

Closing the Revenue Gap: A Strategic Approach for Laboratory Billing Executives

The financial environment for clinical laboratories and pathology practices has never been more challenging. Driven by aging populations, chronic disease, and precision medicine, the demand for diagnostic testing continues to grow. Additionally, labs continue to face relentless pressure on reimbursement rates.

> A gap analysis shows where your billing is falling short and what needs to change to protect revenue. Reach out to us today for a no-risk analysis and ROI on your current billing processes to ensure you're getting paid for the work you do.

Clinical laboratories face unrelenting financial pressure. Declining reimbursement rates, increasing denial volumes, and tightening compliance requirements create constant challenges for billing executives. Many labs have invested in billing software and internal revenue cycle teams only to find that reimbursements remain delayed, denial backlogs grow, and staff are consumed by rework instead of prevention.

A comprehensive Revenue Cycle Management (RCM) gap analysis offers a way forward. This structured, data-driven review reveals where revenue leaks occur, identifies inefficiencies, and highlights compliance exposures before they become costly. For executives, it provides a clear, prioritized roadmap to strengthen financial health.

Why a Gap Analysis Matters

Industry data show labs can lose millions of dollars annually to preventable denials and process failures. A single percentage point reduction in denials can translate into significant revenue gains for even a mid-sized lab.

The benefits of a well-executed gap analysis are substantial:

- Revenue Protection: Identifying and addressing the root causes of denials

reduces unnecessary write-offs and preserves margins.

- Cash Flow Optimization: Cleaner claims and streamlined workflows shorten days in accounts receivable and reduce reliance on credit lines.
- Compliance Assurance: A detailed review of coding, documentation, and billing practices helps labs avoid penalties and payer recoupments.
- Strategic Leverage: Reliable data supports stronger payer negotiations and informed investments in automation and staffing.

Core Components of an RCM Gap Analysis

A best-practice gap analysis evaluates every stage of the billing continuum to uncover weaknesses and opportunities.

Front-End Processes. Front-end operations set the foundation for every subsequent step in the revenue cycle. Weaknesses here almost always multiply downstream.

Key activities include:

- Patient Registration Accuracy: A mistyped date of birth or incomplete insurance record can trigger a denial before a claim reaches a payer.
- Insurance Eligibility Verification: Verifying



coverage before services are performed ensures the lab is paid for the work. Automated eligibility checks integrated with scheduling or order-entry systems can prevent costly last-minute surprises.

- **Prior Authorization:** Particularly critical for molecular and genetic testing, prior authorization requires coordination with ordering physicians and must be verified before samples are processed.

A thorough analysis examines how information is collected, validated, and transferred. It assesses whether electronic requisition systems enforce mandatory fields and whether staff are trained to flag missing documentation at the point of intake.

Mid-Cycle Integrity. The mid-cycle stage converts clinical activity into billable services. Errors here jeopardize compliance and revenue alike.

- **Charge Capture:** Every test performed must be properly recorded. Missed or delayed charges lead to direct revenue loss. A gap analysis checks whether laboratory information systems (LIS) interface seamlessly with billing platforms and whether reconciliation procedures catch omissions.
- **Coding Accuracy:** CPT and ICD-10 coding must match payer requirements and reflect the actual services performed. An audit should verify whether coders receive timely updates on evolving guidelines and whether automated edits flag mismatched or obsolete codes.
- **Documentation of Medical Necessity:** Supporting clinical notes and requisitions must justify each test to withstand audits and prevent recoupment.

The review focuses on data handoffs between LIS, electronic health record systems, and billing modules, ensuring that test results and documentation flow without disruption.

Back-End Efficiency. The back end converts clean claims into cash. Even when front- and mid-cycle processes are solid, breakdowns here can stall collections.

- **Claims Submission:** The analysis examines clearinghouse integrations, transmission schedules, and rejection patterns to ensure claims reach payers quickly and completely.
- **Denial Management:** Tracking denials by root cause, payer, and test type allows staff to correct systemic issues rather than repeatedly resubmit claims. Effective denial workflows shorten resolution times and reduce write-offs.
- **Collections Strategy:** For both payer and patient balances, the analysis evaluates follow-up procedures, payment plan options, and timeliness of outreach.

The goal is to ensure that every valid claim progresses from submission to payment without unnecessary rework or delays.

Technology and Reporting. Data visibility and integration enable every other component to function effectively.

- **LIS/RCM Integration:** Eliminating duplicate data entry and reconciling lab orders with billing systems minimizes errors and improves speed.
- **Real-Time KPI Dashboards:** Dashboards that track denial trends, payer mix, and days in AR give executives immediate insight into performance.
- **Benchmarking and Analytics:** Comparing performance against industry standards highlights areas for targeted investment and continuous improvement.

A gap analysis evaluates whether the current technology infrastructure supports these needs and recommends enhancements, from automated edits to advanced analytics, to sustain long-term results.



Step-by-Step Process

A disciplined 7-step methodology keeps the project focused and produces actionable results.

1. Set Objective

Define a single, concrete business problem to solve, such as cutting denials for a specific payer segment or reducing days in AR for molecular claims. Write the objective so it is clear, financially meaningful, and time bound, and get leadership agreement before moving on.

2. Map Current State

Document how work actually happens from order to payment, not how you think it happens. Capture handoffs, systems, edits, and decision points across intake, LIS, billing, clearinghouse, and payer touchpoints. Pull baseline metrics for denial categories, first pass clean claim rate, days in AR, and write-off patterns so you can quantify gaps later.

3. Define Target

Translate the objective into measurable targets that reflect financial impact. Set explicit thresholds for metrics such as first pass clean claim rate, denial rate by root cause, or AR aging distribution by payer. Align targets with budget, staffing, and technology constraints so they are aggressive yet achievable.

4. Root-Cause Analysis

Drill into the data to isolate the few issues that create most of the loss. Segment by payer, CPT, ICD-10, test type, site, and submitter to see where defects cluster. Validate hypotheses with chart reviews, workflow observations, and claim tracing so you separate symptoms from true causes.

5. Action Planning Using SMART Goals

Convert each root cause into a specific corrective action with an owner, start date, and deadline. Define how success will be measured, how data will be captured, and what policy,

form, or system change is required. Include change management items such as training, quick reference guides, and audit criteria so adoption sticks.

Specific. The goal is clear and unambiguous, stating exactly what needs to be accomplished.

Measurable. Progress and success can be tracked with concrete metrics or criteria.

Achievable. The goal is realistic and attainable with available resources and constraints.

Relevant. It aligns with broader organizational priorities and delivers meaningful impact.

Time-bound. There is a defined deadline or timeframe for completion.

6. Execution and Measurement

Pilot changes in a limited scope first, then scale once results are proven. Track leading indicators weekly, such as eligibility pass rates or clean claim yield, and track lagging indicators monthly, such as denial reductions and cash acceleration. Review progress with leadership on a fixed cadence and remove roadblocks quickly.

7. Gap Analysis Graphic or Fishbone Model

Visualize the problem and its drivers so teams align priorities fast. Use a fishbone diagram to group causes under categories like People, Process, Technology, Data, and Payer Policy, then link each branch to a corrective action. Refresh the graphic as you learn and keep it visible in meetings, so focus does not drift.

Tools, Automation, and Analytics

Automation and data transparency are critical to modern revenue cycle management. Automated eligibility checks, robotic process automation for claim scrubbing, and real-time dashboards all help maintain clean claims and efficient workflows.



Analytics tools track denial patterns, payer performance, and key metrics like days in AR and clean claim rates. While automation reduces manual effort, human oversight remains essential to ensure that algorithms and rules remain accurate as payer requirements evolve.

Organizational Engagement

Revenue cycle management is an enterprise-wide responsibility. Success depends on cross-functional participation from clinicians, intake staff, sales, and IT. Ordering clinicians must provide complete requisition information, including medical necessity documentation, to prevent downstream denials. Intake and accessioning staff need training to catch incomplete or incorrect data before testing begins. Engaging diverse stakeholders promotes accountability and ensures sustainable improvements.

Common Pitfalls to Avoid

Even well-planned projects can falter without careful attention to common missteps. Laboratories that anticipate these challenges will see stronger, lasting results.

Scope Creep

Teams often identify additional issues during analysis and are tempted to expand the project. While continuous improvement is important, expanding beyond the initial objectives can dilute focus and delay measurable progress. Define a clear statement of work at the outset and treat new discoveries as separate future projects.

Front-End Oversight

Failure to address intake errors undermines the entire revenue cycle. Missing prior authorizations, inaccurate demographics, and incomplete test requisitions are leading causes of denials. Addressing these issues requires close coordination with clinicians and intake teams and may involve redesigning electronic

Case Study: Transforming Lab RCM

A mid-sized pathology group processing 100,000 claims per month struggled with:

- 40% claims error rate.
- Frequent denials across commercial payers.
- Average time in AR exceeding 90 days.

Interventions:

- Implemented automated front-end validation.
- Introduced denial tracking with root-cause reporting.
- Trained staff on payer-specific coding requirements.

Results:

- Denials reduced by 30%.
- First-pass claim rate improved by 25%.
- Net revenue increased by 15% within six months.
- CFO reported more predictable cash flow and reduced reliance on external financing.

requisition forms to require mandatory fields.

Insufficient Root Cause Analysis

Under time pressure, it is easy to assume the cause of a problem without thorough investigation. Acting on assumptions can lead to ineffective fixes. Successful teams rely on data and detailed reviews to identify the true source of denials or payment delays.

Inadequate Follow-Up and Governance

Implementing new policies without ongoing monitoring leads to backsliding. Some staff may miss training sessions, revert to old habits, or misunderstand new procedures. Establish a cadence of monthly KPI reviews and quarterly deep dives to ensure compliance and measure improvements. Use dashboards to track adoption and performance across teams.



Limited Training and Communication

A gap analysis often requires process changes across multiple departments. Without consistent education and feedback, employees may feel disconnected or overwhelmed. Regular training sessions, open communication channels, and clear documentation help maintain alignment.

Failure to Update for Payer Changes

Payer policies and coding requirements evolve constantly. Without a process to monitor and implement updates, labs risk unexpected denials and revenue loss. Assign responsibility for tracking policy changes and ensure the billing system reflects the latest requirements.

By recognizing and addressing these pitfalls, laboratories can safeguard their efforts and sustain improvements over time.

Case Study: Turning Analysis into Profit

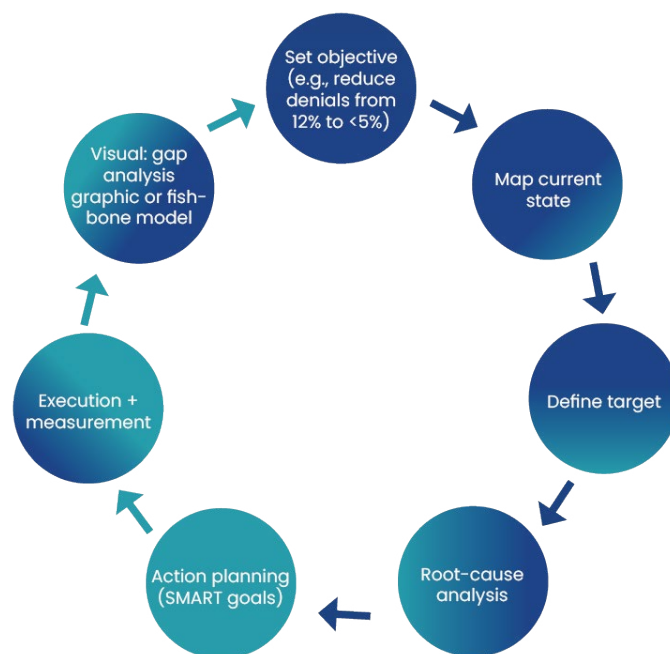
A mid-sized pathology group processing 100,000 claims per month faced a 40% claims error rate, frequent denials across commercial payers, and average days in AR exceeding 90 days. After implementing automated front-end validation, denial tracking with root-cause reporting, and targeted staff training, the lab achieved a 30% reduction in denials, a 25% improvement in first pass claim rates, and a 15% increase in net revenue within six months. The CFO reported more predictable cash flow and reduced reliance on external financing.

Conclusion

A gap analysis is not a one-time exercise but the start of a continuous improvement journey. Monthly KPI reviews, quarterly assessments of denial trends, and annual compliance audits keep the process on track. Regular staff training and leadership engagement ensure that improvements are not only implemented

but also maintained as payer policies and regulations evolve.

For laboratories and pathology practices, the financial pressures of today's reimbursement environment will not ease. Denials will grow more complex, compliance demands more rigorous, and payer negotiations less favorable.



A revenue cycle management gap analysis is the CFO's blueprint for navigating this environment. It identifies revenue leakage, accelerates collections, and strengthens compliance. Most importantly, it transforms the revenue cycle from a cost center into a strategic driver of financial health.

TELCOR is uniquely positioned to partner with labs on this journey. Our deep expertise in laboratory RCM and industry-leading tools provide the clarity and structure executives need to secure their revenue future. Ready to uncover where your lab is losing revenue? Contact TELCOR today for a no risk gap analysis and ROI evaluation.

