

WHITE PAPER

2026 Claim Denial Benchmarks

The latest national denial data, what a physician practice benchmark looks like, and how to measure your own rate so the comparison means something.

ABOUT THIS PAPER

Figures in this paper come from third party studies and are attributed to their sources. They describe the industry, not WeBill Health results. Several of the largest datasets are hospital data, and we label them as such.

Payers are denying fewer claims at the front door and clawing back more money later. This paper pulls together the most recent national data, separates hospital numbers from physician practice numbers, and shows you how to calculate your own denial rate the way benchmarks do.

The short version

- Across more than 2,100 hospitals and 300,000 physicians, the average initial denial rate was 11.81% in 2024 (Kodiak Solutions).
- In the first half of 2026 that rate eased to 10.63%, but payer takebacks after payment rose to 1.57% of net revenue. Denials are moving from the front door to the back office.
- For physician practices, MGMA puts the first submission denial rate that most practices see at 7% to 8%, and says well run practices can get under 5%.
- The share of providers reporting denial rates of 10% or more rose from 30% in 2022 to 38% in 2024 and 41% in 2025 (Experian Health).
- Most denials start with data the practice controls: missing or inaccurate data (50%), authorizations (35%) and registration errors (32%) led Experian's 2025 list.

1. The national picture

The largest current dataset comes from Kodiak Solutions, which tracks claims from more than 2,100 hospitals and 300,000 physicians. Its 2024 average initial denial rate was 11.81%. Kodiak also reports that payers ultimately pay about 90% of claims, which means most denied money is recoverable if someone chases it.

The first half of 2026 looks better on the surface. Kodiak's overall initial denial rate fell to 10.63% from 12.00% a year earlier, and traditional Medicare fell to 4.21%. The catch is takebacks: money recouped after a claim was paid rose to 1.57% of net revenue, up from 1.38%. A lower denial rate does not mean payers are paying more. It can mean they are paying first and recovering later.

Payer segment	Initial denial rate	Source
All payers, 2024	11.81%	Kodiak Solutions, May 2025
All payers, first half 2026	10.63%	Kodiak Solutions, September 2026
Traditional Medicare, first half 2026	4.21%	Kodiak Solutions, September 2026
ACA marketplace plans, in network, 2024	19% (range 3% to 36% by insurer)	KFF, March 2026
Medicare Advantage, first submission (2019 claims)	17.7%	Health Affairs, June 2025

Hospital data or practice data?

Much of the published denial data comes from hospitals, where inpatient authorization and medical necessity dominate. Physician and behavioral health practices see a different mix, weighted toward eligibility, coding and modifier errors. When you compare yourself to a benchmark, make sure it is a practice benchmark.

2. The benchmark for a physician practice

MGMA's July 2026 data puts the typical first submission denial rate for medical practices at 7% to 8%, a figure that has held for four years, and notes that practices can reach under 5%. The KPI framework MGMA published with Conifer in 2023 uses the same targets.

KPI	Industry benchmark
Initial denial rate	5% to 10% typical, under 5% best practice
Clean claim rate	98%
Days in accounts receivable	30 to 40
A/R older than 90 days	under 10%
Net collection rate	95% minimum, 97% to 99% optimal

The trend is not reassuring. Experian Health found that the share of providers with denial rates of 10% or higher rose from 30% in 2022 to 38% in 2024 and 41% in 2025. MGMA's July 2026 poll found days in A/R flat for 43% of practices and higher for 32%, and 48% of practice leaders named denials and appeals as their largest source of revenue leakage.

3. Why claims get denied

Experian's 2025 survey asked providers which causes drive their denials. The top three were all front end problems.

Top denial causes, 2025	Share of providers citing
Missing or inaccurate data	50%
Authorizations	35%
Registration data	32%

The same survey found 54% of providers saying claim errors are increasing and 68% saying clean claims are harder to submit than a year ago. Older Change Healthcare data (2020) found 86% of denials were potentially avoidable. The pattern is consistent: most denied dollars come from a small number of preventable, repeating causes.

4. What a denial actually costs

- Reworking a denied claim cost an average of \$25.20 per claim, according to Change Healthcare data cited by MGMA.
- Hospitals spent \$57.23 per claim to contest a denial in 2023, up from \$43.84 a year earlier (Premier).
- Many denials are never reworked at all. In a Health Affairs study of Medicare Advantage claims, only about 60% of denied claims were resubmitted.
- When claims are pursued, most are paid. Premier found about 70% of hospital denials were eventually overturned and paid.

The math works against practices that rework denials one at a time. Each rework costs staff time, and every claim that falls through the cracks is revenue already earned and never collected.

5. Prior authorization and Medicare Advantage

KFF's analysis of 2024 Medicare Advantage data found 52.8 million prior authorization determinations, with 7.7% fully or partially denied. Only 11.5% of those denials were appealed, and 80.7% of appeals were overturned. That overturn rate has stayed above 80% every year from 2019 to 2024. In other words, most MA authorization denials that are challenged do not hold up, and most are never challenged.

The AMA's 2025 physician survey, released in May 2026, found physicians complete about 40 prior authorizations a week, taking 13 hours of physician and staff time. 40% of practices have staff who work only on prior authorization, and 74% of physicians say authorization denials have increased.

6. What changed in 2026

- Since January 1, 2026, Medicare Advantage, Medicaid and marketplace plans covered by CMS 0057 F must decide standard prior authorization requests within 7 calendar days, expedited requests within 72 hours, and give a specific reason when they deny. Prior authorization APIs are due January 1, 2027. Employer commercial plans are not covered.
- CMS's WISer model started January 1, 2026 in Arizona, New Jersey, Ohio, Oklahoma, Texas and Washington. It adds technology assisted prior authorization to traditional Medicare for a short list of services, including skin substitutes, certain orthopedic pain procedures and nerve stimulators. Behavioral health services are not on the list.
- Takebacks are the new pressure point. Payers recouping money after payment means a clean remittance is no longer the end of the story.

How to measure your own denial rate

Benchmarks only help if you measure the same thing. Use these definitions.

- ✓ Initial denial rate: claims denied on first adjudication divided by claims adjudicated in the same period. Count by claim, and separately by dollars.
- ✓ Exclude clearinghouse rejections from denials, and track them separately. They never reached the payer.
- ✓ Split the rate by payer, by CPT family and by denial reason code (CARC). A single blended number hides the patterns you can fix.
- ✓ Track takebacks and recoupments as their own line. A falling denial rate with rising takebacks is not an improvement.
- ✓ Measure what happens after the denial: share reworked, share paid on appeal, and days from denial to payment.

Where WeBill Health fits

WeBill Health works denials at the root cause instead of resubmitting them one at a time. We maintain internal payer rule libraries organized by specialty and by carrier across more than 500 payer rulesets, and every claim receives human pre submission review against them before it goes out. Our clients run at a 98% clean claim rate, and our fee is a share of what we collect, so a denied claim costs us too. If you want to know where your own rate sits, a Revenue Health Audit shows you by payer, code and reason.

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See where your own revenue is leaking

A Revenue Health Audit reviews your claims and accounts receivable and shows you, in writing, what is recoverable, what is at risk and what to fix first. You get the findings whether or not you ever become a client.

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98%

Clean claim rate

48 hours

Submission
guarantee

40%

A/R reduction within
90 days

**7 to 14
days**

Reimbursement
velocity

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