

wisdom 

Tricks my biller taught me

75 dental billing tips
from the experts who
work claims every day.



Good billers have tricks, great practices know them. So we hunted down 75 of the best billing hacks you can only learn by doing the work.

We went straight to the source: experienced revenue specialists on the Wisdom team with 30+ years of dental experience and asked for the stuff they usually keep in their back pocket.

We pulled all of it into one place so your team can skip a few headaches and borrow a few years of billing experience along the way.

Consider this your shortcut to the tricks that usually take years to pick up.

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Quick-hit advice from billers who've seen it all.

“Dental Billing has a lot of conditions and is not for the faint of heart. It takes curiosity, determination, and sometimes research to get things moving in the right direction.”

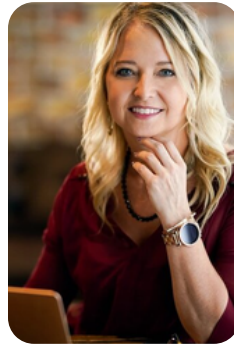
— Sheridan Dufner | Wisdom Operations Manager | 20 years dental experience

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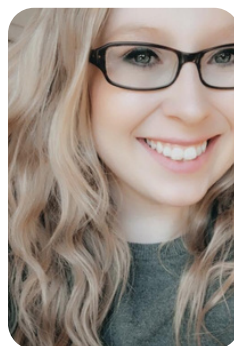
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What Experienced Billers Check First

The tricks that start before the patient sits down

Gather correct insurance information and ensure it stays up-to-date.

The beginning preparation will lead to a positive end result when it comes to receiving payment from insurance, treatment planning, patient payments, conversations to explain to the patient why their insurance wouldn't pay, etc.

Having a starting process helps in any and every aspect.”

— Sarah Wright



“You must verify coverage at every visit. Plans change mid-year, employers switch carriers, and nobody tells the office. Don't let inactive insurance coverage surprise you after the patient leaves the office.”

“Always check frequency history and the fine print and the last date of service on the codes being scheduled. A newer biller might see "active coverage" and stop. That's how you end up doing a crown the plan won't pay for for another eleven months.”

“Get the patient and subscriber details exactly right to avoid larger problems down the line.”

“Always ask about secondary coverage and confirm COB. Sorting out which plan pays first is much easier before the claim starts bouncing between payers.:

“Put verified information where the whole team can use it. A detail sitting on a form, note, or sticky note doesn't help the person estimating treatment or submitting the claim later.”

PART 1: BEFORE THE CHAIR

“If you have a patient coming in and you know they either have a balance or will have a balance, tell them so they are prepared to pay at time of service.”

EXPERT HACK

Ask insurance companies if they pay on the UCR or an allowed amount.

“Give verification a clear owner: When no one is responsible, no one is accountable.”

“If the same verification error keeps happening, fix the process, not just the patient. Recurring demographic, plan, or COB mistakes are telling you something about the workflow.”

EXPERT HACK

Get the full breakdown, you need it all! Don't end up with unnecessary write-offs because it wasn't all gathered.

What your biller wishes was in the clinical note

Document it like someone else has to defend it

Billing begins in the back office.

A claim cannot be paid for without detailed clinical documentation and the right attachments (x-rays, photos, perio chart, etc).

The front office is limited to how well the documentation is and nothing can be put on the claim that is not already in the clinical notes. The front office team cannot diagnose!”

— Ashley Bond



“Document in detail!”

EXPERT DOCUMENTATION HACKS

1. For SRP claims: take vertical bitewings with your full mouth series to show bone level AND make sure x-rays are within 2 years.
2. For any hygiene procedure more than a prophylaxis: take IO pics of bleeding, calculus, or bulbous tissue.
3. Document symptoms and pain.
4. For crowns take IO pics before, during, and after.
5. If you are doing a build-up, put in your clinical notes how much tooth structure was removed.

PART 2: AT THE CHAIR

“Use the SOAP method (Subjective, Objective, Assessment, Plan) to give your notes a consistent structure, and make sure the clinical story has all the pieces.”

“Make the tooth, area, and surfaces unmistakable. Small ambiguities in the clinical record can become much bigger questions once the claim leaves the practice.”

“Take more images - pictures are worth 1000 words!”

“Use templates as prompts—not substitutes for judgment. A note that could belong to any patient may be fast to write, but it may not explain this patient’s treatment clearly enough.”

“Write the note so someone who wasn’t in the room could understand the case. If your billing team has to come back and ask what happened, there may be a gap in the record.”

“Dental billing starts with good clinical notes.”

Don't hit send yet!

The clean-claim tricks experienced billers check first.

“Never blindly submit a claim.

Don't hit send without going line by line through every procedure code to confirm it has the right attachments and clinical notes. Every code has its own recipe.

Roughly 73% of denied claims are denied because the office didn't send the right information the first time.”

“Don't confuse “submitted” with “clean.” Getting a claim out quickly doesn't help if missing or inconsistent information sends it right back.”

“Make sure the claim matches the clinical record. The procedure, tooth or area, and supporting documentation should all tell the same story.”

“Keep a list of what insurance requires for individual procedures that's out of the norm. It's better to submit claims with everything that's required the first time around.”

“Have a system for the clinical team to make sure they get clinical notes written up the same day to prevent delays in claim submission.”

“Never assume an attachment went through. Selected is not the same as transmitted.”

“Save the attachment reference number. NEA/DCN or other applicable identifiers make it much easier to prove what was sent during follow-up.”

“Always check your claim rejections, keeping your claim submissions clean will ensure you get quicker reimbursement”

“Run an unsent or unprocessed claims report. Completed treatment can't become revenue if the claim never actually leaves the practice.”

REMEMBER:

“Clean claims get paid faster, but they do require constant follow up”



— Tami Raymond,

Submitted is NOT the finish line

The follow-up tricks that keep claims from turning into old AR.

“Work insurance claims proactively, not reactively.

Every outstanding claim should have a clear status, documented follow-up, and next step.

If money is owed, you should always know why and what happens next.”



—Erin Stinson

“Don’t submit and forget. A claim still needs an owner after it leaves the practice.”

“Always check your claim rejections, keeping your claim submissions clean will ensure you get quicker reimbursement”

“I always check the claim history and notes before taking action. A quick review can reveal previous follow-ups, denials, corrections, or payer instructions that prevent duplicate work and help determine the right next step.”

“Write your NEA number and all documentation (what they needed, how you sent it, when to expect payment, REF #) in your insurance aging status notes. Save yourself from having to search and keep your notes organized.”

“Work aging by priority, not just by age. Consider dollar amount, age, and urgency within each bucket.”

“Don’t wait until 90+ to start caring. Work open claims consistently before they become old AR.”

PART 4: AFTER SUBMISSION

“Follow up on a consistent rhythm. No claim should sit untouched simply because it hasn’t resurfaced.”

“Use the fastest reliable route to an answer. Use portals for straightforward status checks and calls when the claim needs more digging.”

“Don’t just resubmit it – investigate. Find out exactly why it’s stuck. A quick call to the payer can often uncover a missing attachment, processing error, or additional information needed to get the claim moving again.”

“Opt out of virtual credit cards. You often are paying over 3% just to get paid. That’s often the amount it would cost to get help with outsourcing.”

“Ask for the highest level supervisor that is state-side if you need help getting a stubborn claim fixed and you’ve already resubmitted information. Make sure to use previous reference numbers and detailed claim status notes. It takes a phone call and perseverance.”

EXPERT ADVICE

“Be persistent. I will call every day, make besties with the reps, submit information through a different avenue. DO NOT GIVE UP.”



— Sheridan Dufner

Denied? Now what?

How experts turn a denial into a practical next step

“Always appeal a denial before you send the patient a statement or adjust it off.

If it's an allowable code, it's worth fighting for. Adjusting is not a billing strategy.”



“A denial isn't automatically a write-off.”

“Never blindly trust the EOB. Always verify the validity of what it is telling you.”

“Know whether you're fixing it or fighting it.”

“Don't resubmit the same thing the same way twice.”

“Know when to escalate! Save yourself the delay and if you need to make an appeal, call the insurance directly and gather all of the information needed to be successful in that appeal.”

“Use the CDT code definition in your appeals to prove why the procedure was necessary for the health of the patient.”

“In your appeal, use the clinical note diagnoses verbatim to show why the treatment was necessary.”

“Sent doesn't mean received. Confirm the appeal actually made it into review.”

“Document every appeal touch. Dates, reps, reference numbers, and next steps matter.”

“Don't let a denial disappear at posting. Flag nonpayment before it gets adjusted away.”

“Patterns are clues. Repeated denials usually point to a workflow worth fixing. Use every denial to improve the next claim.”

REMEMBER:

Not every unpaid service is appealable—and not every denial is final.

Post it like a pro

The posting tricks that catch what others miss

“Payment posting deserves your most experienced biller and quiet, uninterrupted time (that's exactly why I believe in outsourcing it.)

Posting is where you catch the mistaken EOB, the tricky adjustment (EOBs are written to get you to over-adjust), and the appeal that should have been fought.

Attention to detail is everything. I've seen thousands of dollars go uncollected because this one position was never properly trained, including in my own father's practice.”

“Posting isn't data entry. It's reconciliation.”

“Read the whole EOB. Payment amount, adjustments, patient responsibility, and remarks all matter.”

“A \$0 payment still needs an answer.”

“Never assume a claim was processed correctly. If it looks wrong, good chance it is.”

“Watch your adjustment categories. Repeated write-offs can hide posting errors or claims that were never fully worked.”

“Common small mistake: Not posting by line item on the claim.”

“Have detailed posting notes so every single time a patient has a balance the team knows why and can explain with confidence.”

“Update payment tables as real payments come in.”

“Don't let a new patient balance sit.”

“Make the ask specific. ‘Your estimated portion is \$X. How would you like to take care of that?’”

“Make it easy to pay. Keep contact information current and remove unnecessary friction from statements and payment options.”

EXPERT HACK:

A surprise bill is when you lose a patient's trust. The system has to work full circle by updating payment tables and delivering proper estimated treatment plans. Set the expectation to collect at time of service but say more than once that this is an estimation.

How to know when something is off

What the billing pros watch behind the scenes

“Every role in a practice is vital to a strong office, and clearly defining and maintaining each role separately goes a long way.

When you outsource insurance verification and claims processing, these roles can then be combined into one position because we provide all the data to support them.

Otherwise, there are simply too many moving parts for one person to navigate for every patient at the level each practice and patient deserves.”

— Brianna Simone



“Production is not the same as money in the bank.”

“Know your collection percentage—but don’t stop there. One good-looking number can hide problems elsewhere.”

“Always dive deep into your adjustments/write-offs. Your collection % may look great, but money can be walking right out the door if this isn’t closely followed.”

“Watch your 90+ insurance AR. Old claims are a sign that something is getting stuck.”

“If your insurance aging looks good, but your patient aging is high check your systems. Make sure claims aren’t being closed and/or insurance verification errors are causing patient portions to be significantly off. “

“Don’t forget the claims that never made it out. Unsent or unresolved claims can hide outside your aging report.”

“Use technology to surface the work—not replace judgment:

Never assume. When it comes to dental billing, process, coverages, codes, laws, all of these change regularly. It is always the best practice to check and then double check your information or data with a second source.”

PART 7: ZOOM OUT

“Review the same reports on the same rhythm. Trends are easier to spot when the process is consistent.”

“Notice your trends and do something about it!

It's not always a singular report. It's more of a IF I see something, I say something. If I'm consistently getting frequency denials or build up denials - I educate the client so that we start seeing those less frequently. I want to make a change as quickly as possible so that we can have immediate revenue.”

“It takes the ENTIRE team to make it work!! From intake, to proper coding, to clinical documentation.”

“Build routines that survive vacations and turnover. If one person has to remember everything, you don't have a system yet.”

“Fix the system, not just the symptom.”

“Communication back to front and front to back (and to us as your billing team) is essential for a team to work through crossroads together.”

— Sarah Wright

EXPERT ADVICE

“Our most successful clients are the ones where the office team and Wisdom team have taken the time to understand what motivates each other, they communicate openly and regularly, and genuinely enjoy working together. That's when it really works!”



— Brianna Simone

Hacks everyone agrees on:

Quick-hit advice from the billers who've seen it all:

Always:

"Appeal a denial before you send the patient a statement or adjust it off. If it's an allowable code, it's worth fighting for. Adjusting is not a billing strategy."

"Put your dental billing in the hands of someone who truly understands how to support the process and cares enough to follow through!"

"Document everything!"

"Notice your trends and do something about it!"

"DOCUMENT IN DETAIL! Documentation saves so much of a headache in the future, from x-rays, to clinical notes, to conversations with patients and carriers."

"Bill for what you do."

Never:

"Blindly submit a claim. Don't hit send without going line by line through every procedure code to confirm it has the right attachments and clinical notes. Every code has its own recipe. Roughly 73% of denied claims are denied because the office didn't send the right information the first time."

"Assume a claim was processed correctly. If it looks wrong, good chance it is."

"Blindly trust the EOB. Always verify the validity of what it is telling you."

"We never want to assume the insurance carrier reps are going to be consistent, never assume the patient is going to remember every conversation with multiple team members, never assume that an item was discussed that's not notated."

"Cut corners."



One last piece of advice...

Give your team the support to stay ahead with Wisdom.

Wisdom combines experienced billing experts, smart technology, and consistent processes to help keep revenue moving and take more of the billing burden off your team.

With Wisdom you get:

- ✓ Clean Claims
- ✓ Insurance Verification
- ✓ Denials and Rejections
- ✓ Aging Reports
- ✓ Patient Billing

Ready to see where Wisdom can help?

Get Started Today

