

The Name on the Door Is Not the Name on the Claim

By Dr. Ray Foxworth, DC, FICC

It is 8:00 Monday morning in a busy chiropractic office. The first patients are checking in, the phones are ringing, and a new associate is starting his first full week seeing patients.

His license has been verified. His NPI is in the system. He has access to the EHR. His schedule is full.

Then a Medicare patient checks in.

The CA at the front desk looks at the schedule and asks a question that can stop a compliance problem before it starts:

“Is Dr. Jones cleared to see Medicare patients yet?”

Someone answers, “He works for Dr. Smith. Just bill it under Dr. Smith.”

Eleven words. Big problem.

On June 15, 2026, Benkay Inc., doing business as Suncoast Chiropractic in Crystal River, Florida, entered into a **\$62,549.13 settlement with the U.S. Department of Health and Human Services Office of Inspector General (OIG)** after self-disclosing conduct involving claims for chiropractic services performed by providers who were not enrolled in Medicare.

OIG’s published notice is short, and we should be careful not to add facts that are not there. We do not know from the notice how the problem started, how many services were involved, or what internal processes failed. What we do know is enough to make every chiropractic owner take another look at the way associates are brought into a Medicare practice.

The lesson is simple: **Working for an enrolled chiropractor does not make another chiropractor enrolled.**

Enrollment Is Not an Office Umbrella

When we hire an associate, it is easy to think about that doctor as part of the practice. Clinically and operationally, that makes sense. Medicare enrollment does not work that way.

CMS includes Doctor of Chiropractic among the physicians who use the Medicare enrollment process. Individual practitioners use the CMS-855I enrollment application to enroll, revalidate, reactivate, report changes, and establish or terminate certain reassignment relationships.

Having an NPI is not the same thing as being enrolled in Medicare, either.

CMS makes clear that the NPI process and Medicare enrollment are separate. An NPI identifies the provider. It does not, by itself, establish Medicare billing privileges.

That distinction needs to be understood by more than the person who fills out enrollment paperwork. Your billing team needs to understand it. Your office manager needs to understand it. Your front desk needs to know when a new associate can and cannot see a Medicare patient whose service will be submitted for payment.

Otherwise, assumptions start filling in the gaps.

“He has an NPI.”

“We submitted the application.”

“She works here now.”

“The owner is enrolled.”

None of those statements answer the question we actually need answered.

Was the chiropractor who performed this service properly enrolled for this date of service?

Reassignment Matters, Too

Enrollment is only one piece of the puzzle.

CMS also has rules governing reassignment of Medicare benefits. Reassignment allows an eligible organization or group to submit claims and receive Medicare payment for Part B services provided by an individual practitioner.

CMS states that both the individual practitioner and the organization receiving the reassignment must be enrolled or concurrently enrolling—before the reassignment can take effect.

That is an important distinction.

Employment and Medicare reassignment are not interchangeable concepts. Putting a chiropractor on payroll does not automatically establish the Medicare relationship necessary for the practice to bill for that chiropractor’s services.

This is where a practice needs a clear onboarding process instead of a collection of assumptions.

Who verifies enrollment?

Who confirms reassignment?

Who documents the effective date?

Who tells the billing department that the associate is cleared?

And who stops the claim if one of those pieces is missing?

If everybody thinks somebody else is doing it, nobody may be doing it.

The Rendering Provider Matters

There is another basic question every claim must answer correctly: **Who actually performed the service?**

CMS instructions for professional Medicare claims provide for reporting the rendering provider's NPI in the appropriate rendering-provider field.

In other words, the claim needs to accurately reflect the provider who rendered the service. An enrolled owner should not simply become the default rendering provider because an associate works in the same practice.

That may sound obvious when we see it written on the page. In a busy office, however, shortcuts can become habits.

A new associate gets added to the schedule before enrollment is finished. The billing software still defaults to the owner. A CA assumes the credentialing company completed something. The billing company assumes the office verified it.

Then the claims start going out.

That is why compliance cannot live in one person's head. It has to live in the practice system.

Watch the Effective Date

Practices should also pay close attention to Medicare effective dates.

Submitting an enrollment application does not mean we should assume every service performed from that day forward can be billed. CMS rules determine effective billing dates and permit limited retrospective billing under qualifying circumstances.

The practical takeaway is straightforward: **verify the approved effective date before submitting claims.**

Suppose an associate begins seeing patients while enrollment is pending. Once approval arrives, the temptation may be to pull up every Medicare encounter sitting in the queue and send the claims.

Not so fast.

Confirm what dates are actually billable under Medicare's rules. Document that information. Make sure the billing team has it. If something does not line up, resolve the issue before the claim leaves the office.

A few extra minutes on the front end can save a tremendous amount of time on the back end.

Do Not Forget Exclusion Screening

Enrollment is not the only federal status we should verify when bringing a chiropractor or other employee into the practice.

OIG maintains the [List of Excluded Individuals/Entities \(LEIE\)](#). Federal healthcare programs generally cannot pay for items or services furnished, ordered, or prescribed by excluded individuals or entities.

OIG recommends checking prospective employees and contractors against the LEIE before hiring or contracting with them and periodically after that. Because the exclusion list is updated monthly, OIG guidance says monthly screening best minimizes potential overpayment and Civil Monetary Penalty exposure.

This is one of those compliance jobs that is easy to overlook because, most months, nothing happens.

That is precisely why it needs a system.

Assign responsibility. Perform the search. Document it. Keep the record.

Compliance is often less about doing something heroic and more about doing something boring every single month.

Build a Gate Before Medicare Billing Begins

If you employ associates, I encourage you to create a written Medicare onboarding checklist. Before a new DC's Medicare claims are released, verify:

- The chiropractor's individual NPI.
- Medicare enrollment status.
- The practice's enrollment status where applicable.
- The appropriate reassignment relationship.
- The approved effective date.
- Correct rendering provider information in the EHR and billing software.
- The provider's exclusion status through OIG's LEIE.
- Documentation showing who verified each item and when.

Then give someone the authority to say **stop**.

If the enrollment is pending, stop.

If nobody can confirm the reassignment, stop.

If the effective date is unclear, stop.

If the billing software identifies the wrong rendering provider, stop.

That is not bureaucracy. That is a guardrail.

What Would an Audit Find in Your Office?

The Suncoast settlement is useful to us not because we should sit around judging another chiropractic practice. We have all operated businesses where paperwork, people, and deadlines collide.

The better question is what we can learn from it.

If an auditor walked into your practice tomorrow and selected claims involving every associate chiropractor, could you produce the enrollment and reassignment documentation?

Could you identify the effective dates?

Would the rendering provider on each claim match the chiropractor who performed the service?

Could you show your exclusion screening records?

Do you know where your risks are?

Those are questions worth asking before someone else asks you.

At ChiroHealthUSA, we have spent years helping chiropractors understand that compliance is not about practicing scared. It is about putting systems in place so we can spend less time worrying about what might be hiding in the billing department and more time taking care of patients.

Use the Suncoast settlement as a reason to sit down with your billing team this month. Pick a few associate claims. Trace them from the patient encounter through the claim. Verify enrollment, reassignment, effective dates, rendering-provider information, and exclusion screening.

You may discover everything is exactly as it should be.

And if you find a gap, finding it yourself is a whole lot better than having OIG find it for you.

References:

1. U.S. Department of Health and Human Services, Office of Inspector General. *Suncoast Chiropractic Agreed to Pay \$62,549.13 for Allegedly Violating the Civil Monetary Penalties Law by Submitting Claims for Services Performed by Non-enrolled Providers*. June 15, 2026.
<https://oig.hhs.gov/fraud/enforcement/suncoast-chiropractic-agreed-to-pay-6254913-for-allegedly-violating-the-civil-monetary-penalties-law-by-submitting-claims-for-services-performed-by-non-enrolled-providers/>

2. Centers for Medicare & Medicaid Services. *CMS-855I Medicare Enrollment Application: Physicians and Non-Physician Practitioners*.
<https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms855i.pdf>
3. Centers for Medicare & Medicaid Services, Medicare Learning Network. *Medicare Provider Enrollment*.
<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/EnrollmentResources/provider-resources/provider-enrolment/Med-Prov-Enroll-MLN9658742.html>
4. Centers for Medicare & Medicaid Services. *Medicare Billing: CMS-1500 & 837P — Provider & Assignment Details*.
<https://www.cms.gov/outreach-and-education/mln/wbt/mln4462429-mln-wbt-1500/1500/lesson04/19/index.html>
5. U.S. Department of Health and Human Services, Office of Inspector General. *Exclusions Program — List of Excluded Individuals/Entities (LEIE)*.
<https://oig.hhs.gov/exclusions/>

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