Your Fees Are Setting The STANDARD

FOR BETTER OR WORSE

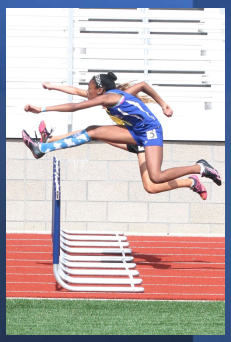
How individual pricing decisions are shaping reimbursement, patient access and the future of Chiropractic in our state.

1

THERE ARE BARRIERS,
THAT GET IN THE WAY OF:

- Patients receiving
- DCs providing
- Others recommending
- Insurers financially benefitting from

EFFECTIVE, SAFE,
ECONOMICAL
CHIROPRACTIC CARE



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BARRIERS
(insurance)

- Reimbursement
- Visit and treatment limits
- Prior authorizations, restrictive reviews
- Transparency of fee schedules, payment methods and compliance

PARITY

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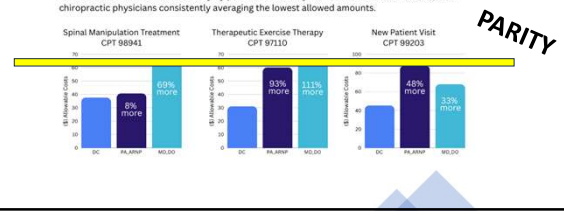


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A BARRIER

Comparative Analysis of Reimbursement and Allowed Amounts

Reimbursement differs substantially by provider taxonomy for identical CPT codes billed, with chiropractic physicians consistently averaging the lowest allowed amounts.



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BARRIERS
(insurance)

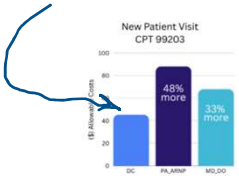
WE OFTEN NEGOTIATE AGAINST OURSELVES

PARITY

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We have set the price for our services, well below parity.



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BEFORE WE BEGIN

Educational Content — Not Legal Advice

This seminar is general education
Fee setting sits at the intersection of antitrust law, healthcare fraud and abuse law, payer contracts, and state regulation. Rules change, and their application depends on your specific facts, contracts, and state. Nothing here creates an attorney-client relationship or substitutes for individualized advice.

Verify before you act
- Confirm current rules with CMS, the OIG, and your state board and insurance department
- Have a healthcare attorney review your fee policies, discount programs, and payer contracts
- Dollar figures shown today are illustrative examples, not recommended fees

One theme to carry all hour
- **Every fee decision must be yours alone**
- Made independently, documented in writing, and applied consistently
- If you remember nothing else, remember; independent, documented, and consistent
- YOUR FEES AFFECT MORE THAN YOU AND YOUR PATIENTS

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HOW FEES (what goes on a claim) AFFECT REIMBURSEMENT

- Every submitted claim is logged; these are aggregated to determine a UCR statewide
- The database does not know why a certain provider bills a lower or higher fee, it just feeds the numbers in, and this calculated into the benchmark fee for that service statewide.
- Private insurance companies don't set rates by the cost of providing a service, they set them by what they see providers accept

They have no incentive to set reimbursement rates higher than what providers are asking to be paid.

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I'm cash, why do I care?

If the cash price can be found, it will be considered in industry averages (esp if low)
Most people either use their insurance or don't get care for non-catastrophic health issues
If you are investigated/sued/board action for anything, your pricing and the rational will be challenged
Your price should properly compensate you, not put an excess burden on the patient and place you where you want to be within the industry

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INDUSTRY IMPACT

The Collective Effect: **What Our Fees Say About Our Profession**

No single chiropractor sets the market — but every chiropractor shapes it.

FEE GAP
30–40%
Below market — the range many chiropractors in our state currently bill for services that physical therapists and other musculoskeletal providers charge full rate for.

BENCHMARK PULL
1 in 4
Chiropractors whose below-market fees are sufficient to pull regional insurer benchmarks measurably downward for every peer in their zip code.

REVENUE LOSS Est. Annual
$38,000+
Estimated annual revenue loss per practitioner compared to value-based peers delivering equivalent clinical services.

When enough of us undercharge, the insurer doesn't need to negotiate — our own data does the work for them.

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The Golden Rule: Set Your Fees Independently

Sherman Act §1 … *price fixing is per se illegal*
Any agreement among competing providers about the fees they charge explicit or implied, written or over coffee is automatically unlawful. No good intentions, no "reasonableness" defense, no minimum market share required.

You are always free to…
- Decide your own fees using your own costs, judgment, and independent research
- Charge more or less than anyone else in town
- Change your fees whenever your own analysis supports it
- Negotiate your own contracts with each payer, one-on-one

You may never…
- Agree with a competing DC (even informally) on fees, discounts, or discount limits
- Coordinate a response to a payer's rates with other practices
- Use an association, study club, or group chat to align fees
- Signal your future pricing to competitors so they can follow

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The Federal Statutes That Touch Your Fees

Sherman Act
Bars fee agreements and boycotts among competitors. Applies to every practice, insured or cash.

Anti-Kickback Statute
Criminalizes giving anything of value to induce federally reimbursable business which includes routine copay/deductible waivers.

False Claims Act
Billing a payer more than your actual charge (e.g., hidden cash discounts) can make each claim "false." Penalties per claim.

Civil Monetary Penalties / Beneficiary Inducement
Fines for offering Medicare/Medicaid patients free or discounted items likely to influence provider choice.

Stark-Type & Fee-Splitting Rules
Federal Stark law rarely reaches DCs directly, but many states ban fee splitting and referral-based pricing outright.

State Insurance Fraud Codes
Misrepresenting your "usual" fee to an insurer is fraud in most states … the root of the dual-fee-schedule problem.

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The State Layer: Your Board and Your Statutes

Where state law reaches fees
- Board rules on advertising discounts, "free" services, and unprofessional conduct
- State insurance codes defining fraud and misrepresentation of charges
- Personal injury / med-pay fee schedules and treatment guidelines in some states
- Workers' compensation fee schedules are usually mandatory, not negotiable
- DMPO registration requirements and state-specific discount rules
- Fee-splitting and anti-rebate statutes

Your homework (before changing any fee)
- Read your board's rules on fees, discounts, and advertising as they vary widely by state
- Check whether your state regulates time-of-service discounts more strictly than the OIG's 5–15% guidance
- Pull your state's workers' comp and PI fee schedules where applicable
- Ask your state association for its compliance resources
- When in doubt, a one-hour consult with a healthcare attorney is cheap insurance

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CONSIDERING WHAT YOUR PRICING DOES FOR YOU?

Needs to be sustainable and profitable

No unreasonable burden on the patient

Position in the market

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THE "GOLDILOCKS" PRINCIPAL

Not too low. Not too high. Just right.

TOO LOW
Payer-defined

TOO HIGH
Hard to defend

JUST RIGHT
Objective value

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WHY COPYING INSURANCE FEES IS A POOR STRATEGY

Because… Payment and value are very different

YOUR FEE SCHEDULE	INSURANCE CONTRACT
VALUE	**PAYMENT**
What your professional services are worth in your practice	What one payer has agreed to reimburse

These are two completely different concepts.

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WHY COPYING INSURANCE FEES IS A POOR STRATEGY

Your fee schedule should answer one question

NOT

- What does Blue Cross pay?
- What does Medicare pay?
- What does my competitor charge?

INSTEAD

"What is this service objectively worth in my practice?"

Payment follows the contract. Value starts with your methodology.

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THE GOLDILOCKS PRINCIPLE

Could you defend every fee?

Imagine explaining your methodology to...

A PATIENT | A PAYER | A BOARD | AN ATTORNEY

A JURY | AN AUDITOR | COMPETING PROVIDER

Would your explanation hold up?

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THE GOLDILOCKS FEE SCHEDULE

The sweet spot is fair to every stakeholder

PATIENT	PROVIDER	PAYER	REVIEWER
Reasonable burden	Sustainable value	Consistent logic	Defensible method

Fair • Objective • Consistent • Defensible

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Three Different Lenses to help Establish Fees

1 · Cost lens

- What does one visit actually cost you to deliver?
- Sets your absolute floor — pricing below cost is a business decision to lose money
- Built entirely from your own books (always antitrust-safe)

2 · Resource (RVU) lens

- Uses Medicare's Relative Value Units to keep fees proportional across your CPT codes
- Prevents the classic error of an underpriced exam next to an overpriced therapy
- One conversion factor of your choosing prices your whole schedule

3 · Market lens

- Independent benchmark percentiles tell you where your number lands
- A positioning check, not a price to copy
- Documents that your fee is "usual and customary" and useful in PI and audit contexts

Floor from costs → structure from RVUs → position from the market. Decide alone; write down all three inputs.

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#1 COST LENS Know Your Cost Per Visit

Cost per visit = **(Annual overhead + Your target compensation) ÷ Annual patient visits**

Count everything in overhead

- Rent, utilities, equipment leases, supplies
- Staff wages, payroll taxes, benefits
- Malpractice and business insurance, license/CE fees
- Software, billing service, marketing, accounting/legal
- Loan payments and a reserve for equipment replacement

Two common mistakes

- **Forgetting to pay yourself:**
- Your target compensation is a cost of running the practice, not what's left over
- **Using aspirational visit counts:**
- Use last year's actual visits (or a conservative forecast) as inflated volume hides your true cost

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Worked Example: Finding the Floor

MADE UP NUMBERS — YOURS WILL DIFFER

$180,000	$120,000	4,500	$66.67
Annual overhead (from your P&L)	Target doctor compensation	Actual visits last year	Break-even cost per visit

How to read this

- At an average charge below ~$67/visit, this practice loses money on every adjustment, no matter how busy it gets
- The floor applies to your average collected amount per visit, so contracted payer discounts and TOS discounts must still net above it
- This single number also tells you which payer contracts are actually unprofitable, so bring it to every renegotiation

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FINDING YOUR NUMBERS

LAST YEAR

OVERHEAD: P&L Total Expenses

TOTAL VISITS: Analytics → Reports → Simple Practice Analysis

OVERHEAD / TOTAL VISITS = what one visit COSTS YOU = Break even cost

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FINDING YOUR NUMBERS

LAST YEAR

OVERHEAD: P&L Total Expenses
TOTAL VISITS: Analytics → Reports → Simple Practice Analysis

PROCEDURE CODES:

(# times each code billed) Analytics → Reports → Col & Productivity → Procedure Code Productivity

(code % billing) Analytics → Dashboard → Charges by billing code

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DIFFERENT PROCEDURES CONTRIBUTE TO COLLECTIONS

LAST YEAR
OVERHEAD / TOTAL VISITS = what one visit COSTS YOU = Break even cost

SPECIFIC CODES – TEST THEM - EXAMPLE
Procedure code analysis shows 60% of dollar value of charges you bill are 98941, then your fee for 98941 x number of times you billed this, needs to cover 60% of your overhead to make the Break even cost

PROCEDURE CODES:
(# times each code billed)Analytics → Reports → Col & Productivity → Procedure Code Productivity
(code % billing) Analytics → Dashboard → Charges by billing code

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#2 RVU LENS — The RVU Method: Structure Your Whole Schedule

Your fee for a code = **Total RVUs for that code × Your practice's conversion factor ($)**

Why RVUs

- Each CPT code's **TOTAL RVUs** already encode **relative** work, practice expense, and malpractice cost
- **Pricing by RVUs keeps a 98941 proportional to a 99203 and a 97110….. automatically**
- RVU values are public = CMS Physician Fee Schedule lookup tool **(web search)**
- You choose one number (your conversion factor); the schedule prices itself

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Choosing Your Conversion Factor

Medicare as a reference point

- The 2026 Medicare conversion factor is about $33.40 which is a public, independently set anchor
- ***Many private practices land somewhere between 1.5× & 3× the Medicare rate for their usual-and-customary fees***
- Where you land in that range is your independent decision — never a number agreed with other practices

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#2 RVU LENS — The RVU Method: Structure Your Whole Schedule

Your fee for a code = **Total RVUs for that code × Your practice's conversion factor ($)**
1.5-3.0 x $33.40

- Suppose CPT XXXX totals ≈ 1.3 RVUs in your locality (verify in the CMS lookup yearly as values change annually)

$33.40 x 2.0
- **At a $67 conversion factor → fee ≈ $87.00**

$33.40 x 2.5
- **At a $84 conversion factor → fee ≈ $91.00**

- Apply the same factor to every code (different RVUs), then round to clean numbers

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Choosing Your Conversion Factor

Pressure-test your factor

- Does the resulting average fee clear your cost-per-visit floor after typical discounts and contractual write-offs?
- Does your highest-volume code land at a percentile you can defend?
- Do the resulting fees respect every binding ceiling of Medicare limiting charge, workers' comp schedules and payer contracts?
- Would you be comfortable explaining the number to a patient, an auditor, or a judge? **Write the rationale down**

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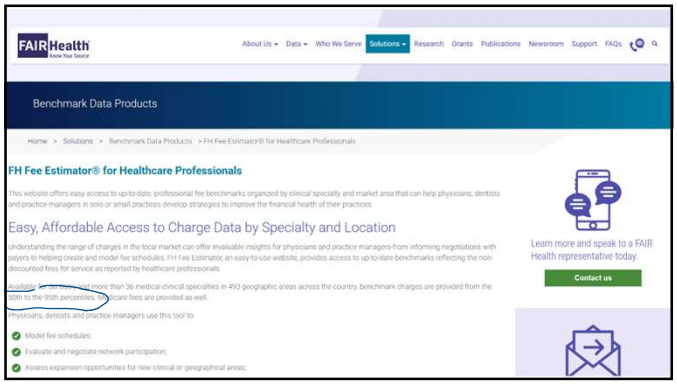
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#3 MARKET LENS Market Data and Percentile Positioning

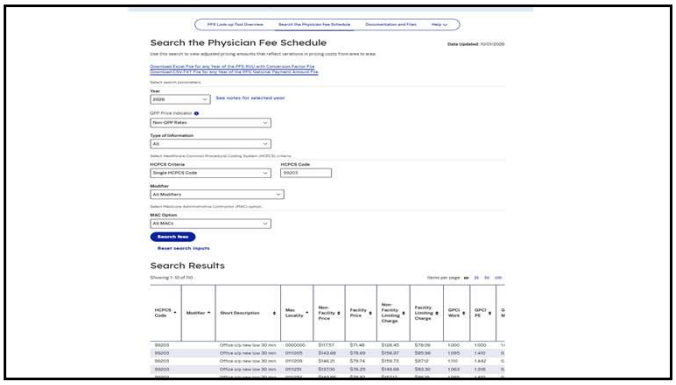
Permissible benchmark sources

- FAIR Health and similar independent, aggregated charge databases
- Published national/regional fee survey data compiled by third parties from historical figures
- The Medicare PFS lookup for your locality
- State workers' comp and PI fee schedules
- **Never trade current fee data with local competitors to "validate" your number.**

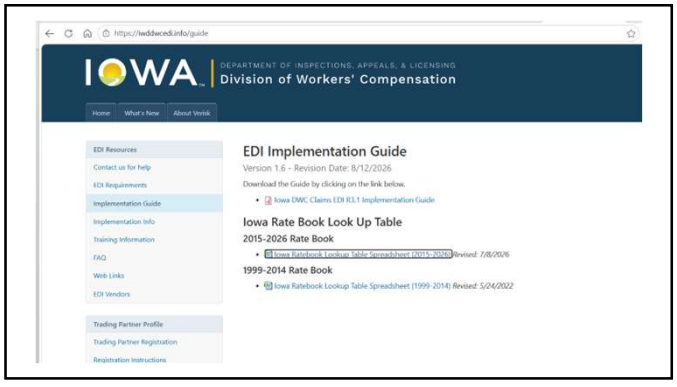
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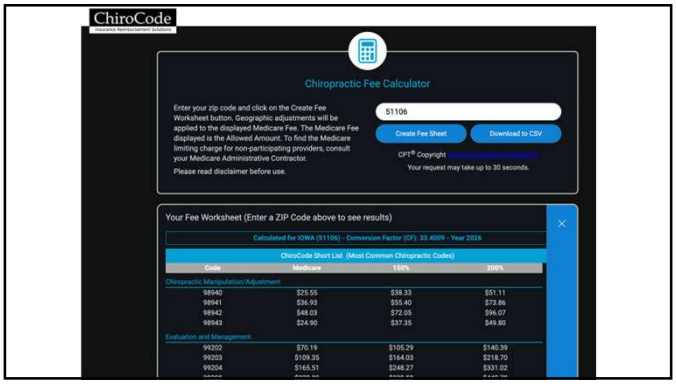
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#3 MARKET LENS Market Data and Percentile Positioning

What percentile positioning signals

~50th percentile:
- **Mainstream pricing; competitive for insurance-heavy, high-volume practices**

~75th percentile:
- **Common target for established practices with strong service differentiation**

~90th percentile:
- **Premium positioning — defensible only with premium experience, and expect more fee conversations**

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Decide alone; write down all three inputs.

COST | **RVU** | **MARKET**

What's it cost me to be in business per visit?

Are my prices for different services ok in relation to each other?
Am I about where I think I want to be in the market?

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When a Fee Review Is Due

Scheduled trigger (non-negotiable)

- **A full review once a year, every year**
- Medical practice cost inflation runs continuously, so a schedule untouched for three years is a silent pay cut of 10% or more
- Tie it to a fixed month, so it survives busy seasons

Event triggers (review early)

- New CMS Physician Fee Schedule / conversion factor (each Nov, effective Jan 1)
- A major payer contract changes
- A significant cost jump: rent renewal, new associate, malpractice premium increase, equipment purchase
- State fee schedule changes (work comp, PI)
- Your quarterly reports show collections per visit approaching your cost floor

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The Five-Step Annual Review

1. **Pull the data** Last 12 months: visits, charges, collections and write-offs by code, payer mix, P&L.
2. **Recompute your floor** Update the cost-per-visit calculation with current overhead and actual visit volume.
3. **Re-anchor the structure** Refresh RVU values and your locality's Medicare allowables; re-run your conversion factor math.
4. **Recheck position & ceilings** Compare to current independent benchmarks; verify every contracted rate, limiting charge, and state schedule you must respect.
5. **Decide and document** Set the new schedule, write a one-page memo of the inputs and rationale, assign an effective date.

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Implementation Mistakes That Create Legal Problems

- **Raising fees for insured patients only** = Congratulations — you've built a dual fee schedule. The master schedule moves for everyone or not at all.
- **No effective date discipline** = Claims spanning the change get billed inconsistently; audits read that as arbitrary pricing.
- **Forgetting the GFE templates** = Self-pay patients scheduled after the change receive estimates at old fees — then bills at new ones. That's a dispute-resolution invitation.
- **Quiet grandfathering for favorites** = Undocumented old-price exceptions for long-time patients are unexplained discounts — the write-off report will flag them, and so will an auditor.
- **Announcing the increase as an apology** = "Sorry, insurance made us do it" is false, undermines the fee, and invites negotiation at the front desk.

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Your Fee-Setting File: The Paper Trail That Protects You

Keep in one folder, forever

- Annual methodology memo: cost-per-visit math, conversion factor, benchmark sources consulted, rationale
- Each fee schedule version with its effective dates
- Written discount policies (TOS, hardship, DMPO) and any revisions
- Sample GFEs and the current financial policy
- Hardship approvals and unusual-exception decisions

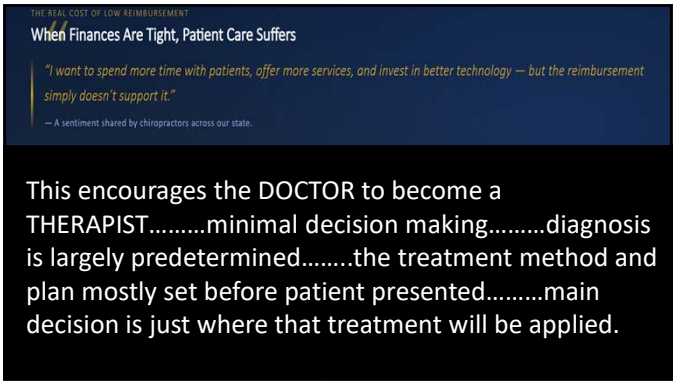
What this file answers

- **For an auditor:**
- "Your charges are inconsistent" → here's the schedule, the policy behind every adjustment, and the dates
- **For an antitrust question:**
- "How did you set these fees?" → independently, from these documented sources, on this date
- **For a payer or PI dispute:**
- "Is this your usual fee?" → yes, and here is the versioned history proving it

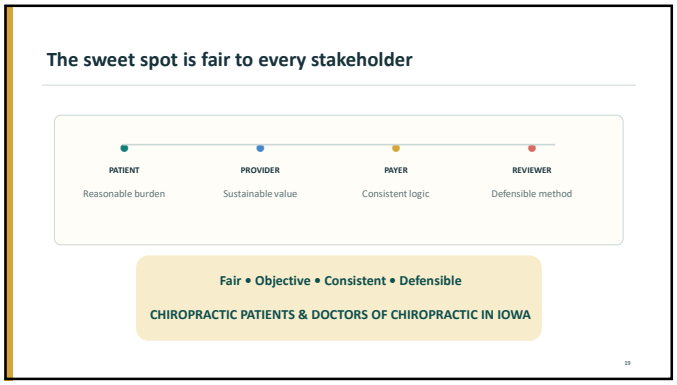
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THE REAL COST OF LOW REIMBURSEMENT
When Finances Are Tight, Patient Care Suffers
"I want to spend more time with patients, offer more services, and invest in better technology — but the reimbursement simply doesn't support it."
— A sentiment shared by chiropractors across our state.
SHORTENED VISIT TIMES
Low reimbursement pushes providers to see more patients in less time, reducing the depth of care each patient receives.
INCOMPLETE CARE PLANS
Financial pressure leads to abbreviated treatment protocols — patients are discharged before achieving the full clinical outcomes they deserve.
MISSING MODALITIES
Dry needling, Class IV laser, advanced rehab, nutritional support — services that complete the clinical picture are often the first cut when revenue is tight.
Insurance companies don't constrain your care intentionally — but they don't have to. When fees are low enough, the financial math does it for them.

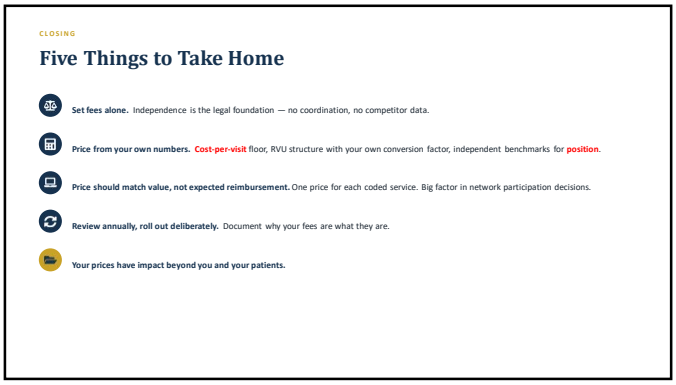
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THE REAL COST OF LOW REIMBURSEMENT
When Finances Are Tight, Patient Care Suffers
"I want to spend more time with patients, offer more services, and invest in better technology — but the reimbursement simply doesn't support it."
— A sentiment shared by chiropractors across our state.
This encourages the DOCTOR to become a THERAPIST……..minimal decision making……..diagnosis is largely predetermined……..the treatment method and plan mostly set before patient presented……..main decision is just where that treatment will be applied.

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The sweet spot is fair to every stakeholder
PATIENT
Reasonable burden
PROVIDER
Sustainable value
PAYER
Consistent logic
REVIEWER
Defensible method
Fair • Objective • Consistent • Defensible
CHIROPRACTIC PATIENTS & DOCTORS OF CHIROPRACTIC IN IOWA

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CLOSING
Five Things to Take Home
Set fees alone. Independence is the legal foundation — no coordination, no competitor data.
Price from your own numbers. Cost-per-visit floor, RVU structure with your own conversion factor, independent benchmarks for position.
Price should match value, not expected reimbursement. One price for each coded service. Big factor in network participation decisions.
Review annually, roll out deliberately. Document why your fees are what they are.
Your prices have impact beyond you and your patients.

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Where to Verify Everything We Covered
Primary sources
• CMS Physician Fee Schedule lookup = RVUs, GPCIs, and allowables for your location
• CMS No Surprises Act pages = GFE rules, templates, and dispute process
• OIG advisory opinions and Special Fraud Alerts = discounts, waivers, inducements
• FTC health care competition pages = current enforcement posture
• Your Medicare Administrative Contractor's chiropractic billing guidance
Professional support
• Your state board and state insurance department State and national association compliance education (education, never fee coordination)
• Independent benchmark databases (e.g., FAIR Health) for percentile data
• A healthcare attorney for your fee policies, discount programs, and payer contracts

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