AETHERA · SPECIALTY BILLING SERIES

Dental Billing Solutions

Maximizing Revenue Across PPO, Medicaid, Medical Cross-Coding, and In-House Membership Plans

PREPARED BY Aethera Healthcare Solutions · Lakeland, FL
SCOPE CDT D-codes · Medical CPT cross-coding · State Medicaid EPSDT · PPO networks
UPDATED 2026 Edition · aetherahealthcare.com · +1 (863) 694-0325



AETHERA · DENTAL RC
202

ABOUT AETHERA

Maximizing Revenue. Minimizing Burden.

Aethera Healthcare Solutions is your full-service medical billing partner headquartered in Lakeland, FL. We handle coding, claims, payments, denials, and collections — so you can focus on patients.

500+
Practices Served
across 25+ medical specialties

$12M+
Revenue Recovered
denied & underbilled claims recouped

95%
Clean Claim Rate
vs 84% industry avg

< 30d
Average AR
days in accounts receivable

01
Personal, Not Corporate
Dedicated account team with deep specialty and payer knowledge — you work with the same humans every month, not a rotating call-center queue.

02
Performance Targets, In Writing
96%+ net collection · <5% denial · 95%+ coding accuracy · 24h posting · 48h submission · 65%+ appeal success.

03
Zero Risk to Start
No setup fees, no long-term contracts, 90-day cancel anytime, free 5-day audit. We earn the relationship every month.

DENTAL · MARKET CONTEXT

Why Dental Billing Matters Now

Dental is the only major healthcare segment where medical and dental insurance run on separate code sets (CPT vs CDT), separate claim forms (CMS-1500 vs ADA), and separate payer networks — creating unique billing complexity.

$

$162B

US dental spend (2024)

Largest non-hospital category after physician services.

77%

Americans with dental benefits (2024)

But 60% of dental plans have annual max $1,500 — unchanged since 1970s.

~ 80%

US dentists in PPO networks

PPOs require 20-40% write-offs vs UCR fees.

23 states

Comprehensive adult Medicaid dental (2024)

Up from 15 in 2010; 8 more states expanding by 2026.

Net effect: dental practices that master cross-coding (CDT → CPT for medical billing), in-house membership plans, and Medicaid enrollment can recover **10-15% of revenue** currently lost to PPO write-offs and uninsured patient no-shows.

DENTAL · OVERVIEW

The Four Pillars of Dental Billing

Each pillar serves a distinct payer, patient population, and revenue mechanic.

01 · PPO

PPO Insurance Billing

CDT-code-based billing to commercial dental insurers. In-network write-offs of 20-40% vs UCR; ~80% of US dentists participate in ≥1 PPO network.

`CDT D-codes · ADA claim form · EOB adjudication`

02 · MEDICAID

Medicaid Dental

State-by-state program; EPSDT mandates comprehensive dental for under-21; adult benefits optional. Fee schedules 30-60% below UCR.

`EPSDT under-21 · Adult benefits in 23 states`

03 · CROSS-CODING

Medical Cross-Coding

When dental procedures qualify for medical insurance (sleep apnea, oral cancer, TMJ trauma, cleft palate), bill CPT codes to medical payer — higher annual max, no PPO write-off.

`CPT codes · CMS-1500 form · ICD-10 medical dx`

04 · MEMBERSHIP

In-House Membership Plans

Direct-pay alternative for uninsured patients: $300-500/year covers preventive care + 10-20% discount on other services. Converts 15-25% of uninsured patients.

`Direct-pay · No PPO involvement · Predictable MRR`

PILLAR 01 · PPO INSURANCE

CDT Codes, Network Write-offs, and EOB Adjudication

PPO (Preferred Provider Organization) dental plans are the dominant commercial insurance model — ~80% of US dentists participate in at least one PPO network. In exchange for patient volume, dentists accept discounted fee schedules 20-40% below their usual and customary rates (UCR). Every claim uses CDT (Current Dental Terminology) codes on the ADA claim form, with payment remitted via EOB (Explanation of Benefits).

⇄ In-network vs out-of-network

In-network: must accept PPO fee schedule. Out-of-network: bill UCR, patient pays balance. ~30% of patients have OON coverage.

◫ Annual maximum

Industry standard $1,500/year; unchanged since 1970s. Patients exhaust coverage by Q3.

✦ Coordination of benefits (COB)

When patient has 2 dental plans, primary pays first, secondary covers remainder up to 100% UCR.

⚠ PPO write-offs represent **25-35% of practice gross revenue** — the single largest revenue leak in dental RCM.

~ 80%
US dentists in PPO networks
At least one commercial PPO contract

20-40%
In-network fee schedule discount vs UCR
Discount accepted in exchange for volume

$1,500
Standard annual maximum
Unchanged since the 1970s

7-14d
Typical PPO claim adjudication window
From submission to paid EOB

PILLAR 02 · MEDICAID DENTAL

State-Run Program with EPSDT Mandate for Under-21

Medicaid dental is administered state-by-state with significant variation. Federal EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) mandate requires comprehensive dental for all Medicaid-enrolled children under 21. Adult benefits are optional.

01

EPSDT (Under-21) Mandate

Federal law requires states to provide comprehensive preventive, diagnostic, and restorative dental services for all Medicaid children. Includes orthodontics if medically necessary.

02

Adult Dental Coverage (Optional)

23 states offer comprehensive adult dental; 14 offer limited; 13 offer emergency-only or none. Expansion trend: 8 more states by 2026.

03

State Fee Schedules

Vary widely: from $25/prophy (low states) to $85/prophy (high states). Avg 30-60% below commercial UCR.

04

Provider Enrollment & Credentialing

State-specific credentialing process; can take 60-120 days. Aethera manages enrollment across all 50 state Medicaid programs.

Top EPSDT Services

`D0120` exam · `D1110` prophy · `D1203` fluoride · `D2391-D2394` fillings · `D2740` crown · `D3220-D3330` endo

Documentation Requirements

Each claim needs: ICD-10 diagnosis, CDT procedure code, tooth number, surface, date of service, provider NPI. EPSDT requires periodicity schedule documentation.

Audit Risk

State Medicaid audits recover **3× billed amount** for EPSDT services lacking medical necessity documentation. Quarterly self-audit recommended.

PILLAR 03 · CROSS-CODING

Bill Dental Procedures to Medical Insurance

When dental procedures are medically necessary (not just dental necessary), they can be billed to the patient's MEDICAL insurance using CPT codes on a CMS-1500 form. Medical plans typically have much higher annual maxes ($2K-$8K vs $1,500 dental), no in-network dental PPO write-off, and apply to deductible/OOP accumulation. Cross-coding captures 8-15% additional revenue for the same procedures.

Sleep apnea oral appliances
OSA patients with medical diagnosis
CPT 21089, E0486

Oral cancer / biopsy
Suspicious lesion biopsy by dentist
CPT 40830, 40808, 40804

TMJ trauma / disorder
TMJ arthrocentesis, splint therapy
CPT 21073, 21499, 20610

Cleft lip/palate
Pre-and post-surgical orthodontia
CPT 42200, 40700, 40720, 21120

ⓘ Cross-coding requires **ICD-10 medical diagnosis code, CPT procedure code, and CMS-1500 form** — completely different documentation set than standard dental claims.

REVENUE COMPARISON

Same Procedure, Two Payers

Oral appliance for OSA — billed two ways

DENTAL D9940
$1,200 reimbursement · consumes $1,500 annual max

MEDICAL E0486
$1,800-$2,400 reimbursement · separate from $1,500 dental max

PER-PATIENT UPLIFT
+$600 – $1,200

Per 50-patient panel **+$30K – $60K / year**

PILLAR 04 · MEMBERSHIP PLANS

Direct-Pay Alternative for Uninsured Patients

In-house membership plans are practice-administered subscription programs — patients pay an annual fee ($300–$500) covering preventive care plus 10–20% discount on other services. No third-party insurer; no claims; no write-offs. Converts 15–25% of uninsured patients to recurring revenue.

01 Coverage included

2 exams, 2 prophys, 2 fluoride treatments, 1–2 bitewing X-rays, 1 panorex — annual value $450–$650.

02 Discount structure

10–20% off restorative, endodontic, periodontic, and oral surgery services.

03 Pricing tiers

Adult: $300–$400/yr · Child (under 14): $250–$350/yr · Periodontal maintenance: $500–$650/yr · Orthodontic: $1,200–$1,800/yr

04 Term and renewal

Annual membership; auto-renewal option; no waiting period; no pre-existing condition exclusions.

ANNUAL FEE / PATIENT
$300–$500
Annual membership fee per patient

CONVERSION RATE
15–25%
Conversion rate of uninsured patients

ARR / 100 MEMBERS
$30K–$75K
Annual recurring revenue per 100 members

⚠ **Compliance note — not insurance**

✦ DENTAL · BILLING CODES

CDT Codes & Cross-Coded CPT Codes — 2026 Reimbursement

Dental procedures (CDT) billed on ADA claim form. Cross-coded medical procedures (CPT) billed on CMS-1500 form to medical insurance.

Code	Service Description	Type	Avg $	Notes
D0120	Periodic oral exam	CDT	$35–65	Billed 2×/year; usually covered at 100%
D1110	Adult prophylaxis (cleaning)	CDT	$75–120	Billed 2×/year; covered at 100% in-network
D1203	Topical fluoride, adult	CDT	$25–45	Often not covered for adults
D2150	Amalgam filling, 2 surfaces, posterior	CDT	$180–260	Tooth # and surface required
D2391	Resin composite, 1 surface, anterior	CDT	$165–220	Tooth # and surface required
D2740	Porcelain crown, anterior	CDT	$1,100–1,450	Pre-auth required by some plans
D3220	Pulpotomy, primary tooth	CDT	$150–220	Pediatric procedure
D3330	Endodontic therapy, molar	CDT	$900–1,300	Pre-auth recommended for multi-canal
D6010	Implant abutment	CDT	$550–750	Pre-auth required; often subject to annual max
21089	Unspecified maxillofacial prosthetic	CPT	$450–850	Used for obturators, surgical stents

Claim forms. CDT codes use the ADA claim form. CPT codes use the CMS-1500 form. Same procedure can sometimes be billed both ways — but never concurrently.

Modifiers. Modifier 25 — Append to E/M services on the same day as a procedure. Modifier 52 — Reduced services. Modifier GT/95 — Telehealth.

DENTAL · DENIAL PREVENTION

Top 8 Dental Denial Reasons & How Aethera Prevents Each

Dental denial rates average 9–14% — higher than medical RCM because of weaker pre-submission eligibility checks. Each denied claim costs $25–50 to rework.

RED **28%**

Missing tooth number/surface

ROOT CAUSE CDT code submitted without tooth #, surface, or quadrant designation.

AETHERA Pre-submission rules engine blocks claims missing required tooth/surface fields.

RED **21%**

Frequency exceeded

ROOT CAUSE Patient exceeded 2 prophys/year, 2 BWX/year, or 1 panorex/3–5 years.

AETHERA Frequency tracker queries payer history before each submission.

AMBER **14%**

Missing pre-authorization

ROOT CAUSE Crown, endo, implant billed without required pre-auth.

AETHERA Auto-submits pre-auth for crowns, endo, and implant codes.

AMBER **11%**

Annual maximum exceeded

ROOT CAUSE Patient hit $1,500 annual max; further claims auto-denied.

AETHERA Real-time annual max tracker alerts patient + practice before submission.

AMBER **9%**

Coordination of benefits not filed

ROOT CAUSE Patient has 2 plans; secondary not billed after primary EOB.

AETHERA Auto-generates secondary claim with primary EOB attached.

GREEN **7%**

Eligibility terminated

ROOT CAUSE Patient coverage lapsed between appointment and claim submission.

AETHERA Same-day eligibility verification before each appointment.

GREEN **6%**

Missing X-rays or documentation

ROOT CAUSE Crown/endo claim without required pre-op radiograph.

AETHERA Documentation checklist per CDT code; auto-flag missing images.

GREEN **4%**

Wrong patient relationship to subscriber

ROOT CAUSE Patient listed as spouse/child incorrectly on claim form.

AETHERA Patient relationship verification at eligibility check.

↘ **Cumulative impact:** Aethera reduces dental denial rate from industry avg 11% to <5% — recovering ~ $45K/year per $500K practice revenue.

CASE STUDY · INTEGRATED DENTAL RCM

4-Operatory Dental Practice — Annual Revenue Impact

A 2,800-patient general practice models the combined upside of PPO renegotiation, cross-coding adoption, and membership plan launch.

PILLAR 01 · PPO

PPO Fee Renegotiation

- 4 PPO plans, 60% of revenue from in-network
- Pre-Aethera: avg 65% of UCR
- Post-Aethera: 73% of UCR (top quartile)
- Revenue uplift on $840K PPO base

ANNUAL REVENUE UPLIFT
+ $67,200

PILLAR 03 · CROSS-CODING

Cross-Coding Adoption

- 120 OSA-suspect patients identified
- 40 consented to oral appliance therapy
- 75% successfully billed to medical (E0486)
- Avg uplift per patient: $800 (medical vs dental)
- Annual revenue: $24,000
- 15 oral biopsies cross-coded to medical
- Additional annual: $9,750

TOTAL ANNUAL REVENUE
+ $33,750

PILLAR 04 · MEMBERSHIP

Membership Plan Launch

- 450 uninsured patients identified
- 90 enrolled in year 1 (20% conversion)
- Membership fee: $350/year
- Annual recurring revenue: $31,500
- Additional in-plan restorative: $18,000

TOTAL ANNUAL REVENUE
+ $49,500

Combined annual revenue recovery: $150,450. *Implementation cost (year 1): ~$48K (Aethera RCM fees + cross-coding training + membership platform). Year-1 net:* ***$102,450.*** *ROI:* ***213%.***

DENTAL · COMPLIANCE HOTSPOTS

Where State Dental Boards, Medicaid, and Payers Audit First

Top compliance risks across the four dental billing pillars.

01 PPO Insurance

- RED — **Upcoding restoration surfaces** — billing D2392 (2-surface) when only 1 surface restored; payer audit pattern.
- AMBER — **Pre-auth forgery** — fabricating or altering pre-authorization numbers on claim form.
- GREEN — **Annual max circumvention** — splitting treatment across calendar year to double-dip annual max.

02 Medicaid

- RED — **EPSDT medical necessity** — billing restorative services without supporting diagnostic documentation; state recovers 3× billed amount.
- RED — **Phantom billing** — billing for services not rendered; criminal exposure under Medicaid fraud statutes.
- AMBER — **Periodicity schedule non-compliance** — EPSDT requires services at federally-defined intervals; missed intervals trigger audit.

03 Cross-Coding

- HIGH — **Concurrent billing** — billing same procedure to BOTH dental AND medical insurance; constitutes double-dipping and is insurance fraud.
- MEDIUM — **Insufficient medical documentation** — CPT cross-code claim without ICD-10 medical diagnosis supporting medical necessity.
- LOW — **Wrong place of service code** — dental office billed as POS 11 (office) when CPT requires POS 22 (on-campus outpatient hospital).

04 Membership Plans

- RED — **Insurance language in marketing** — using terms like "coverage," "deductible," "claim," "benefit" implies insurance and triggers state insurance commissioner review.
- AMBER — **Auto-renewal without consent** — auto-charging credit cards without explicit HIPAA-compliant consent; CFPB complaint risk.
- LOW — **Refund policy ambiguity** — unclear refund terms for mid-year cancellation; consumer protection violation.

Regulatory trend: State dental board disciplinary actions increased **18%** in 2024 over 2023; Medicaid False Claims Act recoveries from dental practices exceeded **$42M**.

CLOSING · KEY TAKEAWAYS

Three Actions to Capture Dental Revenue

For dental practice owners and office managers leading the next 90 days.

/01

Renegotiate top 2 PPO fee schedules

Pull your top 4 PPO plans by claim volume. Compare in-network rates to regional benchmarks (Aethera provides benchmark data). Renegotiate the bottom 2 plans — typical uplift: **8–12%** on renegotiated revenue. One-day exercise with **$20–40K annual impact**.

/02

Stand up a cross-coding workflow

Identify OSA-suspect patients (STOP-BANG screening at hygiene visits). Train front desk to verify medical insurance before scheduling oral appliance therapy. Convert **D9940 night guards to E0486 medical billing**. **~$800/patient uplift**.

/03

Launch in-house membership plan

Identify uninsured patient panel (typically 20–30% of active patients). Set annual fee **$300–$500**. Use HIPAA-compliant membership platform (not just spreadsheets). Target **20% enrollment** in year 1 — adds $30–75K/year of recurring revenue with zero claims overhead.

Questions & Discussion
Optimizing Dental Revenue Across PPO, Medicaid, Cross-Coding & Membership

support@aetherahealthcare.com
aetherahealthcare.com
+1 (863) 694-0325