Why AR90+ Is A Hidden Risk For DSO Valuations

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Today, DSOs' finance executives are juggling cash flow optimization and revenue integrity against rising payer complexity, growing debt costs, and intense investor scrutiny. Staying ahead can feel like a constant game of catch-up.

One area where finance executives can leap ahead is by analyzing and improving AR90+.

Many of the DSOs that come to us show AR90+ at 35% of all accounts, a cash flow killer. Our recent webinar goes into depth on how it occurs. Ideally, AR90+ should be no higher than 15%. Persistent delays in collecting receivables may force the organization to rely on external financing, inflate operating costs, and impair both working capital and strategic flexibility.

When a DSO's finance department lowers 90+ day accounts receivable, the organization sees improved liquidity, reduced bad debt risk, higher EBITDA, and enhanced overall valuation. Faster collections mean more available cash for operations and growth, stronger profitability KPIs, better lender and investor confidence, and less wasted administrative effort. Here, we cover how you can achieve these goals when you attack AR90+.

What DSOs Risk with High AR90+

The first step in controlling AR90+ is acknowledging--and sharing--that it's a problem. High AR90+ can weaken the financial stability of a DSO for several reasons.

Lower Valuation

The common goal everyone in the DSO strives for is maximum valuation. Valuation is dependent on EBITDA. When large accounts receivable amounts make EBITDA appear higher than it actually is, organizations risk disappointing or even misleading potential investors and buyers. If receivables result in write-offs, EBITDA decreases.

The good news is that the DSO with $1,000,000 that can move even 10% of its AR90+ accounts to AR60+ buckets, and 10% of AR60+ accounts to AR30+ buckets improves cash flow by $48,000. (Get a detailed explanation here.) DSOs with revenues in the multimillions stand to improve cash flow in the hundreds of thousands. That's real money that can be used for location growth.

Any finance executive who directly boosts liquidity, profitability, and enterprise value while reducing bad debt and risk exposure is a valued asset. Here, you can review strategies for addressing AR90+ so that you can strengthen valuation with repeatable, data-driven processes that prevent claims from aging into AR90+ in the first place.

Revenue Cycle Weakness

AR90+ (accounts receivable aged more than 90 days) often represents the hardest-to-collect revenue. You don't want to signal weak revenue cycle management, weak collection processes, or systemic workflow bottlenecks. Investors, buyers, and lenders are watching these issues.

In fact, dental practice purchase advisors recommend using accounts receivable to evaluate a practice's health. The organization's ability to attract investors, secure competitive acquisition offers, and support strategic growth initiatives depends on it.

High AR90+ Means Finance Must Act Now

Finance executives in DSOs must treat AR90+ as an urgent priority.

To quickly move aged accounts toward resolution and cash collection, follow these strategies:

Use AI-Powered Claims Management

Given the RCM staffing shortage, one of the fastest ways finance teams can start collecting on AR90+ is by unleashing automation and AI. Automated dental claims management software centralizes claim status, automates payer follow-ups, and pulls explanation of benefits (EOBs) and electronic remittance advice (ERA) directly from payers. Claims management software companies make their money by delivering faster reimbursements, fewer write-offs, and better overall AR performance than staff can provide.

The software handles follow-ups by pulling EOBs and ERAs directly, freeing up staff to resolve exceptions and address aging claims more efficiently.

In addition to claims management, some RCM software companies also provide AI-powered dental claims call follow-up, which utilizes automated dialing platforms to conduct calls to payers. When the average staff wait time on hold is 14 minutes each, according to CAQH's Core Report, conducting this work via technology liberates staff for higher-value work. Technology

minimizes manual effort and ensures overdue accounts don't slip through the cracks.

The revenue cycle management analytics embedded in claims management software monitor and drive team productivity. Workflow analytics reveal individual staff performance on aged claims and realign responsibilities to those who excel at resolving complex or persistent AR90+ claims.

Address AR90+ Right Now with Staff

DSO finance teams determined to make honest revenue from aging AR have to take steps immediately. If using staff is the most immediate option, you can take these steps today.

Prioritize Claims by Aging

Segment AR by aging buckets and focus efforts on the oldest claims first—before they become uncollectible—ensuring high-impact, timely follow-up.

Audit and Clean Documentation

Review denied or outstanding AR90+ claims for missing attachments or inaccurate coding. Correct errors and resubmit claims promptly, using platform data to identify recurring root causes and train staff accordingly.

Go Hard with Payers

It's easy to recommend that building dedicated contact lists and escalation protocols for stalling payers is a best practice. Getting payers to cooperate is another story.

DSO finance teams get what they need from payers by escalating claims through payer supervisor hierarchies. You need to persistently document every outreach and denial for leverage, initiate formal disputes and appeals, and use contractual and regulatory language to pressure timely resolution and payment.

DSOs can initiate formal disputes and appeals by carefully reviewing EOBs and ERAs to understand the reason for denial, gathering detailed supporting documentation (such as clinical notes, x-rays, insurance breakdowns, and correspondence), and submitting a written request for reconsideration with all required evidence directly to the payer's designated appeals department.

If the initial appeal is denied, DSOs should follow the payer's outlined multi-level appeals process, using contract terms and keeping detailed records at each stage to ensure compliance and improve the chances of resolution.

Share these scripts with your team to give them confidence when interacting with payer reps:

Here are example scripts DSO finance teams can use to collect aging accounts from payers and patients:

- "Hello, this is [Name] from [Practice/DSO]. We're following up on claim number [Claim ID], which is now over 90 days outstanding. Can you provide an updated status and a projected payment date? If there are any issues holding up payment, please let us know so we can resolve them immediately."
- "We have previously submitted all required documentation for claim [Claim ID] and have not received payment or an update. Per our contract terms, the reimbursement window has passed. If payment is not processed within the next five business days, we are prepared to escalate this issue under the plan's appeals and disputes process."

Share these scripts with staff looking to collect from patients:

- "Hello, this is [Name] from [Provider Name]. I'm calling to remind you about an outstanding balance for your visit on [Date]. We want to help you resolve this quickly—can we process your payment today over the phone?"
- "Ms. X, we haven't received your payment of $[Amount], which was due on [Date]. If you have any questions about your statement, please let us know. We can help arrange payment or provide you with online payment options."
- "Hi [Patient's Name], you have a payment due for [Service/Visit Date]. To avoid late fees, please make your payment here [Payment Link]. Let us know if you need any assistance—we're here to help."

Consistent, polite, and clear follow-up is key to improving collection rates with both payers and patients, and scripts should be adapted as needed for each situation.

In the most challenging cases, DSOs must resort to engaging legal counsel, state insurance commissioners, or payer-provider ombudsman services when standard escalation fails and high-dollar claims are involved. A comprehensive contact list for state insurance commissioners nationwide is maintained by the National Association of Insurance Commissioners (NAIC).

Set Up Automated Alerts and Dashboards

Real-time dashboards keep finance leaders aware of AR trends and prompt quick action as soon as claims approach aging thresholds, preventing further buildup.

Benchmark and Track Outcomes

Establish AR90+ reduction as a core KPI and celebrate improved metrics, while continuously refining internal processes and technology for better results.

With the right mix of process discipline and actionable analytics, DSO finance professionals can transform AR90+ from a chronic pain point into a consistent source of accelerated cash flow and operational value.

Root Causes of AR90+ & How To Address Them

Staff-driven tactics can deliver immediate results, but lasting AR reduction relies on understanding why claims age in the first place. The next section unpacks the most common operational reasons accounts slip past 90 days, along with proven strategies that finance teams can apply to fix problems at the source and keep AR under control.

Complicated and Non-Standardized Payer Policies

Practices frequently submit claims without being fully current on all payer nuances, leading to denials and requests for additional information that slow down the reimbursement process.

Address this issue by:

- Staying current on every payer's frequent policy changes using automated payer alerts, policy update services, or

subscribing to payer-specific newsletters.
- Developing and maintaining an internal library of payer guidelines accessible to all billing and revenue cycle staff.
- Training teams regularly on policy changes and using software to flag codes or treatments prone to denial before claims submission

Documentation and Coding Errors

Incorrect, incomplete, or mismatched patient data, treatment codes, or attachments are a leading reason claims are denied or require rework. Missing x-rays or clinical notes that don't correspond to a billed code will lead to payer delays or outright rejection.

Address this issue by:

- Utilizing automated claim scrubbing solutions and billing platforms that detect common errors prior to submission.
- Instituting standardized documentation processes and checklists so every claim goes out with the correct attachments and notes.
- Investing in regular coding and compliance training, and reviewing monthly denial reports to address repeat documentation problems quickly.

Delayed or Insufficient Insurance Verification

Failure to proactively verify a patient's insurance status and benefits before the appointment leads to surprises at the time of claim filing, such as ineligibility or uncovered procedures, resulting in denied or pended claims that age into AR90+.

Address this issue by:

- Verifying insurance benefits electronically before every patient visit, including coverage/planned procedures and eligibility dates.
- Implementing automated verification tools that sync with payers and flag potential eligibility issues well before appointments.
- Training staff to re-verify coverage on the day of service, especially for patients with recent job or insurance changes.

Slow or Inconsistent Payer Processing

Even when claims are clean, payers may process dental claims slowly or inconsistently, especially if additional clinical review is required or if the claim is randomly selected for audit. This introduces unpredictable payment delays.

Address this issue by:

- Tracking payers' average processing timelines in your RCM platform and proactively following up with payers once claims reach their typical payment window.
- Using electronic data interchange (EDI) for real-time claim submission and status updates.
- Building relationships with payer reps and escalating claims stuck in review or audit, leveraging payer portals for rapid communication.

Frequent Changes to Coverage and Reimbursement

Payers may change frequency limits, downgrade policies, or adjust code restrictions—sometimes without clear notification—resulting in legitimate claims moving into AR90+ until resolved.

Address this issue by:

- Appointing a team member or vendor to monitor payer bulletins and updates, communicating changes organization-wide.
- Scheduling quarterly reviews of top denied codes and procedures to preempt further issues from coverage changes.
- Setting up real-time alerts in billing software whenever calendar frequency or code downgrades shift for any payer.

Denials and Appeals Management Gaps

Practices may not have an organized process for aggressively following up on denials, correcting and resubmitting claims, or appealing improperly denied services. When denied claims are not worked quickly, they accumulate in AR90+.

Address this issue by:

- Implementing a denial management workflow to classify, prioritize, and track denied claims from initial follow-up through resolution and appeals.
- Dedicating staff or outsourcing denial and appeal tasks to specialized teams that focus on overturning payer decisions.
- Reviewing denied claims weekly to spot trends and update clinical documentation, coding, or front-office procedures as needed.

Lack of Timely Follow-Up

Insufficient or sporadic claim follow-up (often caused by RCM staff instability) prevents early resolution of simple payer issues, allowing unresolved balances to age out of the "actionable" window and turning them into major collections headaches.

Address this issue by:

- Scheduling daily AR worklists so staff act on denied or pended claims within hours—not weeks—of aging into AR, refining follow-up cadence by payer and claim type.
- Using automated reminders, dashboards, and AR reports to keep follow-up tasks visible and urgent for billing teams.
- Implementing a system of escalation for claims that reach 45 or 60 days in AR, before they become AR90+, including payer-level contacts and appeal initiation.

By deploying these recommendations for each issue, DSOs and dental practices can dramatically reduce AR90+, minimize denied claims, and build a more resilient, profitable revenue cycle.

InsideDesk Ensures DSO Finance Teams Leverage AR90+ for Better Valuation

Bringing in a meaningful portion of the AR90+ not only means immediate cash relief but also signals control, discipline, and the

potential to boost valuations, negotiate better lending terms, and respond confidently to payer or market disruption. These are all essential priorities for today's finance executives and DSO leadership.

InsideDesk revolutionizes dental revenue cycle management for DSOs, seamlessly automating claims processing, denial follow-up, and AR tracking, while equipping finance teams with advanced analytics for quick, data-driven decisions. The InsideAssist solution removes bottlenecks by automating manual claims and EOB retrieval, allowing teams to zero in on resolving unpaid accounts and streamlining dental collections workflows. With InsideIQ, leaders unlock powerful AR analytics and benchmarking, comprehensive reporting, and deep revenue cycle transparency—making it easy to monitor financial health, identify process gaps, and target collections opportunities company-wide for higher net revenue and smarter organizational strategies.

Schedule a demo to see how InsideDesk can help manage and collect your DSO 90+ day AR quickly and consistently.

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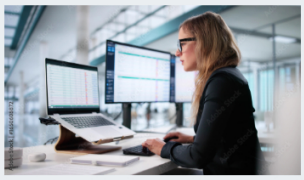

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