In-House, Outsourced, or Both

What each model actually costs an independent lab, which conditions decide it, and the one decision you should make separately from the rest.

A field perspective from TELCOR, informed by Kwami Edwards, Chief Operating Officer, and Sarah Stewart, Vice President, Revenue Cycle Services. Written for CFOs, RCM directors, and lab executives at independent and specialty laboratories.

IN THIS PAPER

Why the in-house/outsourced question is usually framed wrong, what is forcing it now, the honest case for each model, an ROI framework sized to a lab, and a self-assessment you can run before any vendor call.

READING TIME

About 11 minutes. Sections 5 and 7 are built to be used, not just read.

01 / THE DECISION IS USUALLY FRAMED WRONG

One question, three decisions

Planning can lead a lab to this decision, but more often it is triggered by a sentinel event. Established labs arrive at it after a collections shortfall, a discovered backlog, or the resignation of the one person who understood the payer rules. Startup labs arrive at it under time pressure, deciding whether billing is something they want to own while they are still trying to get a test to market. The question is asked in the same form: keep billing in house or hand it to a service.

That framing bundles three decisions that do not have to move together, and that have different time horizons and different reversal costs.

DECISION	WHAT IT ACTUALLY DETERMINES	COST TO REVERSE
Who owns the technology	Automation ceiling, reporting depth, cost per additional claim	High — a system replacement, a data migration, a cash-flow risk window
Who does the staffing	Payer expertise available per claim, capacity elasticity, turnover exposure	Moderate — a hiring cycle or a transition plan
Who is acccountable	Whether anyone can see the numbers behind the numbers	Low, but only if visibility was contracted for at the start

The market has already resolved the crude version of the question. Ninety-seven percent of healthcare organizations now outsource at least one revenue cycle function, and roughly 70% plan to expand what they outsource.[1] But near-universal partial outsourcing is not an argument for an all-or-nothing switch, and an independent lab has far less room than a health system to absorb a bad quarter while finding out. The labs that get the best return are not the ones that pick a side. They are the ones that answer the three questions separately.

> **"There's no wrong decision. It really is about the decision that best suits your organization. It comes down to how you want to execute that control."**
>
> KWAMI EDWARDS

02 / WHAT IS FORCING THE QUESTION NOW

Four pressures, arriving together

None of these pressures is new. What is new is that all four are compounding at once, and each one lands harder on a five-person billing team than on a hospital business office with a bench.

PRESSURE	WHAT THE DATA SHOWS	WHY IT IS WORSE AT LAB SCALE
Reimbursement	Medicare has paid roughly $4 billion less for lab services since PAMA cuts began in 2018, with cumulative reductions of 30% or more on common panels.[2] Cuts of up to 15% on nearly 800 tests are deferred to 2027, not cancelled.[3]	Rate relief is temporary and outside the lab's control; execution is the only lever left.
Denials	Providers reporting denial rates above 10% rose from 30% in 2022 to 41% in 2025; 68% say clean claims are harder to submit than a year ago.[4]	Denial work is near-fixed cost per denial, so a rising rate against flat headcount is a direct productivity loss.
Billing labor	Billing and front-office roles turn over at 30–40% a year, with replacement commonly costed at $25,000–$50,000 per biller.[5]	One departure is 20–50% of a small team's capacity, and there is no one to absorb it.
External shocks	After the 2024 clearinghouse outage, 94% of nearly 1,000 surveyed hospitals reported financial impact and 60% needed two weeks to three months to resume normal operations.[6]	Recovery depends on vendor responsiveness, which is a service question, not a technology one.

Turnover deserves one further note, because the visible cost understates it. Billing work loses

value while it waits: unworked claims age toward appeal deadlines and timely-filing limits, so a vacancy quietly converts delayed work into permanent write-offs.[5] The same scarcity shows up on the technical side of the lab — ASCP's 2024 Vacancy Survey found vacancy rates still above pre-pandemic levels, with retirements accelerating in 10 of 17 lab departments.[7] Institutional knowledge is leaving faster than it is being documented.

03/ THE HONEST CASE FOR IN-HOUSE

The highest ceiling, and three preconditions for reaching it

In-house billing, executed well, produces the best economics available to a lab. The lab controls its costs, its prioritization, its support vendors — clearinghouse, statements, records retrieval — and keeps the whole collections upside rather than sharing it. Nothing about outsourcing improves on that ceiling. The question is whether a given lab can reach it, and that turns on three conditions.

A BILLING OWNER, NOT A BILLING SUPERVISOR

Every in-house program that works has a strong billing manager or VP of RCM at the center of it — someone who understands payer policy well enough to translate it into system configuration, and who hires and directs support staff around it. The team follows that person's judgment, and so does the system: rules, edits and workflows only get built if someone knows which ones are worth building. Labs that keep billing in house without that person are not running an in-house model. They are running an unmanaged one.

A PAYER MIX TWO PEOPLE CAN MASTER

Variety matters more than volume here. A regional lab serving one or two states sees a stable, learnable set of payer behaviors, and a small team can genuinely become expert in it. A similarly sized lab billing nationally faces the same commercial complexity as a large one, with two people to cover it. Size does not determine the answer; payer breadth does.

TECHNOLOGY THAT ABSORBS VOLUME INSTEAD OF ADDING HEADCOUNT

Lab billing is not physician-office billing. A practice sees 30 patients a day; a lab may push thousands of claims through the same period, which means the economics are set by touches per claim rather than by staff count. A scalable platform lets a lab grow revenue on a flat team, which is where in-house margin expansion actually comes from. Without it, growth converts directly into hiring.

The strain points are the mirror image of the strengths. Turnover has no absorber. Ramp time varies by role and is rarely budgeted. System maintenance and payer-policy monitoring are ongoing obligations that compete with the same person's day job. And compliance risk does not transfer in either model — state and federal obligations remain the lab's regardless of who touches the claim. The honest summary: if staffing is already a headache, an in-house model will amplify it. If the lab can staff and manage it, the upside is real and it is the lab's to keep.

04 / THE HONEST CASE FOR OUTSOURCING

Depth on payers, not extra headcount

Outsourcing is the clear answer in four situations: a startup that needs its attention on the science; a lab growing faster than it can hire; a lab that has decided managing a billing team is not a burden it wants to carry; and a lab that has run billing in house long enough to conclude it does not have the expertise to maximize its revenue cycle. The deciding factor is not size. It is a gap between what the revenue cycle requires and what the lab wants to own.

The structural advantage is specialization. A lab with revenue to support one or two billers needs those people to know everything: eligibility, coding, every payer's appeal path. A service organizes the other way. TELCOR's claims teams are segregated by payer — Blue Cross, Medicare, Medicaid, UnitedHealthcare and other commercial payers — so a small lab's five UnitedHealthcare claims are worked by someone handling hundreds of them, who already knows the current policy and what the denial pattern means. That depth is not purchasable at small scale in house at any price.

Capacity elasticity is the second advantage, and it is why fast-growing labs use services deliberately rather than reluctantly. Volume can double without a hiring plan, and without the quality dip that comes from putting new hires into a live system.

What a lab genuinely gives up is control over method. A good service will not always run the process the lab would have designed, and will sometimes push back on a familiar practice that is costing the lab money. That is a feature, but it requires trust and it should be negotiated openly rather than discovered later.

What a lab should not give up is visibility. Outsourcing the work is not the same as outsourcing knowledge of the work. A lab should retain reporting it can drill into itself, insight into how its system is configured, and a standing conversation about its billing performance overall — not a monthly summary of the vendor's performance. Labs that keep that visibility can hold a service accountable and make informed decisions about their own revenue cycle. Labs that hand everything over are relying on someone else's summary of how they are doing.

> **"Seeing a report is great, but if you don't know what's behind it, you don't know what's really happening."**
>
> SARAH STEWART

FIVE RED FLAGS IN A BILLING-SERVICE EVALUATION

A good pitch and a good service are indistinguishable for the first hour. Every vendor has capable billers, and every vendor can produce an attractive report. The differentiation is in whether the

conversation reaches workflow, and the following five signals reliably indicate that it will not.

1. **The pitch leads with reporting and never reaches process.** Dashboards are the easiest thing in the category to build.
2. **No credible answer to your own scenarios.** Split-bill handling, or 10,000 additional patients in a day — what happens, and what does it do to turnaround?
3. **Results attributed to people rather than to method.** If the answer to every performance questions is staffing, you will be paying for headcount, not for collections.
4. **No named escalation path.** Ask what happens when something breaks, and who owns it by name.
5. **Reporting you receive but cannot interrogate.** If you can only see what is handed to you, you cannot verify it, and you cannot make an informed decision about your own revenue cycle.

References should be checked on service, not on satisfaction. The question that separates vendors is what happens when an issue needs resolution or a lab asks for an improvement: how fast the response is, who delivers it, and whether anything changes. A vendor that fails that test leaves the lab on an island, and a lab on an island may as well have picked any solution.

05/ BUILDING THE ROI CASE

Cost is not the comparison

The most common error in this evaluation is comparing prices instead of returns. A lab can employ fewer people, bill adequately, and post a lower cost line than any service would quote. The comparison that matters is what each model collects against what it costs, and the two are not independent: mediocre billing is cheap precisely because it leaves money uncollected.

The second error is comparing unlike scopes. An internal cost line is rarely just salaries. It is the platform, the clearinghouse, statements, records retrieval, and the tools a lab would otherwise license one at a time — some of which a vendor may bundle and others the lab contracts itself.

LINE ITEM	WHAT TO ESTABLISH BEFORE MODELING
Fully loaded headcount	Salary, benefits, overtime and coverage during vacancies, and the productivity shortfall over a replacement's first 60–90 days.
Primary vendor cost	The system or service fee, and how variable it is with volume. A percentage-of-collections model behaves very differently from a licensed platform in a growth year.

Tangential costs	Clearinghouse, statements, records retrieval and per-transaction fees. Some vendors bundle these; others, TELCOR included, leave the lab free to choose its own — usually cheaper and always more portable, but the costs have to be counted separately in any comparison.
Collections today	Percentage of allowed amount collected, split by payer class. This is the baseline; without it, every projected lift is unverifiable.
Realistic collections lift	Two percent or ten, and traceable to something specific: which failure today, corrected by which mechanism. A lift that cannot be attributed should be modeled as zero.
IT cost delta	Internal IT time currently spent on servers, interfaces and ad hoc data pulls — does it go away, or does the new model require adding it?
Efficiency gain	Touches per claim and rework volume. On the in-house side this frequently matters as much as the collections number, because it is what allows growth without hiring.

Time horizon should follow the lab's maturity. An established lab can reasonably ask whether the return lands inside twelve months. A newer lab should model over its own growth plan instead, because first-year volume does not represent the business it is building. Either horizon needs a second question attached: once the improvement lands, does it hold, or is there further upside from re-engineering the process behind it?

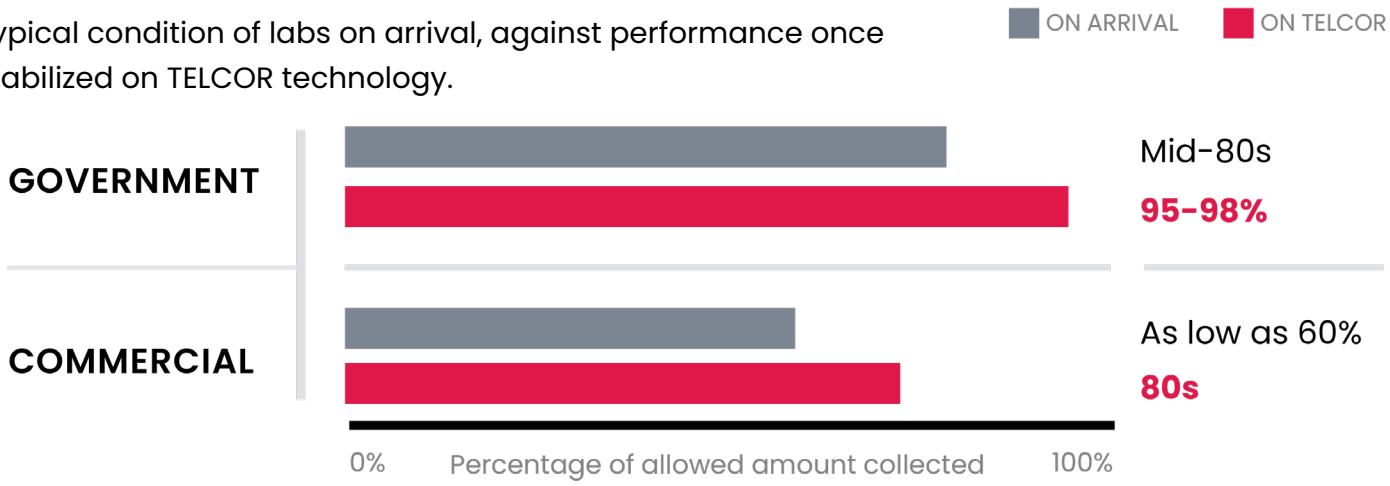
BENCHMARK — PERCENTAGE OF ALLOWED COLLECTED

Percentage of allowed amount is the metric that isolates execution from contract rates, which is why it is the one worth baselining before any vendor conversation. Across TELCOR's lab book, government payers typically run 95–98% of allowed; labs arriving from another model are frequently in the 80s. Commercial performance varies more widely: labs have arrived at roughly 60% of allowed and typically settle in the 80s. One Midwest lab moved from approximately 60% to approximately 80% of allowed after transitioning from unmanaged in-house billing to the service. The gain came from configuration and payer-level process, both of which are available to a lab running the same platform itself.

Observed averages across TELCOR, not guarantees. Results depend on payer mix, contracted rates, and starting condition.

FIGURE 1 — PERCENTAGE OF ALLOWED COLLECTED

Typical condition of labs on arrival, against performance once stabilized on TELCOR technology.



Observed ranges across TELCOR clients, not guarantees. The same collection opportunity is available whether a lab bills in-house or on the service, provided the underlying technology and process are the same. Bars are drawn to the midpoint of each stated range. Results depend on payer mix, contracted rates and starting condition.

06 / THE DECISION THAT OUTLASTS THE OTHER

Technology is the decision you will be living inside either way

The staffing question is answered for the lab that exists today. The technology question is answered for the lab that may exist in three years, and it determines whether changing the staffing answer later is a project or a crisis.

This is the point most evaluations miss, because technology is treated as a consequence of the staffing choice rather than as an independent decision. It is not. Weak technology fails in both models, in symmetrical ways: in house, it puts a capable team in a position where it cannot reach the collections it should; outsourced, it means the lab is paying for people to push buttons instead of paying for the collection opportunity. Automation, not headcount, sets the cost of a claim in either configuration.

A ONE-WAY DOOR

The lab hands over billing wholesale on the vendor's platform. Configuration, history and payer knowledge accumulate somewhere the lab cannot see. Bringing the work back in house means a system selection, an implementation, a data migration and a clearinghouse change — during which cash is at risk. Most labs in this position never move, whatever the performance.

A REVERSIBLE DECISION

The service runs on a platform the lab can license directly. Taking billing in house means the same system, the same configuration, the same history and the same connections, with no clearinghouse change and no cash-flow gap. The staffing model becomes a decision the lab can revisit as conditions change, rather than a commitment.

TELCOR built both models on one platform for this reason. TELCOR RCM is licensed to labs running their own billing; TELCOR Revenue Cycle Services bills on behalf of labs that would rather not, on the same technology, with the same reporting. Labs move between the two without a system change, and some plan for it deliberately — using the service through a period of fast growth, then bringing the work in house once volume stabilizes and a billing team can be built around it.

Control, framed this way, is not a synonym for in-house. In-house offers maximum control, but a lab on a service still needs meaningful control of specific things — reporting depth, configuration visibility, and above all its own client relationships. Labs work hard to win their ordering clients; client services, hierarchy and communication should stay with the lab even when claims work does not.

> **"In an outsourced model, if you don't have solid technology, you're going to pay for people pushing buttons."**
>
> KWAMI EDWARDS

07 / BEFORE ANY VENDOR CALL

The single most diagnostic question a lab CFO can ask is not about cost or vendors. It is about what the billing team does all day.

What are the actual tasks my team performs day to day — data entry, or calling payers and investigating? Entry-level work or higher-level thinking?

The answer separates the two problems that get confused with each other. A team consumed by repetitive entry indicates missing automation: work that should be a rule or an automated process is being done by hand, which is a technology finding. A team already doing payer investigation and appeals, and still falling behind, indicates a capacity or expertise finding. The remedies are different, and labs regularly buy one when they needed the other.

A useful companion question, one a prospect recently put to TELCOR: of all the effort required to bill, what share is human involvement and what share is technology? Ten percent, twenty, fifty? The number matters less than what it reveals — every manual step is both a cost and an opportunity for something to go wrong, and the lab pays for it one way or another.

Then ask the billing team directly what one thing they would change, in the system or in their workflow. "Payers are complex and I have to investigate everything" and "I have to click this button forty times a day" point at entirely different problems, and both convert cleanly into workflow questions for a vendor.

SEVEN QUESTIONS TO ANSWER INTERNALLY

1. What share of the team's day is repetitive entry versus payer investigations?
2. Does one person genuinely own billing — and what happens the week after they leave?
3. What percentage of allowed are we collecting, by payer class, and do we trust the number?
4. How many distinct payer policies does the team have to be expert in?
5. If volume doubled next quarter, what breaks first: the system or the staffing?
6. Where is the backlog of easy, unworked edits, and who is watching it?
7. If we choose a model now, what would it cost to change our minds in two years?

Question six is worth running as an exercise rather than a question. In operational assessments of labs running billing in house, the same findings recur: a system configured once at implementation and never revisited, rules and edits that were never built, and a standing backlog of straightforward corrections that no one owns. None of those are arguments for outsourcing. They are arguments for diagnosing the problem before choosing a model, because both models fail the same way when the underlying process is undefined.

08 / WHERE THIS IS HEADED

Two variables, not one trend

The expectation across TELCOR's lab book is that the mix stays balanced rather than resolving toward one model, and that two variables decide the balance: the local labor market and the rate at which automation reduces the expertise a lab has to employ directly. Those variables pull in opposite directions. If automation lowers the staffing and skill required, in-house becomes viable for labs that could not previously support it. If the labor pool in a given region cannot supply experienced billers at all, outsourcing wins regardless of how good the technology gets.

The broader market is behaving accordingly. Providers are not choosing between outsourcing and automation: McKinsey's 2025 survey found care delivery organizations pairing measured AI investment with integrated outsourcing, with 51% of leaders naming AI and advanced technologies a priority focus, up from 33% the previous year.[8] The staffing question is being repriced by technology in both directions at once, which is exactly why it should not be answered with a permanent commitment.

Which leaves one durable recommendation. Decide the staffing question honestly for the lab that exists today, using the self-assessment above rather than a vendor's framing. Decide the technology question for the lab that might exist in three years, and decide it on its own merits.

Labs that do both keep the option to change their minds. Labs that bundle the decisions usually only get to make it once.

09/WHY THIS IS TELCOR'S PROBLEM TO SOLVE

There is no shortage of revenue cycle vendors. There is a shortage of vendors built for laboratory. The details that decide whether a lab claim gets paid are largely invisible from a general healthcare RCM vantage point: diagnosis codes that arrive on a requisition rather than from a chart, a single specimen split across more than one payer, ordering-client hierarchies that determine who gets billed, and payer policy applied at thousands of claims a day rather than dozens.

TELCOR has spent more than 30 years in that detail. TELCOR RCM is licensed to labs that run their own billing. TELCOR Revenue Cycle Services runs billing for labs that would rather not, on the same platform, with the same reporting, and with the option to move the work in house later without changing systems, clearinghouses or history. That is the same argument this paper makes, which is why it is worth applying the paper's own tests to us.

If you want a second read on your own numbers — percentage of allowed by payer class, touches per claim, where the backlog sits — that is a conversation worth having: telcor.com.

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Kwami Edwards leads operations across TELCOR's laboratory revenue cycle technology and services business. His work centers on how independent and specialty labs execute billing — staffing models, workflow design, and the technology decisions that determine what a lab collects and at what cost. He works directly with lab leadership teams evaluating in-house, outsourced and blended models.

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Sarah Stewart leads TELCOR's revenue cycle service organization, where teams bill on behalf of independent and specialty labs and are organized by payer specialty rather than by account. She also runs operational assessments for labs billing in house, identifying configuration, workflow and staffing gaps — work that informs much of the practical guidance in this paper.

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Quotations are drawn from a recorded conversation with Kwami Edwards and Sarah Stewart, 2026, lightly edited for length and readability.