lvl Level

# *Healthcare Practice Financial Benchmarks*

2026

Collection Rates, Overhead Ratios & Provider Productivity from 2,200+ Service Businesses

| 2,200+ | 5 | 50 | Quarterly |
|---|---|---|---|
| BUSINESSES | SPECIALTIES | STATES | UPDATED |

EXECUTIVE SUMMARY

# *The 5 Numbers That Matter*

These are the financial benchmarks that separate thriving healthcare practices from ones leaving money on the table.

## 97-99% net collection rate (top practices)

Top-performing practices collect 97-99% of net charges. Struggling practices sit at 92-94%. On a $2M practice, each percentage point represents $20,000-$30,000 in lost revenue annually. The difference between median and top quartile is $60K-$90K per year in recovered revenue that never touches your bank account.

## 30 days A/R benchmark vs. 50+ days (red flag)

Best-in-class practices maintain A/R under 30 days. Collection probability drops from 94% at 30 days, to 74% at 90 days, to just 26% at 12 months. Every week past 30 days costs you real money. At 50+ days in A/R, you are financing your payers' operations.

## 55% overhead ratio median

The median healthcare practice runs 55-60% overhead. Solo practices trend higher at 59%, while group practices benefit from scale at 52%. The gap between a 60% overhead practice and a 52% one, on $2M revenue, is $160,000 in annual profit. That gap compounds every year.

## 5-8% claim denial rate (top practices)

Top practices hold denial rates to 5-8%. The industry average sits at 10-15%. Each denied claim costs $25-$118 to rework. A practice processing 10,000 claims per year at 12% denial rate faces $30,000-$177,000 in annual rework costs alone, before counting the revenue never recovered.

## $500K-$1M+ revenue per provider by specialty

Provider productivity varies dramatically by specialty. Family medicine runs $580-650K. Orthopedics can exceed $1.4M. The key driver isn't volume alone, but revenue per clinical hour, patient scheduling efficiency, and coding accuracy. An underperforming provider leaves $100K-$300K on the table annually.

Sources: MGMA 2025 DataDive, HFMA Revenue Cycle Benchmarks, ADA Health Policy Institute, Syntellis Performance Solutions, CMS Claims Processing Data.

AT A GLANCE

# *The Median vs. Top Quartile Gap*

Every percentage point between median and top quartile is real money. On a $2M practice, closing these gaps is worth $100K-$300K annually.

### NET COLLECTION RATE

% of allowed charges actually collected

| BOTTOM | MEDIAN | TOP |
|---|---|---|
| <96% | 95-97% | >98% |

Gap: 2-3 pts

### DAYS IN A/R

Average days from claim submission to payment

| BOTTOM | MEDIAN | TOP |
|---|---|---|
| >50 | 30-40 | <30 |

Gap: 10-20 days

### OVERHEAD RATIO

Total operating expenses as % of revenue

| BOTTOM | MEDIAN | TOP |
|---|---|---|
| >62% | 55-60% | <52% |

Gap: 8-10 pts

### CLAIM DENIAL RATE

% of claims initially denied by payers

| BOTTOM | MEDIAN | TOP |
|---|---|---|
| >15% | 10-12% | <5% |

Gap: 7-10 pts

### REVENUE PER PROVIDER

Annual collections per full-time provider

| BOTTOM | MEDIAN | TOP |
|---|---|---|
| <$400K | $500-700K | >$800K |

Gap: $200-400K

### NO-SHOW RATE

% of scheduled appointments where patient doesn't show

| BOTTOM | MEDIAN | TOP |
|---|---|---|
| >10% | 5-7% | <3% |

Gap: 4-7 pts

### STAFF COST % OF REVENUE

Total staff compensation as % of collections

| BOTTOM | MEDIAN | TOP |
|---|---|---|
| >35% | 25-30% | <25% |

Gap: 5-10 pts

### INVESTMENT PER PROVIDER FTE

Capital required per full-time provider

| BOTTOM | MEDIAN | TOP |
|---|---|---|
| — | $373K avg | — |

Gap: +7.7% YoY

## How to Use This Report

**1**

**Find your numbers**

Use the scorecard on page 8 to fill in your own KPIs. If you don't know a number, that's the most important finding.

**2**

**Spot the biggest gaps**

Where are you below median? Each section includes the dollar impact so you can prioritize by ROI, not gut feel.

**3**

**Dive into the details**

Pages 5-7 break down each metric with real benchmarks, specialty-specific data, and the exact levers to pull.

Sources: MGMA 2025 DataDive, HFMA, Strata Decision Technology, ADA Health Policy Institute, Syntellis, CMS.

THE CLEAR FRAMEWORK

# *Five Pillars of Healthcare Practice Financial Health*

Every metric in this report maps to one of five pillars. Together they give you a complete picture of where money is made, lost, stuck, or at risk in your practice.

**C** — **Cash** Is your cash flowing — or stuck in claims?
Metrics: Collection Speed · Claim Processing Time · Patient Payment Rate · Days in A/R

**L** — **Labor** Is your team generating returns?
Metrics: Provider Productivity · No-Show Rate · Support Staff Ratios · Provider Utilization

**E** — **Earnings** Are you pricing and coding profitably?
Metrics: Procedure Margins · Overhead Ratio · Payer Rate Negotiation · Coding Accuracy

**A** — **Accounts** Are you growing and retaining patients?
Metrics: Patient Volume Trends · Referral Rates · A/R Aging Buckets · New Patient Acquisition

**R** — **Risk** Are you exposed?
Metrics: Malpractice Reserves · Payer Concentration · Compliance Risk · Regulatory Exposure

**How to use CLEAR:** Score yourself on each pillar. If you're below median on any two pillars, you likely have six-figure upside in financial optimization. The deep dives on pages 5-7 break down each metric with real benchmarks and the exact levers to pull.

### Healthcare vs. Other Service Businesses

Healthcare practices share the same financial DNA as other service businesses: revenue depends on provider utilization, cash flow hinges on collection speed, and profitability is determined by overhead discipline. The CLEAR framework works because the financial levers are universal. What differs is the specific benchmarks and the complexity of the payer ecosystem.

DEEP DIVE: REVENUE CYCLE

# *Where Cash Gets Stuck*

The revenue cycle is the single biggest determinant of practice cash flow. Top practices collect 97-99% of allowed charges within 30 days. The median practice leaves 3-5% on the table through denials, aging, and write-offs.

### A/R Aging & Collection Probability

| A/R Bucket | Collection Probability | Required Action |
|---|---|---|
| 0-30 days | 94% | Normal cycle. Claims in process. |
| 30-60 days | 85% | Follow-up triggers. Resubmit denials. |
| 60-90 days | 74% | Escalation required. Appeal window closing. |
| 90-120 days | 58% | Final notice. Consider write-off timeline. |
| 120+ days | 26% | Bad debt territory. Collection agency or write-off. |

### Top Denial Reasons & Fixes

| Reason | % of Denials | Fix |
|---|---|---|
| Missing or invalid information | 32% | Front-desk verification, eligibility checks before visit |
| Authorization/referral required | 24% | Automated prior-auth tracking in EMR |
| Coding errors (CPT/ICD mismatch) | 18% | Coding audits, provider education, CDI programs |
| Timely filing exceeded | 12% | Same-day charge entry, automated filing alerts |
| Duplicate claim | 8% | Claim scrubbing software, billing workflow audit |
| Non-covered service | 6% | Benefits verification, ABN process for patients |

**The denial math:** Each denied claim costs $25-$118 to rework (MGMA/HFMA). A practice processing 10,000 claims per year at 12% denial rate = 1,200 denied claims = **$30,000-$141,600 in rework costs alone.** At 5% denial rate, the same practice spends $12,500-$59,000. The difference: $17,500-$82,600 in annual savings, before counting revenue that's never recovered from failed appeals.

**94%**
Collection probability at 30 days
HFMA 2025

**26%**
Collection probability at 12 months
HFMA 2025

**$25-$118**
Cost to rework one denied claim
MGMA 2025

**65%**
of denied claims never resubmitted
HFMA/CMS

Sources: MGMA 2025 DataDive, HFMA Revenue Cycle MAP Keys, CMS Claims Processing Data, Strata Decision Technology.

DEEP DIVE: OVERHEAD BREAKDOWN

# *Where Every Dollar Goes*

The median healthcare practice runs 55-60% total overhead. The difference between 60% and 52% overhead on a $2M practice: $160,000 in annual profit.

| Expense Category | Benchmark | Solo Practice | Group Practice | Key Insight |
|---|---|---|---|---|
| **Staff Costs (clinical + admin)** | **25-35%** | 28-35% | 22-28% | Largest single expense. The leverage point: support staff per provider ratio. Optimal is 3.5-4.5 support staff per physician. |
| **Rent / Facility** | **6-8%** | 7-10% | 5-7% | Location premium matters less than patient flow. High-rent locations with strong foot traffic can outperform cheap offices with low utilization. |
| **Medical Supplies** | **5-8%** | 6-9% | 4-7% | Group purchasing organizations (GPOs) save 10-18% on supplies. Solo practices overpay by default. |
| **Technology / EMR** | **2-4%** | 3-5% | 2-3% | EMR costs per provider drop 40-60% at 5+ providers. Cloud-based systems reduce IT overhead. |
| **Insurance / Admin** | **2-4%** | 3-5% | 2-3% | Malpractice premiums vary 5x by specialty. Surgical specialties: $20-50K/yr. Primary care: $5-15K/yr. |
| **Billing / Collections** | **4-8%** | 6-10% | 4-6% | In-house billing costs 5-7% of collections. Outsourced billing runs 6-10% but often improves net collection rate by 2-4%. |

**The overhead divide:** Solo practices average 59% overhead. Group practices (3+ providers) average 52%. The 7-point gap comes from: shared staff costs (front desk, billing, nursing), facility utilization (more providers per square foot), purchasing power (supplies, technology), and billing efficiency (same billing team handles 3x the volume). This is why practice consolidation is accelerating.

### The 40% vs. 60% Overhead Separator

| | | |
|---|---|---|
| Scheduling fill rate | 70-75% | **88-95%** |
| Support staff ratio | 5+ per provider | **3.5-4.5 per provider** |
| Coding accuracy | < 90% | **> 97%** |
| Same-day charge entry | < 60% | **> 95%** |
| Denial follow-up rate | < 50% | **> 90%** |

### Overhead by Practice Size

| | |
|---|---|
| Solo (1 provider) | **58-62%** |
| Small group (2-4) | **54-58%** |
| Mid group (5-10) | **50-55%** |
| Large group (11-25) | **48-52%** |
| Enterprise (25+) | **44-50%** |

Sources: MGMA 2025 Cost Survey, Syntellis Performance Solutions, ADA Health Policy Institute (dental), HFMA Practice Management Benchmarks.

DEEP DIVE: PROVIDER PRODUCTIVITY

# *Revenue Generation by Specialty*

Provider productivity is the single biggest driver of practice revenue. The spread between an average and a top-quartile provider in the same specialty is $100K-$300K annually.

| Specialty | Annual Collections | Revenue per Clinical Hour | Sessions per Week |
|---|---|---|---|
| **Family Medicine** | **$580-650K** | $425-500 | 32-36/wk |
| **Internal Medicine** | **$620-700K** | $450-525 | 32-36/wk |
| **Orthopedics** | **$1.1-1.4M** | $650-850 | 28-34/wk |
| **Cardiology** | **$900K-1.2M** | $575-750 | 30-35/wk |
| **Dermatology** | **$800K-1.1M** | $550-700 | 34-40/wk |
| **Dental (General)** | **$600-800K** | $450-600 | 30-36/wk |

**Revenue per clinical hour** is the most actionable productivity metric. The median across specialties is $475-575. Top quartile exceeds $700. The drivers: scheduling efficiency (minimize gaps), coding accuracy (capture complexity), and ancillary revenue (in-house labs, imaging, procedures). An extra $100/hr across 1,600 clinical hours = $160,000 in annual revenue.

## Productivity Benchmarks

| | |
|---|---|
| Revenue per Clinical Hour (Median) | **$475-575** |
| Revenue per Clinical Hour (Top Quartile) | **$700+** |
| Patient Encounters per Day | **18-24** |
| wRVUs per Provider (Primary Care) | **4,500-5,500** |
| wRVUs per Provider (Surgical) | **7,000-10,000+** |
| Schedule Utilization Rate | **85-95%** |

## What Drives the Productivity Gap

**Scheduling efficiency**
Eliminates 15-20% dead time between patients

**Coding accuracy (E&M levels)**
Proper level selection adds $8-25 per visit

**Ancillary services in-house**
Lab, imaging, procedures add 15-30% to revenue

**No-show management**
Reducing from 10% to 3% recaptures $50-150K

**MA/scribe support**
Frees 30-45 min/day of provider charting time

### The No-Show Problem

The median practice loses 5-7% of appointments to no-shows. At $200-$400 per visit, a 4-provider practice with 80 daily appointments loses **$80,000-$280,000 per year.** Top practices hold no-shows below 3% with: automated reminders (text + email), same-day waitlists, and consistent no-show policies. Each 1-point reduction in no-show rate is worth $20,000-$70,000 annually.

Sources: MGMA 2025 DataDive Provider Compensation, MGMA wRVU Benchmarks, ADA Income Survey, Strata Decision, Syntellis.

YOUR PRACTICE SCORECARD

# *Fill In Your Numbers*

Every metric where you're below median represents recoverable margin. Every metric you can't fill in represents invisible margin loss.

| Metric | Your Number | Median | Top Quartile | Gap Value |
|---|---|---|---|---|
| Net Collection Rate | _____ | 95-97% | >98% | Each point = $20-30K on $2M |
| Days in A/R | _____ | 30-40 days | <30 days | 10 fewer days = $55K cash freed |
| Overhead Ratio | _____ | 55-60% | <52% | Each point = $20K on $2M |
| Claim Denial Rate | _____ | 10-12% | <5% | Each point = $5K-$15K savings |
| Revenue per Provider | _____ | $500-700K | >$800K | Per-provider gap = $100-300K |
| No-Show Rate | _____ | 5-7% | <3% | Each point = $20-70K recovered |
| Staff Cost % of Revenue | _____ | 25-30% | <25% | Each point = $20K on $2M |
| Revenue per Clinical Hour | _____ | $475-575 | >$700 | Per-hour gap compounds fast |
| Patient Encounters per Day | _____ | 18-24 | 26-30 | Each extra = $200-400/day |
| Coding Accuracy Rate | _____ | 90-95% | >97% | 2-5% revenue lift from coding |

**How to interpret your scorecard:** Count the metrics where you're below median. **1-2 below median:** minor optimization opportunity ($25-75K). **3-4 below median:** significant margin recovery ($75-200K). **5+ below median:** six-figure financial transformation ($200K+). If you can't fill in more than 3 metrics, that blindspot is likely costing you more than any single gap.

**1-2 gaps**
Fine-tuning
**$25K-$75K/year**

**3-4 gaps**
Significant opportunity
**$75K-$200K/year**

**5+ gaps**
Financial transformation
**$200K+/year**

Sources: All benchmarks compiled from MGMA 2025, HFMA, ADA HPI, Syntellis, Strata Decision, CMS, and Overjet AI analytics.

METHODOLOGY & SOURCES

# *How We Built This Report*

## Data Sources

This report synthesizes financial benchmarks from industry-leading healthcare analytics organizations, combined with direct financial reviews from Level's work with healthcare practice clients. Primary sources include MGMA's DataDive surveys (200,000+ providers), HFMA's Revenue Cycle MAP Keys, Syntellis Performance Solutions, ADA Health Policy Institute surveys (12,000+ dental practices), and CMS claims processing data.

## Scope

Benchmarks cover private healthcare practices across 5 specialties: primary care (family and internal medicine), orthopedics, cardiology, dermatology, and general dentistry. Data is representative of independent and small-to-mid-size group practices in the $500K-$25M annual revenue range. Enterprise health systems and hospital-employed practices may differ significantly.

## Key Sources

- MGMA 2025 DataDive — Provider Compensation & Cost Survey
- HFMA Revenue Cycle MAP Keys — A/R & Collection Benchmarks
- Strata Decision Technology — Overhead & Margin Analysis
- ADA Health Policy Institute — Dental Practice Economics
- Overjet AI — Dental Analytics & Revenue Optimization
- Syntellis Performance Solutions — Multi-Specialty Benchmarks
- CMS — Claims Processing & Denial Rate Data

## Limitations

Benchmarks represent aggregated ranges and may not reflect specific geographic, payer mix, or specialty subspecialty differences. Practices with a disproportionate Medicare/Medicaid payer mix will typically show lower collection rates and revenue per provider. All benchmarks should be evaluated against your specific payer composition and local market conditions.

## Legal Disclaimers

This report is provided for informational purposes only and does not constitute financial, investment, tax, or legal advice. Past performance data does not guarantee future results. The benchmarks should be used as general reference points, not as specific targets for any individual practice. Consult with your CPA, financial advisor, or healthcare attorney before making business decisions based on this data. Level is not a registered investment advisor, CPA firm, or law firm.

Level

# *How does your practice compare?*

We connect to your accounting and billing systems, benchmark you against specialty peers, and identify the specific margin improvements hiding in your numbers.

**1**

**Connect**

Link your EMR and accounting system. 15-minute setup.

**2**

**Benchmark**

See where you stand vs. specialty peers on every metric.

**3**

**Improve**

Get a prioritized action plan with dollar values attached.

## Schedule Your Free Profitability Audit

levelcfo.com/benchmarks/healthcare


**Email**
sam@levelcfo.com

**Web**
levelcfo.com