



- **Title:** Reimbursement and Revenue Protection and Enhancement Strategies for Laboratories
- **XiFin Speakers:** Harley Ross, Chief Commercial Officer (Moderator), Heather Agostinelli, VP of Specialty RCM, and Clarisa Blattner, Sr. Director of Revenue and Payor Optimization
- **Affiliation:** XiFin, Inc. (NYSCCLA Member)
- **Date/Time:** September 9, 2025 | 4:15 PM – 5:00 PM ET

Speaker Disclosures

Choose one

- I have no financial conflicts of interest to disclose
- I have the following to disclose

Speakers



Harley Ross

Chief Commercial Officer
XiFin, Inc.

Harley Ross is Chief Commercial Officer at XiFin, guiding go-to-market strategy, product integration, and business expansion. With 25+ years in sales, marketing, client services, operations, and product development, he brings a track record in creating, delivering and supporting custom RCM solutions and passionate for leveraging technology and data to improve patient outcomes and reimbursement performance for healthcare providers.



Heather Agostinelli

VP, Head of Specialty RCM
XiFin, Inc

Heather Agostinelli is Vice President and Head of Specialty RCM at XiFin, overseeing pathology, pharmacy, and laboratory operations. With 25+ years dedicated to diagnostics and pharmacy revenue cycle management and 29 years in healthcare, she brings deep expertise in optimizing complex billing processes to improve reimbursement and operational performance.

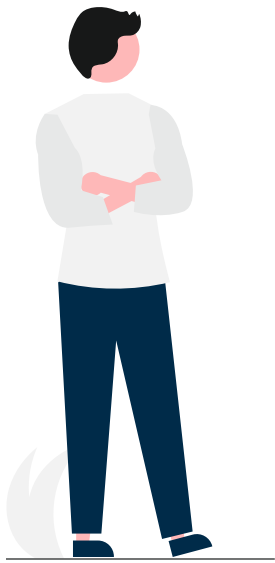


Clarisa Blattner

Sr. Director, Revenue and
Payor Optimization
XiFin, Inc.

Clarisa Blattner is Senior Director of Revenue and Payor Optimization at XiFin, with 25+ years' experience improving reimbursement strategies for diagnostic laboratories. She specializes in prior authorization, coding standardization, and denial management, and brings expertise in molecular diagnostics, pathology, and genetic testing. Clarisa holds a B.S. in Biological Sciences and CCS and CPC certifications.

Speaker Insight



Before we dive in, can you each share a bit about your background and experience, and how it's shaped your perspective on helping labs strengthen reimbursement and protect revenue?

Today's Discussion Will Cover



The Requisition: Your First Line of Defense in Getting Paid

Untangling Prior Authorization for Genetic and Molecular Tests

Decoding Denial Trends: Clinical, Molecular, and Pathology

Spotting Revenue Leakage Before It Starts

Best Practices for Protecting Lab Revenue

Q&A

The Requisition: Your First Line of Defense in Getting Paid



“

“From your perspective, why is the requisition such a critical starting point for getting paid, and what are the most common gaps you see that can cause downstream reimbursement issues?”

”

Sample Requisitions – Women’s Clinical & Cytology

PATIENT	PATIENT ID / ROOM # <small>ENTRIES WILL SHOW ON REPORT</small>		SURGICAL ID #		BLOCK #	
	COMMENTS					
	NAME, LAST (OR CODE NAME) Please Print			FIRST		MI
	STREET				APT. #	
BILLING INFORMATION	CITY		STATE	ZIP	DATE OF BIRTH <small>MM/DD/YYYY</small>	AGE
	PATIENT PHONE NO.	PATIENT EMAIL/FAX		COLLECTED (DATE/TIME) <small>AM PM</small>	BIRTH GENDER <input type="checkbox"/> M <input type="checkbox"/> F	GENDER IDENTITY <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> PREFER NOT TO ANSWER
	RACE/ETHNICITY: <input type="checkbox"/> NATIVE AMERICAN <input type="checkbox"/> ASIAN <input type="checkbox"/> AFRICAN-AMERICAN <input type="checkbox"/> CAUCASIAN <input type="checkbox"/> ASHKENAZI JEWISH <input type="checkbox"/> PACIFIC ISLANDER <input type="checkbox"/> HISPANIC <input type="checkbox"/> OTHER:					
	BILL TO: <input type="checkbox"/> INSURANCE <input type="checkbox"/> PATIENT <input type="checkbox"/> CLIENT <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE					
ALL INSURANCES RELATION TO SUBSCRIBER: <input type="checkbox"/> CHILD <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER:						
INSURANCE CARRIER		INSURANCE ID #		GROUP #		
SUBSCRIBER'S NAME			DATE OF BIRTH			
INSURANCE ADDRESS		CITY	STATE	ZIP		
SECONDARY INSURANCE CARRIER		INSURANCE ID #		GROUP #		
DX CODE (ICD-10)	DX CODE (ICD-10)	DX CODE (ICD-10)	DX CODE (ICD-10)	DX CODE (ICD-10)		
REFERRING PROVIDER <small>SOURCE OF REFERRAL</small>		PRIOR AUTHORIZATION #				
PATIENT STATUS ^ – ONE MUST BE CHECKED						
<input type="checkbox"/> HOSPITAL INPATIENT <input type="checkbox"/> HOSPITAL OUTPATIENT / PROVIDER BASED CLINIC <input type="checkbox"/> NOT A HOSPITAL PATIENT						
					HOSPITAL PATIENT DATE OF DISCHARGE: ____/____/____	

ACCOUNT

PHYSICIANS

ORDERING PROVIDER (Please write in)

SEND RESULTS COPY - 9991-

Name: _____

Street: _____

City: _____

Fax: _____

By submission of this test requisition you to perform the testing indicated; (i) certify that any custom panel and/or ordered test(s) requested herein; (ii) certify that on this test requisition form are reason or treatment of a disease, illness, impairment, symptom, syndrome or disorder; (iii) certify that the patient's condition on this date of service consent to undergo any genetic testing diagnosis code(s) are indicated to the necessity by the diagnosis code(s) submitted with this test requisition.

Signature of Physician or Other Authorized Provider _____ Date _____

SONOFORM # 45349 03/25

PATIENT	PATIENT ID / ROOM # <small>ENTRIES WILL SHOW ON REPORT</small>		COMMENTS		<input type="checkbox"/> FASTING <input type="checkbox"/> NON-FASTING	
	NAME, LAST (OR CODE NAME) Please Print					
	STREET			FIRST		MI
	CITY				STATE	ZIP
BILLING INFORMATION	PATIENT PHONE NO.		PATIENT EMAIL/FAX		COLLECTED (DATE/TIME) <small>AM PM</small>	BIRTH GENDER <input type="checkbox"/> M <input type="checkbox"/> F
	RACE/ETHNICITY: <input type="checkbox"/> NATIVE AMERICAN <input type="checkbox"/> ASIAN <input type="checkbox"/> AFRICAN-AMERICAN <input type="checkbox"/> CAUCASIAN <input type="checkbox"/> ASHKENAZI JEWISH <input type="checkbox"/> PACIFIC ISLANDER <input type="checkbox"/> HISPANIC <input type="checkbox"/> OTHER:					
	BILL TO: <input type="checkbox"/> INSURANCE <input type="checkbox"/> PATIENT <input type="checkbox"/> CLIENT <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE					
	ALL INSURANCES RELATION TO SUBSCRIBER: <input type="checkbox"/> CHILD <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER:					
INSURANCE CARRIER		INSURANCE ID #		GROUP #		
SUBSCRIBER'S NAME			DATE OF BIRTH			
INSURANCE ADDRESS		CITY	STATE	ZIP		
SECONDARY INSURANCE CARRIER		INSURANCE ID #		GROUP #		
DX CODE	DX CODE	DX CODE	DX CODE	DX CODE	DX CODE	DX CODE
REFERRING PROVIDER <small>SOURCE OF REFERRAL</small>		PRIOR AUTHORIZATION #				
PATIENT STATUS ^ – ONE MUST BE CHECKED						
<input type="checkbox"/> HOSPITAL INPATIENT <input type="checkbox"/> HOSPITAL OUTPATIENT / PROVIDER BASED CLINIC <input type="checkbox"/> NOT A HOSPITAL PATIENT						
					HOSPITAL PATIENT DATE OF DISCHARGE: ____/____/____	
CLINICAL INFORMATION						
LAST MENSTRUAL PERIOD: <input type="checkbox"/> G _____ P _____		PATIENT WEIGHT: _____ lbs		<input type="checkbox"/> INSULIN DEPENDENT DIABETES		
MM/DD/YY				<input type="checkbox"/> VAGINAL BLEEDING WITH PREGNANCY		
IVF PREGNANCY: <input type="checkbox"/> Y <input type="checkbox"/> N		DONOR EGG: <input type="checkbox"/> SELF <input type="checkbox"/> NON-SELF		AGE AT EGG RETRIEVAL: _____		
PREVIOUS PREGNANCY HISTORY OF: <input type="checkbox"/> ONTD <input type="checkbox"/> DOWN SYNDROME <input type="checkbox"/> GENETIC DISORDER <input type="checkbox"/> OTHER: _____						
ULTRASOUND INFORMATION *(Document Sonographer information above)						
DATE OF ULTRASOUND: ____/____/____		GA AT TIME OF ULTRASOUND: _____ weeks _____ days		CRL _____ MM (VALID NT CRL RANGE 41-79MM)		
MM/DD/YY				NT _____ MM		
NASAL BONE: <input type="checkbox"/> PRESENT <input type="checkbox"/> ABSENT <input type="checkbox"/> NOT EVALUATED		# OF FETUSES: _____		IF TWINS: <input type="checkbox"/> DICHORIONIC <input type="checkbox"/> MONOCHORIONIC		
		2ND CRL (IF TWINS) _____ MM		2ND NT (IF TWINS) _____ MM		
				2ND NB (IF TWINS): <input type="checkbox"/> PRESENT <input type="checkbox"/> ABSENT <input type="checkbox"/> NOT EVALUATED		
INDICATIONS FOR TESTING (Required)						

ACCOUNT

PHYSICIANS

SONOGRAPHER

NAME: _____ NTQR/FMF: _____

NASAL BONE CERTIFIED: Y N

ORDERING PROVIDER (Please write in if not listed above)

SEND RESULTS COPY - 9991-1 FAX RESULT - 9993-7

Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Fax: _____

By submission of this test requisition and accompanying sample(s), I (i) authorize and direct you to perform the testing indicated; (ii) certify that I am authorized by state law to order the test(s) requested herein; (iii) certify that any custom panel and/or ordered test(s) requested on this test requisition form are reasonable and medically necessary for the diagnosis and/or treatment of a disease, illness, impairment, symptom, syndrome or disorder; (iv) the test results will determine my patient's medical management and treatment decisions of this patient's condition on this date of service; (v) have obtained this patient's written informed consent to undergo any genetic testing requested; and (vi) that the full and appropriate diagnosis code(s) are indicated to the highest level of specificity and support medical necessity by the diagnosis code(s) submitted with this test requisition.

Signature of Physician or Other Authorized NPI Provider _____ Date _____

Untangling Prior Authorization for Genetic and Molecular Tests



“

We know prior authorization can be especially complex for genetic and molecular testing—what makes this process so challenging, and what strategies have proven most effective in getting approvals?

”

Denied Medicare Advantage Claims Covered By PA Policy

Medicare Advantage prior authorization claims split by denial type (PA vs Other):
2024 compared to 2019



6X

Increase in PA denials from 2019 to 2024



~2X

Increase in PA denials



~100%

Use of "other" denial codes for PA



6X

Increase in PA denials from 2019 to 2024

Payor	2019		2024	
	Prior Auth Denial	Prior Auth Other Denial	Prior Auth Denial	Prior Auth Other Denial
Blue Cross & Blue Shield	32%	68%	57%	43%
Cigna	9%	91%	60%	40%
Humana	7%	93%	44%	56%
United Healthcare	2%	98%	0%	100%
Grand total	4%	96%	30%	70%

Source: Source: XiFin data analysis regarding use of prior authorizations denials for Medicare Advantage claims

Improving Prior Authorization Success

Many laboratories struggle with getting prior authorizations approved, particularly for genetic tests

- XiFin developed a new process and invested in personnel who **bring together payor intelligence and clinical expertise** to dramatically improve prior authorization approval success rates for genetic tests
- **Genetic counselors** can play a vital role in navigating the patient experience and working with payors to get tests approved



Physician Welcome Letters

Set expectations with physicians early in the PA process



XiFin has designed a proven tool for facilitating reimbursement by setting expectations with physicians using a *welcome letter*



By reviewing test menus and payor policies for top payors, guidelines can be developed and communicated to ordering physicians regarding:

- Requirements to achieve prior authorization
- What documentation needs to accompany each test specimen



Addressing requirements proactively improves the likelihood of reimbursement and strengthens appeals, when necessary

[DATE]

[COMPANY NAME]
[COMPANY ADDRESS]
[COMPANY CITY, STATE, ZIP]

Dear [RECIPIENT NAME]

Thank you for trusting [COMPANY NAME] with your laboratory needs, especially when it comes to clinical and diagnostic genetic testing. We strive to provide the best service for you and your patients, which includes simplifying the ordering process and reducing patient financial responsibility. When ordering genetic tests, including [TEST NAME, CPT® 81507], there are specific ways we can work together and achieve the best outcomes possible.

Most insurance plans require prior authorization for genetic testing, and each insurance plan has their own prior authorization requirements. This can create confusion and subsequent barriers in the ordering process, such as incomplete or missing prior authorization forms, testing delays, and ultimately higher patient financial responsibility.

For [TEST NAME, CPT® 81507], you can help simplify the process and reduce patient costs by providing all the following at the time of test order, i.e., electronically or with the patient's specimen:

- A completed test requisition form (TRF)
- Diagnoses (ICD-10 codes) supporting medical necessity of the genetic test
 - List the principal diagnosis first
- Most recent clinic note from the ordering provider that includes:
 - Medical necessity and clinical utility of the genetic test
 - Risks, limitations, and benefits specific to the patient
 - Residual risk for negative screening results
 - Patient preference for diagnostic testing options
 - Treatment and evaluation plan
 - Genetic counseling provided
 - Relevant personal and family history, including lab results and imaging
- Insurance-specific prior authorization form(s), as needed
- Registration with 3rd party prior authorization service, as needed

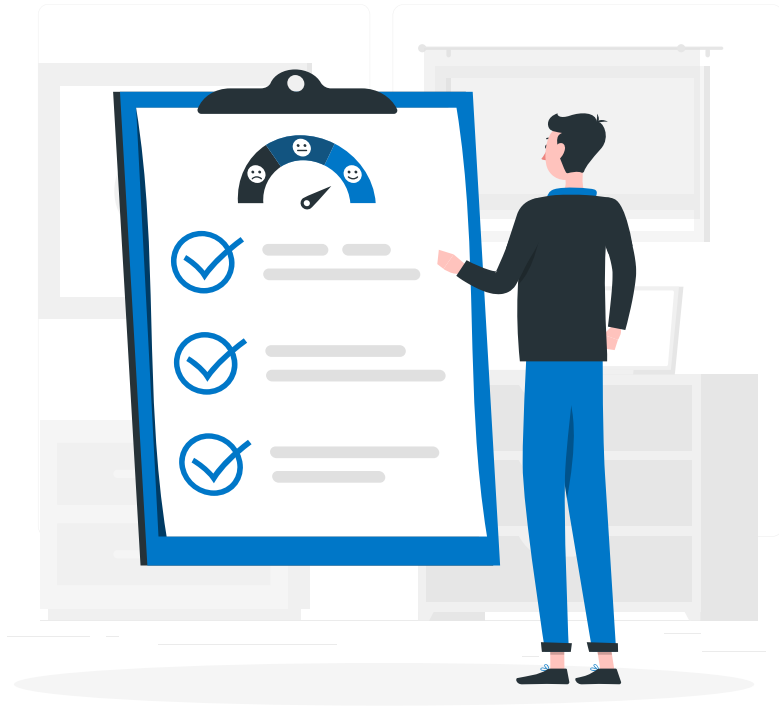
Almost all prior authorization requirements, regardless of insurance plan, can be met by providing this information. If you would like to discuss this information in more detail, or otherwise discuss how we can work together to simplify this process and reduce patient financial responsibility for [TEST NAME, CPT® 81507] or any other genetic test, please contact us at: [PREFERRED CONTACT].

Thank you,

[FIRST AND LAST NAME]
[TITLE]
[FAX] | [EMAIL]

Metrics for Success - Customer Results

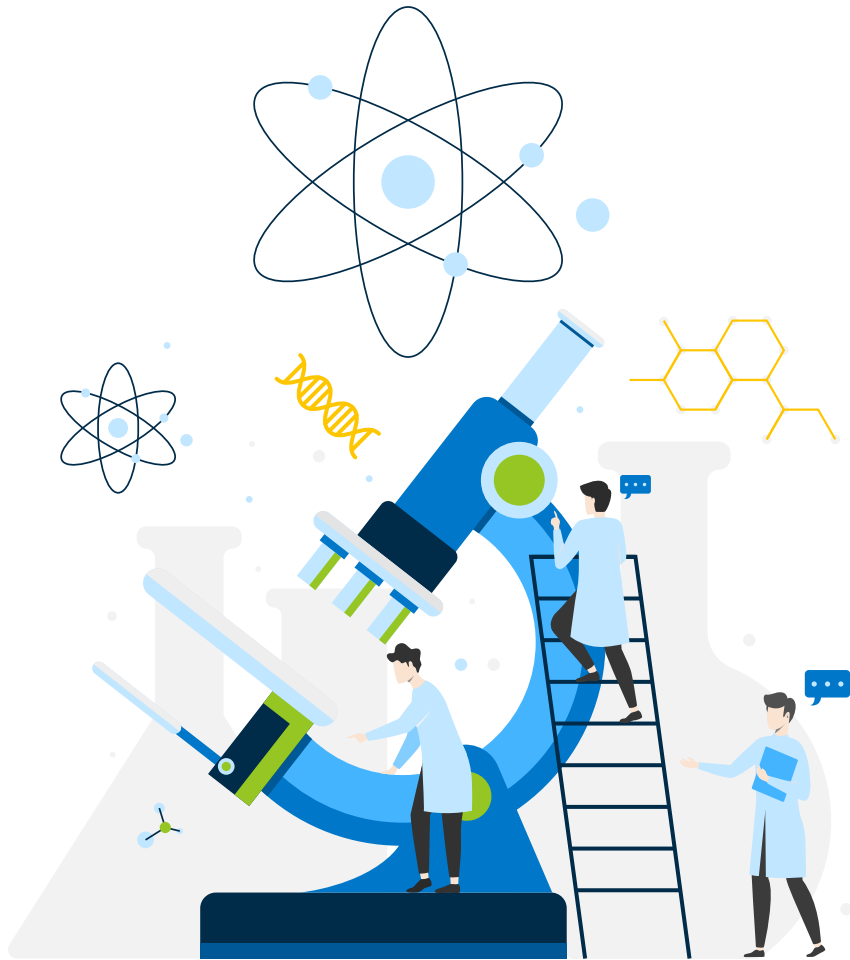
Examples of diagnostic customers who leveraged genetic counselors



Claim Review of Medical Necessity Denials

- **97%** accuracy in predicting PA approval/denial
- A national laboratory with a limited test menu
 - Before GC review, PA success was 30%
 - After GC review, the PA success rate increased to **78.8%**
- Two large national laboratories
 - Patients met Evicore policy, but the payor still denied prior authorizations
 - Patient met payor policy and approved PA, but still denied

Decoding Denial Trends: Clinical and Molecular

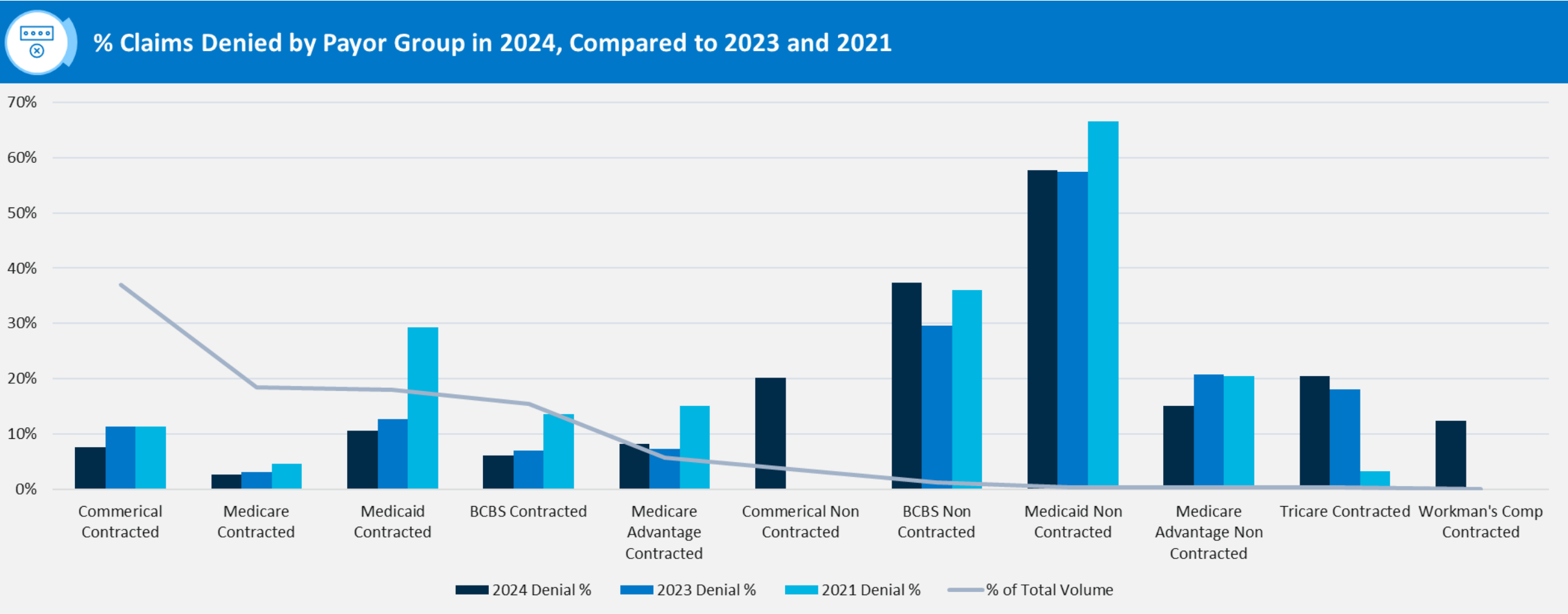


“

Across the labs you work with, what are the most common denial trends you're seeing, and how do these patterns differ between clinical and molecular testing?

”

Denials and Appeals Trends Vary Widely by Payor Group



Top Denials Reasons Remain Consistent

CO151

Payment adjusted because the payor deems the information submitted does not support this many/frequency of services



CO55

Experimental/Investigational, when a procedure code is billed with an incompatible diagnosis for payment purposes, and the ICD-10 code(s) submitted is/are not covered under an LCD or NCD



CO252

Claim will be considered when additional claim information is received



CO96

Non-covered charges



CO50

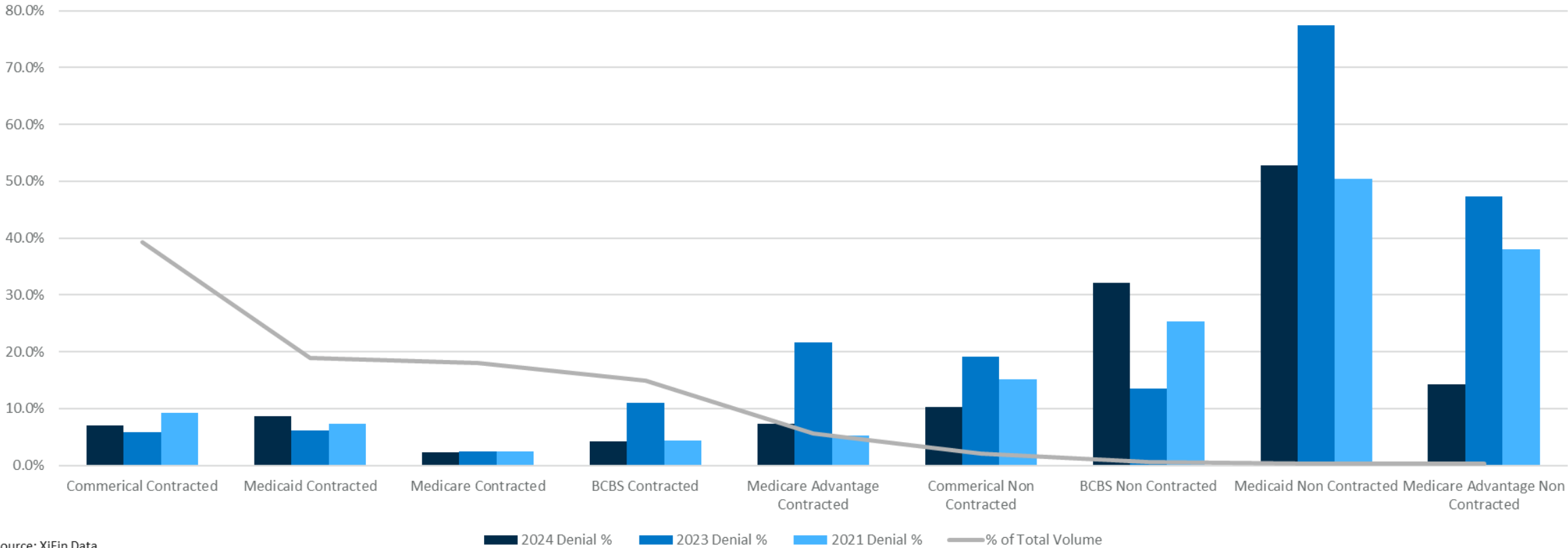
Non-covered services because this is not deemed a “medical necessity” by the payor



Hospital Outreach and Clinical Laboratory Denial Trends



% Hospital & Clinical Lab Claims Denied by Payor Group in 2024, Compared to 2023 and 2021



Source: XiFin Data

Hospital Outreach and Clinical Laboratory Denials by Denial Type

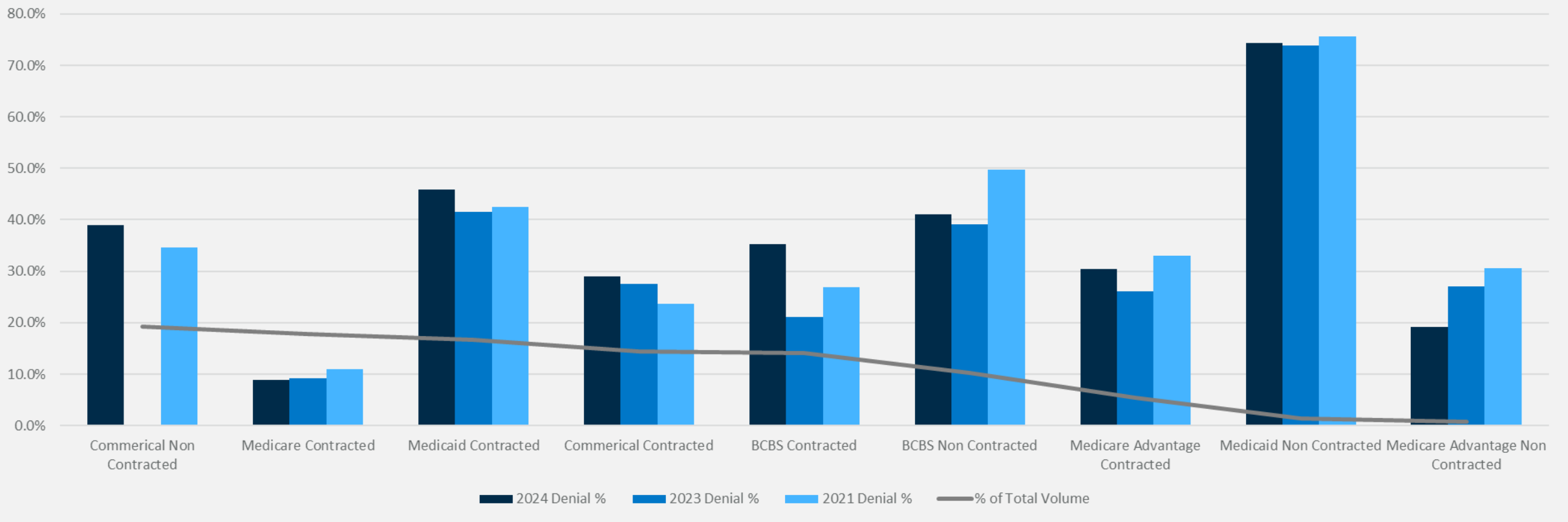
Denial Type (Representing >1% of Total Denials in 2024)	% of Total Denied 2024	% of Total Denied 2023	% of Total Denied 2021	% of Total Denied 2018	% Change 2018-2024
Procedure Not Paid Separately	53.08%	49.79%	37.48%	32.97%	▲ 61%
Duplicate Denial	19.73%	24.32%	25.55%	26.96%	▼ 27%
Non-Covered	7.76%	10.15%	8.28%	13.53%	▼ 43%
Coordination of Benefits	2.68%	4.00%	3.65%	3.71%	▼ 28%
Experimental/Investigational	2.60%	3.76%	5.15%	7.57%	▼ 66%
Prior Authorization	4.26%	2.82%	4.15%	3.60%	▲ 18%

▼ indicates denial rate went down

▲ indicates denial rate went up

Molecular Denial Trends

 % Molecular Claims Denied by Payor Group in 2024, Compared to 2023 and 2021



Molecular Denials by Denial Type

Denial Type (Representing >1% of Total Denials in 2024)	% of Total Denied 2024	% of Total Denied 2023	% of Total Denied 2021	% of Total Denied 2018	% Change 2018-2024
Prior Authorization	26.55%	27.56%	13.13%	22.22%	▲ 20%
Duplicate Denial	17.09%	22.77%	29.35%	24.73%	▼ 31%
Procedure not paid separately	16.19%	15.46%	32.68%	9.30%	▲ 74%
Experimental/Investigational	11.01%	13.16%	4.39%	10.79%	▲ 2%
Non-Covered	6.15%	8.50%	2.89%	13.52%	▼ 54%
Coordination of Benefits	3.09%	4.00%	2.45%	4.02%	▼ 23%
Services not Provided By Network/Primary Care Provider (Out-of-Network)	1.72%	3.30%	8.44%	4.42%	▼ 61%
Coverage Terminated	1.21%	1.28%	0.58%	1.05%	▲ 15%

▼ Indicates the denial rate went down

▲ Indicates the denial rate went up

Spotting Revenue Leakage Before It Starts

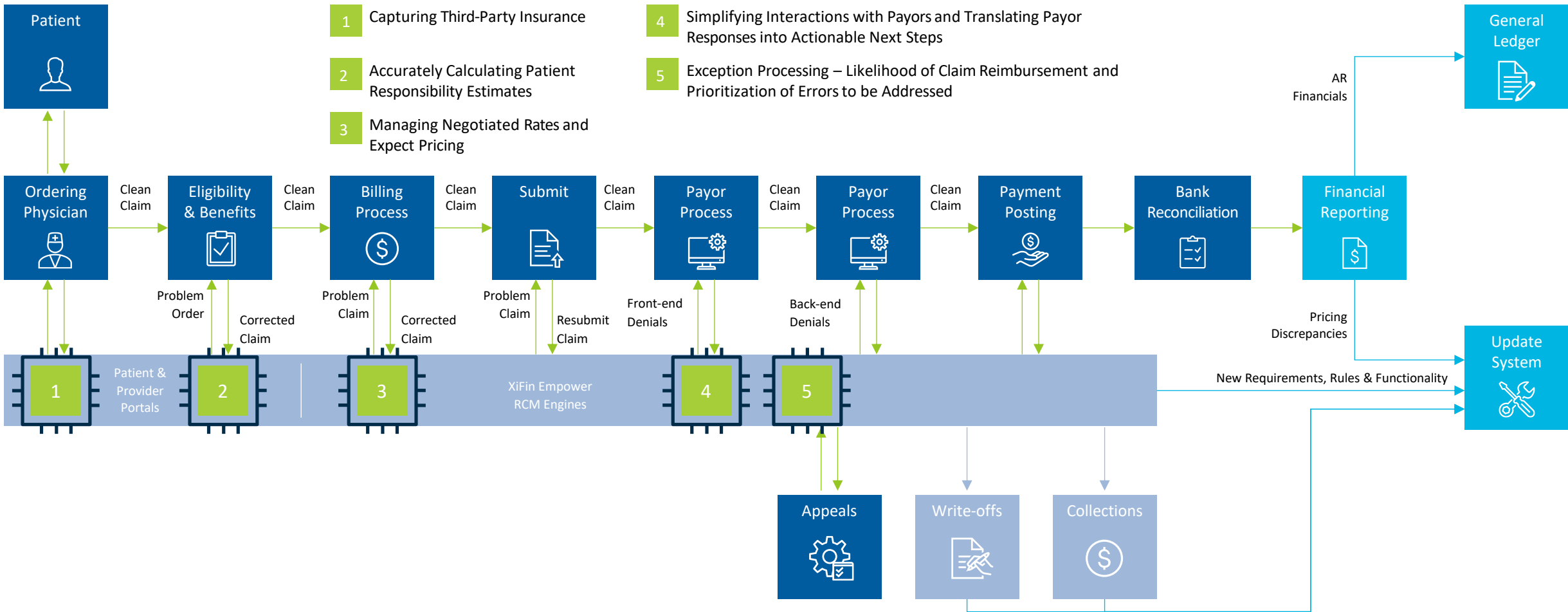


“

When you look at the full revenue cycle, where in the workflow do you most often see revenue leakage start—and how can labs address these issues earlier in the process?

”

Embedded AI: Applications Throughout the Billing Process



Best Practices for Protecting Lab Revenue



“

"If a lab could make just one change tomorrow to improve reimbursement outcomes, what would you recommend—and why would it have the biggest impact?"

”

Best Practices for Protecting Lab Revenue



Design workflows that capture complete and accurate requisitions



Integrate prior authorization awareness into test ordering



Leverage business intelligence and analytics to inform and implement process improvement



Streamline processes through intelligent workflow automation



Continuously adapt to payor policy shifts



QUESTIONS AND ANSWERS



THANK YOU