PRACTICE FINANCIAL POLICY AUDIT CHECKLIST

ChiroHealthUSA Compliance Series | Revised & Legally Reviewed Edition

Practice: _____
Date: _____
Completed by: _____

IMPORTANT LEGAL NOTICE - READ BEFORE USING THIS CHECKLIST

This checklist is an educational compliance awareness tool prepared for use in conjunction with ChiroHealthUSA's Risky Business seminar series. It is intended to help chiropractic practices identify potential areas of financial policy risk and is not a substitute for individualized legal advice. No attorney-client relationship is created using this document. The legal citations and regulatory references included are provided for educational context only. Laws, regulations, and OIG guidance are subject to change. Practices should consult a licensed healthcare compliance attorney for advice specific to their circumstances, state, and payer contracts.

HOW TO USE THIS CHECKLIST

Complete this checklist with your office manager or compliance team. Answer YES or NO to each item based on your current actual practice - not your intended policy. A NO answer is not a finding of wrongdoing; it is a compliance gap that should be addressed. *Legal citation rows (📋) provide the regulatory basis for each requirement. Highlighted rows indicate elevated risk areas.*

🔴 **HIGH RISK =** Known OIG/DOJ enforcement area with documented penalties. ⚠ **CAUTION =** Requires careful documentation and consistent application.

SECTION 1 Fee Schedule Integrity

Your UCR fee is the foundation of every other compliance decision you make.

YES	NO	Compliance Question
YES	NO	Do you have ONE written, documented fee schedule applied consistently to all patients and all payers? 🔴 ***HIGH RISK: Maintaining different fee schedules for different payer classes - without a contractual or legal basis - creates dual fee schedule exposure under the False Claims Act. 31 U.S.C. § 3729.***
YES	NO	Is your UCR (Usual, Customary & Reasonable) fee schedule set at or above your highest contracted or allowable rate, using a credible source (e.g., state Workers' Comp rates, FAIR Health, or ChiroCode)? ⚠ ***CAUTION: Your UCR must function as the ceiling of your entire fee structure. It must exceed every contracted, DMPO, and regulated rate you accept. If any payer's allowable, your DMPO rate, or your cash rate is higher than your UCR, your fee schedule is structurally broken. This creates dual fee schedule exposure, misrepresentation of charges to payers, and audit risk. An incorrect UCR doesn't just mean you're leaving money on the table it could mean your entire discount justification collapses.***
YES	NO	Is the same fee charged for a given service code regardless of payer - before any contractual adjustment is applied? ⚠ ***CAUTION: The fee you submit must be your actual UCR fee. Payer-specific adjustments are applied after the fact through contractual write-offs - not by charging different amounts at the point of service or down coding to achieve a lower fee.***
YES	NO	Do you know your contracted rate with each payer, and does your UCR fee meet or exceed all your contracted rates? If not, you are undercharging.
YES	NO	Do you review and update your fee schedule at least annually and document the date of each review?

SECTION 2 Discounts & Time-of-Service Policies

A discount without a legal basis is not customer service - it is a compliance violation.

YES	NO	Compliance Question
YES	NO	Are discounts offered in your practice based exclusively on one of the following legally recognized basis: (a) a written contractual agreement with a payer, (b) a documented, income-verified hardship policy, or (c) membership in a compliant Discount Medical Plan Organization (DMPO) that establishes a separate allowed fee? 🔴 ***HIGH RISK: Discounts offered outside these three categories - including informal, verbal, or selective reductions - risk classification as a dual fee schedule or unlawful inducement. OIG Compliance Program Guidance; 42 U.S.C. § 1320a-7a.***

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YES	NO	
YES	NO	If you offer a time-of-service (TOS) discount, is it reflective of your actual cost of doing billing? The national average for medical billing is 5%-15%. If your discounts exceed this amount, you must document your actual cost for it to be defensible. If you discount above 5-15%, use a Discount Medical Plan which allows for contractual network discounts above 5-15%. ***⚠ CAUTION: The OIG has informally indicated that TOS discounts in the range of 5–10% may reflect genuine administrative savings. There is no statutory safe harbor for TOS discounts; any percentage must be individually justified by documented actual savings - not a fixed rule. Discounts exceeding this range without documentation present increasing audit risk.***
YES	NO	Are discounts applied consistently and uniformly to every patient who meets the same documented qualifying criteria - without exception, favoritism, or case-by-case discretion? ***HIGH RISK: Selective discounting - applying different reductions to different patients without a documented, consistently applied policy - is a hallmark of dual fee schedule violations and OIG audit triggers.***
YES	NO	For hardship discounts, do you have a written hardship policy, signed by the patient, with documented income verification on file, applied consistently to all qualifying patients?
YES	NO	Do you avoid offering informal verbal discounts or 'we'll work something out' assurances to prospective patients over the phone or at the front desk?
YES	NO	Are any promotional or new patient special prices time-limited, documented in writing, NOT offered to Medicare or Medicaid beneficiaries without a properly executed ABN and documented medical necessity, and consistent with your fee schedule structure? ***HIGH RISK: Promotional pricing offered to federal program beneficiaries without proper ABN protocols and medical necessity documentation may constitute an inducement or false billing violation. 42 C.F.R. § 411.357. (You may NOT use an ABN as an Opt-Out mechanism for patients to self-pay for covered services)***

SECTION 3 Discount Medical Plan Organization (DMPO)

A DMPO does not create a discount - it establishes a separate, contractually defined allowed fee.

YES	NO	Compliance Question
YES	NO	Do you utilize a state-licensed, compliant Discount Medical Plan Organization,(DMPO, such as ChiroHealthUSA) to establish a legally separate, contractually defined allowed fee for self-pay patients? ***⚠ CAUTION: A properly structured DMPO creates a distinct fee tier that is legally separate from your UCR fee - it is not a discount off your UCR. This is a critical legal distinction. The DMPO rate is the 'price' under the member's plan contract, not a reduction from your standard charge. State DMPO licensing statutes vary; ChiroHealthUSA operates under applicable state DMPO regulations.***
YES	NO	Is your DMPO allowed fee schedule documented, consistently applied to all enrolled members without exception, and on file in your practice?
YES	NO	Are your front-desk team members trained to explain DMPO membership to patients as a separate fee plan - not as a discount, coupon, or price reduction? ***⚠ CAUTION: The language your team uses matters legally. 'Our DMPO membership establishes a separate allowed fee for members' is correct. 'We give you a discount through***
YES	NO	Is DMPO membership offered consistently and made available to every patient with non-covered services? ⚠ *CAUTION: Non-covered services include, but are not limited to, self-pay patients, patients with high deductibles, patients who have exhausted their benefits, and insured patients with services not covered under their plan. The DMPO model exists precisely for these situations. Selective or inconsistent application creates compliance exposure. If a patient has out-of-pocket responsibility for any reason, DMPO membership must be part of the conversation.*
YES	NO	Do you understand that your DMPO allowed fee, like a contracted insurance rate, does not affect your UCR fee - and that your UCR fee remains your standard charge for all other payers?

SECTION 4 Medicare Core Obligations

Medicare is a federal program. Its rules apply to every patient encounter, not just to the Medicare claim itself.

YES	NO	Compliance Question
YES	NO	Does your front desk screen EVERY new patient - and EVERY established patient at reassessment - for Medicare status before quoting any fees or scheduling services?

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		🔴 ***HIGH RISK: Quoting a self-pay rate to a Medicare beneficiary for a covered service, without first determining Medicare status and following proper billing protocols, creates False Claims Act and Anti-Kickback exposure. 31 U.S.C. § 3729; 42 U.S.C. § 1320a-7b.***
YES	NO	Do you have a current, properly executed Advance Beneficiary Notice of Noncoverage (ABN) process - using the current CMS Form CMS-R-131 - for services that are not covered or that are expected to be denied as not medically necessary? 🔴 ***HIGH RISK: ABNs must be provided before the service is rendered, must be service-specific, and must include a reasonable cost estimate. A blanket or standing ABN is not valid for Medicare purposes. CMS Medicare Benefit Policy Manual, Ch. 30.***
YES	NO	Do you understand that Medicare covers chiropractic services - specifically spinal manipulation - only when the treating chiropractor documents and certifies that the patient's condition is acute or is expected to improve (i.e., meets the Active Treatment standard), and that the AT modifier must appear on every Medicare claim for a covered manipulation? 🔴 ***HIGH RISK: Medicare does not categorically exclude maintenance care - it excludes care that does not meet the Active Treatment (AT) standard. When a patient's condition transitions from active/skilled to maintenance, the AT modifier is no longer appropriate, and the patient must be transitioned with a valid ABN if they wish to continue care at their own expense. Misuse of the AT modifier - applying it when the standard is not met - is a False Claims Act violation. Medicare Benefit Policy Manual, Ch. 15, § 240.1.***
YES	NO	Do you avoid routinely waiving, reducing, or forgiving Medicare copayments or deductibles without a documented, income-verified hardship determination made in advance? 🔴 ***HIGH RISK: Routine waiver of Medicare cost-sharing - even as a courtesy - constitutes an OIG violation under the Civil Monetary Penalties Law. It also violates the Anti-Kickback Statute because it reduces the beneficiary's out-of-pocket cost, which can incentivize utilization of services. 42 U.S.C. § 1320a-7a(a)(5); OIG Special Fraud Alert (1994).***
YES	NO	Are any free or reduced-price items or services provided to Medicare or Medicaid beneficiaries limited in aggregate value to no more than $15 per item (must exclude cash or equivalents) and $75 per patient per year, as specified in the OIG's Civil Monetary Penalties) guidance on beneficiary inducements? 🔴 ***HIGH RISK: The $15 per item / $75 per year thresholds apply specifically to items or services offered to Medicare and Medicaid beneficiaries. These are not universal limits applicable to all patients - they apply only to federal program beneficiaries. Exceeding these thresholds for a federal beneficiary may constitute an unlawful inducement. 42 U.S.C. § 1320a-7a(a)(5); OIG Compliance Guidance.***

SECTION 5 Raffles, Promotions & Patient Incentives

The Anti-Kickback Statute does not require intent. A well-meaning promotion can still be a federal violation.

YES	NO	Compliance Question
YES	NO	Are raffles, prize drawings, or giveaways you conduct open to the general public - including individuals who are not patients of your practice and who have no obligation to schedule or receive services? 🔴 ***HIGH RISK: Restricting a raffle or drawing to existing patients - particularly Medicare or Medicaid patients - transforms a promotion into a targeted inducement under the Anti-Kickback Statute. 'General public' means genuinely open to non-patients, not merely unrestricted within your patient base. 42 U.S.C. § 1320a-7b(b).***
YES	NO	For any items or services provided to Medicare or Medicaid beneficiaries as part of a promotion, raffle, or giveaway, does the fair market value (FMV) of each individual item does not exceed $15, and does the annual aggregate value provided to any single federal program beneficiary does not exceed $75? (May not include cash or cash equivalents. ⚠ ***CAUTION: These OIG thresholds apply specifically and exclusively to Medicare and Medicaid beneficiaries. Items or promotions directed at commercial insurance or self-pay patients are not subject to this specific limit - though they remain subject to other applicable laws and payer contract terms. OIG CMP Law, 42 U.S.C. § 1320a-7a(a)(5). (Note: Most states follow federal rules and regulations to protect the financial integrity of private health plans such as BCBS, Aetna, Cigna etc. This means if you wouldn't offer it to a federally insured patient, you may not want to consider offering to any insured patient. Consult your Provider Agreement)***
YES	NO	Are all promotions, giveaways, and incentive programs completely decoupled from any requirement, expectation, or encouragement to schedule, attend, or receive a specific clinical service? 🔴 ***HIGH RISK: Even indirect or subtle linkage between a prize and clinical utilization - such as 'come in for your adjustment and enter to win' - creates an illegal nexus under the Anti-Kickback Statute regardless of whether the patient is a federal program beneficiary.***

YES	NO	
YES	NO	Are all promotional materials - including social media posts, flyers, website offers, and verbal scripts - reviewed by a compliance-aware team member before distribution or publication? ***⚠ CAUTION: Social media posts and online advertising are discoverable in government investigations. A post that appears routine to team members may constitute an unlawful inducement offer when reviewed in a compliance context.***
YES	NO	Do you avoid advertising or offering 'free' initial examinations, x-rays, consultations, or other services to Medicare or Medicaid beneficiaries - whether in print, online, or verbally? ***HIGH RISK: Advertising free services specifically to Medicare or Medicaid populations - even if the offer is broadly available - constitutes an inducement violation when the intent or effect is to attract federal program beneficiaries to your practice. 42 U.S.C. § 1320a-7a(a)(5); OIG Compliance Guidance for Individual and Small Group Physician Practices.*** ***(Note: Most states follow federal rules and regulations to protect the financial integrity of private health plans such as BCBS, Aetna, Cigna etc. This means if you wouldn't offer it to a federally insured patient, you may not want to consider offering to any insured patient. Consult your Provider Agreement)***
YES	NO	Do you maintain a written record of every promotion run - including the prize FairMarket Value, eligibility criteria, duration, and whether federal program beneficiaries were included - and retain those records for a minimum of six years?

SECTION 6 Professional Courtesy Policies

Professional courtesy is a long-standing tradition. It is also one of the most frequently misapplied compliance areas in chiropractic.

YES	NO	Compliance Question
YES	NO	Do you have a WRITTEN professional courtesy policy - reviewed by a healthcare compliance attorney - that defines with specificity who qualifies (e.g., licensed chiropractors, licensed medical physicians, current full-time team members, and/or immediate family members of the foregoing), and that is updated at least annually? ***HIGH RISK: A verbal professional courtesy policy provides no legal protection. The OIG's guidance on professional courtesy requires that any such arrangement be memorialized in writing and applied consistently. OIG Special Advisory Bulletin on Professional Courtesy Discounts (2002).***
YES	NO	Is your professional courtesy policy applied to every individual in each qualifying category - with no exceptions, no informal arrangements, and no case-by-case discretion? ***HIGH RISK: Inconsistent application of professional courtesy - treating some DCs' family members but not others, or extending courtesy to select referring providers - is a hallmark indicator of an unlawful quid pro quo arrangement.***
YES	NO	Does your written professional courtesy policy explicitly state that the courtesy is not conditioned upon, expected in exchange for, or in any way related to the referral of patients to your practice? ***HIGH RISK: Under OIG guidance, professional courtesy provided to individuals in a position to refer patients - including physicians, other DCs, physical therapists, and their immediate families - is presumptively problematic under the Anti-Kickback Statute absent a documented showing that the arrangement has no nexus to referrals. This is not a theoretical risk - it is presumptively a violation without proper documentation. OIG Special Advisory Bulletin on Professional Courtesy Discounts (2002); 42 U.S.C. § 1320a-7b(b).***
YES	NO	For any Medicare or Medicaid beneficiary who receives professional courtesy - including a colleague, team member, or immediate family member - do you follow one of these three compliant pathways: (a) bill Medicare/Medicaid in full and collect only the required cost-sharing, (b) provide a properly executed ABN for non-covered or maintenance services, or (c) apply your documented, income-verified hardship policy if the individual qualifies? ***HIGH RISK: Professional courtesy is not a recognized exemption from Medicare or Medicaid billing requirements. Waiving cost-sharing for a federal program beneficiary - regardless of your relationship with that individual - without one of these three compliant pathways constitutes a Civil Monetary Penalties Law violation. 42 U.S.C. § 1320a-7a(a)(5); OIG Special Advisory Bulletin (2002).***
YES	NO	Is the value of any professional courtesy provided - including the service rendered, the amount written off, and the basis for the courtesy - documented in the patient's financial record?

YES	NO	
YES	NO	Do you avoid extending professional courtesy to any individual whose professional relationship with you involves, or could involve, the referral of patients - unless your written policy and records clearly demonstrate that no nexus to referrals exists?

SECTION 7 Front Desk & Patient Financial Communication

What your team says on the phone is as legally significant as what you submit on a claim.

YES	NO	Compliance Question
YES	NO	Does your front desk follow a written, scripted protocol for quoting fees to prospective patients - including a Medicare/Medicaid status screening question asked before any fee is quoted? ⚠ ***CAUTION: Team members who quote fees without first screening for Medicare status may inadvertently quote a self-pay or DMPO rate for a covered service to a federal beneficiary - creating compliance liability for the practice regardless of team member intent.***
YES	NO	Are all team members who communicate fees, quote rates, describe financial options, or discuss billing with patients trained on compliance requirements - and is that training documented and conducted at minimum annually?
YES	NO	Are all patient financial agreements - including fee schedule acknowledgments, DMPO membership agreements, ABNs, and hardship applications - signed by the patient or their representative and placed in the chart before services are rendered?
YES	NO	Do you have a written policy explicitly prohibiting team members from offering informal discounts, price adjustments, or 'deals' without written authorization from the provider or practice administrator under a documented policy?
YES	NO	Is your practice's financial policy - describing available fee structures, DMPO membership, hardship eligibility, and Medicare/Medicaid protocols - provided to patients in writing at the first visit and made available on request?

SCORING GUIDE

All YES	1–4 NO	5+ NO
Strong compliance posture. Schedule a team review to confirm policies are documented and current.	Compliance gaps identified. Address each NO item with your team and document your corrective steps.	Significant compliance risk. Consult a healthcare compliance attorney or expert before your next billing cycle.

MY ACTION ITEMS - Complete before your next team meeting

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Need compliance guidance for your practice? Reach out to ChiroHealthUSA: **Heather@ChiroHealthUSA.com**