jiro

JIRO SPECIALTY PRACTICE ECONOMICS · BENCHMARK 2026

Gastroenterology Practice Economics

GI's scale gap is common. Its second-procedure economics are not. A claims-based benchmark of pricing, payment and same-visit procedure reductions.

Larger independent GI groups post prices 12.5% above small practices

The scale gap is common. GI's second-procedure economics are not.

GI leaders do not need another reminder that scale influences contracting. The more useful question is how large the effect is, how GI compares with other specialties, and where the economics are distinctive enough to warrant action. Jiro's benchmark answers all three, holding procedure, insurer and market constant.

EXECUTIVE SUMMARY

For comparable work, larger independent GI groups post prices 12.5% above small independent practices; on paid claims, the gap is approximately 8% to 10%. That gap is meaningful but not exceptional. GI ranks 18th of 56 screened specialties, against a cross-specialty median of 8.8%.

What distinguishes GI is the interaction between procedure frequency and payment. 28.4% of visits include two or more procedures, gastroenterologists retain approximately 32% to 38% of a second procedure's normal price, and 64.1% of additional same-visit work is affected by the CMS same-scope rule.

Jiro benchmarked GI against 56 specialties. These four findings followed:

01 · SCALE

12.5%

Posted-price premium for larger independent GI groups over small practices. On paid claims, approximately 8% to 10%.

02 · CONTEXT

18th of 56

GI's rank among screened specialties. The cross-specialty median gap is 8.8%; GI sits in the moderate 8% to 15% tier.

03 · FREQUENCY

28.4%

Of GI visits include two or more procedures, exposing a large share of work to second-procedure reductions.

04 · DEPTH

20.7%

Of paid GI second procedures retain less than one-quarter of their normal price, the highest share measured. The next-highest is 6.8%.

PART I — THE SCALE GAP

The scale gap is real, precisely measured and common across medicine

Jiro's analysis found that larger independent GI groups post prices 12.5% above small independent practices for comparable work, holding procedure, insurer and market constant. On paid claims, the gap is approximately 8% to 10%.

Across 56 screened specialties, the median posted-price gap between larger and small independent practices is 8.8%. GI ranks 18th and falls in the moderate 8% to 15% tier. Forty-seven specialties show a statistically significant positive gap.

Large independent groups perform roughly on par with private-equity-backed practices, suggesting that scale may matter more than ownership structure alone.

GI's scale disadvantage is real, but it is not uniquely large. It is a contracting reality GI shares with most of medicine.

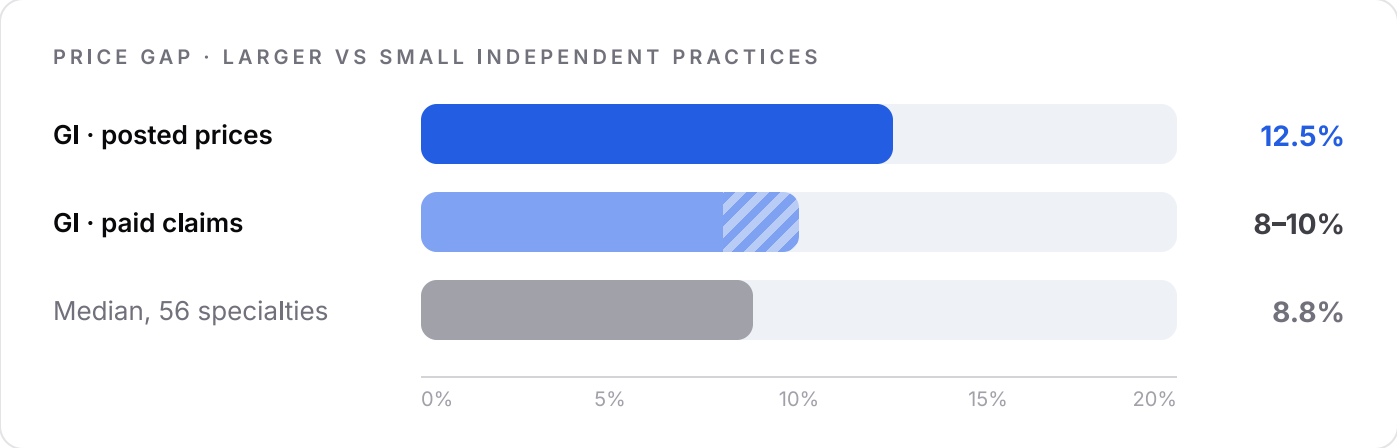

Figure 1. Posted-price and paid-claims gap between larger and small independent practices for comparable work, holding procedure, insurer and city constant. Paid-claims range shown hatched. Source: Jiro analysis of 2025 claims and 2025–2026 insurer price-transparency files.

56
Specialties screened

47
With a statistically significant positive gap

18th
GI's rank, moderate 8% to 15% tier

PART I — WHAT THE SCALE GAP MEANS IN DOLLARS

A small GI practice is paid about $5,900 less per physician each year

The negotiated base price determines what a practice can be paid before operational performance enters the equation. The benchmark isolates the scale effect so practice leaders can distinguish a contracting disadvantage from revenue-cycle execution.

$5,894
Paid shortfall per physician per year

$17,681
For a representative three-doctor practice

21.2%
Of benchmarked allowed dollars

6–17%
Below local peers per claim, five largest insurers

Measure	Result
Top vs bottom quartile, same city, same insurer, same procedure	**20–30% more**
Small practices vs local peers, five largest insurers, per claim	**6–17% below**
Paid shortfall vs larger local independents, per physician per year	**$5,894**
Representative three-doctor practice, per year	**$17,681**
Shortfall as a share of benchmarked allowed dollars	**21.2%**

Table 1. Scale effect on gastroenterology payment, compared with larger local independent practices. Source: Jiro analysis of 2025 claims and insurer remits.

LEVER 01

Contracting

The negotiated base price sets the ceiling on what a practice can be paid. This is the gap the benchmark isolates.

LEVER 02

Revenue-cycle execution

Denials and payment variance act after the price is set. They still matter, but they are a separate problem.

Because Jiro does not observe every claim, the dollar estimate is a floor, not a guaranteed recovery.

PART II — SECOND-PROCEDURE ECONOMICS

GI is unusual on both the frequency and the depth of second-procedure reductions

28.4% of GI visits include two or more procedures. The typical GI physician retains approximately 32% to 38% of a second procedure's normal price, and 64.1% of additional same-visit work falls under the CMS same-scope rule.

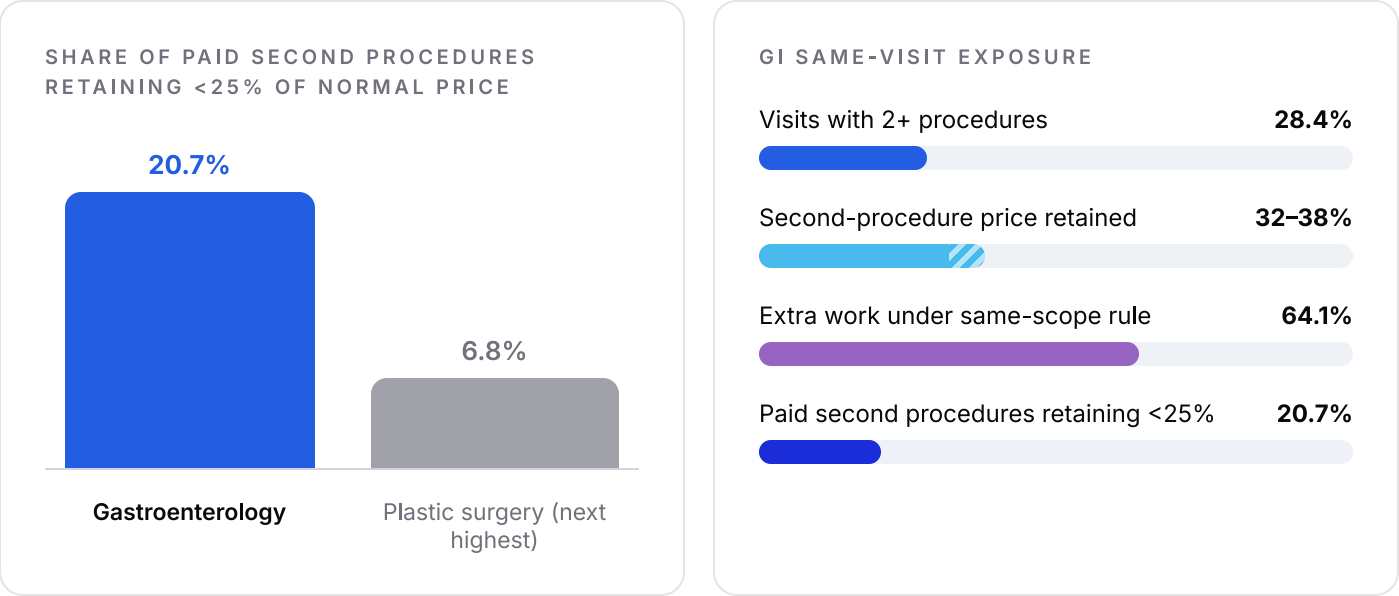

Figure 2. Frequency and depth of second-procedure reductions in gastroenterology. Retention range shown hatched. Source: Jiro analysis of 2025 claims and insurer remits.

Specialty	Multi-procedure frequency	Second-procedure retention	Same-scope exposure
Gastroenterology	28.4% of visits	32–38%	64.1%
Mohs surgery	Higher than GI	About half	—
Pulmonary	Similar to GI	Less consistent across methods	Similar to GI

Table 2. Other specialties show different combinations of frequency, retention and scope exposure.

PART II — WHAT DRIVES THE REDUCTION

Ownership and size do not change the reduction. Payer policy does.

Ownership and practice size do not materially change the second-procedure reduction itself. Across 20 specialties, the median small-versus-large difference is effectively zero. Unlike the base-price gap, this is not a problem scale solves.

Payer policy does matter. Many commercial books adopt Medicare-like endoscopy reductions, while others apply different percentages or payment logic. Not every reduction is recoverable, but every practice should know which rule is being applied.

OWNERSHIP
No material effect
Independent and private-equity-backed practices see similar reductions.

PRACTICE SIZE
Effectively zero
Median small-versus-large difference across 20 specialties.

PAYER POLICY
Varies by book
Medicare-like endoscopy reductions, other percentages, or different payment logic.

> The value of the benchmark is not to label every difference as unjustified or recoverable. It is to show practice leaders exactly which pressure they are facing.

PART III — WHAT CAN A GI PRACTICE DO?

Each finding should lead to a specific decision path

The benchmark is a starting point. Practices must connect it to their own contracts, remits, denials and procedure mix.

Base prices trail peers	Use payer- and procedure-level evidence to inform contract renewal and negotiation strategy.
Payment misses the contract	Document the discrepancy and pursue payer escalation or correction.
Denials drive the loss	Prioritize root cause, prevention and recovery workflow rather than treating it as a contracting problem.

The reduction is correct	Quantify its impact for forecasting, service-line planning and compensation instead of spending resources on an unsupported appeal.
Sizing every opportunity	Express each in annual dollars and wRVUs so leadership can focus first on the changes that materially affect the practice.
Scale is the constraint	Evaluate lawful shared contracting, analytical, affiliation or enterprise options that fit the practice's strategy; ownership change is not the only path.

PART IV — THE BROADER TAKEAWAY

GI practices face two different economic pressures

PRESSURE 01 · COMMON

The scale gap

Larger independent practices tend to command higher prices across medicine.

PRESSURE 02 · DISTINCTIVE

Second-procedure exposure

Frequent additional procedures whose payment is deeply reduced by same-scope rules.

For GI, visibility must connect four comparisons. The point is not simply to know where the practice stands. It is to know what decision the finding should trigger.

FOUR COMPARISONS THAT MATTER

Local peers
Small versus larger local independents

Specialties
GI versus other specialties

Payer policy
Payer-specific second-procedure rules

Procedure mix
The practice's own case mix

METHODOLOGY

How the benchmark was built

Data

2025 claims and insurer remits, alongside 2025 to 2026 insurer price-transparency files.

Contract-price comparisons

Held procedure, insurer and city constant.

Paid-claims comparisons

Held procedure, insurer and city constant, and also matched care setting.

Scale comparison

Includes the 56 specialties that met screening criteria.

Second-procedure analyses

Use the specialties with sufficient complete observations for each measure.

Scope

Figures reflect professional fees only; facility fees are excluded.

LIMITATIONS

The analysis identifies patterns, not insurer intent, recoverability or causation. Dollar estimates are floors because Jiro does not observe every claim. Not every reduction is recoverable; a contractually correct reduction should be planned for rather than appealed.

SOURCES

Jiro analysis of 2025 claims and insurer remits, and 2025 to 2026 insurer price-transparency files, across 56 screened specialties. Figures reflect professional fees only.

ABOUT JIRO

Jiro Health is a public benefit corporation that turns real-world practice data into personalized clinical, operational and financial intelligence for clinicians, benchmarked against relevant peers and updated continuously. Jiro is HIPAA compliant, SOC 2 certified and offers accredited CME.

- HIPAA compliant
- SOC 2 certified
- Accredited CME

www.jirohealth.com

Disclaimer. This report is provided for informational purposes only. It presents benchmark estimates derived from claims, remits and price-transparency data; it does not constitute legal, financial, coding or reimbursement advice, and no organization should rely on it as a projection of its own results.