TELCOR®

PATHOLOGY BILLING

THE PATIENT YOU NEVER MEET

Fixing pathology's front-end data problem and the denials it creates.

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Fixing pathology's front-end data problem and the denials it creates.

A field perspective from TELCOR by Brandon Effle, Vice President, Customer Engagement, and Megan Edwards, Vice President, Integration. Written for billing and revenue cycle leaders, practice administrators, and CFOs at pathology groups.

IN THIS PAPER

We follow a pathology case from specimen to paid balance: where intake data breaks, what it costs, why moving billing into the LIS doesn't fix it, and a playbook any practice can use.

READING TIME

About 15 minutes. Exhibit 3 is built to be used, not just read.

EXECUTIVE SUMMARY

Pathology bills for patients it never sees. The name, birth date, insurance, and address on every claim were collected by someone else, usually a hospital or a referring office with little reason to get them right.

When that data is wrong, the claim is wrong before anyone in the practice has touched it. That makes the front end the cheapest place to recover revenue. When a practice fixes its intake data, the money shows up in a predictable order.

01

Fewer denials

The claim goes to the right payer with the right member ID the first time.

02

Faster cash

No research, rework, and resubmission loop between the claim and the payment.

03

Better patient collections

Statements reach the right person while the visit is still fresh in their mind.

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/ AT A GLANCE

The front end is where the money leaks

32%

of providers name incomplete or incorrect registration data as a leading cause of denials, up from 30% a year earlier.

Experian Health, State of Claims 2025[1]

90%

of denials need at least some human review before they go back out.

Experian Health, State of Claims 2025[2]

$57.23

average cost to fight one denied claim at hospitals and health systems in 2023, up from $43.84.

Premier Inc., 2025

These figures cover every kind of provider. Pathology, which collects none of its own intake data, sits at the hard end of that range.

Key takeaways

01	**The problem starts outside the lab.** Hospitals and referring offices send whatever their systems output, and most have no financial reason to send more.
02	**Payer information fails most often.** Wrong payer, missing member ID, and missing secondary coverage lead the list.
03	**Small claims make small errors expensive.** When working a denial costs more than the claim pays, the claim gets written off.
04	**Time is the hidden cost.** Every week spent chasing the right insurance shrinks the timely filing window and makes the patient less likely to pay.
05	**Moving billing into the LIS is not the fix.** Validation at intake, visibility by referring client, and a billing record built around the patient are.

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01 / THE PATIENT YOU NEVER MEET

Billed on data someone else collected

A biopsy arrives at a pathology group on a Tuesday. With it comes an electronic requisition from the hospital's order entry system. The patient is listed as Jenny J. Smith. The payer field says "BCBS NE," typed in manually. There is no member ID, no secondary coverage, and no guarantor address.

The pathologist reads the slide, adds a special stain, and signs the case out. The diagnosis code that goes on the claim comes from that read, not from the hospital. Then the billing work starts. Someone has to figure out which Blue Cross plan "BCBS NE" means. The eligibility check comes back under Jennifer J. Smith. Weeks later, a Medicare remittance reveals a secondary payer nobody mentioned. Two months after that, the hospital sends a new order for the same patient, now named Jenny Joe Smith, with the old insurance attached.

By the time the claims are paid, the patient owes a balance. Her statement arrives months after a procedure she barely remembers, from a lab she has never heard of. If the address on file is wrong, it never arrives at all, and the balance is eventually adjusted off.

This case is a composite, but every detail in it comes from pathology groups the authors have worked with. None of it is unusual.

DAY ONE	SIGN-OUT	INTO BILLING	WEEKS LATER	TWO MONTHS ON	MONTHS LATER
Order arrives as Jenny J. Smith. Payer typed as "BCBS NE." No member ID.	The pathologist reads the slide, adds a stain, and sets the diagnosis.	Eligibility runs and comes back under Jennifer J. Smith.	A Medicare remit reveals a secondary payer nobody mentioned.	A new order arrives as Jenny Joe Smith, with the old insurance.	The statement reaches a patient who barely remembers the visit, or never arrives.

"Every hospital has their own way of providing data, if they provide any data at all. You deal with a lot of red tape. And the truth is that some hospitals are simply not invested in helping the pathology group get reimbursed."

MEGAN EDWARDS

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Why pathology is different

Most providers collect their own registration data. A physician office has a front desk, a copy of the insurance card, and a patient standing in front of them. A pathology group has none of that. It receives a specimen and whatever data the referring site chose to send, and every error made at that site travels straight into the claim. Pathology then adds its own complexity on top.

Split charges
A global charge is often split: the professional component to insurance, the technical component to the client, by contract, payer, and procedure.

Legacy credentialing
Many groups were credentialed decades ago and carry payer requirements newer practices never see.

The pathologist's diagnosis
The diagnosis that matters is usually set after the slide is read, not the one on the order.

Each of those rules depends on the patient's basic facts. The professional component only reaches the right insurer if the payer on file is right, payer requirements only apply if the claim goes to the right plan, and the pathologist's diagnosis only gets paid if it lands on the right patient's claim. When those facts are wrong, the specialized work goes unpaid. That is where the money starts to leak.

02 / WHERE THE DATA COMES FROM AND WHERE IT BREAKS

It starts outside the lab's walls

A pathology group's intake data comes from many places at once: one or more hospitals, physician offices, outpatient clinics, and other referring clients. Each sends data its own way. Hospitals typically send a standardized flat file and leave the lab to work with it. Physician offices and clinics send electronic orders from a range of order entry systems, and some still send paper requisitions. Faxes have not gone away, though most now move electronically rather than through a machine.

Hospitals	Standardized flat files, sent as they always are
Physician offices	Electronic orders from many order entry systems
Clinical and other clients	Electronic orders and some paper requisitions
Fax	Still in use, now most electronic

→

Pathology Group
Every source in its own format, before any system the lab owns has touched the case.

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Hospitals are usually the messiest source. Both authors agree on this, and the reason is economic. The hospital may bill the technical component, but collecting the professional component is the pathology group's job. Sending complete, accurate data is extra work, and nothing pays the hospital to do it. Labs, for their part, rarely hold a test while they wait for missing information, because nobody wants to stand between a patient and a diagnosis.

Smaller groups often won't ask for better data. Larger practices have the leverage to require certain fields from their clients. Smaller ones worry that a client asked to do extra work will move to a lab that doesn't ask. So they take what they get, sometimes just a last name, first name, date of birth, and gender, and do the rest of the legwork themselves.

More sources mean more ways to break. A group that serves several hospitals has two basic options. It can route every feed through its LIS and map each one there, or it can push each file directly into its billing system. Either way, every format has to be normalized, and patients who visit more than one referring site have to be matched across them. In a large market, name, birth date, and gender are not enough to tell one Smith from another. A shared patient identifier helps a great deal.

Repeat patients create a quieter risk. Pathology sees the same patients again and again. If the billing team has cleaned up a record and confirmed coverage, the next order from a careless source can overwrite that work with the same bad data. The fix is to control updates by source: accept them from referring sites that send good data, and block them from those that don't.

WHAT A BARE-BONES ORDER CAN LOOK LIKE

LAST NAME	FIRST NAME	DATE OF BIRTH	GENDER
Smith	Jenny J	Received	Received
PAYER	**MEMBER ID**	**GUARANTOR**	**ADDRESS**
Missing	Missing	Missing	Missing

Four fields arrive. The four the claim and the statement depend on are left for the pathology group to find.

EXHIBIT 1

The intake errors that cost pathology the most

RANK	BREAKDOWN	WHAT IT LOOKS LIKE	WHERE IT SHOWS UP
1	**Wrong or outdated payer**	Coverage not rechecked at the referring site, or a change never passed along	Failed eligibility check, or a denial
2	**Missing member ID**	Payer named, ID field blank	Claim held, or rejected

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3	**Missing secondary coverage**	Only the primary payer sent	Found when Medicare crosses the claim over to another payer
4	**Free-text payer names**	"BCBS," "BCBS of Nebraska," and "BCBS NE" for the same plan	Manual payer matching for every new spelling
5	**Inconsistent patient names**	Jenny Joe Smith, Jenny J. Smith, Jennifer J. Smith	Eligibility mismatches and duplicate records
6	**Missing guarantor information**	Patient data sent, responsible party left off	Statements can't go out, and guarantor balances age
7	**Bad updates over clean records**	A new order resends old insurance	Accounts already fixed break again

The first three are the errors the authors see most often. The rest are common enough that every practice should plan for them.

03/ HOW BAD DATA BECOMES DENIALS

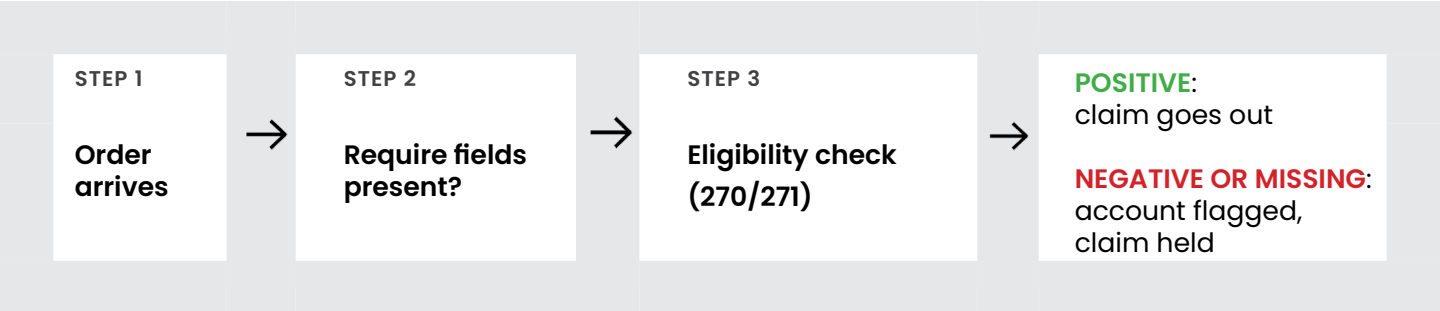
Caught at the door or caught by the payer

Every intake error ends up in one of two places. Either the billing system catches it before the claim goes out or the payer catches it afterward. The first costs a few minutes. The second costs a denial, a rework cycle, and weeks of waiting.

The industry numbers show how often it goes the second way. In Experian Health's 2025 State of Claims[3] survey, incomplete or incorrect registration data ranked as the third most cited cause of denials, named by 32% of providers. More than a quarter of respondents said at least 10% of their denials trace back to data collected at intake.

WHAT GOOD FRONT-END CONTROLS CATCH

A well-run billing operation stops bad claims at the door. If a field the claim requires is missing, the claim is held until someone fixes it. If the payer is known, an electronic eligibility check (the 270/271 exchange) confirms coverage. A positive response lets the claim go. A negative response flags the account and holds the claim.



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80 to 85%

of eligibility problems are corrected before a claim goes out when the system is properly configured, in Brandon Effle's experience

Those controls have limits. Some eligibility responses don't flag a problem even when there is one, and some payers don't support eligibility checks at all. Those claims go out and come back as eligibility rejections. Even so, the controls catch most problems before a claim is ever sent. That saves the lab the cost of submitting a claim only to submit it again.

WHAT SLIPS THROUGH

Missing secondary coverage is a common example. The practice often learns about it only when Medicare processes the claim and crosses it over to another payer. A good system can detect that crossover and add the secondary payer to the account automatically. Without that automation, someone has to catch it manually, and the claim waits.

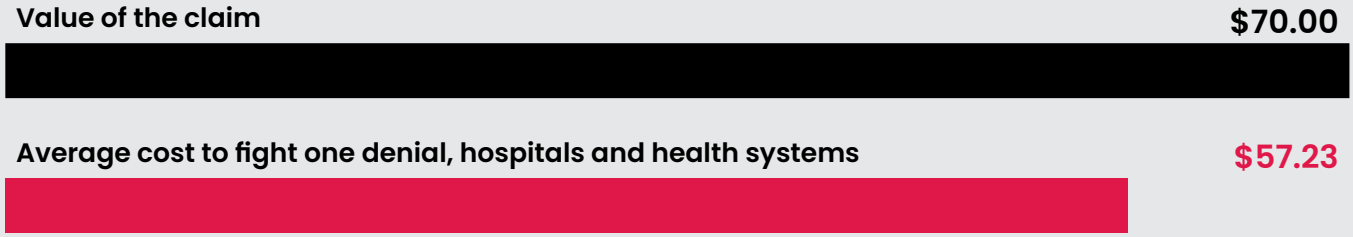
Coding adds another layer. In pathology, the pathologist usually sets the primary diagnosis after reading the slide, and many groups have certified coders review the result report before the claim goes out. When the rendering pathologist doesn't code, or codes inconsistently, claims slow down and coding denials need a specialist to sort out.

The common thread is timing. Too often, a practice learns the data was wrong only when the denial comes back.

SIDEBAR

The $70 claim problem

Picture a pathology claim worth about $70. It is denied because the member ID was missing.



Cost figure: Premier Inc., 2025, a survey of 280 hospitals covering 2023 claims[4]. Bars drawn to scale.

In Premier's survey, most of that cost was staff labor, often spread over several rounds of review lasting 45 to 60 days each. A pathology denial is usually simpler to fix than a hospital one, but even a fraction of that cost eats most of a $70 claim.

Practices know this math, which is why many small denials are never worked. Some practices set rules that automatically adjust off denials they know they cannot win on a given code and payer. That is a sensible way to clear the queue, but it is still lost revenue.

The only way to collect the $70 is to get the claim right the first time.

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> **"Fixing a claim costs more than just getting it right the first time. When a denied claim gets worked by a person, it has to be researched, corrected, and resubmitted, and sometimes appealed. But the cost of working that claim can sometimes exceed the reimbursement you get."**
>
> MEGAN EDWARDS

04 / THE COLLECTIONS COST

Accuracy is a collections strategy

Front-end accuracy is not a clerical task. For a CFO or practice owner, every intake error carries three costs at once: the labor to fix it, the delay before the money arrives, and the risk that the money never arrives at all.

THE MONEY MOVES IN A SEQUENCE

Asked where a practice would see the benefit first if it cleaned up intake, both authors gave the same order. Each gain sets up the next.

01
Denial rates fall
Claims reach the right payer with the right ID

→

02
Payments speed up
No research and resubmission cycle.

→

03
AR work shrinks
Fewer claims need a person to touch them.

This matters more in pathology than in many other lab settings. Most pathology services are covered codes on the Medicare fee schedule, and payment rarely depends on arguing medical necessity. When the claim goes to the right payer with the right information, it usually gets paid. That makes intake data the biggest variable a pathology group can control.

> **"The further you get away from the service date, the more questions the patient's going to have and the more hesitancy they're going to have to pay the statement."**
>
> BRANDON EFFLE

TIME IS WHERE THE DOLLARS DISAPPEAR

The cost of bad data is not only the rework. It is the calendar. Finding the right payer can take months, and every day without it, the timely filing window gets shorter.

The patient side suffers, too. A claim that finally goes out two or three months after the date of service may still be paid in full by the payer. But if there is a patient balance, the statement now reaches someone who has forgotten the procedure and has never heard of the lab. The further

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the bill lands from the date of service, the more questions the patient has and the less likely they are to pay.

A missing guarantor address makes it worse. The payer can process the claim without one, so the balance moves to guarantor accounts receivable and sits there. When the address is finally found, the statement may arrive a year after the service. The patient calls, upset, and most labs adjust the balance off.

EXHIBIT 2

ONE INTAKE ERROR, TWO WAYS THE DOLLAR IS LOST

PAYER SIDE	PATIENT SIDE
Intake error Wrong payer, missing member ID or secondary	**Intake error** Bad address, phone, or email; no guarantor
↓	↓
Claim rejected or denied Caught by the payer, not before submission	**Balance waits in guarantor AR** The payer pays; the statement can't go out
↓	↓
Research and rework Staff time to research, fix, and resubmit	**Statement arrives months late** The patient no longer recalls the service
↓	↓
Small denials left unworked The cost to work them exceeds what they pay	**Patient calls or ignores it** Unknown lab, unfamiliar date of service
↓	↓
Written off Or paid late, close to the timely filing limit	**Adjusted off** The balance is never collected

Every step adds weeks, and the timely filing window keeps closing. The same intake error can cost a practice twice: once on the claim, and again on the patient balance.

REACHING THE PATIENT WHEN THE DATA IS WRONG

Digital channels give practices a way around a bad mailing address. Statements by email, text reminders, and patient portals can reach the responsible party even when the address is wrong.

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Email statements	Text reminders	Patient portal	A bill to the patient
Reach the responsible party without a street address	A nudge that arrives while the visit is recent	One place to see the balance and pay it	Often the fastest way to surface the right insurance

Sometimes the fastest way to find the right insurance is to send the patient a bill. A patient who gets an unexpected $300 statement tends to call quickly with the right information. Many pathology groups treat that as a last resort, preferring to do the legwork themselves. It is worth reconsidering, because the legwork costs money and time the practice may not have.

THE EXECUTIVE MEASURE

Clean claims are the floor. The measure that matters is dollars collected and how fast they arrive.

A practice that tracks intake errors with the same rigor it tracks denials will find most of its recoverable revenue upstream.

05/ THE PATIENT SIDE

One medical event, a stack of bills

To the patient, it was one medical event. They went in for a procedure. Then the bills started arriving from providers they had never heard of.

A single pathology patient can generate a biopsy, special stains, molecular tests, and clinical tests, sometimes ordered by more than one provider. Each can become its own encounter and its own statement. Some of the confusion is outside the lab's control. When the technical and professional components are billed by different entities, the patient will get separate statements. Some payers also require the date of service to be the date the pathologist signed the case out, so the explanation of benefits shows a date that doesn't match anything the patient remembers.

ONE PATIENT, TWO WAYS TO BILL

Billed encounter by encounter

Biopsy → Statement

Special stains → Statement

Molecular test → Statement

Clinical tests → Statement

Four bills for one procedure, from a lab the patient has never heard of.

Billed around the patient

Biopsy, special stains, molecular test, clinical tests ↓

ONE STATEMENT

One balance across every ordering client with a letter that explains who the lab is.

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Practices can still do a lot to make the experience clearer:

01

Consolidate statements

One statement per patient, across every ordering client, replaces a stack of small bills with a single balance the patient can understand.

02

Introduce the lab early

An automatic account letter names the ordering provider and explains that a statement may follow, so a later text or email isn't dismissed as spam.

03

Start at the ordering office

Patients trust their own provider. A short explanation there that a separate lab will bill for the pathology work heads off many calls.

All of this depends on intake. A practice cannot send a clear statement, an account letter, or a text reminder to a patient whose address, email, or phone number is wrong. And every week spent fixing bad data pushes the first statement further from the date of service, when the patient is least able to make sense of it.

> **"You can't communicate with your patient if you don't have clean data for their email, phone number, or address."**
>
> BRANDON EFFLE

06 / WHY MOVING BILLING INTO THE LIS ISN'T ENOUGH

The worst data never touches your LIS first

A common pitch in pathology is that billing belongs inside the laboratory information system. Put the LIS and billing on one database, the argument goes, and the data silos disappear.

There is something to that. A shared database helps with data the lab creates itself, such as results, sign-out dates, and the pathologist's diagnosis. But the data that causes the most denials is not created by the lab. It comes from dozens of referring systems, from order entry screens that allow free text, from faxes, and from paper. It is already wrong when it arrives, and sharing a database inside the lab does nothing to fix it.

OUTSIDE THE LAB'S WALLS

Where the errors start

Free-text payer names / skipped fields / faxes and paper / hospital order entry systems / stale coverage

→

INSIDE THE LAB

LIS and billing on one database

Shares the data the lab creates. The errors have already arrived with the order.

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> **"Whether it's in the LIS or the RCM solution, you can't do anything with data you don't have."**
>
> MEGAN EDWARDS

Effle puts it in practical terms. The problem starts at order entry. If a hospital can type any payer name it likes, or skip a field entirely, the damage is done before the specimen reaches the lab. Most hospital orders come from the hospital's own order entry system, not the lab's LIS, so changing where billing lives doesn't change what comes in the door.

There is also a cost to the all-in-one route. Replacing an LIS to fix billing is a long and risky project that touches every part of the lab. Practices can fix the front end without ripping out the systems their pathologists and technologists rely on.

WHAT HELPS: TOOLS THAT WORK ON THE DATA WHEREVER IT COMES FROM

Validation at intake

Hold claims with missing required fields, check eligibility before the claim goes out, and validate formats such as the Medicare beneficiary identifier.

Normalization across sources

Translate every referring site's format, payer spelling, and code set into one clean structure.

Update controls by source

Accept updates from referring sites that send good data, and block them from sites that would overwrite a record the billing team already fixed.

A record built around the patient

One permanent demographic record that tracks every transaction and insurance change, including when and why each change occurred.

	BUILT AROUND EACH ENCOUNTER	BUILT AROUND THE PATIENT
Insurance corrections	Fixed on every encounter	Fixed once and every claim follows
Statements	A separate statement for each encounter	One consolidated statement
Payer frequency rules	No way to see the earlier test	The second order is flagged before it goes out
History	Scattered across encounters	Every change, when it happens, and why

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OUTSIDE THE LAB'S WALLS

1. What happens to data that arrives wrong from a referring client we don't control?
2. Can we block updates from one source while accepting them from another?
3. Can we see intake errors and denials broken out by referring client?
4. How do you handle a payer name that was typed in as free text?
5. If we correct a patient's insurance once, does every open claim follow?
6. Do we have to replace our LIS to get any of this?

Most pathology groups can't force their referring clients to send better data. They can make bad data visible, make good data easier to send, and stop errors before they become claims.

Make the problem visible, client by client

Track intake errors by referring provider. Trend eligibility rejections, remittance codes, and missing fields for each client. That turns a vague complaint into a specific conversation: here is every order you sent without a member ID last quarter, and here is how you compare with our other clients.

Then choose the right messenger. Some groups send these reports to the internal sales rep who owns the client relationship. The rep's commission often depends on that client's claims getting paid, and the rep can raise the issue without the billing team becoming the bad guy. Larger groups sometimes go further and bill the client for orders sent without required information. Smaller groups usually can't risk that, which makes visibility and the sales channel even more important for them.

FOUR CHANGES TO MAKE NEXT QUARTER

01	**Make it easy to order correctly** Move clients to electronic orders wherever possible. Make key fields mandatory and replace free-text payer fields with a pick list.
02	**Use every validation rule you have** Hold claims that are missing required information. Validate formats, such as the Medicare beneficiary identifier. Tighten eligibility rules so the right payer is on the claim the first time. Automate crossover payers so a secondary that Medicare identifies is added to the account without anyone touching it.

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03	**Fix interface mapping at the source** If the same error keeps showing up from one interface, it is usually a mapping or configuration problem. Fix it once and the error stops for every future order from that source.
04	**Clear the noise on the back end** If a certain denial on a certain code from a certain payer is never worth fighting, set the system to adjust it off automatically. Then the workqueue holds only claims with money behind them.

> **"Let the system automate the button pushing activities and have your staff become the critical thinkers for items outside of the scope of normal."**
>
> BRANDON EFFLE

WHERE AI HELPS TODAY AND WHERE IT DOESN'T

Where AI helps

AI is useful where referring providers send no electronic data or too little. It can read a paper requisition or a pathology report and turn it into a billing file, replacing manual charge entry. It can also read diagnosis codes from a requisition.

Where a person stays in charge

In every case, a biller should still review the output before it goes out. It is faster than manual entry, but a person stays accountable for the result.

AI is also not the only lever. Many of the biggest gains in pathology billing come from automation and configuration that need no AI at all: rules that split technical and professional charges by contract, validation that holds bad claims, and interfaces that bring data in cleanly. A practice that hasn't used those tools fully will get more from them than from any new AI feature.

THE MISTAKES PRACTICES MAKE WHEN THEY FIX THIS ON THEIR OWN

The most common mistake is not asking. One pathology group the authors worked with kept entering charges by hand for months because the billing team assumed an electronic charge file wasn't possible. When someone finally asked the lab manager, the answer was yes. Long-established groups often do things a certain way because they always have, and nobody goes upstream to check whether that is still true.

The second mistake is copying the old process into a new system. Changing vendors is a chance to rethink the workflow, not to rebuild the same manual steps on better software.

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> Don’t buy a Porsche and drive it like a Buick.”
>
> THE LATE JIM TERRANO, TELCOR CO-FOUNDER

EXHIBIT 3

Front-end self-assessment

Check each statement that is true for your practice today. Any box left empty is a place where revenue is likely leaking.

☐ Most of our orders arrive electronically, not on paper or by fax.	☐ Referring clients choose the payer from a list instead of typing it in.
☐ Claims missing a required field are held automatically before they go out.	☐ We check eligibility electronically before every claim is submitted.
☐ We validate member ID formats, including Medicare beneficiary identifiers.	☐ Secondary payers identified by Medicare are added to the account automatically.
☐ We can block updates from a referring source that sends bad data.	☐ A patient’s insurance is corrected once, and every open claim follows.
☐ We can report intake errors and denials by referring client.	☐ We share those reports with clients or their sales reps at least quarterly.
☐ Low-value denials we never win are adjusted off by rule, not by hand.	☐ Patients receive one consolidated statement by mail, email, text, or portal.

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08 / HOW TELCOR APPROACHES IT

Clean the data wherever it comes from

TELCOR has built lab revenue cycle software for more than 30 years, and pathology groups have been part of that work from the start. The approach in this paper is the one we use with our own clients: clean the data wherever it comes from, catch errors before they become claims, and keep every dollar visible.

Built for data you don't control	TELCOR RCM works with any LIS, EHR, or clearinghouse, so practices fix the front end without replacing lab systems. It normalizes every referring source, holds claims with missing information, checks eligibility first, and controls which sources can update a record.
Built around the patient	Each patient has one permanent record. Change the insurance once and every claim follows. Patients get one consolidated statement across ordering clients, plus account letters, email, text, and portals.
Built for pathology's complexity	Technical and professional splits are automated by client contract, payer, and procedure. Crossover payers are added automatically. Payer rules for units, modifiers, and frequency are configured so claims go out in line with policy.
AI where it earns its place	TELCOR AI Systems handles the document work behind the claim, such as reading paper requisitions and records and turning paper into billable data, with a biller in command of every result.
Accountable, with no black box	Exception-based workqueues put staff on the claims that need them. Real-time dashboards show every claim, denial, and payment by client, payer, and CPT code, whether billing runs in house or with TELCOR Revenue Cycle Services, the TELCOR billing service.

18%

more collected on average

Fixed-price implementation

To see where your intake data is costing you, start with the self-assessment in Exhibit 3. Then talk with a TELCOR revenue cycle specialist.

Talk to us

telcor.com

TELCOR®

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ABOUT THE CONTRIBUTORS



Brandon Effle

VICE PRESIDENT, CUSTOMER ENGAGEMENT, TELCOR

Brandon Effle leads TELCOR's customer engagement team. In almost 14 years with the company, he has implemented billing for 20 to 25 pathology groups, working through the client contracts, legacy credentialing, and technical and professional splits that make pathology billing different. He pushes new clients to rethink their workflows rather than carry old ones onto a new system.



Megan Edwards

VICE PRESIDENT, INTEGRATION, TELCOR

Megan Edwards leads TELCOR's integration team, which gets client data into and out of the TELCOR platform. In 13 years with TELCOR, starting in customer engagement, she has worked with roughly 25 pathology groups and many more labs with a pathology component, normalizing hospital feeds, mapping interfaces, and matching patients across referring sources.

SOURCES

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Quotations are drawn from a recorded conversation with Brandon Effle and Megan Edwards, October 16, 2026, lightly edited for length and readability. The opening case is a composite drawn from the authors' work with pathology groups.

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