Small-practice billing compliance checklist

Mapped to the OIG's seven compliance elements — scaled for a practice of one to ten people.

Source: HHS Office of Inspector General, *General Compliance Program Guidance* (November 2023), Section III (the seven elements) and Section IV.A (compliance programs for small entities).

The OIG's guidance is voluntary and nonbinding. This checklist is general guidance, not legal advice — have a healthcare attorney or a certified coder review anything that affects your own billing.

Element 1 — Written policies and procedures

- [ ] A written billing policy exists. Two pages is enough.
- [ ] It states who selects codes, and on what basis.
- [ ] It states that a code is only billed when the note supports it.
- [ ] It covers the cosmetic-versus-medical line for every treatment you offer both ways.
- [ ] It covers superbills: same documentation standard as a filed claim.
- [ ] It names the procedure for correcting a claim after submission.
- [ ] Every person who touches billing has read it and signed that they have.
- [ ] It is reviewed once a year and dated.

Element 2 — Compliance leadership and oversight

- [ ] One named person owns billing compliance questions.
- [ ] That person does not select codes or submit claims, where staffing allows.
- [ ] They report to the owner at least quarterly on what they checked and what they found.
- [ ] The owner understands that ultimate responsibility sits with them, not with the biller.
- [ ] The name is written down somewhere the team can find it.

Element 3 — Training and education

- [ ] Every new hire who touches billing gets documentation and coding basics at onboarding.
- [ ] Everyone gets one refresh a year.
- [ ] Clinical staff are trained on what a note has to contain to support the code billed.
- [ ] Front desk staff are trained on what they may and may not tell a patient about coverage.
- [ ] Attendance is recorded, with dates.
- [ ] Annual code-set updates (CPT, ICD-10) are reviewed when they take effect.

Element 4 — Effective lines of communication

- [ ] There is a written open-door rule for raising billing concerns.
- [ ] It says explicitly that there will be no retaliation for a good-faith report.
- [ ] Staff know who to raise a concern with.
- [ ] There is a low-friction route for someone who does not want to raise it face to face.
- [ ] The OIG Hotline details are posted where staff can see them.
- [ ] If you use an outside biller, you have a named contact there for compliance questions.

Element 5 — Enforcing standards

- [ ] Consequences for knowingly billing unsupported codes are written down in advance.

- [ ] Staff know that failing to report a problem is itself a problem.
- [ ] The policy leaves room for people to ask questions and admit mistakes.
- [ ] Consequences have been applied consistently when they were needed.

Element 6 — Risk assessment, auditing, and monitoring

- [ ] A compliance risk review is done at least once a year and written down.
- [ ] At least one claims audit is run each year (OIG's floor for a small entity).
- [ ] **Practical addition:** a monthly sample of 5–10 claims is checked against the notes.
- [ ] The sample covers your highest-volume codes and your highest-value codes.
- [ ] The sample includes any service you bill both cosmetically and medically.
- [ ] Every employee and contractor is screened against the OIG exclusion list (LEIE) monthly.
- [ ] Applicable state Medicaid exclusion lists are screened too.
- [ ] Licenses and certifications are checked for currency.
- [ ] Denial and rejection patterns are reviewed for what they say about coding.
- [ ] Unusual shifts in code utilization are investigated, not explained away.

Element 7 — Responding to detected offenses

- [ ] One named person decides whether a reported issue is a real violation.
- [ ] There is a written procedure for investigating and documenting what was found.
- [ ] Identified overpayments are reported and returned within 60 days of identification.
- [ ] You know that "identified" uses the False Claims Act knowledge standard, which includes deliberate ignorance and reckless disregard.
- [ ] You know the 60-day clock can be suspended for up to 180 days while you investigate related overpayments in good faith.
- [ ] The root cause is fixed, not just the individual claim.
- [ ] Corrective action is written down: what happened, what changed, when.
- [ ] You know the OIG Self-Disclosure Protocol exists and when to consider it.

First-year additions for a practice new to insurance billing

- [ ] Every rendering provider is credentialed and contracted before the first claim.
- [ ] Someone in the practice is trained in coding, or a certified coder reviews your claims.
- [ ] Superbills carry the same codes you would have filed yourself, and no others.
- [ ] Incident-to and supervision rules have been checked for your payers and your state.
- [ ] Patients are told before treatment what insurance may cover and what they pay, in writing.
- [ ] Nobody in the practice has ever said "we'll code it so it goes through."

The one-line test

If an auditor read only the note, would they arrive at the code you billed?

If not, the code is wrong — however the visit felt.

Prepared by Pabau. General guidance only, not legal advice.