Maximum Efficiency

Better Patient Care

Accelerated Cost Savings

Welcome

bServed

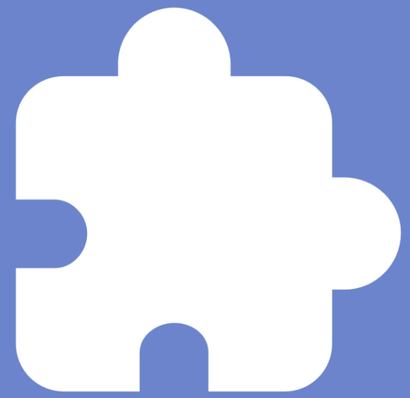
bServed Services are 24/7, Real-time, and Proactive.

We work with existing teams and workflows

Seamless integration

Fast Secure Go-Live

Both Tech and Teams



Problem Areas

- Hospitals do not have comprehensive or up to date payor requirements for providers
- Incorrect or Insufficient Communication by hospitals with payors
  - Admission Notification
  - Securing Authorizations
  - Daily Admission Justification
- Denial rates increasing
- Hospitals don’t have concurrent or even retrospective analytics on Utilization Management, Authorization Status, or Denials.
- Lack of clear understanding of correct level of admission for every patient and real-time update for level of care
- Hospital nursing shortage, lack of expertise and quality control
- Prolonged length of stay /Avoidable days

The Problem

Margin Leakage • **Increasing Labor Costs** • **Strict Regulatory Changes**

The Causes

Notification delays and authorization non-compliance	Lack of Post Stabilization Protocols	Manual submission errors and delays	Lack of concurrent denial prevention	Payer policy mismatch	No 24/7 coverage	RN shortage or lack of expertise
Lack of UpToDate payor requirements database Lack of staff training	Missed Admissions for out-of-network patients	OCR fines + denied claims	2–3 days of non-reimbursed care and missed Peer-to-peer call window	Incorrect InterQual/MCG usage	After-hours denial windows and backlog of concurrent cases	Registry and specialty nurses cost 2-3xs, lack of quality oversite and training

KEY POINT:

- Hospitals face financial **penalties** for non-compliant authorization workflows while **payers tighten criteria**
- The cost of delays and errors are now regulatory and financial, a double pressure that **bServed monetizes by solving**

Why Current Market Fixes Fail

In-House UM Teams

Operational Reality
- Rising overhead
- Limited shift coverage

Failure Point
- Missed Authorization
- Incomplete Submission
- Training & Oversight

Business Process Optimization

Operational Reality
- Disconnected from clinical EHR workflow
- Do not take actions, only report

Failure Point
- Still dependent on In-House Teams and Tech
- Disruptive training
- Multiple vendors required

Software Dashboards and Reporting

Operational Reality
- Expensive
- After-the-fact analytics

Failure Point
- No payor engagement
- No Cash Impact
- Diagnostic but not remedial

Consultancies

Operational Reality
- Advisory only
- Lack incentivized alignment
- Limited scope

Failure Point
- Short term
- Not sustainable

Operational example:

- Average BPO review TAT = 8 hours; bServed median = 25 minutes
- No existing competitor offers full EHR embedding plus payer execution layer

KEY POINT:

Where others offer staff or software, bServed delivers both the **team and the technology** built to work together

bServed's Fullscope Solution

In the ED

Solution

- Continually Update Payor Grid Post Stabilization Protocol
- MCG/InterQual Medical Necessity Review (MNR) sent to physician

Result

- Payor is Notified
- Out of Network Patients Meet Payor's Admission Requirements
- Authorization is Secured
- Correct Level of Care Assigned by Physician
- Denial is Prevented

During Admission

Solution

- MNR within first 24 hours
- MNR According to payor's required intervals
- EMR Messaging Integration
- Level of Care (LOC) Validation

Result

- CMS/Payor Compliance
- Realtime LOC Alerts for Physicians
- Concurrent Denial Escalation to Peer2Peer Calls if necessary
- Denial is Prevented

At the Time of Discharge

Solution

- Complete Case Continuity and Documentation/Reporting
- MNR/Payor Communication/and LOC Validation Removed From In-House Case Managers

Result

- Improved Discharged Planning
- Complete Compliance
- Maximized Reimbursement
- Denials Prevented
- Knowing which cases will be paid

Post Discharge

Solution

- Denial Recovery Management
- Aggressive Appeals Process

Result

- Denials are Overturned
- Complete and Transparent Analytics for Every Case
- Denial Root Cause Analysis and Process feedback loops
- Maximized Reimbursement
- Reduced AR Days

Result:

Maximum Reimbursement
Minimum AR Days
Compliance

KEY POINT:

bServed's solution starts in the ED and aggressively prevents denials, improves revenue, and yields valuable insight for hospital leadership

Product Deep Dive- Starts in ED

ED Level

- Payer Notification - Immediate and compliant notification to all payers upon patient arrival/admission
- Post-Stabilization Review - Stable/Non-Stable for transfer, out of network, transfer timeframe compliance by payers
- 24/7 Real-Time ED Initial Review – Immediate assessment against InterQual or MCG criteria
- Real-Time ED Provider Notification –Direct message to ED provider with MCG or InterQual admission criteria and the level of care the patient meets.

Admission Decision

- Admission Inpatient or Observation Medical Necessity Review - Within 24 hours of admission per CMS requirements keeping you in compliance
- Submit medical records and medical necessity reviews to payers

Payer Communication and Securing Authorization

- Concurrent Authorization Management – Real-time communication with payers (payer portals, phone calls, fax) to secure authorization approvals as care evolves
- Records Submission – Timely delivery of all supporting clinical documentation to payers
- Escalation When Needed Peer-to-peer review or CMO/ Physician Advisor escalation

Inpatient Utilization Management

bServed

Detailed Payor's Grid

Obtain payer authorization

Concurrent Medical Necessity Reviews performed before multidisciplinary rounds (8-10am)

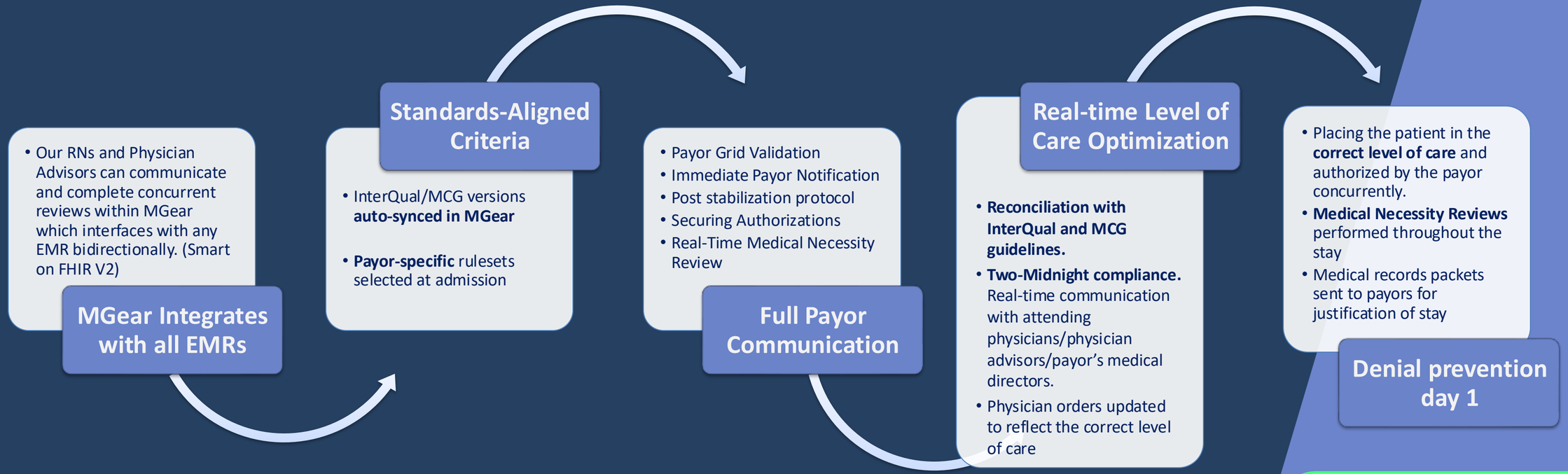
- Identify levels of care: ICU vs Telemetry vs MedSurg
- Avoidable days
- Medical Records and MNRs are sent to payers
- Direct Communication and coordination with PA/ Attending Physicians
- Payor Communication with prompt resolution
- Internal Quality Assurance process

Your hospital case manager will have additional time to work on patient care coordination and discharge planning

Denials management: All level of appeals, Peer to Peer, and Reporting

bServed + MGear: The Service and Software Solution

Embedded Experts • Single Vendor • Scalable



KEY POINT:

- Delivers **execution and compliance in one layer.**
- **Replaces multiple vendors** and manual steps with a single verifiable stream that CFOs and auditors can trust.

Results Driven

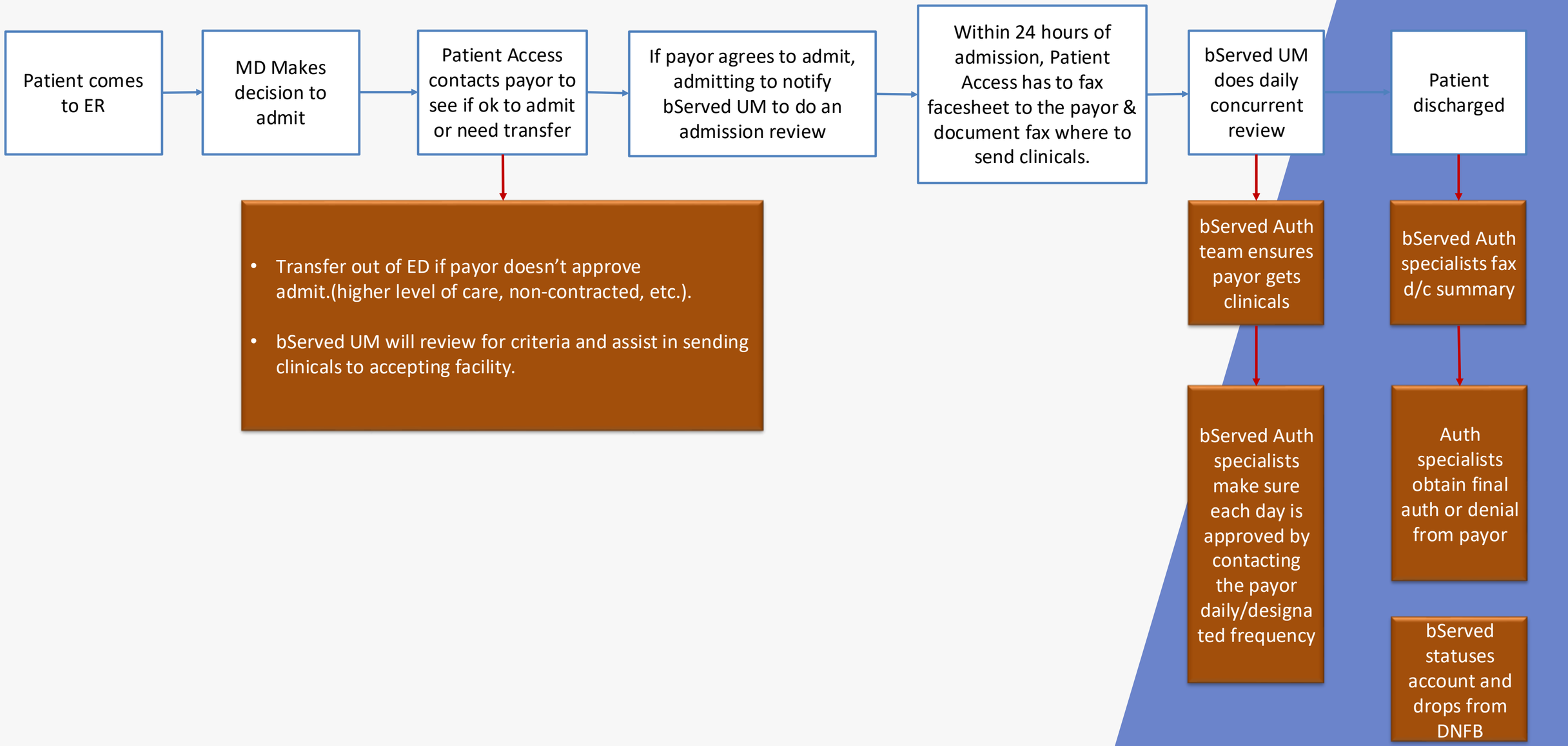
- **bServed embeds clinicians**, nurses and revenue cycle experts into hospitals and healthcare systems
- **We developed MGear, a proprietary software** that maximizes reimbursement and reduces payment delays

27%	Improved admission rate
25%	Reduced denial rates
45-63%	Staffing cost saving
24/7	Nursing and Support teams
0.5 - 1Day	Reduction in length of stay

KEY POINT:

- Regulatory change has turned Revenue Cycle/Utilization Management from a hospital cost center into a financial necessity
- CMS 2026 rules require electronic auth and real-time payer response
- bServed is already there

HIGH LEVEL PROCESS OVERVIEW



ED UM Dashboard: Follow trends and detect admission errors with full transparency

Date	Time	Account No.	Payer Name	Patient Name	Age	Sex	Triage Level (1-5)	Chief Complaint	Provider	Medical Necessity Review	Admission Recommendation	Admission Order	Reviewer Name	Medical Director Review	
														Provider	Note
8.1.23	1300	123456	Medicare	John Smith	65	M	2	Chest Pain	Dr. Spock	xyz	Inpatient	Inpatient	Argo		
8.1.23	1300	123456	Medicare	John Smith	65	M	3	Chest Pain	Dr. Spock	xyz	Observation	Observation	Argo		
8.1.23	1300	123456	Medicare	John Smith	65	M	3	Chest Pain	Dr. Spock	xyz	Criteria Not Met	Discharge	Argo		
8.1.23	1300	123456	Medicare	John Smith	65	M	3	Chest Pain	Dr. Spock	xyz	Criteria Not Met	AMA/Eloped/Refused/ Admit	Argo		
8.1.23	1300	123456	Medicare	John Smith	65	M	4	Chest Pain	Dr. Spock	xyz	Inpatient	Observation	Argo		
8.1.23	1300	123456	Medicare	John Smith	65	M	4	Chest Pain	Dr. Spock	xyz	Observation	Inpatient	Argo		
8.1.23	1300	123456	Medicare	John Smith	65	M	3	Chest Pain	Dr. Spock	xyz	Inpatient	Discharge	Argo		
8.1.23	1300	123456	Medicare	John Smith	65	M	4	Chest Pain	Dr. Spock	xyz	Observation	Discharge	Argo		
8.1.23	1300	123456	Medicare	John Smith	65	M	3	Chest Pain	Dr. Spock	xyz	Inpatient	HM Refused Admission	Argo		
8.1.23	1300	123456	Medicare	John Smith	65	M	3	Chest Pain	Dr. Spock	xyz	Observation	HM Refused Admission	Argo		
8.1.23	1300	123456	Medicare	John Smith	65	M	4	Chest Pain	Dr. Spock	xyz	Inpatient	Transfers	Argo		
8.1.23	1300	123456	Medicare	John Smith	65	M	3	Chest Pain	Dr. Spock	xyz	Observation	Inpatient	Argo		
8.1.23	1300	123456	Medicare	John Smith	65	M	4	Chest Pain	Dr. Spock	xyz	Criteria Not Met	Inpatient	Argo		
8.1.23	1300	123456	Medicare	John Smith	65	M	3	Chest Pain	Dr. Spock	xyz	Criteria Not Met	Observation	Argo		

MNR Result = ADMISSION ORDER	MISSED ADMISSION	LEVEL OF CARE MISMATCH	DENIAL RISK

Inpatient UM Dashboard: Provided to Case Management Daily for MDRs/DC Planning

UM LOG							Inpatient vs. Observation			Level of Care				Delays of Care	
Patient Name	AccountNo.	Room No.	DC Date	Insurance	Diagnosis	LOS	Current Status	Criteria Met	Recommended	Current Level	Criteria Met	Recommended	PA Referral	Reason	Avoidable Days
Doe, John	123456789	P2/222-A		Caremore	Fecal incontinence, rectal cancer, rectal bleeding	16	Inpatient	Yes		Tele	No	Discharge		Placement	2
Doe, John	123456789	312-A		Angeles	Septicemia & disseminated infections	8	Inpatient	Yes		Step-Down	No	Discharge		Procedure	1
Doe, John	123456789	CCU/33-E		Medicare	GI Bleed, anemia	2	Inpatient	Yes		ICU	Yes				
Doe, John	123456789	SE/519-B		Medicare	Cellulitis of left food	2	Inpatient	Yes	Observation	Med-surge	Yes				
Doe, John	123456789	SE/510-A		Medi-cal	Acute metabolic encephalopathy, DM	46	Inpatient	Yes		Med-Surge	No	Discharge			
Doe, John	123456789	SW/509-B		Axminster	GI bleed, HTN, UTI	13	Inpatient	Yes		Tele	No	Discharge		Placement	10
Doe, John	123456789	SW/503-B		Medi-cal	Hyperglycemia, nausea, vomiting	1	Inpatient	Yes	Observation	Tele	Yes			Procedure	1
Doe, John	123456789	S40-B		Bella vista	Abdominal pain, diarrhea, CBD dilation	6	Inpatient	Yes		Med-surge	No	Discharge		Placement	2
Doe, John	123456789	P2/221-B		Promise Health	Upper GIB, Gastritis	3	Inpatient	Yes			No				
Doe, John	123456789	215-A		BSBS	Nonspecific Cerebrovascular Disorders	14	Inpatient	Yes		Tele	No	Discharge		Placement	3
Doe, John	123456789	222-B		Angeles	Alcohol abuse & dependence	4	Inpatient	Yes		Tele	No	Discharge		Placement	2
Doe, John	123456789	ICU/332-C		LA Care/Medi-Cal	PNA, AKI	48	Inpatient	Yes		ICU	Yes				
Doe, John	123456789	CCU/33-C		Medicare	Pneumonia CAP vs. Aspiration, Dysphagia, Colitis	4	Inpatient	Yes		ICU	Yes			Imaging	1

Meet Our Team

Max Bekalo MD, MHA

Founder and CEO

As CEO of **bServed**, With a 25-year background in healthcare leadership roles across Regal Medical Group, CHA Hollywood Presbyterian Medical Center, Southern Regional Medical Center, and Prime Healthcare, he brings deep expertise in case management, clinical documentation, and revenue cycle performance. His career has been defined by building systems that bridge hospitals and payers, streamline care coordination, and elevate operational standards across the continuum.

Argo Babakhanyan MSN, RN, PHN

Co-Founder, Software Development Lead

Argo is the Co-Founder and Software Development Lead at bServed, where he drives both operational strategy and product innovation. With a Master of Science in Nursing and a background in utilization management and throughput coordination, he uniquely bridges clinical expertise with technology.

Boris Kotelnikov BSHA/PH/HS, RN-BC CM

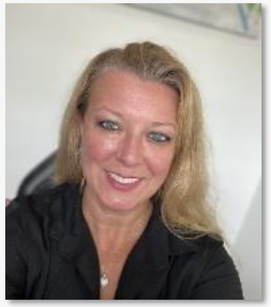
Chief Operations Officer

Formerly HCA Division VP of Case Management with 20 years of leadership spanning bedside nursing, care coordination, and utilization management He now leads operations at bServed. Having overseen an average daily census of over 5,000 patients he brings a wealth of experience.

Edwin Mendoza MD, MHA

Chief Revenue Officer

With over 25 years in healthcare, business and education, he brings an ability to understand needs and provide the foundation to strong relationships within the industry. Edwin holds a master's in healthcare administration with a focus in finance as well as over 7 years in clinical documentation integrity allowing him to bring strong insight to hospitals and healthcare organizations.



LORIE CROCKER RN-BC, CM

Director of Operations

Lorie Crocker is a Healthcare management leader with 33 years of experience, including 15 years focused on care management working with one of the nation's largest healthcare payors. A U.S. military veteran with 8 years of service, she brings deep insight in performance and operations.

KEY POINT:

- **Cross-functional** leadership (clinical + payer + SaaS ops)
- **De-risks execution** and supports rapid enterprise scale.

Quick Vendor Search Guide

Contact information
Edwin.Mendoza@bserved.us

bServed

What We Offer

1. Real-Time Clinical Review & Authorization

- We update and maintain the payor grid (requirements, policies, contacts, submission portals, etc.).
- We notify the payor and secure the authorization.
- We perform Medical Necessity Reviews within **20–25 minutes** (real time).
- We communicate with physicians **in real time** for level-of-care validation.
- At discharge, you know exactly where reimbursement stands.
- If there's a denial, we create the appeal letter, send the full patient info packet, and overturn it.
- We handle or schedule the **peer-to-peer** call.

2. 24/7 Team + Technology

- **Full team + proprietary tech** — 24/7, turnkey, works with any EMR.
- **Fast launch:** ready in 3–6 weeks.
- **We pay for HL7 feed setup** for all new business.

3. Flexible, No-Risk Engagement

- **90-day opt-out** if it's not working — no long-term lock-in.
- **No implementation fee.**
- **12-month denial look-back and recovery** on contingency (no upfront cost).
- **Free missed opportunity audit.**

What to Look Out For

1. Lack of True Clinical Expertise

- Generalists pretending to specialize in Utilization Management.
- Automated tech with little or no clinical oversight.
- No physician-to-physician (peer-to-peer) support.

2. Reactive, Delayed Processes

- Retrospective reviews done after admission or discharge.
- Lack of real-time payer communication and concurrent authorizations.

3. Poor Transparency & Oversight

- Weak or limited reporting with no live data access.
- No visibility into performance or denial prevention results.

4. Inconsistent or Low-Quality Teams

- Offshore or rotating review teams causing inconsistency.
- One-size-fits-all programs that ignore hospital workflow.

5. Hidden Costs & Risky Contracts

- Hidden setup fees and long, restrictive contracts.