planet DDS

2026

Dental Industry Outlook

DEEP DIVE

What We Learned from Thousands of Practices

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The Numbers That Matter, Before the Nuance

63%
of practices grew

4.0%
weighted avg. growth

33.5%
grew over 10%

This report emerged from analyzing more than 8,500 dental practices operating on the Planet DDS platform throughout 2025. It includes general dentistry, specialty practices, emergency clinics, and mobile units. It spans DSOs with hundreds of locations and solo practitioners with one.

What the data reveals is both more complicated and more useful than any simple benchmark. The industry is bifurcating. One-third of practices grew by more than 10% last year. Nearly 14% declined by more than 10%. The middle is getting squeezed.

KEY INSIGHT: Six Drivers of Growth

New patient acquisition is the primary lever. Operational consistency compounds. Efficiency beats size. The 26–50 office range is a growth trap. Case completion, not acceptance, is the bottleneck. Revenue cycle efficiency is the silent EBITDA lever.

The State of Practice Operations

Let us begin with what might be called the vital signs of the dental practice: the operational metrics that tell you whether a practice is healthy, struggling, or somewhere in that vast middle ground where most practices actually live.

	2025	2024
Case Acceptance Rate	**58%** ↑	57%
Case Completion Rate	**47%** ↑	42%
New Patients/Month (Avg.)	**46** ↑	43
Cancellation Rate	**12.9%** ↑	15.5%
No-Show Rate	**6.9%** ↑	7.4%
Hygiene Reappointment Rate	**63%** ↑	60%
Daily Production/Practice	**$8,764** ↑	$8,436

Case Acceptance: The Number Everyone Knows but Few Understand

The industry average case acceptance rate in 2025 was 58%. This is up from 57% the year before, which is progress of a sort, though perhaps not the kind that should inspire celebration.

Nearly 10% of practices have case acceptance below 30%. That means for every ten patients who need treatment, seven or more are walking out the door without scheduling. And on the other end, another 9% of practices are converting 90% or more.

Case Acceptance Range	% of Practices
0%–29%	9.8%
30%–49%	25.7%
50%–69%	35.7%
70%–89%	19.7%
90%–100%	9.1%

The gap between the 10th percentile and the 90th percentile is not a gap. It is a chasm. And somewhere in that chasm lives the opportunity cost that keeps CFOs awake at night.

Case Acceptance by Case Value

Median $ per Case: $169 | Mean $ Acceptance Rate: 58%

Case Value Tier	Median $/Case	$ Accept Rate	Count Accept Rate
<$50	$35	82.9%	73.9%
$50–100	$74	70.2%	64.6%
$100–150	$125	59.3%	61.4%
$150–200	$176	50.3%	54.6%
$200–300	$241	48.3%	50.3%
$300–500	$378	46.0%	43.1%
$500+	$655	56.1%	45.6%

Two acceptance rates are reported for each tier: the Dollar Acceptance Rate (total dollar value of accepted cases ÷ total dollar value of all cases presented) and the Count Acceptance Rate (number of cases accepted ÷ total number of cases presented). These can diverge significantly—a practice may accept 80% of cases by count but only 50% by dollar value if high-cost treatments are disproportionately declined.

Correlation with Growth

Metric	Correlation	Interpretation
$ per Case → Growth	+0.044	Weak positive - higher value cases slightly correlate with growth
$ Accept Rate → Growth	-0.094	Weak negative - higher acceptance doesn't guarantee growth
Count Accept Rate → Growth	-0.084	Weak negative - volume acceptance doesn't drive growth

KEY INSIGHT: Case Value Pattern

Lower-value cases (<$50/case) have the highest acceptance (82.9%). Acceptance rates decline as case value increases. $500+ tier shows recovery in $ acceptance (56.1%)—high-value patients who commit, commit fully.

Case Completion: The Metric That Actually Pays the Bills

Here is a fact that should probably be more widely discussed: The average case **completion** rate, meaning treatment plans created in the first half of the year that were actually finished by year end, was 47%. Up from 42% the year before.

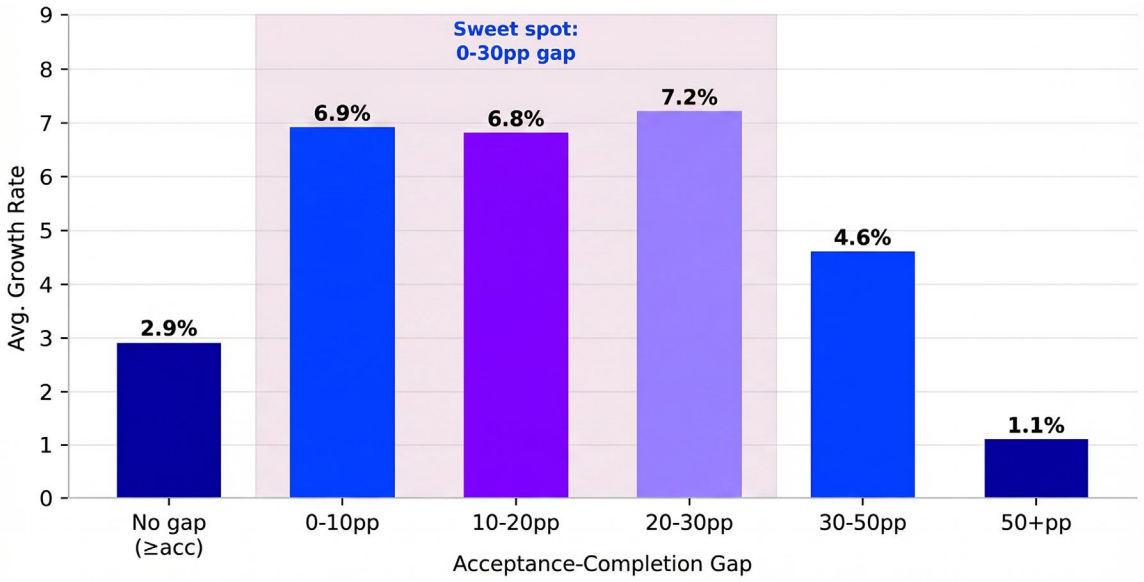
Think about that for a moment. For every two procedures presented, roughly one gets completed. The other one lives in a kind of liminal space, neither rejected nor fulfilled, a phantom revenue that shows up in forecasts but never quite materializes into actual production.

KEY INSIGHT: The Completion Bottleneck

Case completion is the real constraint, not case acceptance. Patients accept treatment but often walk out the door without the next appointment scheduled, and that's where follow-through breaks down.

And here is where it gets genuinely counterintuitive: Practices with a moderate gap between case acceptance and case completion actually grew faster than practices with no gap at all.

Growth Rate by Acceptance-Completion Gap



Acceptance-Completion Gap	Avg. Growth
No gap (completion → acceptance)	2.9%
0–10 percentage points	6.9%
10–20 percentage points	6.8%
20–30 percentage points	7.2%
30–50 percentage points	4.6%
50+ percentage points	1.1%

The sweet spot appears to be somewhere between 0 and 30 percentage points of gap. These practices have strong SOPs in place: scheduling the next appointment before the patient walks out and systematically following up on unfinished treatment. They have healthy tension in their operations—busy enough to grow but disciplined enough to close the loop.

The practices with no gap at all? They likely have slower schedules and lower patient volume, doing same-day treatment for everyone while constantly following up to fill gaps. That's not inefficiency; it's a different operating model, but one with limited growth ceiling.

The practices with massive gaps? They have poor follow-through at getting patients back after they walk out the door. The treatment was accepted—the patient said yes—but the practice lacks the scheduling discipline and follow-up systems to convert that yes into completed production.

Does Case Acceptance Drive Revenue Growth?

All Practices

Case Acceptance Tier	Avg. Growth
<30%	5.8%
30–45%	6.1%
45–55%	6.0%
55–65%	3.4%
65–80%	4.9%
80–100%	3.2%

DSO Practices

Case Acceptance Tier	Avg. Growth
<30%	5.6%
30–45%	6.5%
45–55%	5.9%
55–65%	3.5%
65–80%	4.8%
80–100%	3.1%

Practices with 50+ point gaps have 77.2% case acceptance but only 19.7% completion. They are accepting cases they cannot or will not complete.

Solo Practices

Case Acceptance Tier	Avg. Growth
<30%	6.7%
30–45%	2.5%
45–55%	8.1%
55–65%	2.9%
65–80%	5.2%
80–100%	4.1%

KEY INSIGHT: Non-Linear Relationship

Case acceptance does NOT drive growth linearly. Mid-tier case acceptance (30–55%) correlates with strongest growth. The 55–65% tier is a "dead zone" for growth. Offices with very high case acceptance may be mature/saturated with limited growth potential.

The New Patient Equation

If there is one finding in this entire report that should fundamentally change how you think about growth, it is this: **New patient volume is the single strongest predictor of revenue growth**. Not case acceptance. Not completion rates. Not chair utilization. New patients.

The average practice on our platform saw **46 new patients per month**, up from 43 the year before. But averages, as we have established, obscure more than they reveal.

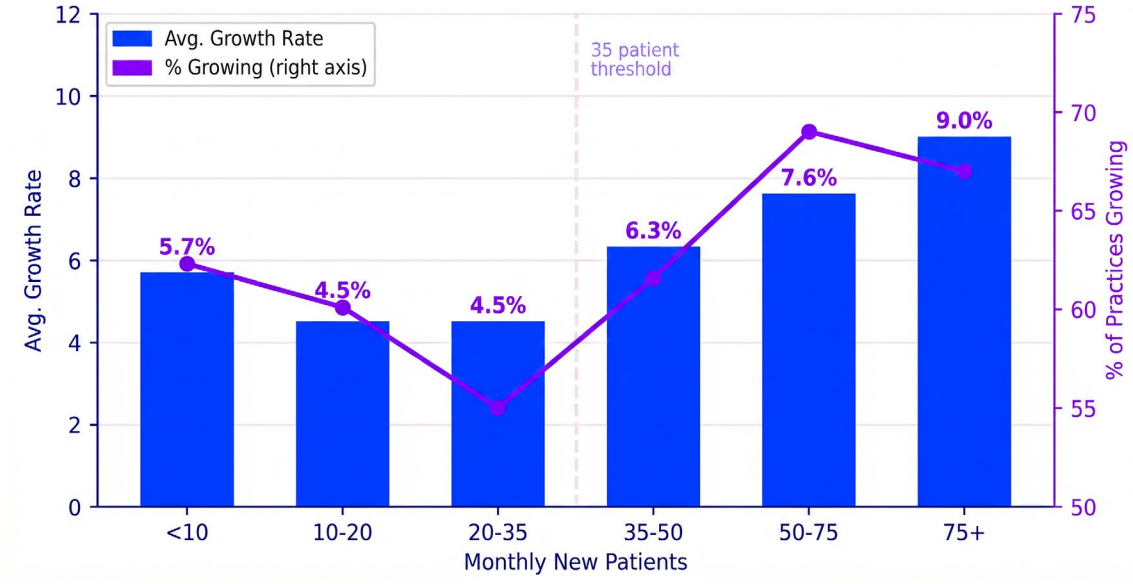
Monthly New Patients	% of Practices
0–19	38.8%
20–39	19.0%
40–59	14.9%
60–79	9.5%
80+	17.7%

Nearly 40% of practices are seeing fewer than 20 new patients per month. Meanwhile, almost 18% are seeing 80 or more. That is a 4x difference in new patient acquisition between the top tier and the bottom tier.

9.0%
Growth rate for practices with 75+ new patients per month

Nearly double
the rate of practices with fewer than 35

Growth Rate by New Patient Volume



The Growth Rate Curve

When we analyzed growth rates by new patient volume, the pattern was unmistakable:

Monthly New Patients	Avg. Growth	% Growing
10–20	4.5%	60.1%
20–35	4.5%	55.0%
35–50	6.3%	61.6%
50–75	7.6%	69.0%
75+	9.0%	67.0%

Practices with 75+ new patients per month grow at **9.0%**, nearly double the rate of practices with 10–35 new patients. And 69% of high-volume practices are growing, compared to only 55% of mid-volume ones.

KEY INSIGHT: The 35 Patient Threshold

Somewhere around 35 new patients per month, growth rates start accelerating meaningfully. Below that threshold, practices are essentially treading water. Above it, they are building momentum.

If DSOs want to drive growth, investing in new patient acquisition has the clearest payoff. Case acceptance and completion matter, but new patients are the number one lever.

The Revenue per New Patient Paradox

The fastest-growing practices had the highest ratio of new patients to revenue. Offices with the highest revenue dependency ratio (4.8%) acquire 20× more new patients and grow 60% faster YoY than those with the lowest ratio.

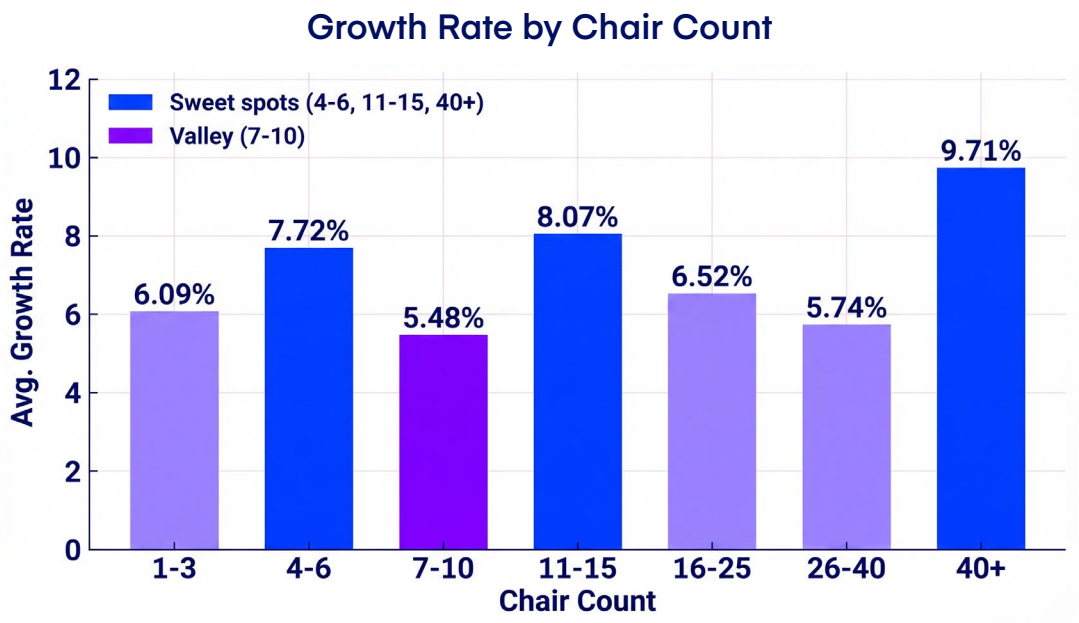
Monthly New Patients	Revenue Dependency Ratio	Avg. Growth
<10	0.14%	5.71%
10–20	0.77%	4.49%
35–50	2.75%	6.18%
50–75	3.23%	7.64%
75+	4.80%	9.00%

Offices with the highest revenue dependency ratio (4.8%) acquire 50× more new patients and grow 60% faster YoY than those with the lowest ratio. A higher ratio signals a practice fueled by new patient growth, not reliant on legacy patients.

The practices growing at 9% per year have **built scalable acquisition engines**. They have accepted that the cost of growth is, well, the cost of growth. The practices heavily dependent on existing patients are not efficient; they are **vulnerable**.

The Size and Efficiency Matrix

One of the most persistent myths in dental group management is that growth requires expansion. More chairs. More locations. More square footage. The data tells a different story.



Chair Count and Growth: A Non-Linear Relationship

When we analyzed growth rates by chair count, we found two distinct sweet spots:

Chair Count	Avg. Growth
1–3	6.09%
4–6	7.72%
7–10	5.48%
11–15	8.07%
16–25	6.52%
26–40	5.74%
40+	9.71%

The first sweet spot is at **4–6 chairs** with 7.72% growth. The second is at **11–15 chairs** with 8.07% growth. And notice that valley in the middle, the 7–10 chair range where growth drops to 5.48%.

This is the awkward adolescence of practice size. Too big to be nimble, too small to have true operational scale. Practices in this range are often caught between two worlds, neither lean startup nor efficient enterprise.

The Real Driver: Revenue per Chair

But chair count alone misses the point. What matters is how efficiently you use the chairs you have.

Annual Rev/Chair	Avg. Daily/Chair	Avg. Growth
<$50K	$134	5.31%
$50K–$100K	$289	6.49%
$100K–$150K	$496	7.09%
$150K–$200K	$693	7.20%
$200K–$300K	$974	6.69%
$300K+	$1,907	8.73%

Practices generating $300K+ per chair achieve 8.73% growth versus just 5.31% for practices generating less than $50K per chair. That is a 64% difference in growth rate, driven entirely by how well you use existing capacity.

Revenue per Chair by Segment

Segment	Total Revenue	Total Chairs	Avg. Rev/Chair	Median Rev/Chair
DSO	$5.14B	59,139	$205,690	$156,741
Solo	$427.7M	2,099	$236,286	$184,502

Solos are more productive per chair (+15% higher average, +18% higher median). DSOs trade utilization for scale and growth capacity.

You do not need more chairs to grow faster. You need to maximize the chairs you have.

The Efficiency vs. Size Quadrant

When we categorized practices into four quadrants based on size (chairs) and efficiency (revenue per chair), the pattern became even clearer:

Quadrant	# Offices	Avg. Growth
Small & Efficient (<14 chairs, >$118K/chair)	995	7.58%
Big & Efficient (14+ chairs, >$118K/chair)	289	6.85%
Big but Inefficient (14+ chairs, <$118K/chair)	1,050	6.27%
Small & Inefficient (<14 chairs, <$118K/chair)	233	4.41%

Practices generating $300K+ per chair achieve 8.73% growth versus just 5.31% for practices generating less than $50K per chair. That is a 64% difference in growth rate, driven entirely by how well you use existing capacity.

Optimal Chairs × Efficiency Sweet Spot

Which Chair Count × Efficiency combination produces the highest growth?

Chair Count	<$100K/chair	$100K–$200K	$200K–$300K	$300K+
1–5	2.88%	10.00%	8.70%	13.83%
6–10	4.79%	5.76%	5.65%	5.72%
11–15	4.56%	9.30%	11.50%	3.49%
16–25	6.88%	5.98%	3.53%	15.36%
26–50	8.21%	5.83%	1.52%	13.40%
50+	4.27%	10.90%	7.24%	N/A

Small and efficient practices outperform big but inefficient practices by 1.3 percentage points. The biggest opportunity in the data? Those 1,050 big but inefficient practices, averaging **44 chairs but only $56K revenue per chair**. They are prime candidates for optimization. They have the capacity; they are just not using it.

KEY INSIGHT: Strategic Takeaway

You do not need more chairs to grow faster. You need to maximize the chairs you have. 41% of all practices analyzed have capacity they are simply not using—1,050 big but inefficient practices averaging 44 chairs at only $56K revenue per chair.

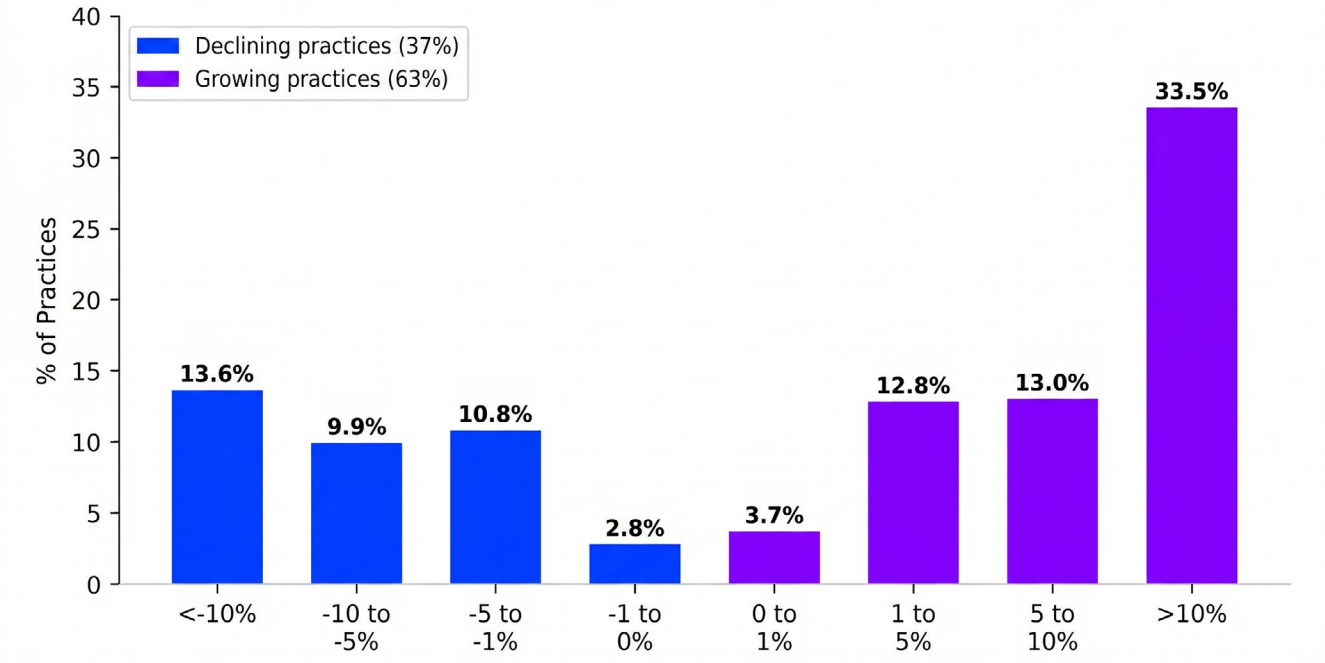
Same-Store Growth

Across the **3,294 practices** we analyzed for YoY comparison, **63%** achieved same-store growth in production in 2025 compared with 2024. Which means, of course, that 37% did not.

Measure	Q1 2025	Q2 2025	Q3 2025	Q4 2025	Full Year
Simple Average	8.1%	9.8%	10.0%	7.7%	6.6%
Trimmed Mean	4.5%	5.9%	6.8%	4.1%	4.9%
Weighted Average	3.5%	4.6%	4.8%	3.4%	4.0%

The simple average, which treats every practice equally regardless of size, shows 6.6% annual growth. The weighted average, which reflects total revenue performance across all practices, shows 4.0%. That gap tells us something important: **Smaller practices grew faster than larger ones.**

Distribution of YoY Production Growth



The industry is not experiencing uniform growth; it is experiencing segmentation. Market leaders are strengthening their position, while others face headwinds.

The Distribution of Growth

YoY Production Growth	% of Practices
Worse than -10%	13.6%
-10% to -5%	9.9%
-5% to -1%	10.8%
-1% to 0%	2.8%
0% to 1%	3.7%
1% to 5%	12.8%
5% to 10%	13.0%
Over 10%	33.5%

One third of practices grew by more than 10%. But nearly 14% declined by more than 10%. The industry is not experiencing uniform growth; it is experiencing bifurcation.

Growth by Office Size

When we segment by revenue tier, a clear pattern emerges:

Revenue Tier	# Offices	Avg. Growth	% Growing
<$500K	115	23.5%	70.4%
$500K–$1M	469	10.9%	70.4%
$1M–$2M	1,027	5.3%	61.5%
$2M–$5M	818	3.4%	60.5%
$5M+	141	3.5%	57.4%

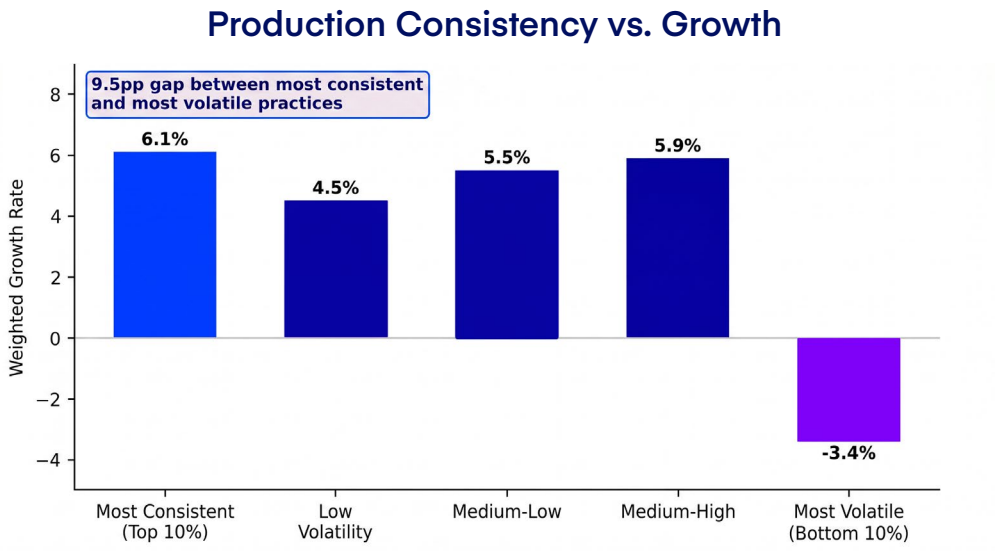
Smaller offices (<$500K) grow at ~24% versus larger offices ($5M+) at ~3.5%. Growth decelerates as offices mature. Smaller practices are in the expansion phase. Larger practices are in the optimization phase. They are EBITDA generators, not growth accelerators.

The Operational Consistency Thesis

Perhaps the most important finding in this entire analysis concerns something that sounds almost too mundane to matter: **operational consistency**.

Consistency is measured using the Coefficient of Variation (CV)—a standard statistical measure of volatility calculated as the standard deviation of daily production divided by the mean. A low CV means the practice produces a similar amount each day. A high CV means production swings dramatically—packed Tuesdays followed by near-empty Fridays, strong months followed by slow months.

Each practice's CV was calculated from daily production records across all of 2025, then matched to its year-over-year revenue growth rate. "Most Consistent" (Top 10%) refers to offices with a CV at or below 0.19—meaning their daily production varied by less than 20% around their average. "Most Volatile" (Bottom 10%) had CVs at or above 0.83.



9.5pp
Growth gap between most consistent and most volatile practices

10% shrink
while consistent practices grow at 6.1%

Daily Production Volatility

When we measured how much daily production varied within practices (using coefficient of variation) and compared it to growth rates, the pattern was stark:

Volatility Tier	Avg. Growth	Avg. Daily Production
Most Consistent (Top 10%)	6.1%	$9,927
Low Volatility	4.5%	$9,409
Medium-Low	5.5%	$9,520
Medium-High	5.9%	$9,094
Most Volatile (Bottom 10%)	-3.4%	$7,189

The most volatile 10% of offices actually **shrink by 3.4%** while consistent offices grow at 6.1%. This is a massive **9.5 percentage point difference**.

The most consistent practices produce 28% more per day than the most volatile ones ($9,927 vs. $7,189). They are simply running more efficient operations. The chairs are fuller, the schedule is more predictable, and the compounding effect of that consistency shows up in the growth numbers.

The Friday Problem

Friday is the industry's Achilles heel. Average Friday production runs well below Tuesday peak. Practices that buck this trend—with Friday as their peak day—substantially outgrow their peers.

Day	Avg. Production	% of Peak (Tuesday)
Monday	$9,452	93.1%
Tuesday (Peak)	$10,152	100.0%
Wednesday	$9,734	95.9%
Thursday	$9,633	94.9%
Friday	$7,388	72.8%

Average Friday production is **$7,388** compared to $10,152 on Tuesday, **27% lower**. Most offices have Friday as their weakest day.

But here is the thing: The 9% of offices with Friday as their peak day show **8.1% weighted growth** versus 4.2% for others. That is a 3.9 percentage point advantage for offices that buck the industry trend.

Growth by Peak Production Day

Peak Day	# Offices	Avg. Growth
Monday	360	5.7%
Tuesday	423	6.1%
Wednesday	366	5.2%
Thursday	382	8.0%
Friday	159	12.0%

KEY INSIGHT: Friday Opportunity

Every practice that closes early or runs light on Fridays is sacrificing growth potential. Offices with Friday as their peak production day achieve 12% avg. growth vs. 6.2% for all others—a 5.7pp advantage.

Seasonality: The Hidden Tax

When we analyzed how monthly production varied throughout the year, we found a dramatic threshold effect:

Industry Seasonality Pattern (Average Production by Month)

Month	Avg. Daily Prod	% of Peak	Month	Avg. Daily Prod	% of Peak
January	$9,316	83.7%	July	$9,943	89.3%
February	$9,175	82.4%	August	$9,621	86.4%
March	$9,843	88.4%	September	$9,036	81.2%
April	$11,130	100.0%	October	$9,203	82.7%
May	$10,117	90.9%	November	$9,910	89.0%
June	$9,456	85.0%	December	$10,043	90.2%

Growth by Seasonality Tier

Seasonality Tier	# Offices	Avg. CV	Avg. Growth
Very Stable (Low)	107	0.22	6.5%
Moderately Stable	107	0.37	8.1%
Moderately Seasonal	106	0.50	4.9%
Highly Seasonal	107	0.75	5.2%

Extreme Comparison: Top 10% vs. Bottom 10%

Group	# Offices	Avg. CV	Avg. Growth
Most Stable (CV ← 0.22)	43	0.18	9.7%
Most Seasonal (CV → 0.73)	43	0.92	7.9%
GAP	-	-	1.8%

Monthly seasonality was measured using the same Coefficient of Variation (CV) method as daily volatility—but applied to average monthly production rather than daily production. A practice with CV = 0.22 has low month-to-month variation; its January and September look similar. A practice with CV = 0.73 has high seasonal swings—strong spring and summer, sharp fall and winter drops.

There is a cliff at the boundary between moderately stable and moderately seasonal. Practices below that threshold average 7% weighted growth. Those above average only 2%. Smoothing out monthly production swings is essentially a **3.5x growth multiplier**.

April is peak production month at $11,130 per day. **September** is the trough at $9,036. That is a 23% swing driven by school schedules and family calendars. The practices that figure out how to smooth that curve are the ones that grow.

The DSO Size Paradox

There is a pattern in the data that should concern any DSO executive planning for growth, and it concerns the relationship between organizational size and growth rates.

DSO Size	# DSOs	Avg. Growth	% Offices Growing
2–5 offices	166	9.0%	62.1%
6–10 offices	55	6.9%	66.1%
11–25 offices	45	8.8%	68.0%
26–50 offices	20	2.8%	55.3%
51–100 offices	22	7.4%	64.9%
100+ offices	14	7.1%	61.6%

DSO size is measured by the number of active practice locations within each group in both 2024 and 2025. Groups with only one location are excluded from this analysis; the smallest tier begins at 2–5 locations. Growth rates are revenue-weighted within each tier.

The 26–50 Office Danger Zone

DSOs with 26–50 offices grow at just **2.8%**, less than one-third the rate of smaller DSOs. Only 55% of their offices are growing, the lowest of all tiers. This is the awkward adolescence of DSO scale.

What happens in this range? The entrepreneurial energy that drove early growth has dissipated. The systems that worked for 15 offices buckle under the weight of 40. But the organization is not yet large enough to justify the infrastructure that enterprise scale demands.

KEY INSIGHT: Strategic Implication

If you are a DSO at 20 offices, do not rush to 50. You may hit a growth wall. Either stay lean and nimble, or build the infrastructure to push through to enterprise scale. Do not get stuck in the middle.

2.8%
Growth rate for DSOs with 26-50 offices

One-third
the rate of smaller DSOs

DSO vs. Solo Practice Comparison

When we categorized DSOs by both growth rate and case acceptance rate, four distinct profiles emerged:

Segment	Avg. Growth (Weighted)
DSO	4.2%
Solo	3.9%

Sample Composition: The dataset skews heavily toward DSO-affiliated practices. Based on total chair count, DSO practices represent approximately 97% of the sample (59,139 chairs) while solo practices represent approximately 3% (2,099 chairs). This reflects Planet DDS's customer base and should be considered when interpreting findings.

KEY INSIGHT: Surprisingly Close

DSOs grew 4.2% vs. Solo at 3.9%. Both segments had exactly 63% of offices growing, suggesting operational maturity and specialty mix drive performance more than ownership structure.

Seasonal YoY Revenue Growth by Segment

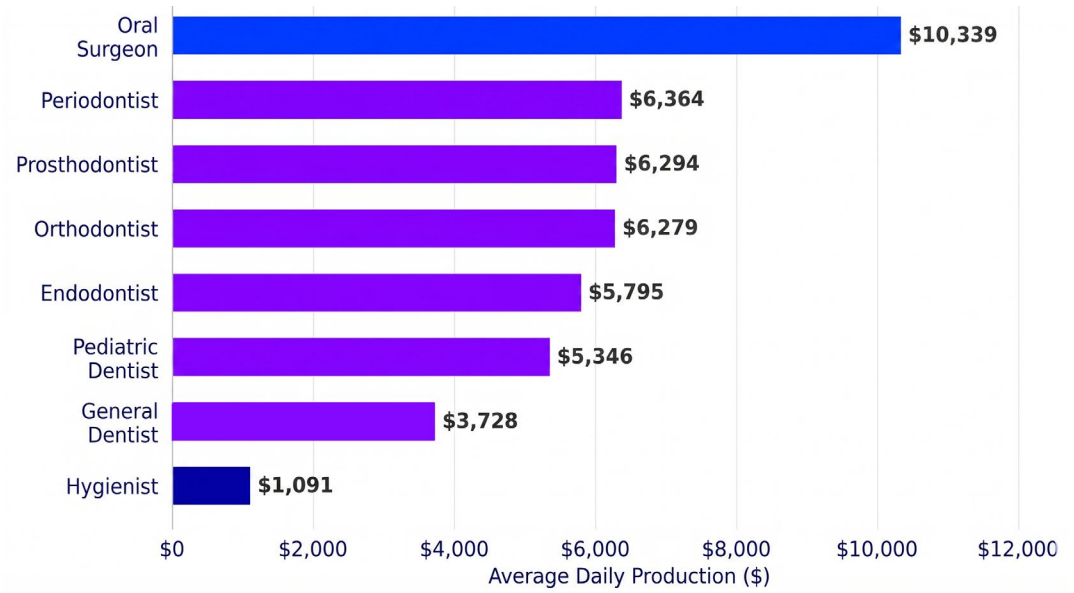
Quarter	Overall	DSO	Solo
Q1	3.5%	3.5%	5.3%
Q2	4.6%	4.9%	4.8%
Q3	4.8%	4.9%	6.5%
Q4	3.4%	3.7%	2.8%

There is a clear summer surge (Q2–Q3) and winter dip (Q1, Q4).

Production Benchmarks

The average daily production per practice was **$8,764** (Denticon), up from $8,436 the prior year, and **$9,419** for orthodontic practices (Cloud 9). But production varies dramatically by provider type and specialty.

Average Daily Production by Provider Type



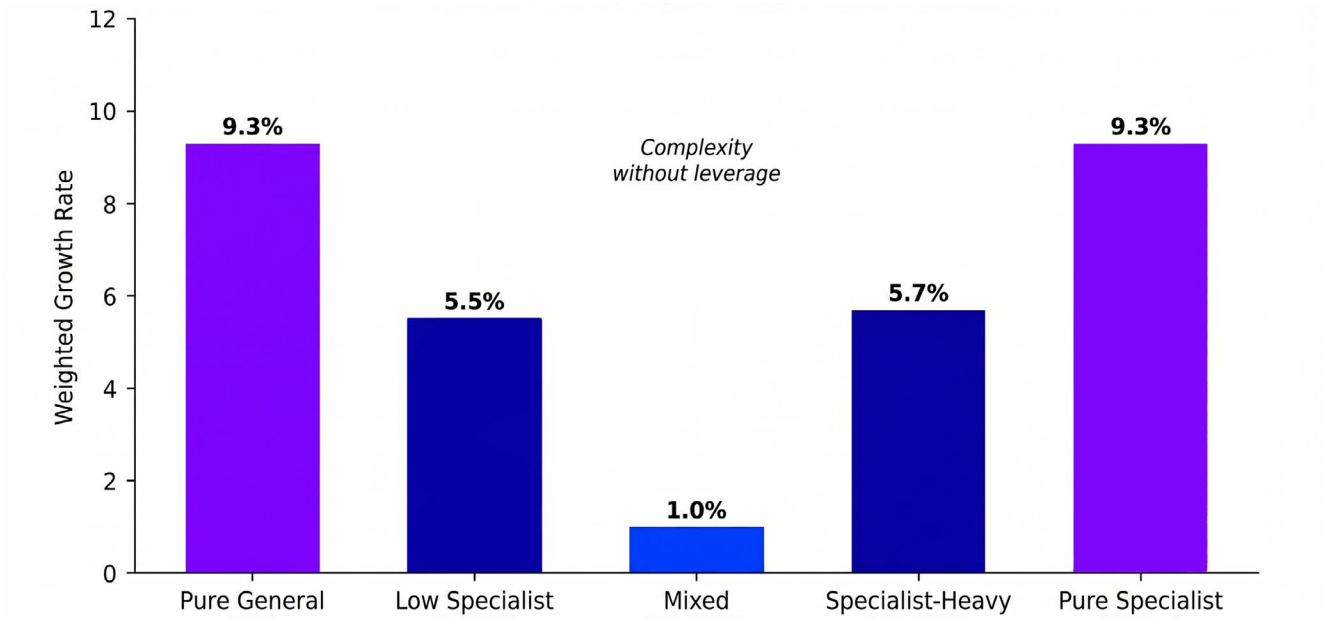
Daily Production by Provider Type

Provider Type	Average Daily Production
Hygienist	$1,091
General Dentist	$3,728
Pediatric Dentist	$5,346
Endodontist	$5,795
Orthodontist	$6,279
Prosthodontist	$6,294
Periodontist	$6,364
Oral Surgeon	$10,339

Note: Gross production figures are calculated by expected collections, not UCR fees. These do not reflect adjustments or write-offs.

These are gross production figures calculated by expected collections, not UCR fees, and they do not reflect adjustments or write-offs. Still, the range is instructive: An oral surgeon produces nearly 10x what a hygienist produces in a day.

DSO Growth by Specialty Portfolio Mix



Specialty Mix and Growth

When we analyzed DSO portfolio composition, focused portfolios outperformed:

Specialist Mix	Avg. Growth
Pure General (0% specialist)	9.3%
Low Specialist (0–25%)	5.5%
Mixed (25–60%)	1%
Specialist-Heavy (60–95%)	5.7%
Pure Specialist (95%+)	9.3%

Pure General and Pure Specialist DSOs both grow at 9.3%. The Mixed category grows at only 1%, with less than half actually growing. This screams **complexity without leverage**, classic strategy drift.

KEY INSIGHT: Strategic Takeaway

Focused portfolios outperform. Pure General and Pure Specialist DSOs both grow at 9.3%. Mixed (25–60%) grows at only 1%, with less than half actually growing—complexity without leverage.

The Revenue Concentration Reality

When we analyzed revenue by clinical service line, two different businesses emerged hiding inside one DSO:

Service Line	Revenue Share	Revenue/Case	Nature
Implants (Surgical & Restorative)	$256M	$1,351	Value Engine
Major Restorative (Crowns/Veneers)	$1.8M	$1,396	Value Engine
Orthodontics (Comprehensive)	$740K	$2,245	Value Engine
Preventive	$597M	$60	Volume Engine
Diagnostic	$431M	$53	Volume Engine

Implants dominate economics at ~98% of top 20 high-value revenue. If implant production stalls, the network stalls. If implants accelerate, the network accelerates.

Appointment Operations

Cancellation Rates

The average cancellation rate was **12.9%**, down from 15.5% the prior year. Progress. But when we look at the relationship between cancellation rates and growth, a clear pattern emerges:

Cancellation Rate	Avg. Growth
<5%	8.9%
5–10%	6.0%
10–15%	8.2%
15–20%	6.3%
20–25%	6.1%

KEY INSIGHT:
Cancellations Crush Growth

Elite practices achieve <5% cancellation with **8.9% growth**. The practical benchmark for most DSOs is 10–15% with 8.2% growth—but the data shows further improvement is possible and rewarded.

The No-Show Paradox

No-shows are different from cancellations, and the data reveals something counterintuitive:

No-Show Rate	Avg. Growth	% Growing
<3%	5.3%	63.7%
3–6%	5.7%	63.7%
6–10%	7.0%	62.0%
10–15%	8.3%	60.3%
15–20%	10.8%	63.0%
20%+	9.5%	64.0%

Higher no-show rates actually correlate with **higher** growth. This seems paradoxical until you think about what drives no-shows: **demand**. High-demand practices attract more patients but also experience more no-shows. The net effect is positive because demand exceeds lost appointments.

KEY INSIGHT: Strategic Insight

Do not prioritize no-show reduction if you are trying to grow. Focus on demand generation first. No-show rate is a symptom of demand, not a cause of decline. Cancellations are the real growth killer.

Orthodontics

Cloud 9 Analysis

An analysis of more than **2,500+ practices** on Cloud 9 orthodontic practice management software revealed significant variation in performance.

New Ortho Patient Consults Distribution

Annual Consults per Location (2025)	% of Practices
0–99	9.0%
100–199	8.1%
200–299	10.1%
300–399	12.3%
400–499	11.3%
500–599	9.0%
600–699	8.9%
700–799	5.1%
800–899	5.0%
900–999	3.5%
1000+	17.5%

633.5
Average new ortho patient exams per practice

68.3%
case acceptance for orthodontic treatment

Ortho Performance Bands Benchmark

This answers: "Where are your offices clustered, and where is the opportunity?"

Performance Band	Daily Production	% of Network	What It Means
Best Practice	$14.5K+	25%	Elite throughput
Strong	$9.4K–$14.5K	25%	Healthy ops
At Risk	$5.9K–$9.4K	25%	Underperforming
High Opportunity	<$5.9K	25%	Major leakage

Sample size: 982 practices on Cloud 9. Performance band thresholds are exact quartile boundaries from the data.

Specialist Mix vs. Growth

Growth by Practice Specialty Type

Practice Type	Avg. Growth Weighted	Revenue
General/Family	4.0%	$9.83B
Pediatric	4.8%	$453.5M
Orthodontics	3.9%	$40.5M
Endodontics	1.3%	$53.7M
Periodontics	2.0%	$84.9M
Oral Surgery	4.2%	$116.4M
Multi-Specialty	4.3%	$571.5M

DSO Portfolio Mix vs. Growth

Specialist Mix	# DSOs	Avg. Growth	% DSOs Growing	Avg. Offices
Pure General (0%)	235	9.3%	69%	7.8
Low Specialist (0–25%)	29	5.5%	66%	9.4
Mixed (25–60%)	14	1%	43%	12.6
Specialist-Heavy (60–95%)	5	5.7%	60%	18.2
Pure Specialist (95%+)	38	9.3%	76%	5.1

KEY INSIGHT: Focused Portfolios Outperform

Pure General and Pure Specialist DSOs both grow at 9.3%. Mixed (25–60%) grows at only 1%, with less than half actually growing. Complexity without leverage—classic strategy drift. Pediatric is the safest specialty (70% offices growing). Endo/Perio are the slowest growers.

Best "safe growth" specialty
Pediatric (70% of offices growing)

Highest ticket but volatile
Oral Surgery

Highest upside specialty
Ortho

Slowest
Endo/Perio

Revenue Leakage Index

Leakage Quantification

Leakage Type	Leakage in $	Worst vs. Best Growth Delta	What It Really Impacts
Cancellation	$131M	-3.1 pts	Growth + Revenue
No-Show	~$100M	Mixed	Efficiency
Collection	$414M	Margin Only	EBITDA
Completion	~$250M	-2 pts	Throughput

$545M+
verified operational leakage exists today

Closing half
would create hundreds of millions in EBITDA without adding a single new patient or chair

KEY INSIGHT: The Biggest Levers

Cancellations are the only clear growth killer (worst performers grow ~3–4 pts slower). Collections leakage is pure EBITDA—doesn't require new patients or providers. No-shows matter less than expected for growth—treat as operational hygiene. RCM data confirms this: Poor OTC collection rates and elevated bad debt directly suppress margin without affecting top-line growth.

Growth = capacity + scheduling | *Margin = collections + admin*

Revenue Cycle Health

The Billing Gap

Every DSO starts with gross production — the value of care delivered before any adjustments. That number flows through five sequential stages before cash reaches the bank. The first stage is structural: contractual fee schedule discounts and insurance adjustments that are a fixed cost of doing business in dental. The remaining four are operational. They represent real dollars that were earned, billed, and lost—not because of payer contracts, but because of workflow gaps that already have solutions.

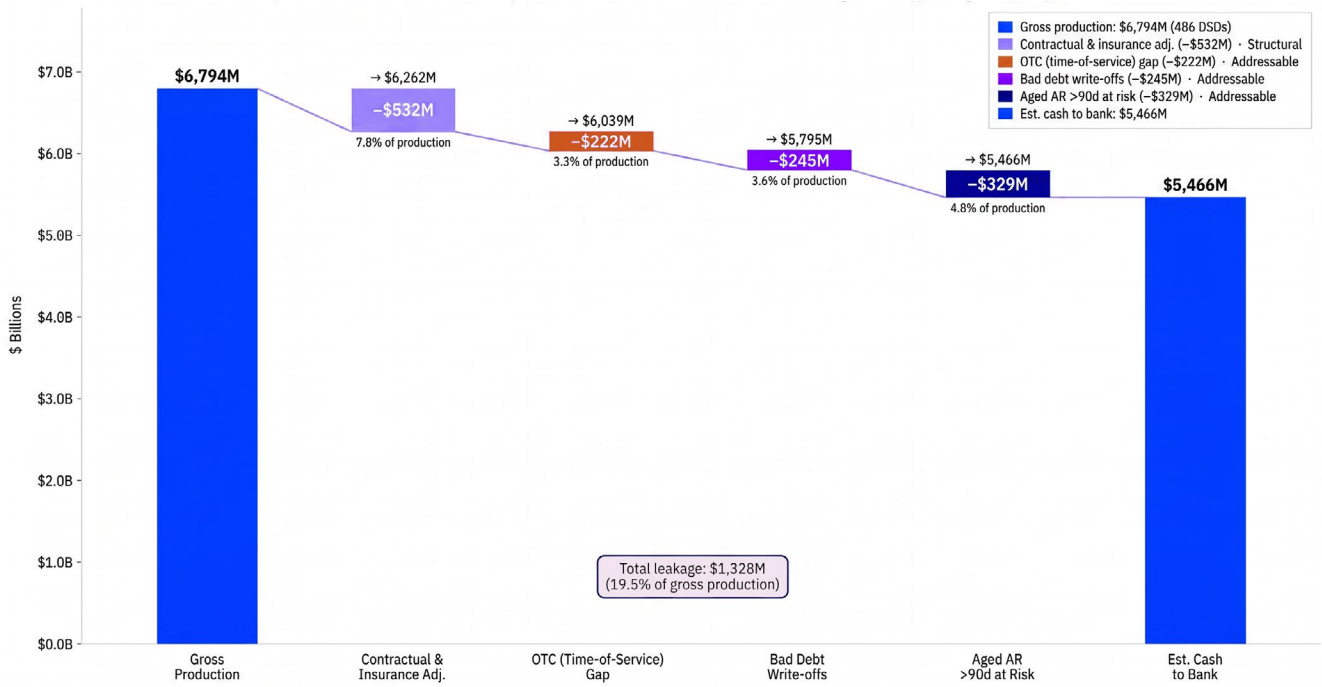
SECTION 1

The Cash Conversion Waterfall

Every DSO starts with gross production—the value of care delivered before adjustments. That number flows through four sequential gates, each draining real dollars before cash reaches the bank.

Revenue Leakage Waterfall - Gross Production to Cash (2025)

enticon customers only I 497 DSOs I 4,857 practice locations I $6.794B gross production
Average OTC rate applied I Aged AR recovery est. 45% I 2025 full year%



Stage	$ Remaining	Loss at Stage	% of Gross Production	Type	Root Cause
Gross Production *n=486 DSOs, all care delivered*	$6.794B	—	—	—	Baseline before adjustments
Contractual & Insurance Adjustments *7.8% of gross, 477 DSOs*	$6.236B	–$558M	8.2%	Structural	Fee schedule discounts, PPO write-downs, insurance contractual adj.
OTC (time-of-service)Gap *3.3% of gross, avg OTC 87.9%,495 DSOs*	$5.593B	–$643M	9.5%	Addressable	Patient co-pays not collected at chair; correctable through workflow
Bad Debt Write-Offs *3.6% median, 478 DSOs*	$5.395B	–$198M	2.9%	Addressable	Explicitly identified uncollectable accounts written off
Aged AR at Risk *AR >90d, 55% est. unrecoverable, 492 DSOs*	$5.132B	–$263M	3.9%	Addressable	Receivables aged past recovery window
Estimated Cash to Bank	$5.132B	–$1.662B total	24.5% total	$532M fixed $796M addressable	Combined revenue cycle leakage

Contractual adjustments sourced from production adjustment columns in the Bad Debt Rate sheet (477 DSOs, $6.83B gross). OTC (time-of-service) gap is the residual between the NCR shortfall (88.9% median NCR, 486 DSOs) and the contractual portion—representing patient co-pay balances not collected at the chair. Cross-validated against the spread between OTC median (91.3%) and OTC mean (87.9%) applied to gross: $231M, within $9M of the $222M derived figure. Gross-basis collection rate (80.4% = $5.466B / $6.794B) should not be benchmarked directly—the correct efficiency metric is net-adjusted collections against net production, on which Denticon DSOs operate at approximately 88–89%.

Structural leakage (non-recoverable)

$532M · 7.8%

Contractual fee schedule discounts and PPO adjustments. A cost of doing business in dental— no amount of operational improvement changes this number.

Addressable leakage (operational)

$796M · 11.7%

OTC gap $222M + bad debt $245M + aged AR $329M. All three are workflow and adoption failures—correctable without adding a single patient, provider, or location.

KEY INSIGHT: The Addressable Gap Is $796M and It Requires No New Patients

Of the $1.328B in total leakage, $532M is structural—contractual fee schedule discounts that no operator can change. The remaining $796M is entirely operational: $222M lost at the chair before the patient walks out, $245M written off as bad debt, and $329M sitting in receivables too old to recover. None of the $796M requires a new patient, a new provider, or a new location to fix. It requires collecting what is already owed. For a DSO generating $10M in gross production, closing the average operational gap adds approximately $890K in annual EBITDA without touching the top line.

SECTION 2

RCM Health Score - How DSOs Compare

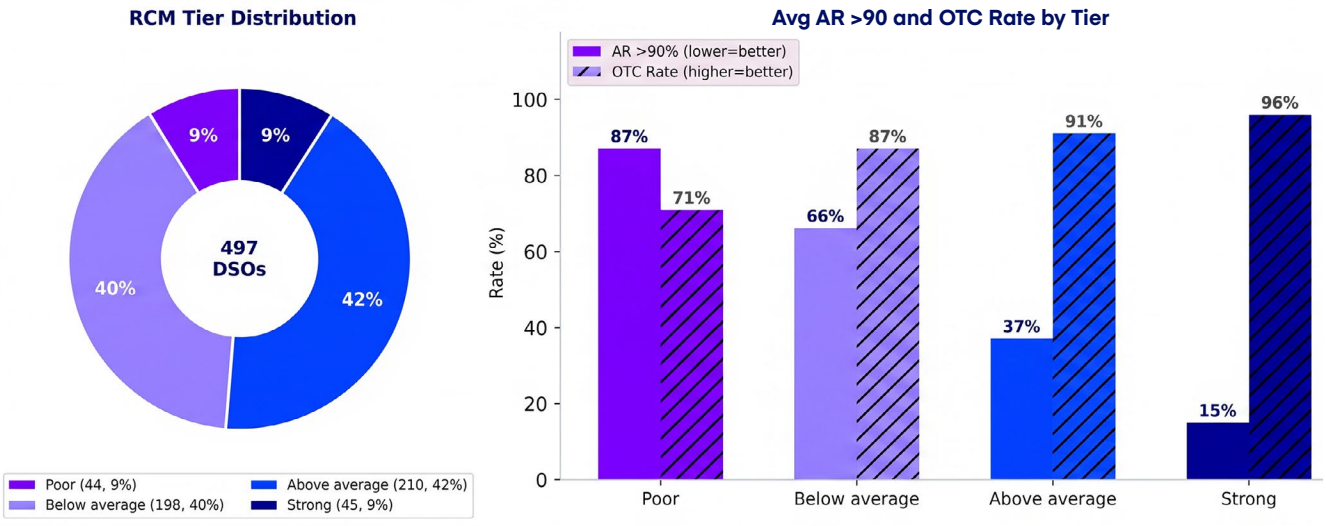
A composite RCM Health Score (0–100) was computed for 497 DSO practice groups using five equally weighted metrics: AR >90, Days in AR, OTC collection rate, bad debt rate, and patient pay collection rate. It enables an apples-to-apples comparison across DSOs of different sizes, geographies, and payer mixes.

The score is built from five equally weighted components (20 points each): AR >90 aging rate (lower is better), Days in AR (lower is better), OTC collection rate (higher is better), bad debt rate (lower is better), and patient payment collection rate (higher is better). Each metric is scored on a 0–20 scale relative to the full DSO population—a practice at the best-performing end of each metric earns a full 20 points; the worst-performing end earns 0. Scores are additive, producing a composite from 0 (worst on all metrics) to 100 (best on all metrics). The scoring is relative to platform peers, not absolute clinical benchmarks.

RCM Tier	Score Range	# of DSOs	% of Network	Profile
Strong	75–100	45	9.1%	At or near target on most metrics; minimal AR aging
Above Average	50–75	210	42.3%	Solid fundamentals; 1–2 metrics need attention
Below Average	25–50	198	39.8%	Multiple metrics below benchmark; clear path forward
Poor	0–25	44	8.9%	Severe underperformance across most categories
Median Score	50.5	497 total	—	Mid-range; 48.7% of DSOs below median

Only 1 in 11 DSO practice groups reaches Strong RCM health. The median of 50.5 is mediocre by industry standards. The concentration in the 40–50 score band—the largest single cluster—represents a ceiling that better billing workflows could materially raise.

RCM Health Score - Composite DSO Ranking (0–100)



SECTION 3

The Same-Day Claims Gap - The Most Actionable Fix

Same-day claim submission produces the clearest operational causal chain in the dataset: faster submission, faster payer processing, and lower days in AR. A "same-day claim" is defined as a claim submitted to the insurance payer on the same calendar date as the date of service. The submission lag in this report measures the average number of calendar days between the date of service and the date the claim was transmitted electronically.

Same-Day Rate	% of DSO	Avg. Submission Lag	Profile
<20% same day (worst)	37.4%	10.4 days	Claims batched days after service; slowest reimbursement
20–40%	18.9%	9.5 days	Partial adoption; inconsistent
40–60%	15.4%	7.6 days	Approaching average
60–80%	14.7%	6.3 days	Good habit; not yet at target
>80% same day (target)	13.5%	3.0 days	7.4-day lag advantage over worst tier

KEY INSIGHT: A Configuration Switch, Not a Culture Change

37.4% of DSO groups submit fewer than 20% of their claims on the day of service. The gap between the slowest and fastest tiers represents a 7.4-day reduction in average submission lag—directly translating to faster reimbursement without adding staff.

SECTION 4

The Recovery Opportunity - What Is Addressable Right Now

The leakage identified above is not evenly distributed. It concentrates in specific tiers — and within each tier, it shows up differently. Poor and Below Average groups have meaningful OTC gaps at the chair, severe bad debt problems, and large aged AR balances. Above Average and Strong groups have largely solved their time-of-service collection problem but still carry significant bad debt and aging receivables. Every tier has a dollar opportunity. The table below shows where it is and how large it is, broken out by lever and per practice location.

RCM Tier	# DSOs	Gross Production	Avg OTC	OTC Gap *per practice per annum*	Bad Debt Recovery *per practice per annum*	Aged AR Recovery *per practice per annum*	Est. Annual Recovery
Poor (0–25) *433 practices*	43	$162M	73.3%	$56,817	$43,610	$117,577	$218,003
Below Average (25–50) *1,256 practices*	144	$1.99B	87.0%	$28,931	$139,853	$81,623	$250,407
Above Average (50–75) *433 practices*	189	$3.56B	91.8%	$5,949	$57,240	$21,680	$84,869
Strong (75–100) *143 practices*	33	$279M	94.9%	$216	$20,363	$6,540	$27,119
Network Total *All Tiers 4,290 practices*	409	$5.99B	88.4% avg	$76M	$338M	$208M	$621M *$144, 847 practice avg*

All recovery estimates based on closing gap to targets: OTC - 90%, Bad debt - 1%, Aged AR - 45% recovery of >90d balance. Per-location = total tier recovery ÷ total practice locations in that tier. OT

Across all tiers, the total addressable recovery opportunity is $622M annually—without adding a single new patient, provider, or location. Bad debt reduction is the single largest lever at $338M, followed by aged AR recovery at $208M and OTC improvement at $76M. The opportunity is already inside the system. It is a workflow and adoption problem, not a growth problem.

OTC (time-of-service) Gap

$76M

Closing avg OTC to 90% target. Concentrated in Poor and Below Average tiers.

Bad Debt Recovery

$338M

Improving bad debt rate to 1% elite target. Largest lever; present in every tier.

Aged AR Recovery

$208M

45% of AR >90d estimated recoverable with active follow-up. Disproportionate in Poor tier.

STRATEGIC IMPLICATION: The Revenue Is Already in the System

The most important RCM finding is that the opportunity does not require growth. The practices with the largest billing gaps are already on the platform, already treating patients, already generating production. The gap between net production and cash collected is a workflow and adoption problem. For DSO leadership and their PE sponsors, the fastest path to EBITDA improvement is not the next acquisition—it is fixing the revenue cycle on the locations already owned. For a DSO generating $10M in gross production, closing the average operational gap adds approximately $890K in annual EBITDA without touching the top line.

Revenue Concentration by Clinical Service Line

Top Production by Service Line

Rank	Service Line	Total Revenue	Revenue/Case	Growth Contribution
1	Implants – Surgical & Restorative	$256M	$1,351	~4.4 pts
2	Orthodontics – Comprehensive	$740K	$2,245	~0.01 pts
3	Major Restorative – Crowns/Veneers	$1.8M	$1,396	~0.03 pts
4	Endodontics – Retreat/Complex	$300K	$1,438	~0.05 pts
5	Prosthodontics – Fixed/Dentures	$1.7M	$1,215	-
6	Other/CTG/Misc. Specialty	$58K	$1,304	-

1. This analysis reflects the top 20 procedures by total revenue across ~5,200 Denticon locations. Procedure categories not appearing in the top 20 by revenue (such as standard root canals) are not included. Orthodontics data from Denticon represents a smaller sample size than the broader Cloud 9 ortho network; for comprehensive ortho benchmarks, refer to the Cloud 9 analysis in Part One.

2. Orthodontics revenue shown here reflects Denticon data only (comprehensive banding codes). For ortho-specific benchmarks, including case acceptance and daily production, see the Cloud 9 Orthodontics analysis, which covers 2,500+ dedicated ortho practices.

3. Endodontics shown here reflects only retreat/complex endo procedures, which ranked in the top 20 by total revenue. Standard root canal procedures did not rank in the top 20 by revenue volume and are not reflected in this table. Procedure categories were grouped by ADA code and procedure description. Due to variation in how practices name procedures in Denticon, similar procedures (e.g., "Implant Crown," "Implant Treatment Crown," "Crown - Implant") were consolidated into single categories. Revenue figures represent expected collections, not UCR fees.

4. Procedure categories were grouped by ADA code and procedure description. Due to variation in how practices name procedures in Denticon, similar procedures (e.g., "Implant Crown," "Implant Treatment Crown," "Crown - Implant") were consolidated into single categories. Revenue figures represent expected collections, not UCR fees.

Top 20 Procedure Categories by Revenue

Rank	Procedure Category	Total Revenue	Total Volume	Rev/Procedure
1	Preventive	$596.6M	9,903,992	$60
2	Restorative	$540.2M	3,417,117	$158
3	Restorative: Crowns	$476.3M	725,996	$656
4	Diagnostic	$431.0M	8,083,613	$53
5	Oral Surgery	$283.6M	1,258,169	$225
6	Uncategorized*	$267.8M	995,954	$269
7	Periodontics	$215.9M	1,684,684	$128
8	Implants**	$214.5M	164,302	$1,305
9	Orthodontics**	$185.0M	757,723	$244*
10	Restorative Crowns (alt)	$183.3M	194,638	$942

* "Uncategorized" includes procedures with non-standard descriptions that could not be mapped to clinical categories, as well as miscellaneous billable items (e.g., supplies, lab fees, administrative charges). Procedure naming conventions vary by practice within Denticon, and not all entries follow standard ADA code descriptions.

** The $256M implant figure consolidates all implant-related procedure codes (surgical placement, abutments, crowns, and restorative components) into a single service line total. The Top 20 Procedures table below shows implant procedure codes separated by type — the $214.5M 'Implants' line reflects the primary implant body code category; crown-on-implant procedures are captured separately in the Restorative Crowns rows.

*** Orthodontics revenue per procedure ($244) reflects a blended average across all ortho procedure codes posted to Denticon, including retainers, adjustments, and repairs—not comprehensive case fees. This figure should not be used as a benchmark for ortho case value. For comprehensive ortho case economics, the D8080 banding code (adult/adolescent comprehensive treatment) averages approximately $3,600 per case start. For dedicated ortho benchmarks including case acceptance (68.3%) and daily production ($9,419/practice), refer to the Cloud 9 Orthodontics analysis in Part One, which covers 1,500+ ortho practices.

Implants are absurdly high leverage: One implant = 22 preventive visits. Implants are the highest ROI growth lever in the entire system.

Crowns are your hidden giant: Combined $659M revenue at $650–940 per procedure. Most repeatable growth lever.

KEY INSIGHT: Your Growth Is Already Inside the Building

Volume engine (Preventive, Diagnostic) = traffic. Value engine (Implants, Crowns, Ortho, Surgery) = profit. One implant = 22 preventive visits in revenue. Crowns: $659M combined revenue at $650–940 per procedure—the most repeatable high-value lever.

Case Acceptance - Production Sensitivity

Denticon Network

Current average case acceptance: 58%

The production lift estimates below assume a linear relationship: Each percentage point improvement in case acceptance applies uniformly across the analyzed practice base. The per-practice-per-day figures divide the total network lift by the number of practices and 220 clinic days. These are sensitivity estimates, not forecasts—actual results will vary based on case mix, payer type, and how acceptance improvement is operationalized.

Acceptance Improvement	New Acceptance	Daily Lift	Annual Lift*	Per Practice/Day
+1 pt	58.95%	$902K/day	$198.5M/yr	$151/day
+3 pts	60.95%	$2.71M/day	$595.4M/yr	$454/day
+5 pts	62.95%	$4.51M/day	$992.4M/yr	$756/day
+10 pts	67.95%	$9.02M/day	$2.0B/yr	$1,512/day

*Annual assumes 220 clinic days.

Cloud 9 Network

Current average case acceptance: 68.2%

Acceptance Improvement	New Acceptance	Daily Prod Lift	Annual Lift	Per Practice/Day
+1 pt	69.3%	+$186K/day	$41M	+$190
+3 pts	71.3%	+$558K/day	$123M	+$568
+5 pts	73.3%	+$925K/day	$204M	+$942
+10 pts	78.3%	+$1.86M/day	$409M	+$1,895

KEY INSIGHT: Your Growth Is Already Inside the Building

You don't need new markets, new providers, new chairs, or acquisitions. A 5-point improvement in case acceptance across the Denticon network unlocks ~$1B/year in incremental production with $0 capex—more growth than most DSOs create through acquisitions. Acceptance-driven growth is high-confidence growth—exactly what investors underwrite.

Production Volatility vs. Growth

Volatility measured using Coefficient of Variation (CV = StdDev / Mean). Lower CV = more consistent daily production.

Volatility Tier	# Offices	Avg. CV	Avg. Growth Weighted	% Growing	Avg. Daily Prod
Low (Most Consistent)	515	0.20	4.5%	65.0%	$9,409
Medium-Low	515	0.37	5.5%	64.5%	$9,520
Medium-High	514	0.52	5.9%	62.6%	$9,094
High (Least Consistent)	515	0.84	2.0%	58.8%	$7,607

Extreme Comparison: Top 10% vs. Bottom 10%

Group	# Offices	Avg. CV	Avg. Growth Weighted	% Growing	Avg. Daily Prod
Most Consistent (CV ← 0.19)	206	0.15	6.1%	68.4%	$9,927
Most Volatile (CV → 0.83)	206	1.02	-3.4%	54.9%	$7,189
GAP	-	-	9.5%	13.5%	$2,738

Volatility Effect by Practice Size

Size Tier	Consistent WG	Volatile WG	Gap
Small Practices	10.8%	10.0%	0.7%
Medium Practices	6.0%	4.6%	1.5%
Large Practices	3.2%	2.8%	0.4%

The "High Volatility" quartile (bottom 25%) includes the most extreme 10% of offices that shrink at -3.4% (see Part Five). The 2.0% figure here represents the full bottom quartile average, which includes mid-range volatile practices.

KEY INSIGHT: Volatility Destroys Value

Consistent offices produce 28% more per day ($9,927 vs. $7,189). The most volatile 10% actually SHRINK while consistent practices grow at 6.1%. Volatility impact is strongest for mid-size practices. Focus on stabilizing daily production schedules before chasing growth initiatives.

What It All Means

If you have made it this far, you have encountered a lot of data. Here is an attempt to synthesize it into something actionable.

The Six Things That Actually Drive Growth

1. **New patient acquisition is the primary lever.** Nothing else in this analysis comes close to the correlation between new patient volume and revenue growth. If you are investing in anything, invest in filling the top of the funnel.

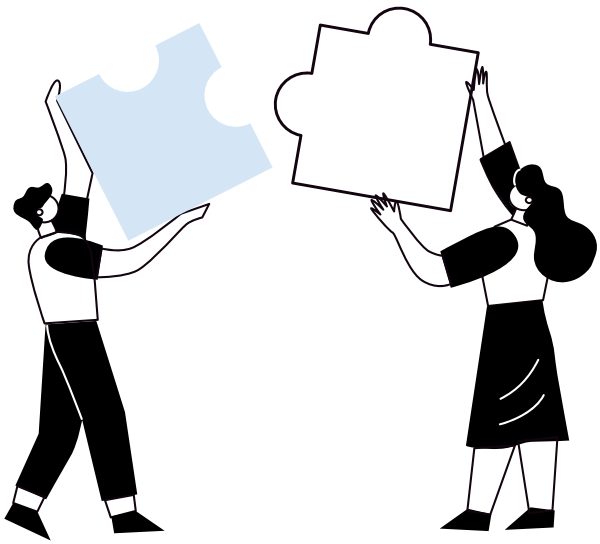
2. **Operational consistency compounds.** Volatile practices shrink while consistent practices grow. The practices that figure out how to smooth their daily production, fill their Friday schedules, and manage their seasonality are the practices that win.

3. **Efficiency matters more than size.** You do not need more chairs; you need to maximize the chairs you have. Small and efficient beats big and inefficient every time.

4. **There is a dangerous middle in DSO growth.** The 26–50 office range is a growth trap. Either stay nimble or push through to enterprise scale.

5. **Case completion is the bottleneck, not case acceptance.** Practices with moderate acceptance-completion gaps grow fastest. Massive gaps signal operational problems that need addressing.

6. **Revenue cycle efficiency is the silent EBITDA lever.** Growing practices are not necessarily collecting practices. Unlike the five growth drivers above, fixing this does not require new patients, new providers, or new locations. It requires collecting what is already owed. For a DSO generating $10M in gross production, closing even half the average billing gap adds roughly $890K in annual EBITDA without touching the top line.



The Numbers to Watch

Metric	Warning Zone	Target Zone	Elite Zone
Daily Production Volatility (CV)	>0.5	0.3–0.5	<0.3
New Patients/Month	<35	35–75	75+
Revenue Per Chair (Annual)	<$100K	$150K–$200K	$300K+
Acceptance-Completion Gap	>30pp	10–30pp	<20pp
Friday vs. Tuesday Production	<60%	70–80%	>80%
Cancellation Rate	>20%	10–15%	<10%
OTC Collection Rate	<80%	80–95%	>95%
AR Aged >90 Days	>50% of AR	15–30%	<15%
Same-Day Claim Rate	<20%	40–80%	>80%
Bad Debt Rate	>5%	1–3%	<1%

The Strategic Imperative

The dental industry is bifurcating. One-third of practices grew by more than 10% last year. Nearly 14% declined by more than 10%. The middle is getting squeezed.

The winners are not winning because they have better technology or more locations or fancier marketing. They are winning because they have figured out the fundamentals: Fill the chairs, smooth the schedule, convert the patients, and complete the treatment.

That is not glamorous. It is not disruptive. It is not the kind of thing that makes headlines at industry conferences. But it is what the data says works.

The winners share one common trait: they've transformed operational excellence into a competitive moat. Consistency beats complexity. Discipline beats disruption. Execution beats strategy.

How We Did the Analysis

The analyses in this report are based on de-identified, aggregated data from dental practices operating on the Planet DDS platform throughout 2025.

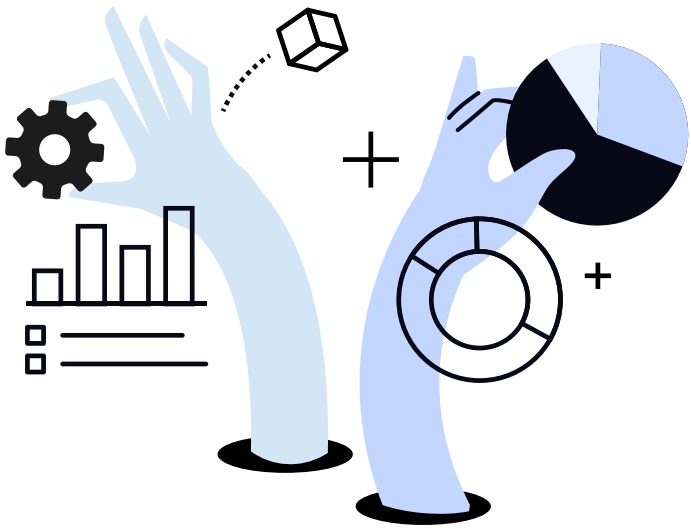
Data Point	Detail
Total Practices Analyzed	8,593
Practices with YoY Comparison	3,294
DSOs Analyzed	497
Cloud 9 Ortho Practices	2,500+
Time Period	January–December 2025

Different analyses use different subsets depending on data availability. All sample sizes are disclosed per section.

The sample includes general dentistry practices, specialty practices, emergency dental clinics, and mobile dentistry units. Individual practice results are influenced by their patient, provider, and payer mix.

Production figures represent expected collections, not UCR fees, and do not reflect adjustments or write-offs. Growth rates are calculated on a same-store basis comparing 2025 to 2024 performance.

The patterns identified represent statistical tendencies, not guarantees. **Correlation does not imply causation**. Your mileage may vary.



Glossary of Abbreviated Terms

All shortened terms, acronyms, and industry shorthand referenced in the report, in order of first appearance.

TERM	FULL NAME	DEFINITION IN THIS REPORT
DSO	Dental Service Organization	A company that owns or manages two or more dental practice locations under a centralized administrative and support structure.
Solo	Solo Practice	A single-location dental practice operating independently (not affiliated with a DSO).
YoY	Year-over-Year	Comparison of a metric in one calendar year to the same metric in the prior year. In this report, always refers to 2025 vs. 2024 on a same-store basis.
KPI	Key Performance Indicator	A quantifiable metric used to evaluate performance against a target or benchmark.
CV	Coefficient of Variation	A statistical measure of variability calculated as: Standard Deviation ÷ Mean. In this report, used to measure daily production volatility. Lower CV = more consistent daily production schedule. A CV of 0.20 is highly consistent; 0.84 is highly volatile.
OTC	Over-the-Counter Collection Rate	The percentage of patient-responsible balances (co-pays, deductibles, and non-covered amounts) collected at the point of service.
NCR	Net Collection Rate	Used in two related but distinct contexts in this report. (1) NCR: The percentage of gross production actually collected across all payers—insurance and patient combined. (2) Waterfall-stage NCR (insurance settlement rate): In the Cash Conversion Waterfall, "Post-Service NCR" refers specifically to the insurance reimbursement rate—the percentage of the balance remaining after OTC collection that insurers actually pay, net of contractual adjustments, underpayments, and denied claims.
AR	Accounts Receivable	Money owed to a practice for services already rendered but not yet paid—by insurance, patients, or both.
AR >90	Accounts Receivable Aged Over 90 Days	The portion of total outstanding AR that has been unpaid for more than 90 days.
Days in AR	Days in Accounts Receivable	The average number of days from claim submission to payment receipt.
RCM	Revenue Cycle Management	The end-to-end process of managing a practice's financial transactions from patient registration through final payment — including insurance billing, claim submission, payment posting, and collections.
EBITDA	Earnings Before Interest, Taxes, Depreciation, and Amortization	A standard PE/investor measure of operating profitability.
SOP	Standard Operating Procedure	A defined, repeatable workflow used across practice locations.
UCR	Usual, Customary, and Reasonable	The full fee a provider would charge without insurance. Production figures in this report are based on expected collections (fee schedule rates), not UCR fees.
CDT	Code on Dental Procedures and Nomenclature	The ADA's standardized coding system for dental procedures.
ERA	Electronic Remittance Advice	A digital explanation of payment from an insurance payer, delivered via the 835 electronic transaction standard.
PP/pp	Percentage Points	The arithmetic difference between two percentages.

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For questions about this analysis, contact Planet DDS

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