Strategic Partner Review

A Texas-Based Rural Hospital

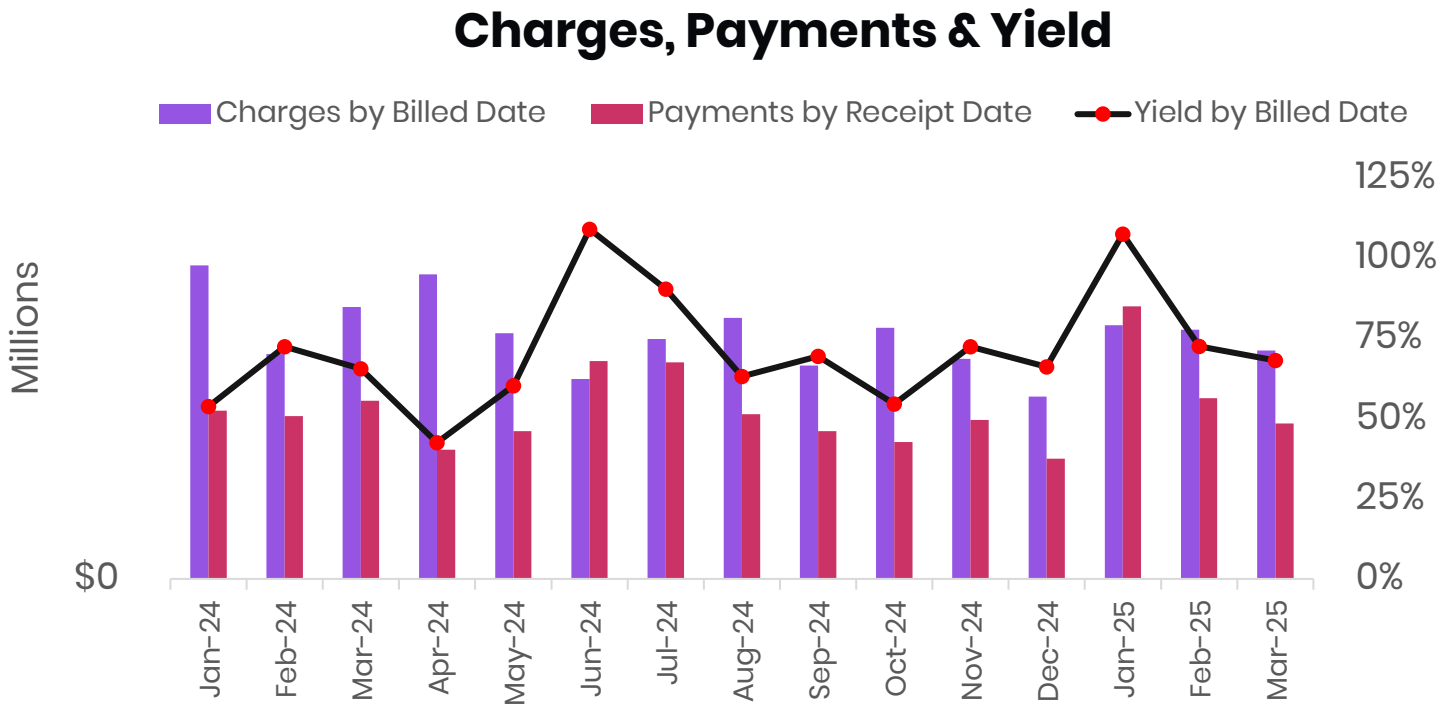
June 2025

Jindal Healthcare

Executive Summary

- **Estimated annual upside of $1.5–$2M in collections (~30-40% increase)**, with an additional **~$240K in cost savings**, driven by targeted process improvements and right-sized RCM operations.
- **Biggest opportunities in payment posting, denial and AR follow-up**
  - **Payment Posting -** Partial payments are accepted as final without review.
  - **Clean claim rate and billing timeliness need improvement**, with recurring rejections delaying cash flow.
  - **Patient access and point-of-service collections are inconsistent**, reducing early revenue capture and increasing downstream workload.
  - **Financial reporting lacks accuracy and transparency**, with no clear view of billed charges and ambiguous categorization of AR vs. non-AR payments—impacting both operational decisions and annual cost reporting.

2024-25 Volume Trends



Encounters

Redacted

Key Takeaways

- **Encounter volume** showing a downward trend over the past 15 months, where Q1 2025 has 16% lower encounter volume relative to the same time last year – Redacted
- **Charges** (by Billed Date) have also dropped a corresponding 10% from Redacted
- However, **payments appear to have ticked up 19% –** Redacted in 2025 Q1, up Redacted Q1 '24**.**
- **While this seems celebratory,** inconsistencies are seen in payment posting – late posting, double posts and reports seem to be inflating this number. **This is truly closer to $45(** Redacted
- The yield is unreliable due to reporting limitations/variances and adjustment of charges.

34% of AR >90 Days

Age	Balance	% of AR	Benchmark
0-30	Redacted	42%	57%
31-60		17%	12%
61-90		8%	7%
91-120		7%	5%
120+		27%	19%

Service Type	0-30	31-60	61-90	91-120	120+	Grand Total
Ambulance	$27,620	$9,318	$5,786	$443	$8,268	$51,435
Clinic						-
Inpatient						-
Miscellaneous			Redacted			-
Outpatient						-
OP - Sec to MCR						-
Profee-Clinic						-
Swingbed						-
Grand Total						-

Key Takeaways

- ~34% of open insurance AR is over 90 days, compared to an ideal benchmark of 15%. Medicare and Medicare Advantage accounts for ~50% of the total outstanding AR.
- Service type wise, Profee-Clinic has more than 50% of its total AR in over 120+ days and O/P Secondary to Medicare is also nearly 50% in the 120+ section.

The Four Metrics that Matter Most

Charge Capture Rate

How many of your appointments were **actually** billed out?

Clean Claims Rate

How many claims went through the clearinghouse **without being rejected?**

Clean Payments Rate

How many claims got paid without **any** follow-up?

Net Collections Rate

What percent of your expected payment were you **actually** paid?

What do these answer?

- Are we billing for all billable visits?
- Are there billing delays?
- What is causing the delay?

- Repeated rejections point us to what is not working optimally?

- What are the typical pay cycles for providers?
- How many unnecessary follow-ups are being done?
- What is causing claims to pile up?

- What are the denials?
- What are the underpayments?
- What are the unpaid claims?
- What is the appeal performance?

Charge Capture

1. Unbilled Insurance Report
2. HIM Coding Worklist

1

Discharge Date	Approved	Pending	Ready to Bill	Unchecked	Grand Total
<2024	Redacted				
2024					
2025 - Q1					
Apr '25					
May '25					

2

Discharge Date	Visits	Total Charges
2010	Redacted	
2022		
2023		
2024		
2025		

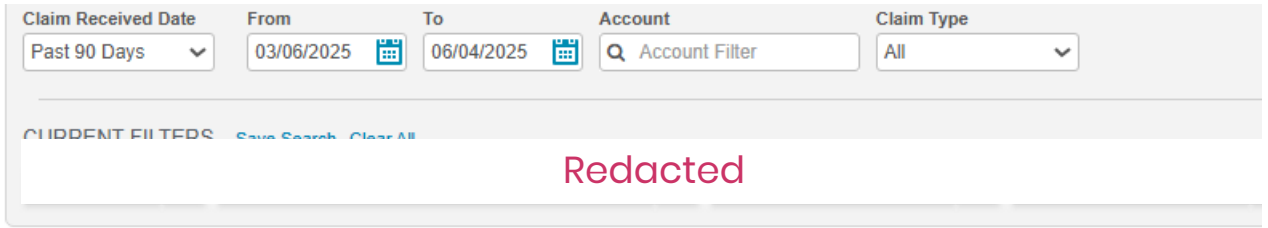
Billed/Unbilled Charges information is limited:

- 456% variance between “Pending + Unchecked” from Unbilled Insurance report vs. HIM Coding Worklist
- Several ED encounters appear to be missing a radiology report.
- HH and EMS encounters might need to be excluded from consideration.

Clean Claim Rate

90-Days Clean Claim Performance, (Benchmark >98%)

Month	REDACTED		
March	89.6%	91.2%	88.9%
April	85.3%	84.3%	89.3%
May	87.2%	84.4%	87.9%



Key Takeaways:

- Average Clean Claim Rate for the last 90 days – all locations combined – 87.1% against an ideal benchmark of 98%
- At Redacted per month, we are looking Redacted tions per month.
- Breakdown of outstanding rejections and rejection reasons on the following slide.

Outstanding Rejections (1/2)

Rejection Date	Out of Balance - Posting Issue	Enrolment Issue	Billing Error	Eligibility Issue	Set up Issue	Coding	Grand Total
2024	**4**	**48**	**1**	**13**	**1**	**1**	**68**
2025	**93**	**38**	**58**	**20**	**17**	**3**	**229**
Jan		**4**	**1**				**5**
Feb	**2**	**2**					**4**
Mar		**5**	**1**	**1**			**7**
Apr	**4**	**10**	**1**				**15**
May	**16**	**6**	**33**	**15**	**10**	**1**	**81**
Jun	**71**	**11**	**22**	**4**	**7**	**2**	**117**
Grand Total	**97**	**86**	**59**	**33**	**18**	**4**	**297**

Rejection Reason	REDACTED			
Out of Balance - Posting Issue	48	10	39	97
Enrolment Issue	31	10	45	86
Billing Error	21	32	6	59
Eligibility Issue	8	4	21	33
Set up Issue	7	9	2	18
Coding	2	1	1	4
Grand Total	**117**	**66**	**114**	**297**

Key Rejections and Solutions:

- Enrolment-related rejections for missing LTSS NPI with Medicaid:
  - The true cause of these rejections - Redacted
  - These claims are being billed with "non-enrolled MCO-EVV" specific payer ID which is typically for home health and not for true outpatient services.
- Enrolment-related Triwest VA CCN Rejections
  - Notes saying enrolment not done for NPI but looks like these were/are due to missing referral information on the claim.
  - Redacted s billed on paper with auth information only in Sept 2024. Follow-up notes from Dec 2024 do not refer to the latest submission but did get the original claim reprocessed with the referral information.
  - Claim was paid a few days later in Dec 2024 but was touched again only in April 2025 to collect payment/offset information.

Outstanding Rejections (2/2)

Key Rejections and Solutions:

- Posting Issue – Out of Balance: Charges worth ~27K currently impacted and unresolved
  - Visit 1 Redacted 1
  - Medicare partially approved the claim at 77% but **denied the critical care E&M (CPT 99291) as bundled**.
  - This **denial should have been disputed** but was accepted as processed correct and **written off** and secondary payer was billed.
  - The rejection is caused because instead of just the primary payment amount going out on the claim in Box 54, **payment + contractual adjustment is going out as the payment amount.**
  - Medicare paid $3070.53 and the contractual adjustment was $1237.38 and the amount that went out is $4307.91.
  - This rejection has since then been **archived on Waystar** with no resolution.
  - **Most other similar rejections have the same issue.**

Redacted images to show variance between what the EOB says and what was posted

Key Metric Data Is Limited/Missing

KPI	Calculation	Unable to Access Reason
Clean Payments	$\frac{\text{Claims paid WITHOUT follow-up}}{\text{Total Claims}}$	No follow-up activity report
Net Collection Rate	$\frac{\text{Payments Received}}{\text{Charges- Contractual Adjustments}}$	1. Non-contractual adjustments also entered as contractual 2. Most partially paid claims have been accepted as paid correct, inflating the adjustments 3. Data inconsistencies in reports but no method to reconcile since data assumptions are missing

Claims Review Analysis

Coding		Patient Access		Payment Posting		AR & Denials	
Delay in Billing	19	Patient Collection	13	Incorrect Work/ Ownership	17	Follow-Up Issues	14
Incompatible Codes	9	Incorrect/ Incomplete Information	4	Recoup Not Posted	3	Denial Resolution Delay	11
		Referral Information Missing	4			Incorrect Work/Denial Resolution	7
Error %	**35%**		**26%**		**25%**		**40%**

We reviewed 81 claims in depth for RCM issues and non-payment- some of these claims had multiple issues and are repeated in the chart.

Key Takeaways

- Key area of improvement is **Payment Posting, AR and Denial Follow-Up:**
  - **All payments are being accepted as paid correct**, including partially denied claims.
  - Several of the claims reviewed were **not worked or not worked frequently enough leaving money on the table.**
  - Denial resolution process also appears to be varied.
- Verification should also be optimized with **initial estimation of patient liability** that would boost point-of-service collections.

Coding/Billing Opportunities

Detail	Date of Service	Value of Claim	Payor	Type of Claim	Findings
Redacted		**$12K**	**Medi-care**	**I/P**	**11 days delay in billing** claim **Possible Incorrect Revenue Code Selection** *Claim was stuck in T status for revenue code 524 and has since then been updated to 521.*
		$10K	**BCBS**	**ER-OB-IP**	**38 days delay in billing** claim **Incorrect Revenue Code** 0636 for non-specialty pharmacy drugs instead of 0250 **Insufficient Resolution** *Follow-up notes from 06/10/25 say that denial due to R&B charges and it is being added to issues log. However, a correction was attempted on 06/04 but it is still erroneous – it has an incorrect type of bill and does not carry the original claim number.*

Process updates

- **Create additional scrub edits** for CPT/ICD/Rev Code compatibility to boost clean claim/payment rate.
- **Track billing lag** as a KPI for the coding/billing function.
- Build **feedback loop** with the AR team on coding-related denials.

Patient Access Opportunities

Claim Number	$ impacted	Findings
Redacted		• Patient came into the ER in Feb 2025 and their Medicare was billed in March without any verification of coverage. • Medicare denied due to termed coverage. • Patient had another ED visit in March which was again billed to Medicare and denied. Notes from March say that all balance from 4 claims will be private pay. • The entire balance was dropped to the patient and no payment has been received till date.
		• **Poor point-of-service collection and inflated patient balances** • **10 patients hold over $100,000 in open self-pay balance** from just 30 encounters in total. This is a combination of three issues: • *Insufficient POS collection due to lack of EPR calculation* • *Incorrect payment posting where non-covered charges on partially paid claims are being dropped to the patient* • *Lack of any active follow-up on self-pay AR cause them to pile up.*

Process updates

- Verification scope to be expanded to **calculate estimated patient liability.**
- Verification to serve as the **last checkpoint to ensure we have everything we need.**
- **Feedback loop** with the AR team on eligibility and auth-related denials and rejections.

Payment Posting Opportunities

Claim Identifier	Detail of Findings
Redacted	Claim billed to Cigna for $11587 in Jan 2023. Notes suggest that Cigna split the claim and paid $710 with a write-off of $7635 in Feb 2023. This **does not appear to be posted** actually – notes say added to log for posting. Notes say **EOB** available on Availity but has **not been scanned** into the account. Account **balance – however – appears adjusted** accordingly without a proof of payment **No follow-up on the denied charges of $7635**. For the second portion of the claim, notes say part of Cigna litigation.

Redacted images to show that the balance has been adjusted off without true payment posting

Process updates

- **Incoming payments should be reviewed for accuracy** before assuming correct application.
- Implement **monthly reconciliation** between received and applied payments.
- Ensure all **paper EOBs are scanned** and linked to the patient account.

Denials Overview

- JHC had limited access to denials data due to the unavailability of Denials module in Waystar.

- Typically, Redacted ıs per month at a 7% denial rate. we would exp Redacted enials over 5 months. At an average of $ Redacted claim, we're looking at $ Redacted n potential denied revenue so far in 2025.

Denial Management Issues

Claim Identifier	Detail of Findings
Redacted	**Dropped bill to Medicaid-eligible patient** — Patient's ED visit from Nov was billed to HTW and denied *correctly* because this was a diabetes-related medical condition. This was straightaway billed to the patient for all balance in Feb 2025; however, her visit from Dec 2024 has been billed to and paid by Superior Medicaid. We need to ensure it covered Nov Dos and bill Superior. **Claim denied as duplicate but billed to secondary ultimately** — Medicare initially denied this ER claim duplicate to another claim for the same DOS. There are notes saying a condition code is being added but a "G0" was added in box 18 which is technically a modifier and not a condition code. This denied again and although the notes say rebilling w/correction, it was submitted to secondary Aetna.

Process updates

- **Create SOPs** for handling claim and denial scenarios.
- **Track turnaround times for rejections and denials.**
- Perform **RCA and implement corrective actions** for all denials.

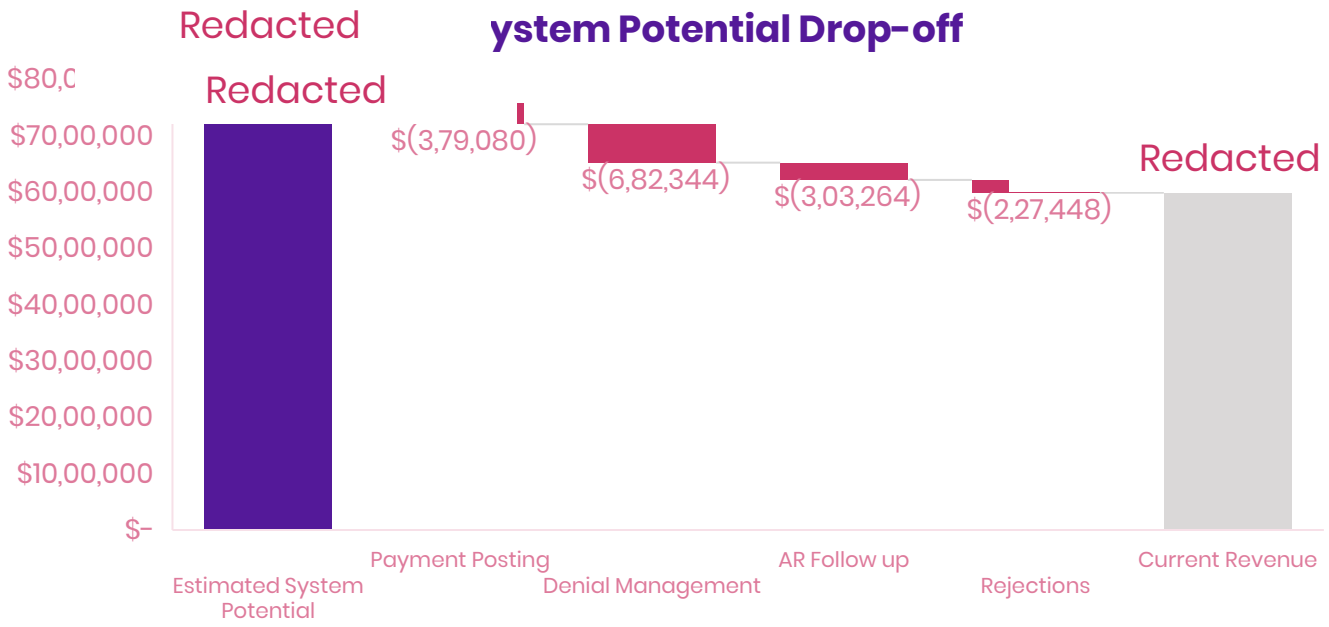
AR Follow-Up Opportunities

Claim Identifier	Detail of Findings
Redacted	**Delayed billing, incorrect posting and unworked AR** — This claim to Wellcare was sent after 23 days and initially rejected due to missing admission code. Corrected via Waystar, this claim initially **paid $1777 and denied multiple codes.** The **corrected claim resulted in a total recoup** which was not posted correctly in CPSI. The new denial has not been worked during the last 60 days. The claim stands at zero balance right now due to posting error but has effectively brought in no money.
	Delayed billing, incorrect posting and unworked AR — This ER claim to Wellcare was sent out on 01/23/25 and remains unpaid effectively. They initially **paid $2850 and denied a $25 medication** for incorrect revenue code. When a **correction was submitted**, they reprocessed the entire claim and **recouped all original payment** and the claim remains unpaid till date. The **denial reason code 216 is generic** and needed further research but has **not been worked during the last ~100 days**. **Posting issues have caused an incorrect balance** to show up on the account.
	No follow-up at all since submission on 11/15/24

Process updates

- **Activate reporting** to understand AR non-payments, underpayments and write offs.
- Implement **AR prioritization.**
- **Capacity enhancement**

Potential Uplift of $1.5M-$2M



Detail	Current	JHC Added	Revenue Increase
Collections	Redacted		
Cost to Collect			
Net Collections			**42%**

Potential Collections defined:
1. Medicare rate at 77%
2. Medicaid assumed at 20%
3. All commercial yield assumed at 50%
4. Collectability reduced to 90% to account for unknown credentialing issues

JHC Proposal

JHC Proposed

Function	Monthly Volume	FTE Target	FTEs Needed	Monthly Cost
Coding				
Verification				
Auth		Redacted		
Posting				
AR				

Current Cost

Detail	
AR FTEs	
Posting FTEs	
Verification & Prior Auth FTEs	Redacted
Headcount	
Cost per month	
Outsourced Coding	
Total Monthly RCM Cost	

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