

CEREC[®] Supplement

For Clients of Charles Blair, DDS
(Client Use Only)



Pinnacle Processional Park
547 Highland Street
Mount Holly, North Carolina 28120
866.858.7596 * 704.827.6295
704.822.3142 (Fax)

info@drcharlesblair.com * www.drcharlesblair.com

Discard Outdated Editions

CEREC[®] 3D Business Q&As

*Business tips for CEREC[®] users, accountants, CEREC[®] specialists,
Patterson branch managers, equipment managers and territory representatives*

Updated 2010



*Dr. Charles Blair is a contributing editor of Dental Economics magazine. His consulting services include fee, insurance and procedure mix consulting (averaging over an \$86,000+ increase in net per practice consulted. He is a highly sought after speaker for dental meetings and conventions nationwide. Dr. Blair is available to work with CEREC[®] users regarding specific fees, strategies and coding related to CEREC[®]. Proper alignment of fees and proper insurance coding in the practice is very important. There are many changes in the CDT-2009/2010 coding which went into effect 1/1/09. Obviously, dentists are unaware of their many mistakes, which average \$100 to \$500 a day! **Virtually every dentist can “get a CEREC[®] for free” with Dr. Blair’s Revenue Enhancement Program and a \$100,000 tax deduction!** He can be reached at 866.858.7596 or email info@drcharlesblair.com.*

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CEREC® FEASABILITY

1. Q: I'M WORRIED ABOUT SPENDING \$100,000 FOR A PIECE OF EQUIPMENT THAT MAY BE WORTH NEXT TO NOTHING IN 5-7 YEARS. OBSOLESCENCE SCARES ME! IF IT'S WORTH ZILCH IN SEVEN YEARS I CAN'T AFFORD THAT KIND OF LOSS!

A: Your initial fear of obsolescence is not uncommon. However, there is a huge trade off you may not have considered that should eliminate this fear.

First, determine the current cost of your outside lab bill over the same 7 year period. Let's assume you have a \$600,000 practice and spend 10% on the outside lab bill. \$60,000 per year X 7 years equals \$420,000. The amount is much greater than the CEREC® cost and you have ZERO to show for the amount spent on the outside lab bill.

Furthermore, outside lab bills are expensed, while the \$100,000 cost of the CEREC® is amortized over *total units produced over time*. It may be thousands of units over the life of the machine, dependent on the unit volume produced. Even if you "toss out for scrap" the CEREC® machine at the end of the seven year term, its obsolescence is no greater than your current outside lab bill, which once paid has *zero residual* value.

While previous models (CEREC® I and CEREC® II) were self-contained and non-Windows-based, the current CEREC® 3D model is modular with the optical camera and Windows-based computer in one unit with a separate milling chamber. The only upgrade option with the two previous versions was from one model to the next. Since CEREC® 3D now has a Windows-based approach, hopefully future upgrades will not require the purchase of a new machine, but rather component parts with more user-friendly software updates. This remains to be seen, but I have no doubt that the CEREC® software will continue to be upgraded over time to increase productivity, lower the learning curve and to offer additional features.

2. Q: I'M ALREADY TREMENDOUSLY IN DEBT FROM MY PRACTICE EQUIPMENT AND FACILITY (\$200,000 AND \$400,000, RESPECTIVELY). HOW IN THE WORLD CAN I AFFORD TO NOW BUY CEREC®? MY WIFE IS SCARED STIFF THAT I'M ALREADY IN DEBT OVER MY HEAD AND MY BANKER IS SHAKY OVER MY DEBT. I DON'T THINK HE'LL LEND THE MONEY.

A: First, cover the basics. A dentist needs adequate term life insurance (very cheap) to pay off all debt and create an estate (money) for protection of family. Furthermore, disability insurance should be purchased for 60% of current salary with a six month waiting period to reduce the premium. Discuss these disability coverage basics with your accountant.

The next issue is, should the doctor go into additional business debt? The proper answer is yes, if the debt is offset by additional revenues, lower overhead or stress,

and increased profitability. CEREC® technology, properly integrated into the practice and used, will accomplish all of the above. While debt is increased, the re-allocation of the current lab bill, plus the conversion of some of the low cost operative units into longer-lasting and higher cost CEREC® units, will easily offset any debt payment. Just be sure you will be using the machine for a number of 15-20 units a month. The banker may not understand the results of increased revenues and net profit related to the associated debt. If the banker won't do it, the leasing companies are standing in line.

3. Q: I'VE HEARD THAT CEREC® TECHNOLOGY IS EXPENSIVE.

A: CEREC® is expensive, but so are outside lab bills, which every general dentist faces. CEREC® is a reallocation of the current lab bill. The typical practice pays \$40,000 - \$60,000 a year to an outside lab. A reallocation of a portion of this outside lab expense will generally pay for CEREC®—not to mention converting some of the current (lower cost) amalgams/composites to the longer-lasting (higher cost) CEREC® restorations.

4. Q: WILL THE PRICE OF CEREC® STILL BE A SALES OBSTACLE?

A: Dentists remain “cost-based,” not “revenue savvy.” The CEREC® specialist, territory representative and equipment manager should be consultative versus a pure sales-orientation in the process. While discussing the positive economics of CEREC® is important, encouragement of the dentist to get their fees, procedure mix, and insurance codes properly positioned will, itself, pay for CEREC®. Encouraging the dentist to consider sale adjuncts to CEREC (intraoral camera, electro surgery, and practice management) is consultative and enhances the success of CEREC® in the practice.

5. Q: I'VE HEARD OVER THE YEARS THAT CEREC® TECHNOLOGY “ISN'T QUITE THERE YET.” ANY COMMENTS?

A: CEREC® 3D technology is here, now, today - - it fits! Labs have also acknowledged CAD/CAM's fit and use it!

6. Q: WHAT DO YOU THINK OF THE NEW CEREC® 3D SOFTWARE?

A: The 3D software is not just a major step forward. It is phenomenal! In only one release, these major barriers/obstacles were addressed:

- a) A three-dimensional view with easily changed design features was implemented - - easily accomplished by the dentist or by the staff.
- b) Adjusting occlusion of the CEREC® restoration is virtually eliminated - - a breakthrough!
- c) There is now great clinical efficiency in a multi-unit appointment, not just a single unit - - another breakthrough!

7. Q: I HEARD THE CEREC® 3D SOFTWARE IS MUCH MORE EFFICIENT FOR QUADRANT DENTISTRY? IS THAT TRUE?

A: Yes. The objective of quadrant dentistry is to increase efficiency by performing several clinical procedures at the same visit. Both a higher dollar-per-hour and dollar-per-visit appointments result.

CEREC® 3D allows the clinician to image the quadrant in such a way that a restoration can be milling while the clinician is prepping or seating another restoration - - a breakthrough for the software!

8. Q: THERE HAVE BEEN COMPLAINTS IN THE PAST REGARDING THE TIME REQUIRED TO OCCLUDE THE CEREC® RESTORATION. WHERE DOES THE NEW 3D SOFTWARE STAND IN THAT RESPECT?

A: The time required to adjust the occlusion of the milled unit has been drastically reduced. The bite excursions of the opposite arch can now be imaged resulting in minimal occlusal adjustment time – a breakthrough!

9. Q: I’VE HEARD THAT A HIGH DOLLAR-PER-HOUR AND DOLLAR-PER-VISIT PROFILE IS HIGHLY DESIRED FOR CLINICAL EFFICIENCY. DOES CEREC® 3D FIT THE CRITERIA?

A: Yes. Fees (and longevity) for CEREC® restorations are high compared to many other dental procedures, including amalgams and composites. The inefficiency of the second visit is eliminated. In addition, multiple units milled at one visit can now be efficiently produced with the CEREC® 3D software.

Proper use of the CEREC® 3D technology plus third party financing (for multiple units at one visit) yields a high dollar-per-hour and dollar-per-visit result.

10. Q: I’M PERPLEXED WITH VARIOUS COMMENTS FROM CEREC® USERS. AFTER THE PURCHASE SOME DOCTORS REPORT SMALL INCREASES IN VOLUME AND NET INCOME, WHILE OTHERS REPORT HUGE INCREASES. WHAT GIVES?

A: Dentists vary greatly in clinical speed, organization, staff motivation, and commitment. This technology, as all technologies, is sensitive as to maximizing its implementation. The cash flow increases from the purchase of a CEREC® will be minimal from simply converting some of the outside lab bills (unless the practice is quite large). On the other hand, adding the additional ingredients of *converting* existing fillings (operative) to inlays/onlays to CEREC® substantially increases cash flow. In addition, the marketing aspect of generating new patients will increase CEREC® cases plus the additional non-CEREC work generated. Finally, this new technology often encourages the dentist to charge a higher fee profile consistent with the commitment of the dentist and staff. Bottom line, the result of purchasing the CEREC® technology is *directly* impacted by its successful implementation.

COMPLEMENTARY TECHNOLOGIES

- a) **Digital Camera:** Provides high-resolution full face, full mouth and quadrant pictures for patient education, motivation, and insurance justification/documentation.
- b) **Intraoral Camera:** Magnification allows the patient to see the need for CEREC[®] restorations and provides insurance justification/documentation.
- c) **DIFOTI[®] (Digital Imaging Fiber-Optic Trans-Illumination):** Little-known technology consisting of a self-contained light source with a recording camera – use of light waves improves detection of caries, fractures and failing restorations. DIFOTI[®] pictures are used for patient education and insurance justification/documentation. (www.difoti.com)
- d) **Electro-surgery/Laser:** Can remove edematous tissue around the natural tooth, providing a dry operating field (required for CEREC[®] and adhesive dentistry) while improving tissue health around the new restoration.
- e) **Isolite[™] Dry Field Illuminator:** Provides light to see by, moisture and tongue control, and isolation of the tooth/quadrant. (www.isolitesystems.com)
- f) **Digital X-ray:** An adjunct to CEREC[®] in terms of diagnosis, patient education and insurance justification/documentation.

OPERATING ISSUES

11. Q: I'VE HEARD THAT SOME DENTISTS USE TWO MILLING UNITS. CAN THE COST OF THE SECOND MILLING UNIT BE JUSTIFIED?

A: The new 3D software is designed for multi-unit quadrant dentistry, greatly enhancing efficiency.

There are several factors to consider in a decision to purchase a second milling unit:

- a) The operator's efficient use of auxiliaries and the auxiliaries' competence level.
- b) The laws of the state regarding what functions the auxiliary may perform (the more the better).
- c) The volume of multi-unit vs. single-unit appointments.
- d) Multi-doctor use of the same imaging unit, if applicable.
- e) Relative productivity of the operator (dentists typically produce \$250-\$400 per hour). The higher the doctor productivity per hour, the higher the value of time savings.

Also consider in the purchase equation the after-tax ramifications which reduce the purchase price of the milling unit about 30%-35%.

Finally, the bottom line of any technology purchase is the volume of use, and its daily cost.

12. Q: WE ARE TWO PRACTITIONERS WHO SPACE-SHARE AN OFFICE, EACH WORKING FROM EITHER 7:00 AM-2:00 PM OR 12:00 PM-7:00 PM FOR THREE STRAIGHT DAYS.

WE EACH ALSO WORK ONE ADDITIONAL DAY ALONE FOR THE HOURS 8:00 AM-5:00 PM. CAN WE SAVE ON PURCHASING JUST ONE CEREC®?

A: One CEREC® will work nicely with your staggered office hours. For three days a week, you must ensure through proper scheduling that the 12:00 PM -2:00 PM “overlap” period does not result in both doctors needing the unit at the same time, of course. It is no problem on the one day a week worked alone by each doctor. The economics of the deal is outstanding as the capital cost and maintenance is shared. Your cost per unit will be low.

13. Q: CAN DENTAL ASSISTANTS PERFORM CERTAIN CEREC® PROCEDURES?

A: Yes, they can design the restoration for the doctor’s review, and mill the unit. In most states, they can adjust contact points and occlusion *on the restoration* itself. They also could stain and characterize, if desired. The dental assistant can save significant dentist’s time. The dentist must prepare the tooth and bond the restoration in all states.

FEES

14. Q: I PURCHASED A CEREC® 3D AND HAVE NO IDEA HOW TO POSITION MY FEES RELATIVE TO THE CROWN, 3/4 CROWN, ONLAY AND INLAY.

A: Fee surveys of various qualities are available. Fee alignment is only one component, as operating protocols and proper insurance compliance are almost as important. There are many changes in the new CDT-2009/2010 codes, and most dental offices are making many mistakes with both these new and old codes. Consider Dr. Charles Blair’s **Revenue Enhancement Program** for further fee, procedure mix, and insurance coding explanation. Most every practice is leaving \$100 to \$500 a day “on the table.” Contact him at 866.858.7596 to learn how to achieve dramatic results (and pay for that CEREC® 3D for free!) to your practice profitability.

EXPENDABLES COST

15. Q: ASSUMING THE CEREC® MACHINE IS PAID FOR, WHAT IS THE EXPENSE FOR THE VARIABLE COST, I.E. BURRS, CERAMIC BLOCK, POWDER, ETC. TO MAKE A RESTORATION?

A: \$25 - \$30 per unit.

16. Q: "I'M A PATTERSON TERRITORY REPRESENTATIVE WITH A HIGH-VOLUME CEREC® USER. LAST WEEK THIS DOCTOR 'AMBUSHED' ME WITH COMPLAINTS OF HIS OVERALL SUPPLY COST PERCENTAGE. HIS ACCOUNTANT, WHO HAS SEVERAL OTHER DENTAL CLIENTS, SAID HIS PERCENTAGE WAS TOO HIGH. THE DOCTOR ALSO QUESTIONED HIS WIFE (WHO PAYS THE BILLS) AND SHE CONFIRMED THAT SHE HAD BEEN POSTING THE PATTERSON BILL CORRECTLY. I DON'T WANT TO LOSE

THIS DOCTOR AS A CUSTOMER FOR NON-CEREC[®] SUPPLIES SINCE I KNOW OUR SUPPLIES ARE COMPETITIVELY PRICED. WHAT SHOULD I SAY?"

A: This is a "classic" complaint of many dentists, including some CEREC[®] users. The problem lies in the fact that this doctor's spouse received the Patterson invoice and as in the past, posted it and charged it to "dental supplies". However, the invoice listed small instruments, CE courses for staff, equipment repairs, and CEREC[®] blocks and burs - - NONE of which are dental supplies!

The problem is the failure to split the invoice into the various (and correct) categories. The dental supply category on the accountant's P&L is overstated, while the lab expense, repairs and CE categories are understated. The CEREC[®] blocks and burs should be posted to "inside lab expense", not dental supplies.

You should go over the invoice with the doctor and his spouse and explain where each of these items should be correctly posted and they will find that with this proper breakdown, Patterson's dental supplies will fall within industry standards.

17. Q: A FRIEND BOUGHT A CEREC[®] AND REPORTS HIS DENTAL SUPPLY PERCENTAGE ON THE P&L INCREASED, ACCORDING TO HIS CPA? WHAT GIVES?

A: The expenses of CEREC[®] were improperly allocated to dental supplies. All CEREC[®] expenses should be coded "inside lab expense" on the doctor's Profit & Loss. Then the correct percentage for lab expense and dental supplies will be depicted on the doctor's P & L. The dental supply percentage should stay about the same while the outside lab expense will drop.

DENTAL INSURANCE ISSUES

18. Q: CAN A CORE BUILDUP (D2950) BE REPORTED IN ADDITION TO THE CROWN FOR AN ENDODONTICALLY TREATED TOOTH?

A: If a core buildup is separately milled and is *required* for the retention of the crown - - yes.

If the crown is milled in one piece extension, then absolutely not. A core buildup is a separate procedure performed to facilitate the retention of a crown.

19. Q: WHAT IS THE BEST WAY TO DOCUMENT A CEREC[®] ONLAY FOR INSURANCE COVERAGE?

A: Take a preliminary x-ray and intraoral camera photo. Then take a photo of the prep and submit with an appropriate narrative. The narrative should mention missing cusps, fractured cusps, undermined cusps, fractured, and decay as appropriate. Also, always make mention of capping cusp(s) and list the surfaces involved on the claim form. For an onlay, a facial or lingual surface is involved. Proper documentation or lack thereof can make or break insurance coverage.

Often the x-ray (alone) will not clearly demonstrate the need or appropriateness of the onlay or crown. Intraoral cameras go hand-in-hand with CEREC®. The camera provides insurance documentation (for fracture) and enhances patient communication with regard to necessary treatment.

20. Q: I HEARD THAT AN ONLAY DOES NOT HAVE TO COVER THE CUSP. IS THAT TRUE?

A: No, you are wrong. Some have suggested even recently, that the cusp doesn't need to be covered, since adhesive dentistry is involved. To be specific the ADA's CDT-2009/2010 *Glossary of Common Dental Terms* defines an onlay: "An indirect restoration made outside the oral cavity that overlay a cusp or cusps of the tooth which is then luted to the tooth". In addition, the following question: "What percentage of the cusp needs to be covered for a restoration to be considered an onlay?" The cusp tip must be overlaid!

21. Q: DOES DENTAL INSURANCE COVER TYPICAL CEREC® RESTORATIONS?

A: First, the bad news...inlays and veneers are generally not covered (an exception would be a specific dental plan for "executives" which covers almost anything). Inlays are not reimbursed because a routine (direct) amalgam/composite will suffice, say most insurance carrier's policies. Veneers are not reimbursed as they are considered cosmetic. These negatives are no big deal as they apply to the non-CEREC® user also.

Now, the great news! Properly documented CEREC® onlays, full crowns, and 3/4 crowns are generally covered. Thus, CEREC® can be used to fabricate many of the existing restorations sent to an outside lab. In addition, many of the practice's existing direct restoration (fillings) will be converted to CEREC® technology. This will enhance the practice's profitability while providing a long-lasting single appointment restoration for the patient. This is a win-win for the patients and the practice!

22. Q: OUR PRACTICE BOUGHT A CEREC® RECENTLY AND WE ARE HAVING TROUBLE GETTING CERTAIN ONLAYS COVERED BY DENTAL INSURANCE. ANY IDEAS?

A: Onlays are generally covered by most policies, with a few exceptions. A very few, flat-out, will not cover onlays. A few will not cover a specific material, the resin-based composite, while covering metallic or porcelain as the material. The ADA's CDT-2009/2010 defines that "all fiber porcelain or ceramic reinforced polymer material/systems are considered resin-based composites". Thus the 3M ESPE block material may be excluded in some cases while the Vita and ProCad block materials are generally reimbursed.

23. Q: I WOULD LOVE TO DO MORE INLAYS BUT MANY PATIENTS ARE RELUCTANT BECAUSE THEIR INSURANCE REIMBURSEMENT IS AT THE LEVEL OF A FILLING (AMALGAM/COMPOSITE). ARE THERE ANY STRATEGIES TO GAIN PATIENT

ACCEPTANCE AND IMPROVE MY USE OF CEREC® FOR THESE OUTSTANDING RESTORATIONS?

A: Typically, the CEREC® 3D crown, ¾ crown, and onlay are priced at the level of a conventional crown (\$750-\$950). **If** the *volume* of these high-fee restorations will “cover” the monthly payment, then the only cost to manufacture *inlays* is the direct (variable) cost of about \$30/unit (burr, block, materials). Thus, the concept of the “low-fee” CEREC® 3D inlay strategy:

The long-lasting inlay is offered as an *alternative* to the amalgam/composite at a fairly low fee, say \$450. If the materials are \$30, the net gross profit is \$425. *If* the dentist works with two assistants, the dentist’s chair time for CEREC® 3D will be equal or less than an amalgam/composite. One of the assistants does the imaging, designing, milling and making small adjustments outside the mouth, while the dentist produces with the other assistant elsewhere. The dentist only preps the tooth and bonds the inlay to place. “Low-fee” inlays will be quite profitable if the dentist is willing to train/utilize the dental assistant. Many patients will accept inlay treatment if they only pay the difference of \$450 and the amalgam/composite reimbursement fee, out of pocket, could be less than \$200 in some areas. The patient is grateful for a single appointment and long-lasting inlay at an affordable price, while the dentists makes a profit offering the best conservative dentistry one has to offer. The “low-fee” inlay goes hand-in-hand with quadrant diversity.

24. Dental Insurance Issues, Coverage, and Documentation for CEREC® 3D Restorations

Communication of insurance matters for CAD/CAM restorations is critical. In order to file insurance efficiently, the doctor and administrative assistant must develop appropriate insurance documentation/justification applicable to these restorations. In most cases, ceramic onlays, ¾ crowns and full crowns are covered with appropriate documentation, as described later.

Patient education as to the uniqueness and benefits of CEREC® 3D should be discussed chairside by the doctor and staff. The digital camera, DIFOTI® technology, intraoral camera, and CEREC® 3D go hand-in-hand.

With the intraoral and/or digital camera, the doctor should take photographs and x-rays to accompany the insurance claim, along with an in-depth narrative to build a strong case for reimbursement. Explaining to patients that insurance coverage is merely supplemental, and explaining that the longer-lasting treatment is worth the extra out-of-pocket expense will counter most concerns. The economic decision for coverage by insurance companies is not based on what is necessarily best for the patient clinically or esthetically, but the level of benefits the employer purchases.

Understanding these dilemmas and indoctrinating the staff to proper insurance protocol of codes and narratives will lessen the continual battle between the practice, patient, and insurance company.

25. INSURANCE COVERAGE FOR CEREC® 3D RESTORATIONS

Most dental insurance policies do not reimburse any type of inlay. The reimbursement level is at the silver amalgam or composite fee. Thus, the inlay reimbursement level would be at a low reimbursement percentage of the CEREC® fee for the insurance patient. For the private pay patient, insurance reimbursement policies are immaterial.

On the other hand, most dental insurance policies do reimburse ceramic onlays, ceramic full crowns and ¾ ceramic crowns. Ceramic veneers are considered cosmetic and generally not reimbursed. However, replacing “failed” veneers may be reimbursed.

At present, several manufacturers produce the solid ceramic-type machineable blocks, as used by the CEREC® machine. The advantage of a manufactured ceramic block versus an outside lab’s hand-packed porcelain crown is the controlled, homogeneous superiority of the manufactured block. The result is greater strength and fracture resistance, with more uniform size distribution of particles. Each of the three material type blocks has distinct properties and its own clinical advantages and applications.

Following is a table with the types of blocks that are currently available:

Manufacturer	Stock Type	Description	Similar Material Made by Same Manufacturer	ADA Coding Category
Vita®	VITABLOCS® Mark II	Ceramic	N/A	Ceramic
Ivoclar® Vivadent	ProCAD®	Lucite reinforced glass-ceramic	IPS Empress®	Ceramic
3M EPSE®	Paradigm MZ100®	Polymer-reinforced Ceramic	3M™ Z100™ (Belleglass HP)	Resin-based (<u>NOT</u> ceramic)

CEREC® 3D ADA Coding for two of the material blocks (Vitablocs® and ProCAD®):

These two blocks are considered “ceramic” under the current coding.

Clinical Procedure

VITABLOC/PROCAD BLOCKS

	<u>ADA Code</u>	<u>Insurance Coverage</u>
1 Surface ceramic inlay	(D2610)	Typically reimbursed at amalgam/composite fee
2 Surface ceramic inlay	(D2620)	Typically reimbursed at amalgam/composite fee
3 (+) Surface ceramic inlay	(D2630)	Typically reimbursed at amalgam/composite fee
2 Surface ceramic onlay	(D2642)	Generally reimbursed
3 Surface ceramic onlay	(D2643)	Generally reimbursed
4 (+) Surface ceramic onlay	(D2644)	Generally reimbursed
¾ Ceramic crown	(D2783)	Generally reimbursed
Full ceramic crown	(D2740)	Generally reimbursed
Porcelain (ceramic) veneer	(D2962)	Generally not reimbursed (cosmetic)

CEREC® Coding for 3M EPSE®’s Paradigm MZ100 block: There are three different blocks available for the CEREC® 3D. The Paradigm block is considered “resin-based” while the Vitabloc® and ProCAD® block is considered “ceramic” under current coding. There can be a problem for lab resin-based composite restorations, which are specifically excluded from coverage by various insurance policies about 10-15 percent of the time; or if approved, but with lowered reimbursement levels.

<u>Procedure</u>	<u>ADA Code</u>	<u>Insurance Coverage</u>
3M Paradigm block		
1 Surface resin-based inlay	(D2650)	Typically reimbursed at amalgam/composite fee
2 Surface resin-based inlay	(D2651)	Typically reimbursed at amalgam/composite fee
3 (+) Surface resin-based inlay	(D2652)	Typically reimbursed at amalgam/composite fee
2 Surface resin-based onlay	(D2662)	Generally reimbursed, but material is denied 20% of time
3 Surface resin-based onlay	(D2663)	Generally reimbursed, but material is denied 20% of time
4 (+) Surface resin-based onlay	(D2664)	Generally reimbursed, but material is denied 20% of time
Full (lab) resin crown	(D2710)	Generally reimbursed, but material is denied 20% of time
Porcelain (resin) veneer	(D2961)	Generally not reimbursed (cosmetic)

Improving Insurance Reimbursement and Documentation for CEREC® 3D Restorations: For CEREC® 3D or other restorations, dental insurance coverage can be enhanced and delays eliminated with excellent documentation. A narrative should *always* be provided. A beginning x-ray and photo of the tooth should be provided, along with a photo of the prep as documentation. This documentation, along with the *narrative*, should be filed *initially* with each CEREC® 3D restoration for payment, greatly reducing hassles, delay, requests for additional information, etc. Expect trouble, delays, and headaches without an intraoral camera or DIFOTI for additional documentation! Photos often show problems that x-rays do not. Submit photos routinely. Get one and don’t delay this purchase!

NOTE: Intraoral photos (D0350) are generally not reimbursable - - exception, orthodontic records. They are a cost of doing business.

Porcelain veneers (D2962) and resin-type veneers (D2961) for anterior teeth are considered “cosmetic” for insurance purposes. Expect no reimbursement for this type restoration.

26. ONLAY CONTROVERSY: There has been some controversy as to what constitutes an onlay versus an inlay. Some prognosticators have opined that a prep extending 50% or more from the fossa to cusp tip height is classified as an “onlay” for insurance purposes. The theory is that the cusp doesn’t actually have to be capped, when “adhesive” dentistry is involved. The ADA and recent CDT-2007/2008 coding handbook states that the cusp must be capped or “shoed” in order to code as an onlay procedure. At least one cusp must be capped to code it as an onlay.

Existing operative (fillings) upgrade potential to CEREC[®] 3D Inlays- a “bonus”

There is no insurance reimbursement for inlays. The equivalent of an amalgam or composite fee is reimbursed to the patient. Thus, many patients are reluctant to pay a large amount “out of pocket” for inlays, and dentists rarely mention them for this reason. There is a strategy for CEREC inlays, however.

Typically, the CEREC[®] 3D crown, ¾ crown, and onlay are priced at the level (or just below) of a conventional crown (\$700-\$900). **If** the *volume* of these high-fee restorations will “cover” the monthly payment, then the only additional cost to manufacture *inlays* is the direct (variable) cost of about \$25/unit (burr, block, materials). Thus, the concept of the “low-fee” CEREC[®] 3D inlay strategy:

The long-lasting inlay is offered as an *alternative* to the amalgam/composite at a fairly low fee, say \$395. If the materials are \$25, the net gross profit is \$370. *If* the dentist works with two assistants, the dentist’s chair time for CEREC[®] 3D will be equal or less than an amalgam/composite restoration. One of the assistants does the imaging, designing, milling and making small occlusal and interproximal adjustments outside the mouth, while the dentist produces with the other assistant elsewhere. Thus, the dentist only preps the tooth and bonds the CEREC[®] inlay to place. “Low-fee” inlays will be quite profitable if the dentist is willing to train/utilize the dental assistant properly. Many patients will accept inlay treatment if they only pay the fee difference of \$395 and the amalgam/composite reimbursement fee. The patient’s out-of-pocket could be less than \$200 for an inlay with some plans. The patient is grateful for a single appointment and long-lasting inlay at an affordable price, while the dentists makes a profit offering the best conservative dentistry one has to offer.

27. Q: FOR A CEREC[®] INLAY, IS THE CHOICE OF THE BLOCK MATERIAL IMPORTANT FOR CASH OR INSURANCE PATIENTS?

A: First, inlays are generally not covered by insurance plans. They are reimbursed at an equivalent amalgam or composite fee, regardless of the inlay material (gold, porcelain, or resin-based). Thus, any of the current three block-types may be utilized and the result is the same.

NOTE: The CEREC[®] block material itself may be an issue with onlay reimbursement, however. Certain insurance carriers will not consider coverage for resin-based block materials (3M EPSE[®]) or may lower the reimbursement level for that material.

TAX ISSUES

28. Q: I’M BUILDING A NEW FACILITY, WHICH WILL BE READY IN SIX MONTHS. I AM PLANNING TO PURCHASE ABOUT \$100,000 OF EQUIPMENT FOR THE NEW FACILITY. IN ADDITION TO THIS EQUIPMENT, I’M ALSO INTERESTED IN PURCHASING CEREC[®], BUT WONDER ABOUT THE “TIMING” OF ALL THIS.

A: The best route tax-wise is to purchase the CEREC[®] this year, utilizing the increased \$125,000 Section 179 expensing election limit.

Your equipment purchase for the new facility would then fall in the *next* calendar year resulting in a full deduction for the new equipment. The equipment must be “in service” to take the deduction.

By purchasing the CEREC[®] now you can integrate and optimize its use in the practice prior to the move. The increased productivity and net cash flow from the CEREC[®] purchase will help fund your new facility and equipment cost. Regarding your new facility, consult your accountant in regards to a “cost segregation study,” which allows a faster write-off.

29. Q: I WANT A DIGITAL X-RAY, NEW COMPUTERS, AND A CEREC[®] 3D. WHICH SHOULD I BUY FIRST, THIS YEAR, TO GET THE BEST WRITE OFF? THE TOTAL PURCHASE IS \$150,000.

A: With the recently passed tax law, go ahead and buy everything this year to reduce taxes. Why not gain the improved productivity, profitability and enhanced customer service now? Immediate production far outweighs any timing of purchases. Don't let taxes solely determine the timing of technology purchases.

30. Q: I'M BUYING A NEW CEREC[®] 3D. WHAT'S THE TAX WRITE-OFF?

A: The new tax law (2009) allows up to a \$125,000 Section 179 expense election. The CEREC[®] 3D plus any other equipment is now fully deductible in the year of purchase (assuming the total purchase price including sales tax is less than \$125,000).

NEW LAW EXAMPLE, effective 1/1/09

\$150,000	Purchases (CEREC [®] 3D, x-ray, computers etc.)
<u><125,000></u>	Section 179 expense
\$ 25,000	÷ 5 years = \$5,000 annual write off

1st year	\$130,000 = \$125,000 + \$5,000
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2 nd year	\$ 5,000
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3 rd year	\$ 5,000
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4 th year	\$ 5,000
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5 th year	<u>\$ 5,000</u>
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TOTAL	\$150,000 Depreciation Deductions
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31. Tax Strategies for Purchasing the CEREC[®] 3D and Complementary Technologies

The acquisition cost of today's dental technology is greatly reduced by current tax incentives. Doctors considering technology purchases should act now, so these lucrative

tax provisions are not lost. With the easy-to-use CEREC[®] 3D technology, substantial tax law incentives, relatively low interest rates, and availability of complementary technologies, it makes sense for doctors to buy now.

The monetary cost of CEREC[®] is actually a *reallocation* of the current outside lab expense (typically 7-12% of gross practice collections). Thus, the average \$600,000 practice with a current annual lab expense of \$35,000-\$60,000, can reallocate these funds to easily cover the monthly payment and cost of materials. Therefore, practice overhead will not increase, provided the CEREC[®] machine is used to produce an adequate number of units per month (15-20 units). Additional economic benefits are gained by the conversion of operative procedures to the longer-lasting CEREC[®] restoration and single-appointment economics resulting in increased cash flow.

Doctors interested in purchasing CEREC[®] often ask if this purchase should be timed in *conjunction* with complementary technologies and/or other equipment purchases. Actually, the CEREC purchase can stand alone, irrespective of other equipment purchases. However, doctors may want to consider purchasing the following technologies, which complement CEREC[®] while also taking advantage of current tax law incentives:

There are several approaches to timing tax deductions for the CEREC[®] and concurrent equipment purchase. For higher income dentists, tax deductions are usually “loaded” on the *front end*, cutting taxes in the current year, with fewer write-offs in the future (present value concept). Newer dentists may spread the depreciation out over a fixed 5-7 year period due to lower income and lower tax bracket. This “saves” write-offs for a presumably higher tax bracket in later years. It is recommended that doctors consult a CPA regarding the correct tax strategy for their individual technology purchase(s). CPAs who specialize in working with dental professionals include member-firms of the Academy of Dental CPA’s (www.adcpa.org).

Various tax strategies are listed below:

EXPENSE ELECTION STRATEGY (QUICK WRITE-OFF): The \$100,000 CEREC[®] 3D purchase (includes sales tax, training, etc.) is written off under Section 179, assuming qualified equipment purchased that year is less than \$400,000. This expensing benefit is phased out on a dollar-for-dollar basis for amounts greater than \$400,000 in the same tax year.

NOTE: Tax savings of \$35,000 would be realized in the 35% tax bracket.

FIVE OR SEVEN YEAR WRITE-OFF STRATEGY (DELAYED WRITE-OFF): The regular write-off for equipment is seven years while Section 168(I) of the IRS code specifies that “qualified technological equipment” can be written off over a five-year period of time. With this *level* approach, either depreciation period may be selected:

$\$100,000 \div 5 \text{ years} = \underline{\$20,000}$ per year depreciation- Accelerated five year depreciation

$\$100,000 \div 7 \text{ years} = \underline{\$14,286}$ per year depreciation- Regular seven year depreciation

LEASING STRATEGY: The equipment may be leased and the monthly payment deducted. At the end of the lease, the dentist generally has an option to purchase the equipment (often at 10% of original cost) or “walk” from the lease.

CONCURRENT EQUIPMENT PURCHASES: For qualifying purchases, which exceed the current (2007) \$125,000 expense election limit, the remaining balance can be written off over the succeeding four years.

Example: CEREC[®] and complementary equipment purchase totaling \$150,000:

Purchased equipment (total)	\$ 150,000	
Less: Section 179 expense election	<125,000>	(A)
Net adjusted basis	\$ 25,000	
Less: 5-year write off @20%	<5,000>	(B)
Amount left to depreciate over next four years	\$ 20,000	

Total 1st year depreciation (A + B) = \$125,000 + \$5,000 = \$130,000 1st year

NOTE: Tax savings of \$45,500 would be realized in the 35% tax bracket.

32. Q: IS PATTERSON’S \$195/MONTH FEE FOR SOFTWARE UPGRADE/ MAINTENANCE/REPAIR DEDUCTIBLE?

A: Maintenance and repairs are fully deductible in the current taxable year. The after-tax cost of the service is approximately \$125 per month, assuming a 35% tax rate.

33. Q: I WANT TO INCORPORATE CEREC[®] 3D EFFICIENTLY INTO THE PRACTICE. WHAT OTHER CLINICAL EQUIPMENT SHOULD I HAVE TO OPTIMIZE ITS USE IN MY OFFICE?

A: Excellent question. Several technologies are helpful:

- a) Bi-polar electro surgery and/or the soft tissue laser go hand-in-hand in “troughing” and/or eliminating edematous tissue adjacent to fillings, onlays and crowns. These technologies permit a dry field for the optical impression. Also, with the single appointment, the CEREC[®] 3D restoration is bonded on the spot and tissue health is restored. This is superior to the traditional alternative where the patient wears a less-than-ideal temporary, which re-inflames the tissue, while waiting for lab fabrication.
- b) The powerful, quick-cure light saves time in the bonding process. Time is money!
- c) Some CEREC[®] 3D operators prefer the Isolite (www.isolitesystems.com) dry field illuminator for isolation.

With the improved efficiency and the impact of the new tax law changes, it makes sense to purchase appropriate accessories in conjunction with the CEREC[®] 3D purchase and deduct it all.

*Dr. Charles Blair is a contributing editor of Dental Economics magazine. His consulting services include fee, insurance and procedure mix consulting (averaging over an \$86,000+ increase in net per practice consulted. He is a highly sought after speaker for dental meetings and conventions nationwide. Dr. Blair is available to work with CEREC[®] users regarding specific fees, strategies and coding related to CEREC[®]. Proper alignment of fees and proper insurance coding in the practice is very important. There are many changes in the CDT-2009/2010 coding which went into effect 1/1/09. Obviously, dentists are unaware of their many mistakes, which average \$100 to \$500 a day! **Virtually every dentist can “get a CEREC[®] for free” with Dr. Blair’s Revenue Enhancement Program and a \$100,000 tax deduction!** He can be reached at 866.858.7596 or email info@drcharlesblair.com.*