every cone beam taken is required to be read by a radiologist. In some states in the U.S., you can't even get a cone beam without a certificate of need. So there are some issues there. But ultimately here's what it boils down to, modern cone beams are about the same field of view as a panorex. You're responsible for the area of your expertise.

So as a dentist, you are not an expert in the brain. You are not an expert in the spinal cord. You are an expert in the maxilla and the mandible. So your job is to review, I use the word review versus read. To me, in my definition, the only person that can read a cone beam scan is a trained oral maxillofacial radiologist or a radiologist. As a dentist, you can review your radiographs.

So we review every scan that we take. It takes approximately two to three minutes per scan. We do it right in the hygiene room or right in the operatory, wherever we're looking at the scan and I do it right there

with the patient. Because it's a way for me to show the patient exactly what this is and to build value in our practice. So the liability issue is more, it's an excuse to be quite honest with you, Chuck.

Very few people, I don't know of any cases where somebody can point to and say, "I got sued because I missed something on a cone beam." Those same things that you miss on cone beam exist in your panorex. You just don't see them as well in a panorex as you do on cone beam. I would say, in fact, with cone beam you see things easier than you see it with a panorex.

Chuck: I think the machines that have the multiple views and the size of the volume certainly addressed a lot of that and I think taken a lot of the fear factor out.

T-Bone: Yeah, today you have 8 x 8 scans, 11 x 10 scans, and you have full head scans. What we find in the sweet spot for most general dentists is somewhere in the 10 x 11, 11 x 10 field of view. That gets you your full maxilla. That gets you a full mandible. That gets you your airway.

Chuck: What do you say to the listener, this comes up often, and we've both done a lot of courses and this comes up, I've seen the doctor in the back of the room who says, "I'm doing 100 implants a year. I'm doing three a month. I've never needed this. 90 percent of dental implants are placed with a pan and a PA." What do you say to that person?

T-Bone: I say they're not wrong.

Chuck: Okay.

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T-Bone: My first thing is, I can't try to convince the un-convincible.

Chuck: Sure.

T-Bone: But here's what I'll tell you, here's what we've seen with cone beam. We can do implants where we thought implants weren't possible. We can see the bone better. The biggest thing I tell somebody who's been doing implants, number one, they don't believe that they place their implants at wrong angles. Okay? That's the first problem.

So telling somebody, "Hey you need cone beam because you can place your implants better" is like telling somebody they suck. Nobody wants to hear that. What I would ask the person who says, "I'm doing implants. I don't need cone beam." I say, "How many immediate placements are you doing?" Because what I have found is that most dentists, most implant-capable dentists, are not doing nearly as many immediate placements. By immediate placement what I'm referring to is the day you take the tooth out is the day you put the implant in.

We don't call it tooth extraction anymore. We call it tooth-replacement therapy in our practice. I stole that from Mike DiTolla. So most people aren't doing immediate placement. What cone beam allows you to do, it allows you to see exactly how much bone you have, allows you to see the furcation space, and allows you to see how much palatine bone you may have, allows you to put implants where you say, it's too hard for me to have the hands to get my implant there. Nobody likes to admit that.

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Then cone beam combined with guided surgery allows you to make implants go where you didn't think they could go before. The other thing with cone beam for the person placing the implants is I would say, how many implants do you go to surgery with? Think about that. Do you go to surgery with one implant? The answer is well I don't know if it's a 5 x 10 or a 5 x 11 or a 4 x 10.

What that tells me is you're going to surgery with multiple implants. What that tells me is that you're keeping a lot of inventory. Inventory costs money. It's money that you outlay that you could be earning interest on, that you could be doing more business-minded things with instead of having it sitting on your shelf.

Chuck: it's just cash flow.

T-Bone: Yeah, at the end of the day, that's what it is. So I would say that. Now the other thing I would ask that person who says well I'm doing implants, I say, "How conservative are you doing your implants? Are you laying a flap every time? What about a case that could be done with a punch? Which would your patients prefer?"

"Well my patients don't mind laying a flap." My question is, "Have you ever asked them?" Which would you prefer if that were your case? Would you prefer to have a punch or would you prefer to have a flap, assuming punch is appropriate treatment.

Then the last thing I would ask them is, "Do you not believe that you could get better case acceptance if you had cone beam?"

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Chuck: Let me ask you a question. We're in a market now that is just technology-driven.

T-Bone: Well the whole world is technology-driven.

Chuck: But we talk about RTP. We talk about that. Everybody knows Research Triangle. We hear about Silicon Valley.

T-Bone: We're not Silicon Valley.

Chuck: But you talk about that. You hear that a lot. So we feel like here that people really demand this technology. We see that 50 percent of CEREC owners are also cone beam owners. Why do you think that is?

T-Bone: Because they get it. Quite honestly, they get it. Here's the other difference. They're not afraid to sign their name on the bottom line. It's like breaking the seal.

Chuck: That's a great way to put it.

T-Bone: The first time—I don't want to really—it's okay, the first time I bought a six-figure car it was unbelievably hard for me to sign the deal for that kind of car. The second time was easier. The third time was even easier. So once you've done something that costs that much money and you've put that kind of faith into it and you see the reward of that faith, it becomes unbelievably easier to do that. I'm going to go on a rant, Chuck, so I apologize.

Chuck: We expect it.

T-Bone: I get so angry sometimes. My wife says I have anger issues, by the way. I get so upset and when I talk to dentists and I look at them and I ask them do they love

what they do, and they say no. This isn't, “Hey, cone beam is the answer.” But I say to them, I said, “How did you get here, where you're at today?” They look at me like I’m crazy, “What do you mean by that?” I go, “Did you buy a practice or did you start from scratch?” Some say I started from scratch, some say I bought.

I say, “What did that take?” They say, “It took risk.” I said, “Think about that. I want you to go back to when you got out of school, whenever you bought it. You were in debt because you had student loans, you had family loans, you had kids, you were a young family, you were just married, whatever it is and you took this risk. That risk that you took at that time got you to where you're at today.”

I look at them, I say, “When was the last time you took a risk?” Then some smartass will say to me, “Well I got into a car and drove down the street today.” I’m like, “Dude, come on. I’m talking about a real risk. When is the last time you took a risk? That’s why you're stuck. You get where you're at.”

Every business reaches the point that they reach because they took risks. Then we get comfortable and we no longer take risks. That’s why practices are stuck. That’s why our listeners who are stuck are just stuck, because they're not willing to take that risk. So buying cone beam is a risk. It’s an unbelievably calculated risk, but it’s a risk. And it takes risks to equal reward. If you want reward without risk, you just got to be lucky or something. But risk equals reward. You people need to take risks.

Chuck: I love what you said on this. Sometimes you need a shot in the arm. I heard someone say this years ago and it was

our buddy, Imtiaz. He said, “You know, I love it when you're talking with a client. They’ve done something, they’ve started their practice and they’ve got from point A to point B and they're satisfied, but they're not really excited anymore. They're not growing, they're kind of plateaued, but they're getting by.”

He always asks everyone, “How much experience do you have?” Their like, “Look, I’ve been doing it this way for 20 years and it’s served me well.” He’s like, “Have you always done it this way?”

“Oh, yes, and we’re doing great with that.” He says, “Well that’s not fair to say that you have 20 years’ experience.” Often he would say, “We’ve had one year that we’ve repeated 19 times.”

T-Bone: Yeah, that’s true.

Chuck: So I love the idea of coming out of our comfort zone but let’s talk about this. You know my clientele pretty well, and we’re in North Carolina. North Carolina. We’re not in Seattle. We’re not in L.A. We’re not in Manhattan.

T-Bone: That’s salt of the earth. Greatest state in the country.

Chuck: But you know North Carolina. They make fun of us, how we talk.

T-Bone: What? What you talking about, boy?

Chuck: They make fun of our hockey team.

T-Bone: Bless your heart.

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Chuck: But why is it that 75 percent of my clients use CEREC? 50 percent of my GPs use cone beam? Why is this market so different?

T-Bone: But it's not. We're all human beings.

Chuck: I know that.

T-Bone: We're all human beings. Our market is no different. The difference is our market has made a decision and Chuck I would say your customer base is different. It's an unfair argument to a certain degree. Our market is no different. I can point to areas in L.A. I can point to areas in New York, San Francisco. I can point to areas in podunk-ville North Carolina where people have cone beam.

Chuck: Right.

T-Bone: The people who have cone beam are those who are interested in bettering their practice. So here's the hidden value of cone beam. Cone beam has made my team members better.

Chuck: Interesting.

T-Bone: It has made my assistant so much better. My assistant knows so much more. I say this very humbly. My assistants could run circles around the vast majority of cone beam owners because it's gotten better.

How do you keep good people? So what is the number one challenge practices face? It's team members, right? It's how do you keep and maintain good people? How do you cultivate good people? I think you have to cultivate

good people by being modern. Modern doesn't mean bleeding edge.

Listen, if you have an iPhone, why do you want to work with a flip phone? A flip phone is a panorex. Digital or non-digital, why in the world would anybody want to work with a flip phone when the iPhone exists today, or you know, a Samsung phone or whatever, Android phone. It keeps good people.

My assistant knows that I will always invest in the latest technology, maybe sometimes too early, maybe sometimes I'm a little bit late. Never too late. She knows that I will always allow her to grow, to feel professionally satisfied, and to bring her along with me.

Chuck: Let's walk through that real quick. I know we're probably running out of time.

T-Bone: It's okay, it's an important topic. We promise that basically we'll go every time.

Chuck: So you say that your assistant is doing great and I know these ladies are doing well but let's talk about what that really means. What are they doing with cone beams? What's a typical scenario? Let's talk about two things, new patient, right? And the second, let's talk about the hygiene visit. So what are they doing with it?

T-Bone: New patient and hygiene kind of are together. So my hygienists are fundamentally sound at being able to open the cone beam x-ray, walk through it with the patient, show them what we're seeing, do an initial screening for me, then point out those areas that I need to pay

particular attention to, and quote\unquote pre-diagnose, pre-warn our patient.

They're also able to take that cone beam image when they find something, they're able to screenshot it and put it in their digital patient record. They're also able to virtually plan an implant. Now that doesn't mean "plan it," plan it.

Chuck: Just get it close.

T-Bone: How about even if it's upside down, you're patient doesn't know any better. So they can stick it in there. They can do all those things. Now they know how to segment the airway so when I walk in, they've already talked about sleep apnea from that perspective, or at least the correlation between collapsed airways and sleep apnea. So they make that easy for me.

Now let's take a look at my assistant. That's who is really shining with cone beam. So I can not be in the office, my associate could be here, or I can be in my office in the back, my assistant can essentially do everything for me except plan the implant. She can take the radiograph. She can take the cone beam. She can integrate the CEREC data. She can do the virtual wax up from the CEREC, integrate it into the cone beam.

She can essentially virtually plan an implant, not "plan it," plan it. Then I can do the planning and then she can mill the guide. She can do all of those things without me. She can walk through the scan. She can take the screenshots. There's so much that we can do. At the end of the day,

does she make more money because of it? Of course. But I make more money because of that.

Chuck: When do you take that shot? Does every new patient get a cone beam?

T-Bone: I don't like using the word every.

Chuck: Toothache? When do you use it? Just because you have it, do you use it all the time?

T-Bone: I do use it all the time. Not just because I have it but because I believe firmly that it's something we do. So here's our basic "rules," I'm using rules in air quotes here. We don't take cone beam on young children unless they're going to the orthodontist. We don't take cone beam on cancer patients or people at high-risk for those kinds of things. I don't believe that cone beam causes cancer. I don't believe that there's a high correlation between cancer and cone beam but at the end of the day, I take that risk. Obviously, we don't cone beam pregnant people either.

Basically, anybody who's of adolescent orthodontic age, through age 60-70, will get a cone beam. Not just people that are missing teeth because I don't know if they're missing teeth until I do an exam and we want the cone beam to do a proper exam. In my perfect world, the analogy I try to use is cone beam is a metal detector. If I can mount that in my doorway and make you take one when you walk into my office, that's how I would use it.

Chuck: I tell you one of my pet peeves and your team does a good job with this. One of my pet peeves is to see a 40 inch TV in every operatory and there's something on that

monitor other than dental. It drives me absolutely nuts. I either see Rachel Ray on, which you know, I like Rachel Ray. You see CNN, or something like that.

T-Bone: People watch CNN?

Chuck: You see so much on. What I do notice here…

T-Bone: Isn't that the Communist News Network?

Chuck: You really use that technology for patient education. I mean they're coming to the dentist. People know they're coming to see you and they expect…

T-Bone: They want you to be thorough.

Chuck: They want you to be thorough. So talk to us, one last point on this, what is your policy in your practice with what's on that screen when you walk in the room?

T-Bone: Oh, god, listen I won't do a hygiene check if there's not a photograph taken, number one. A digital photograph has to be taken, my hygienist, "Well, there's nothing to take." I'm like, "Take a picture of the beautiful teeth and tell them how beautiful they are. Take a picture and have a record."

Number two, if we take a cone beam, I better see the 3D up on the scan and I better not be the first one showing it to the patient. They should have reviewed that and shown the patient what it is so I can do high-level or very detailed use of that.

I believe that if a patient is missing a tooth, we're going to plan an implant there virtually so that we can show them what it would look like. Why I do that is number one, that

patient may not say yes but that patient may have a friend who says yes. That patient may get wowed by it.

The other thing that I like to see and this is the area that we can do better so if my team is listening, we can do better at this. I would like us to see, send more patients home with a burned CD of their image. We know that patients don't accept treatment right away. In fact, I would say probably only about 20 percent of patients accept treatment the same day. Our treatment acceptance goes up to about 50 to 60 percent over the next few months.

I think one of the things that you can do to increase that is send them home with a burned CD of that. That burned CD they can stick in any Windows-based computer and they can literally see exactly what you saw. They can't manipulate and change the data, but they can see what you saw.

So if planned an implant, it's going to be there. If I planned a nerve, it's going to be in there. If I did a virtual wax up, it's going to be in there. If I brought CEREC data in, it's going to be in there. I think we could do a better job of that. We're not as good as I want to be but we're less sucky than everybody else on that.

Chuck: Do you think it's unrealistic, often I hear folks say this, "Chuck, do you think I could get referrals from other general dentists to take their images?"

T-Bone: It doesn't matter.

Chuck: But let's talk about that. I agree. You know that, but do you think that's realistic?

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T-Bone: Not anymore.

Chuck: I don't think you should—I definitely don't think you should buy…

T-Bone: Let me back up on that. Maybe in small town America that's possible. In fact, I use to have a couple of specialists that would send me patients to take cone beams. Now those places all have their own cone beam. But I think in metro areas, that's a failed business model. That's a failed expectation. Does it occur? Of course, it does occur. Is it to expect it? I would say the answer is no. But in rural America, I think that could certainly work.

Chuck: Last point. Eight years into this, I know you guys still stay excited about it, but are your patients, do you think they expect it or are they still blown away by it?

T-Bone: That's a good point. I don't think a majority of the patients, no. A funny story on a side note, I'm a cone beam educator. I mean, it's what I do. I would probably say I train or touch probably 50 percent of all cone beam owners at least through Sirona in the U.S.

My mother-in-law one day called me and one of her friends down in south Florida is a dentist, she called me, she said, "Oh my god, you have got to see Dr. X's new office. He has this amazing technology where it takes a 3D x-ray of your head and they show it to you. Do you have this?"

I said to myself, I said, "Who did you go see?" She said who Dr. X was. I said, "I just trained him two weeks ago. I trained him." What it told me is that we don't showcase

this technology enough. In fact, you don't have to say just this technology. We don't showcase anything enough.

To my CEREC owners listening, when is the last time you showed your patient your drawer of blocks of different colors that you have so that you can say to your patient, "You know, we have all these different colors so that we can match your tooth the best." When is the last time we had our patients see the milling unit? When is the last time we showed them what the camera looks like and the design process is? How do we involve our patients in things? Same thing with cone beam.

I don't think we do enough with our patients. I don't think we involve them enough. I think it's very easy to get stagnate and to think it's normal. Our team especially, we're spoiled because we have so much and I want them to go to other offices sometimes and see how good we have it. Maybe not in terms of how nice I am or not nice I am or how much I try to drive them so hard, but more about the patient experience.

Chuck: I want to touch on one last thing, I did a blog post about three years ago. It tells you what a small world it is, it was actually a patient that came to you for a consult. They had already been to a general dentist and I've told you before I appreciated you taking the highroad on this.

T-Bone: Yeah.

Chuck: It was a really interesting conversation. They came to you for a second opinion on an implant. The irony of this and I'll tee this up here, the other dentist used the exact same technology as you. They had cone beam and they had

CEREC and they had everything. Do you remember that story?

We talked about is your technology helping you or is it hurting you? That's what we did the blog post on. Share that story again because one thing, there are a lot of people listening who do have cone beam and some people who don't. This is specifically addressed, this story, to you who do have cone beam and don't take for granted that your patient understands what you're doing.

T-Bone: We always joke patients remember what they want to remember. They hear what they want to hear. It's not a joke, it's truly true. I had a patient that came to see me for a second opinion, was missing a couple of lower left teeth. She wanted teeth that stayed in place and a fixed bridge wasn't an option because she didn't have a terminal tooth there.

She came in and she says, "I want implants," blah blah blah. She must have seen or heard about us somewhere and she came in. At her consultation visit, I showed her a CEREC scan, I showed her the virtual wax up. I planned the implant with her. I talked to her about where we would need bone, what our challenges were, where the nerve was, how I needed to be careful around the nerve. I even showed her what it would like if I put an implant through a nerve. Because I want to show them everything.

Then I asked her just matter-of-factly, "Where are you coming from? Who is your last dentist?" She told me who it was and I looked at her, I said, "You know, I know that office and I like that person, those persons." I said, they have the same technology. You should just go and have

them do this. She looked at me and she said, “Well, they didn’t show it to me. They just talked about it. They didn’t show it to me. I want to go with you. You know what you're doing.”

I said, “Listen, I really want you to go talk to them about it. If you chose me afterwards, that’s fine.” It just goes to show that it’s not enough to have it. You’ve got to use it and you’ve got to show it to your patients and you have to be excited about it every day.

The analogy I use that applies to me is Louis Malcmacher, we were speaking together at a program. I said, “Louis, I’m bored of doing this program. I do the same thing over and over again.” He goes, “Man, you can't be like that. It’s a show every time. This is somebody’s first time seeing you speak and you want them to remember the low-energy you or the high-energy you? Just because you’ve heard it or seen it 100 times doesn’t mean that it’s not somebody else’s first time.” That applies to our patients.

Chuck: Absolutely. They're going to spend about $4,000 on average to have an implant placed and restored so just remember the technology is for them as much as…

T-Bone: Technology is all about the patient. It’s not about anything else.

Chuck: So don’t hide that and put it in your back pocket.

T-Bone: Showcase it. Have an LED light behind that thing. Have a sign board that shows your patient what it is when they walk by they ask. Have you team members where a button that says, “Ask me about 3D x-rays.” Stuff like that.

Ep #8: Why Your Practice Needs Cone Beam Computed Tomography

Chuck: How long are we into CEREC now? 30 years?

T-Bone: Roughly, yeah.

Chuck: Just 30 years. So, it's just normal business here. I've been selling CEREC for almost 19 years now.

T-Bone: It's interesting you talk about CEREC. I'm excited about CEREC again. We're doing more and more anterior cases. I did my first bridge in our practice in three and a half, four years, and I did it with CEREC yesterday.

Chuck: I'm 19 years into this. I was in an office recently and you know what I saw? I saw a patient with their bib on standing there looking at a milling chamber and guess what they were doing?

T-Bone: Videotaping it.

Chuck: They were recording it and grinning from ear to ear. I'm like, goodness gracious. To us, it's old, but to a patient still, again, make sure you showcase your technology because even though only 20 percent of dentists are doing this nationally, patients are blown away by it. So, great, great podcast. Thanks for covering this tonight.

T-Bone: I want to close with a couple of remarks, my last rant of the day. If you're listening to this still, thank you. If you're stuck and you need something to pick you up, if you want to do more, if you want to make more, or you want to make more time off, everybody has their different hot buttons, I need you to take a serious consideration at several things.

Ep #8: Why Your Practice Needs Cone Beam Computed Tomography

I want you to listen to one of the podcasts I have up on my site where I talk about how to grow your practice organically through medical billing, sleep apnea, orthodontics, and dental implants. I want you to understand that cone beam can be the platform for those things.

Cone beam for me is my ability to medically bill. It's why I got into medical billing. Then the side benefit was so many things beyond cone beam for medical billing. It's how we're really ramping up our sleep apnea and it's how we've been doing implants for the last eight years. I would say that the way we do implants is unique, it's different, it's unbelievably patient-centric.

This is my way out of doing restorative dentistry. I don't want to do fillings anymore. Quite honestly, if I were to be totally honest with you, I'm above it. Not that there's anything wrong with doing fillings but why should I get paid the same as my first-year associate? He gets paid for the MOD the same way I do. I think that's unfair. But it's the world we live in.

Today, cone beam has been that platform for us. We've doubled our practice without any net patient growth over the last seven or eight years. I want to repeat that. We've doubled our practice without any net patient growth. Now we have new patients but we lose just as many as we get and our practice hasn't grown in terms of the volume of patients we see. It's grown in terms of the dentistry that we're doing on our patients.

Cone beam is a great springboard to creating the practice that you want. If you want to learn more about cone

beam, I have to admit I am clinically-biased towards the Sirona technology. I want to invite you to attend a 3D Summit, www.3dsummit.com, with Sirona. It's a wonderful day and a half, two-day event where you'll hear from multiple clinicians talking about how this technology has greatly impacted their practice.

It's a great way to hear from people that will resonate with you. Maybe it will me, maybe it will be Neil, maybe it will be August, maybe it will be Chris, maybe it will be Jay, but somebody will resonate with you. You owe it to yourself to at least fully explore what this can do for you.

If you're a dental rep listening to this and you haven't really educated yourself on the possibility of cone beams, if you buy into the negativity, you owe it to yourself to go to a 3D Summit. If you haven't been to the Summit in several years, you owe it to yourself to go again because it's changed. It's different. We all need that re-energization—I don't even know if that's a word—George Bush, strategery. We need to reenergize ourselves. You owe it to yourselves.

Again, we ask for two things. Number one, thank you for listening but we ask for two things. One, visit iTunes and leave us a review. We want to get great reviews. We want honest reviews but we want great reviews so we can increase our ranking in iTunes.

Number two, we'd love to hear back from you. There are two ways to get in touch with us. Number one, you can visit www.tbonespeaks.com and get in touch directly with me. If you'd like to get in touch with Chuck, you can visit

www.askchuckmckee.com. Thank you again and we'll see you on our next episode.

Thanks so much for listening to *T-Bone Speaks* with Dr. Tarun Agarwal. Remember to keep striving for excellence and we'll catch you on the next episode.