Med Device Explants Credits: Everything you need to know to comply

With Al Brander

Episode 55

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Jim (00:01):

Welcome to the Healthcare Leadership Experience Radio Show. This show, hosted by Lisa Miller and Jim Cogliostro, brings you insights from both the business and clinical sides of healthcare.

Jim (00:11):

Lisa Miller, CEO and founder of VIE Healthcare Consulting and Managing Director at SpendMend, has established herself as a recognized leader in healthcare operational performance improvement. And, with her team, has generated over $1 billion in financial improvements for VIE's clients since 1999. Lisa loves to think differently and collaborates with healthcare leaders and their teams to solve challenges and create new, innovative approaches that directly impact the business and clinical side of healthcare.

Jim (00:43):

As a registered nurse since 2007, Jim Cogliostro has worked in critical care, perioperative services and outpatient settings at nationally recognized medical facilities across three states. His passion for the patient, along with his experience in a variety of healthcare settings gives him a unique

perspective on how to enhance the patient experience and workplace culture for any health system, big or small.

Jim (01:09):

On this show, you will hear from innovators and leaders from within healthcare and across multiple industries. We will bring you relevant and trending topics in healthcare that includes strategy, finance, patient experience, innovation, leadership, communication, marketing, and much, much more.

Lisa (01:28):

Hi, this is Lisa Miller and welcome to the Healthcare Leadership Experience.

Lisa (01:32):

Today I'm really excited. Jim and I are doing the podcast together for the first time and launching a whole new series on the clinical and the business side of healthcare. And our first guest together is Al Brander. And Al, we are so excited to have you here. You are the Chief sales Officer at SpendMend and we're looking forward to a great conversation.

Al (01:58):

Thank you, Lisa. I am too. This is a great experience for me as well.

Lisa (01:59):

Great. So can we just start learning about you because I met you a few years ago and your background is just really fascinating. On the clinical side, on the business and the technology side. Can you just tell everybody about you?

Al (02:13):

Yeah, I took a very interesting path to get where I am today. I started out actually wanting to go to college to be a minister. Decided early on that I really wasn't cut out to be someone's moral shepherd, but I still wanted to help people.

Al (02:28):

So, I ended up in social work and did that for about 10 years, ending up at Northwestern Hospital in Chicago, working with their dual diagnosis program and inpatient psychiatry for adolescence. And during that time there was a huge nursing shortage and so ended up going into nursing and deciding I loved the stretcher better than the couch, when working with patients. And had just that real impact with helping people.

Al (02:54):

And so did that for a number of years and then just kind of naturally got into leadership. Started as being a charge nurse, then a supervisor, then finally the director of a level one emergency room and did that for a while. Then moved up to the OR and was the director of what was a 30-suite OR at that time. Then mergers and acquisitions happened, and I moved up and became the chief nursing officer of a system in Michigan that's now 22 hospitals.

Al (03:21):

And so did that, loved leading the nursing efforts and came up with an idea for medical software. So, it took a complete left turn and created some software to help hospitals track their tissues and implants to meet all of the FDA standards. And did that for 10 years. Never thought I would do anything else and then SpendMend came calling and now I'm working for them and leading the sales effort on the SpendMend side.

Lisa (03:47):

So, there's a lot to unpack there. But now I could call you Pastor Al.

Al (03:51):

Well, that's my dad. He's pastor Brander. I'm just a PK who still loves to take care of people and make their lives a little better.

Lisa (04:01):

Yeah, that's great. Now, I knew everything except for that, so that's awesome.

Lisa (04:06):

So, we want to jump into medical device warranty and what work you're doing because you do have work... You have experience and you were really revolutionary or visionary on the tissue implant tracking side. So, you've taken that, and I know there's a lot of other softwares that you've had vision for, but here at SpendMend, you've taken medical device, the issues that surround that and you've created not just a software, a solution, but really an awareness.

Lisa (04:35):

So can you just tell everybody... Kind of give everybody the background on medical device and why they should be paying attention to this?

Al (04:43):

Yeah, absolutely. So, there are all kinds of great implants that we put into people to make their lives better, the most common of which is a pacemaker, but there's all kinds of neural stimulators, total joints, all of these items. And so interestingly, all of them come with kind of a warranty. They're expected to last for a certain amount of time, but all of us have cell phones, so we understand that batteries and motherboards don't always last as long as they're supposed to. And so, for years, CMS, the Center for Medicare and Medicaid Services, is the primary buyer of these things because most of them go into our elderly patients. And so, CMS realized that "hey, we pay for the first device to get put in and then if it does fail, we pay for the second device to get put in and the hospitals are supposed to be sending back these devices, back to the manufacturer to see if there's a warranty." When the hospital gets that money, well really, it's not their money, it's CMSs money.

Al (05:43):

And so, the new standards came out in the late 2000s, actually. And what the expectation was is, when there's a device that fails, for whatever reason there's a malfunction or patient morbidity that happens because of that device, when it gets switched out, hospitals are expected to send it back to the manufacturer and pursue those warranty credits.

Al (06:05):

So, in order to incentivize hospitals to do this every time, they've said, "Hey look, if that warranty credit is 50% or more of the replacement cost of that device, then send it back to us. But anything that's 49% or below you guys get to keep. We know we've paid for the full cost of the device, but that additional 49% is yours because you've gone through the effort to return it."

Lisa (06:30):

So, there's two parts to that, right? So, there's a part where... There's a compliance part. Where if hospitals aren't sending them back, they could be at risk for a penalty. But you and I spoke earlier about the reward side, you mentioned it just now, the 49%. So, I know we look at this from a compliant and risk mitigation, which is important, but I think there's a reward side to this, too.

Lisa (06:52):

Could you talk us through the risk-reward and why this makes sense, not just to avoid penalties but we can move towards adding revenue?

Al (07:01):

Correct. So, the first part to remember about these is that probably 90% of the warranties are going to be below those 50% threshold. So, this is just money that the hospital gets to keep. And I can tell you as a bedside nurse, there was a huge reliance on the vendor rep and just asking them, "Hey, do we need to send this back for warranty?", "Is this under recall?" Because in the heat of the moment, in that case I would have no idea. And so, if the rep said no, I would throw that device into the biohazard bag, literally throwing cash in the trash can. Because these devices could have anything from a $3,000 to a $15,000 warranty credit on them. And I just tossed it away. So, it's important that you get that.

Al (07:45):

So, where this really has changed in the last number of years is that there's been slight wording changes in the CMS standards.

Al (07:53):

So, the first is under the prudent buyer standard. Before it was, "if you got the credit, repay the credit" and now they've said, "Hey, regardless of whether you get the credit or pursue the credit, if there was a warranty, you owe it to us." So that's where it's a double whammy for the hospital. If they don't return that device but there was a credit, they lose out on that money and they have to pay CMS. The fines have greatly changed. It used to be a $5,000 flat fee and they would have you return the monies that you had and maybe charge a slight interest payment if you've had it for a number of years. Now they've gone to a per-instance fine. So, the bottom of that fine is about a little over $11,000. The high end of that fine is 22.9, so almost $23,000.

Al (08:43):

So if you take a $20,000 credit that you don't get, now you need to pay that fine. And what CMS has said is that, "hey, if you don't do this correctly, you don't just owe us that credit, you owe us three times that credit. So that $20,000 you just lost out on now turns to $60,000 and if we apply the high end of the fine, you're now at $80,000." So, it adds up very fast.

Lisa (09:11):

And for those listening to those numbers or it kind of sounds like, "oh, we may never get audited, this is not possible. It's like a needle in a haystack." I think you should tell the audience your hospital got audited. And there's an interesting fact that you mentioned to me about how much OIG is putting into funding these reviews.

Al (09:35):

So, this... Really, non-compliance of this falls under the False Claims Act. So, this is Medicare fraud. So, hoping that they don't find you committing Medicare fraud is never a good plan.

Al (09:46):

But when they did a huge survey recently, or they released, I should say, the results of 911 hospitals and when they looked at this, they said, "okay, we looked specifically at about 6,500 claims, found that hospitals half the time

were not doing this correctly. And that if we just looked at those 65 claims, it was $33 million in overpayments that the hospitals owed CMS." And when they extrapolated that out across healthcare and all of the hospitals, they're like, "this is about 1.5 billion a year."

Al (10:20):

So, they went back to Congress this year and they said, “Hey, we need to increase the enforcement of this”. And they were granted $50 million to hire more auditors and to do more of these provider audits, specifically in this area looking at Medicare fraud around warranty credit non-reporting, because they consider that an overpayment. Because we paid for this the first time it got put in, we paid for this the second time it got put in. And so really this money is an overpayment because you should deduct the cost of that warranty back.

Al (10:50):

And for the hospitals that listen to this, what's the most interesting is looking at the legal and financial accountability. It is not the original implanting hospital that has any accountability. It's not the manufacturer who made the device, it's not the rep in the room who says, "I'll handle this for you. You guys don't need to worry about this. You got so much going on I'll handle this." It is 100% with the explanting hospital has all legal and financial responsibility.

Lisa (11:17):

Yeah, that's really interesting. And that was something else you'd mentioned when we spoke earlier. Can we take another step back because someone, maybe the CFO or someone in leadership's like, "okay, well this is easy, we could track this. You know what, we got this. This is such a big area either of mitigation or to improve our revenue by having that 90%, getting some of that money back, we should be doing this right? So, we got this, I'll hire somebody, or our team can do it." Can you explain the complexity around tracking or who is involved in this?

AI (11:51):

Yeah, and it is, it's the most interesting standard in the hospital. I call it the orphan standard because at the beginning, clinical has to do the right thing. Whether you're in the OR taking out a neural stimulator, whether you're in the cath lab taking out a pacemaker, you have to identify that this device is under warranty or should be returned, then you ship it back. Supply chain should be doing that. So now you've got two departments very quickly involved in this.

AI (12:18):

And then it goes out into a black hole, which is the manufacturers themselves. They do an interrogation and work up this device. It could take a month; it could take six months, and nobody knows. Suddenly, here's a credit report that comes back to the hospital. So, the AP department sees this credit memo and there's 20 things that you return that you didn't use, 10 things because you're switching out a model number, all of these different parts of it and they may not even notice right in the middle there's a warranty credit.

AI (12:47):

So have someone has to recognize that that credit happened and clinical is no longer involved. I mean we've moved on to a whole new patient schedule. We're done with this as nurses in the room or nursing leadership. So now AP has to recognize this, then someone has to do the math and know the warranty program. Well, how much is the warranty? How long was it in the body? Is this over 50%? Then they have to reach out to revenue cycle, to your government payer side, and tell them you need to update the UB-04.

AI (13:18):

So, the UB-04 is the patient billing record at CMS, which is its own complicated document. But two years ago, actually it's been four years ago now, I always lose two years of my life because of COVID. Four years ago, they changed the condition and value code that you have to actually put on the UB-04 when you put that money in there as a credit so that everyone recognizes it.

Al (13:38):

So, you have compliance overall, on top of this. You've got two separate clinical departments that never have the same leadership or rarely. You have AP that has to recognize the credit. You've got the supply chain folks who are getting the new device in and then sending this old device back and then the rev cycle. So, you've got all of these departments. And typically, when we go into a hospital, what we see is six different spreadsheets. Nobody quite knows what's going on, but they know they need to do this. So, it's very cumbersome.

Lisa (14:06):

So, we're going to get to really your mastermind behind how you've process mapped this for hospitals and the technology and the solution you've created and the services. And I've been doing a lot of thinking about our conversation and really, it's like one of these explants has the ROI really to have a service come in and really offer this protection. You're going to walk us through this.

Lisa (14:32):

So, a couple of things, I'm going to throw a left curve at you. So, while Medicare is the largest payer, a lot of private pay managed care payers follow suit when they see opportunities and see what Medicare is doing, they follow suit. And I'm wondering if you've yet seen private payers' kind of mimic this ruling tool for them.

Al (14:53):

Yeah, they have. And what's interesting is folks like the Blue Cross Blue Shield, Aetna, United are all writing these in there and saying, "Hey, if we've done this and we're the payer, we want the same terms as CMS has." So, what that means for a hospital is now they're auditing this same information again and tracking it all for their commercial payers.

Al (15:15):

So, it definitely is. We're seeing more and more of that in the expectation that these are returned. So, it has gone from just CMS and cardiac devices to any implantable device that fails or is recalled and any insurance company.

And really the right thing to do is if there was a private payer involved, there should be some payer credit, in my opinion, and pay them back because if they private paid this, the hospital is getting back a $20,000 credit or $10,000 credit that really the patient's already paid for and that should be returned as well.

Lisa (15:52):

Yeah, absolutely. I agree. And another question, does this show up on the cost report, Al? Or where does this show up? Or is this just the re-billing when they have the second surgery? Is that where it shows up? Do they do any reporting on the cost report or no?

Al (16:03):

No. It really is the identification of the credit and then it shows up on the revenue cycle side as a credit that has to be issued back to CMS. So, it's a debit there, but it definitely would hit the P & L of the department.

Lisa (16:18):

Yes.

Al (16:19):

If you're returning all of these devices and the software that we've created returns and make sure that you get every one of those. And so, for all of our customers there's a positive ROI, because we just make sure they return the money they get to keep and then report properly the money they have to return.

Lisa (16:37):

Right. And so, one of the things that I've really wanted to do on this podcast was help healthcare leaders in the business and the clinical side to give them ideas, new innovation and really help them avoid and move towards more profitability, increasing their margin. And I just love the work you're doing.

Lisa (16:57):

So, this is a billion dollar issue, now. This is going to be a bigger issue for CMS, so they probably are going to put some more pressure on. I want to kind of move to just two things before you get to show us the software. One is the mock audits. Can you just talk through, A. Why you feel mock audits are so important? The industry's used to different mock audits, right? JCAHO and so on, but why you feel mock audits are really important in this space.

Lisa (17:25):

And two, leading up to, we can do a demo and show us what you're offering.

Al (17:31):

Right. Yeah. The mock audit conversation is exactly right. We do this all the time in the hospitals. We have a pre-CLIA audit for the lab. We have a HRSA audit for our 340B pharmacy program. We have a pre-joint commission audit before six months, eight months before we're expecting the next joint commission audit. Just to make sure how we're doing.

Al (17:52):

This mock audit follows the same pattern. We go in, we get information from the hospital on what they've purchased, what devices they've had. So, they're paid history from the big fours, we call them, the big four cardiac manufacturers. Then we get all of the credits that they've issued to the hospital, all of the devices they've sent for the hospital to have warranty. And then we plug it into our database that has all of these warranties to figure out which ones qualified, which ones do they need to report back. Then we take a deep dive into the UB-04s of all of those patients, to make sure it was credited properly, and the right condition and value code was there.

Al (18:32):

So those are invaluable to the hospital. One of the things this is really falls into that low frequency high-risk area. So, we recently just did an audit for a 250-bed community hospital. Standard average American hospital across the country. There's more of those than just about any other size hospital.

And they did 2,200 implants/explants a year. So, over the six years, you guys can do the math, they only had 28 mistakes. So, if you're a nice statistics geek, that's way inside of the standard bell curve. But when we extrapolated out that money, those 28 mistakes were just over $300,000. And if OIG had found that $300,000, they would've had to pay back $900,000, because it's the three times rule. And if they applied the low and high jeopardy, you were between a $1.5 and $2 million finding.

Al (19:30):

And so, by us going in there and doing this mock audit, we were able to find where the holes were in their process, have them report it without having any fines. One of the things that has been very cool is we help hospitals self-report this. We've never had a hospital fined in hundreds that we've done across the country — large and small health systems.

Lisa (19:49):

So that's extraordinary, right? Because you think... You gave a classic example of the hospitals a size to all across the country and they were high performing and yet this is a $1.5 to $2 million penalty that they would've had in a very high-performing hospital. That should really get everyone's attention.

Al (20:09):

Yeah. And some of the big systems, we've done 20-hospital systems, 40-hospital systems, we see between six and 12 million. So, in today's age when we have negative margins or 1% margins, I didn't realize how lucky I was living in the era of 4-6% margins to be able to fund healthcare and get the new CT scanner and do all this stuff. Most of the hospitals are negative. So, all of a sudden if they have to write this check, it's very painful to that health system.

Lisa (20:37):

Yeah, it's almost like everything we've come through with COVID and now increasing inflation costs and some issues with getting patients back and volumes, now you have this, it's almost insurmountable. So, it leads us perfectly into, could you show us the solution for med device that

SpendMend has and that you've been behind? And it'd be great if you could just walk us through and while you're walking us through it on video, for those hearing us on podcasts, you may have to talk through little things in more specificity.

Lisa (21:09):

So, Jim, anything you want to add while Al is getting the screen up?

Jim (21:14):

Sure. I'll just echo something that you mentioned earlier, Al, and that is at the bedside... I know I never was thinking about this. I mean the existence of these medical device warranty credits, but the need to emphasize that to those that are in the OR at the bedside. I think it's so important that you mentioned, and I mean the numbers alone should speak loud enough in terms of telling staff, “Hey, this is an issue." But I appreciate that you brought that up.

Jim (21:39):

And then the one other thing that you mentioned was in terms of the language in medicine, the standards of practice are always changing. Did you ever come across a hospital that felt confident in, "Hey, we're doing it well, we're on top of this." But then you say, "hey, that was two or three years ago. Now things are a little bit different."? Like you mentioned the language changes.

Al (21:59):

Yeah, that has definitely been the case. And what we found is even the hospitals, like the community hospital, it's a very FT effort to be able to meet this standard. I mean you've got to run reports out of your EHR, you've got to reconcile that with the manufacturers and track down manufacturer information. So even the ones that do this well, it's a burden because we all know Jim, you and I lived in the hospital side long enough, they always say all other duties as assigned.

Al (22:28):

So, somebody's getting this to do besides their day job to track this down. And what's crazy about it is there's some serious time limits on this. You've got 30 days from when that explan happens to getting the device back. You have 60 days from when you get that credit to reporting it to CMS. So not only is it difficult to do, there's some very significant time triggers that have to happen.

Al (22:53):

So, you could do everything right and just miss by two days getting that device back. Well, guess what? You now are liable, and you have to pay that money even though you didn't get that device back in time.

Jim (23:05):

That's great. Thank you.

Al (23:07):

And I'll tell you, as a nurse in the room, I know we were always supposed to have that great resource book with every single warranty that's happened, but some of these recalls go back to 2010 and the warranty changes. There was 59 devices that were recalled last year in the cardiac space. 59 separate devices that I'm supposed to know the difference of, and it just didn't happen as a bedside nurse.

Jim (23:28):

Right. Thanks.

Al (23:29):

You bet. So, can you guys see my screen?

Lisa (23:32):

Yes.

AI (23:33):

So, what we have here is really the credit of three groups of people.

AI (23:37):

One, the IT folks who can take these standards and the process that we outline for them and turn it into a useful tool.

AI (23:48):

Two, the audit team. We've got a group of auditors on our side who have been doing medical device warranty since the early 2014s, 2012s. They know all of this inside and out.

AI (24:00):

So, what we really did is the IT folks took the auditor's brain and what they needed to do, the nursing or clinical hospital side and what we needed to do, and put this into a workflow that is manageable and simple. One of the core tenets of what we do at SpendMend is to take things that we call dark data. Things where you don't know exactly what's happening and bring visibility and insight to it so that you can understand what's going on and be able to manage the program.

AI (24:31):

And then from there we look for opportunities to optimize. I mean that's something that Lisa, you and your team are so great at, is where those opportunities to optimize revenue and get monies into a hospital.

AI (24:44):

So, what you see in front of you is our workflow. This is everything CMS and the OIG are expecting you to do. So as a bedside nurse when there's a procedure, when I just go, "Oh, I'm taking something out and replacing it with something new." I put it into the system. Six data points, very simple. Nothing else you need to do. And then we upload the documents that the vendor provides at the beginning of the case, the interrogation report of that device and the original implant record that they have to keep, because

it's required by the FDA that they know who gets these devices and where they are. Who has them in case there is an issue.

AI (25:20):

So once that happens, SpendMend actually takes the burden from there. We review everything to make sure that all the documentation is complete. We run it through our database to see if there's a credit due. If there is, we actually send a shipping label and pre-fill out all the documentation. The worst thing that can happen is you don't document correctly. So, the vendor denies it, or you don't get it back within that 30 days. So, we monitor that. If this device hasn't been picked up within 10 days, this turns yellow. We are creating another task in the system and sending an email saying, "Hey, you've got to get this device back." At 20 days, it turns yellow, we elevate it again and there's a whole escalation to make sure that it gets back.

AI (26:05):

Once it gets back to the vendor, we then have direct communication with the vendors. They let us know when a device has been approved, when a device has been denied, that a device is still pending investigation and they don't have results. So, you don't have to hunt them down. We do that and once a device has been... Well first of it's been denied, we're going to look at it and see if we agree about three to five times across our ecosystem, we find denials, which are money right out of the hospital's pocket typically, because those are the 49% or less denials, and get that money back for them.

AI (26:41):

But then when something is credited, our software does the decision making there. It looks at that device, it looks at that credit and says, "hey, this is over 50%." We then create a new task in the system that is directly at the revenue cycle, and they then update the UB-04. We let them know the right condition and value code and we have them update the UB-04.

AI (27:04):

So, the key to this is that on the clinical side, all I need to do or worry about as a clinician is the front end of this. And if I do my part right, and

SpendMend's going to make sure that I do, we're going to be okay. Then when it's time to send it back, we're working with supply chain, "Hey, you need to send this back. Here's the label." You can get boxes still from the manufacturers. In fact, we have a link in our help section where you can just go on and order those boxes from each manufacturer. Then when it goes to the vendor, we're communicating with them. It's amazing how often we hold the vendors accountable. They'll say, "Well, we didn't get that device didn't ever show up." We can prove from the shipping label, "Yes it did. “Well, it came after 30 days.” No, it didn't. This is Joe who signed for it on the loading dock, and you did get it." We also hold them accountable to their warranty rules. What is very interesting about this, CMS does not dictate what a warranty is. CMS does not dictate what qualifies. CMS doesn't even have a list, which would be incredibly helpful, of all the devices that have warranties. It is 100% up to the manufacturer to create those rules and conditions for returning that warranty. However, once that warranty is returned or once there is a warranty on that device, now CMS is involved, making sure that you return those.

Lisa (28:22):

Can I ask you a question for one minute?

Lisa (28:24):

So, the manufacturers dictate, or they write their warranty rules. Are there various warranty rules or are they somewhat similar? Are they wildly different now?

Al (28:34):

They are wildly different, even within manufacturers. So, Medtronic, they make neural stimulators, they make pacemakers, they make AICDs. Each of those will have their own warranty terms even within Medtronic and a different pacemaker that's a newer generation may now have new warranty rules than the old one.

Al (28:54):

So, it is all over the place. There is literally tens of thousands of devices and warranty rules.

Lisa (29:01):

For that alone, and I can think of many other reasons, I mean just looking at this process map and you explaining the process map and the diligence you do to ensure it's returned and to get the boxes and hold the vendors accountable. However, for the amount of knowledge that you have at the system has on the warranty rules. I mean that's incredible. I mean that you've built it into this technology.

Al (29:24):

Yeah, and it's crazy because, again, think if I'm a hospital in Florida that's taking care of Snowbird, they got this device up north somewhere. Good, good point. So, they have no idea when did it get put in? What was the warranty terms in 2012 when this device was placed? Suddenly I now have to know them and be able to make that critical decision that this device needs to go back.

Al (29:46):

So that's where SpendMend really helps in not relying on a rep or not relying on a database that's hospital built to keep up with this. Because every month there are new devices that brilliant people out there are coming up with to help make our lives better as we age and move through the life cycle. So many of these great devices that help with disease, that help with things like Parkinson's and pain and joints as they wear out, all of those are great and there's new of them every day. And so, we are constantly updating the database and working with vendors as new devices show up, so that hospitals don't have to do that work. They can focus on their mission of taking care of patients.

Lisa (30:29):

Yeah. So, I have a couple of questions and I think that point is really, really valuable and should never be understated because the more time that... I mean you both are nurses, and the more time you're away from bedside doing these administrative things, it does impact patient care. And these tools really get you working with patients. So, I think that's really important and I'm so glad you mentioned that, Al. And Jim talks about it a lot.

Lisa (30:54):

You ended at the vendor processing. We're still on the second layer of their process map. And do you want to finish, and can you also speak about some differentiators on what SpendMend offers in this technology?

Lisa (31:08):

Because you and I have talked about it, there's also this core principle of making sure this is done completely to the end. And I think that's really key.

Al (31:17):

Yeah. So once that vendor has determined that the credit and the credit is issued, SpendMend again gets involved and makes sure that that credit is identified and lets the revenue cycle know that it's updated. So, CMS gets that overpayment credit.

Al (31:31):

What we learned early on, the first software that I worked on the tissue side, that was one where we could sell a software to a hospital, and they could run it. They could manage the program. With this, because it's five to six departments over across a six-month timeline, we learned very early on that the service was the critical component to this. And that service, looking back at what you've done previously to make sure you have no risk. And then day to day. We don't just sell a software and walk away, we sell you a process, we sell you the software to make you standardize.

Al (32:09):

My mantra, when I was running the OR, was "consistency in procedure is going to lead to predictability of results." There is no process flow out there that needs more consistency and procedure. Imagine a health system with 14 hospitals and each cath lab and each OR all have to do this. And each supply chain, and each of those hospitals have to track this.

Al (32:31):

So by putting this software out there, this gives visibility and insight as to what's going on and SpendMend manages it for you. Anything that's critical, we alert, we make sure that the next step is identified. We put in a task. We know that hospitals are not going into our software every day. They're in their patient softwares, their EMRs. And so, when with this compliance software needs attention, then we get involved to let them know, "Hey, look at the software. There is something you need to do." So that we assure that they're critical.

Al (33:02):

And then just like, should you be audited by the IRS, we come in the back end. And because we've been involved in this process, because we have this tool that does all the documentation, we actually provide audit defense. So you're not alone.

Lisa (33:19):

So this is one of my favorite parts. This is really great. So, I... Sorry to interrupt you, but if somebody sees this that's auditing a hospital or... The audit's probably much done, but go ahead, Al.

Al (33:33):

Yeah. So, if your Mac provider comes to you or the OIG themselves and said, "Hey, we're doing this audit." Or even a commercial payer says, "we want to audit all of the accounts that we've paid on explants." So, because of how we capture the information, and the OCR technology we use to get all of this information, you'll have all of your procedure information here from the patient all the way down. And we take our PHI very seriously. In order for me to see patient information, because it's always encrypted, I have to actually make a separate call to the server to pull this information in.

Al (34:05):

But you will see all of the information about the original device that we get from that manufacturer's implant record. The information on the replacement device. And here is what's so cool. It's the activity, everything

the hospital did, everything SpendMend did, everything the vendor did, all the way down to when CMS takes credit for that device and acknowledges it. And then all of the paper, that trail that you're going to need. So, no need to report things out of different systems, it's all going to be in here. That patient interrogation report, the vendor original implant record, the face sheet so we can identify who that payer is, the shipping label so we can prove its movement from the hospital to the vendor. The credit memo itself. The UB-04 being updated. And then finally when CMS remits this.

Al (34:55):

So if I'm an auditor, I go into this and I look at one record, "And you have this for every explant?", "Yes.", "In every department?", "Yes.". "Okay, we're done. Randomly give me 10 of these." It's going to give you everything you need to be compliant.

Lisa (35:10):

This is just remarkable. I mean, every bit of this process has been thought out. I love the activity log, and this is providing just enormous protection for our hospitals. But as we talked about a little bit, but it also can provide some extra revenue opportunities, too. We've definitely focused on the protection side. But there is a revenue side to this that should be thought about, too. That's 90% of the 49%, right Al?

Al (35:40):

Absolutely. So, part of what we do in the dashboard, because if you get higher up in the food chain, you're less involved in the details, right? So, I can go in as the chief nursing officer or the chief compliance officer and say, "Hey, what's going on?" And I can go to this dashboard, and I can look at how many devices, explant procedures we've had in this system, how many of those qualified for a warranty and are sent back. At a glance, I can see the total dollars were received, what we sent to the payers, what we retain. This is the money that we now, and we want to see this go up every year at those hospitals.

Al (36:13):

And then of course, how many fines have we avoided? And then for those compliance folks out there, this is where we get to look at the holes in the cheese.

Al (36:21):

Where did our system break down? How many explants were there credits issued? And again, we tried to make it simple because I have to help train this thing, too. One click of the button allows me to drill down and see each of these three credits that the hospital received, that were never recorded in the system that came back as either a credit memo or else that manufacturer told us, "Yes, we sent these two devices last month and we never got a credit request."

Al (36:47):

So, we track all of this for the hospital and put this all at their fingertips so they can be assured that if they use this system, follow the workflow, allow SpendMend to quarterback it for them, we will assure their compliance.

Lisa (37:03):

So, Jim, I don't know if you have anything to say at the moment as we wrap up, but I'll let you start, and I will finish.

Jim (37:10):

Yeah, I just wanted to add, I know you've seen this before, Lisa, this is my first time seeing this and, Al, I'm so thankful you're breaking it down step by step. But just to visualize it, I was going to say, I don't know how your team is able to manage all this with, like you said, the warranties are always changing, all the different devices. You might have patients who was implanted in a different hospital. But just to see this flow chart and then to see that explant detail, I understand why hospitals, unless they have a dedicated team to focus on this, I mean there's no way you could keep track of all this. I'm very impressed and you see how this would work and I know you got a strong team working with you on these and it is just, I'm very impressed. That's all I wanted to say.

Lisa (37:50):

And it's the vision and he's utilizing technology with AI, OCR and really has advanced this so that while there's some human thinking, which I think we always need, that they've also made this into a proven process. And I love consistency with procedures, provides predictable results. I think you could put consistency in blank and provides predictable results.

Lisa (38:20):

I love it, Al.

Al (38:21):

Yeah, that's my thing. It also works on the golf course. You have a consistent set up, grip, alignment, stance. You're much more predictable than where that shot is going to go. So, it applies to so many areas of life.

Lisa (38:34):

Agreed, Agreed.

Lisa (38:36):

Al, thank you so much for joining us on the Healthcare Leadership Experience Show. We are a SpendMend show, now. So, this is the first show that we've done together with Jim, but it's been with you, part of the SpendMend family. So, we're really excited about that. We're going to have a number of other podcasts about SpendMend and what we're all doing together to elevate the cost cycle solution and that you're part of leading and Dan and Rob and team. So, we're excited to be here.

Lisa (39:06):

If you're listening, you can reach out to Al Brander, we'll have some information in the show notes. And we really appreciate you continuing listening to the Healthcare Leadership Experience Radio Show. We have some great shows coming up. Thank you for listening.

Jim (39:21):

If you have any questions about VIE Healthcare Consulting, a SpendMend company or if you want to reach out to me or Lisa Miller, you can find us both on LinkedIn.

(39:32):

We at VIE love helping hospitals save money and enhance the patient experience. And we're hoping that today's episode gave you some new insights or ideas to consider and use in your career and healthcare organization.

MEET LISA MILLER

"It's important for hospitals to have a clearly defined cost savings strategy with purchased services as a component to that strategy. We provide our clients with a focused roadmap to achieve those savings through our expertise since 1999."

Lisa Miller launched VIE Healthcare Consulting in 1999 to provide leading-edge financial and operational consulting for hospitals, healthcare institutions, and all providers of patient care.

She has become a recognized leader in healthcare operational performance improvement, and with her team has generated more than $720 million in financial improvements for VIE Healthcare's clients.

Lisa is a trusted advisor to hospital leaders on operational strategies within margin improvement, process improvements, technology/ telehealth, the patient experience, and growth opportunities.

Her innovative projects include VIE Healthcare's EXCITE! Program, a performance improvement workshop that captures employee ideas and translates them into profit improvement initiatives, and Patient Journey Mapping®, an effective qualitative approach for visualizing patient experience to achieve clinical, operating, and financial improvements.

Lisa has developed patented technology for healthcare financial improvement within purchased services; in addition to a technology that increases patient satisfaction through front line insights.

Lisa received a BS degree in Business Administration from Eastern University in Pennsylvania and a Masters in Healthcare Administration from Seton Hall University in New Jersey.
She is a member of the National Honor Society for Healthcare Administration – Upsilon Phi Delta. Her book The Entrepreneurial Hospital is being published by Taylor Francis.

MEET JIM CAGLIOSTRO

Jim joined VIE Healthcare Consulting in 2018 and brings to the role over a decade of critical care nursing experience at highly regarded medical facilities across three states.

During that time, he observed both the 'good and bad' of hospital operations in a number of regions, giving him a unique insight and understanding which he brings to VIE Healthcare Consulting's clients

MEET AL BRANDER

Al Brander RN FACHE MBA BSW BSN is the Chief Sales Officer for SpendMend. He has over 30 years of healthcare experience in clinical social work, bedside nursing and hospital administration, including holding positions as the Director of Emergency Services of a Level I Trauma Center, Director of Surgical Services of a 30 Suite OR, and CNO over 2 hospitals and 2 Long term care facilities in a 22-hospital system.

Alan is a Fellow in the American College of HealthCare Executives and a HealthCare Accreditation Certified Professional. He is a serial entrepreneur and patent holder. He has developed several healthcare software solutions including TrackCore Tissue and Implant Tracking solution, Turnover Tracker and collaborated with SpendMend's Audit and IT teams to create the Explanted Medical Device Warranty Credit Tracking solution. Alan has been married to Susan who is also and RN for 33 years and they have two adult daughters who are both educators.

He is an avid golfer who loves to read and travel in his free time.