PETTY MICHEL & ASSOCIATES
PRACTICE DEVELOPMENT

June 9, 2010

Yolanda McGowan, Esq.
Legal Counsel – Wisconsin
Chiropractic Examining Board
1400 E. Washington Avenue
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Dear Attorney McGowan:

It was a pleasure meeting you at the May 27th Chiropractic Examining Board meeting. As per our conversation, I am writing to you to get clarification for my clients on the new regulations promulgated by the WCA and included in the annual budget bill concerning the treatment of co-payments and co-insurance.

There seems to be considerable confusion on the application of these regulations even between the CEB, the DRL and the state chiropractic association. As we discussed, I am hoping to provide some "real life" examples and get clarification from the legal counsel of the CEB so I can advise my clients.

By way of introduction, we are a twenty-five year old Wisconsin-based chiropractic business consulting firm that works with hundreds of clinics nationwide on sound, ethical, and sustainable business practices. We work with many of the largest chiropractic providers in Wisconsin.

I have been working with billing, coding and collections issues for most of the twenty-five years. I oversaw a six person insurance billing/collections department for several years, currently do coding and compliance work, I've been involved in billing audits with Medicare, Medicia, Medicaid, Blue Cross, CMS, WPPN, and others. I've set up billing for chiropractic clinics, medical offices, physical therapy and nursing homes, including CBRFs, IMDs, and SNFs and CORFs. I was elected to the Board of Supervisors for Sheboygan County and served on the committee for health care services for the county. I also serve or have served on two medical boards, Moraine Park CT Advisory Board, and three business boards including Milwaukee Harley-Davidson.

Overview

I am including the WI CEB in this letter to provide them with references they may want in coming up with sound decisions on the enforcement of the new regulations.

As you are aware, there are countless rules, regulations and contractual obligations imposed by federal, state, chiropractic boards and insurance company contracts across the country. Many of these conflict with one another and many are open to interpretation.

In dealing with discounts, patient self pay, prepay or cash patient payment plans, it is important to first separate out the myths and untruths that surround this subject. There are many seminar firms and consultants that have an agenda or program to sell to allow for "cash discount programs", prepay membership plans, or "compliance plans" to allow for greater collections.

In my opinion, any plan or program proposed by a chiropractic board or a state association should first and foremost take into consideration how it will impact the consumer. Does it serve the general interests of the public and protect their rights, or does it cater to the profession or some vested interest at the expense of the citizens. State Boards across the country, chiropractic and otherwise, are generally under the oversee of State Departments of Consumer Affair & Business Regulation or State Departments of Regulation & Licensing. As you are well aware, the state boards are established to oversee the profession with the explicit duty and trust of ensuring the safety and fair treatment of the public.[1,2]

Further, any plan or program proposed by a chiropractic board should be legal and enforceable. As there are numerous rules and regulations state by state, most consultants in the healthcare industry look to Medicare guidelines as the de facto "gold standard" when determining new rules or guidelines. Many insurance companies also default to or adopt the Medicare guidelines for care and reimbursement. While Medicare regulations are sometimes open to interpretation, the Office of the Inspector General (OIG) is responsible for the overseeing and enforcement of the various regulations.[3] It therefore behooves a board or state association proposing new regulations to be familiar with their policies and opinions.

Therefore, in developing regulations on a State level, it is critical that any new regulation protects and benefits the chiropractic healthcare consumer and adheres to existing State and Federal statutes. Lastly, it would provide for the needs of the chiropractic healthcare provider and it would be wise to do a general survey of chiropractors in the State (or even within the state association) prior to imposing new regulations that affect all providers.

The Question of Self Pay

If I may restate the problem as I understand it: It is routine and expected that chiropractors develop treatment or "care plans" on a case-by-case basis for patients. These usually consist of

additional diagnostic services, a series of chiropractic adjustments and sometimes ancillary modalities, rehabilitation or therapies to aid the healing process. It is nationally recognized that a chiropractic care plan is separate and distinct from an allopathic treatment plan.[4] Medicare further requires that every patient under chiropractic care have an actual treatment plan as part of the initial visit documentation.[5] Treatment plans generally include the duration and frequency of recommended care.

Once a treatment or care plan has been developed, it is up to the patient to decide if they wish to receive care. A critical factor (albeit not the only one) in this decision is the financial impact that accepting care will have on the patient.

Certainly some patients still have excellent health insurance, but numerous surveys in the last decade have shown that health insurance benefits are being seriously curtailed by employers and insurance companies throughout the State. Patient copayments have risen from $5.00 for an office visit to $25, $35, $50 and higher. Deductibles have risen from the standard ten years ago of $100, $250 or $500 to the $1,000 to $10,000 range. At the same time, more and more insurance companies are putting "caps" or limits on the amount of chiropractic care the patient can receive, such as a 12 visit per year limit, or a $1,000 maximum annual benefit.

We also face a large percentage of the population that still has no health insurance and currently a large percentage that are under or unemployed in Wisconsin. Both groups desire and deserve access to quality healthcare.

With higher copayments, reduced chiropractic benefits and the large portion of still uninsured consumers, even a modest treatment plan[6,7] will exceed the available coverage and impose a potential financial hardship on the patient. Both NHIC Medicare and Mercy Guidelines generally show average treatment plans ranging from 12 to 48 visits per condition [ibid].

So the question becomes: **How can we regulate or define patient self pay, cash or prepay requirements for <u>all patients</u> (not just those without insurance, but those with limited plans or the underinsured) within the chiropractic healthcare setting while providing for the best interest of the consumer and adhering to Federal, State and Board regulations as well as managed care agreements.**

Addressing Consumer Needs First

The best interest of the healthcare consumer is to be able to obtain competent, medically necessary care in a timely and affordable manner.

For an independent provider to offer various payment options for patients, including discounts for prompt or prepayment, the consumer is benefiting through more affordable care and the

provider is not in violation of inducement ("... by definition, [prompt pay discounts] are designed to induce prompt payment, and thus do not appear to violate the [anti-kickback] statute."[8])

As precedent, other types of healthcare providers have developed financial policies that best suit the type of services they offer and the urgency of care they provide. In the case of a hospital emergency room, there is little concern upfront for affordability or financial ability as the care rendered is generally crisis care. This seems to be the model the WCA wishes chiropractors would adopt. Orthodontics, on the other hand, is more elective in nature and they have historically developed prepayment plans, payment options and cash discounts that cover an extended course of care. Prenatal care is generally prepaid when no insurance reimbursement is available and covers the entire pregnancy care up until birth. Many elective surgical centers provide financing, prepayment options, and cash discounts. Not to be too personal, but Aurora Hospital offered me a 15% discount if I paid my coinsurance in full upfront. West Bend Mutual offered to waive my $100 deductible if I used their recommended auto glass replacement company.

Federal Opinions & Regulations

Regulations on financial agreements are seldom spelled out for specific healthcare providers, but general guidelines do exist. Looking first on a federal level, Medicare has very clear regulations on collecting from Medicare patients for covered services. In looking at the OIG opinions on financial arrangements, these generally fall into two categories:

a) Offering discounts to patients based on hardship, and
b) Offering discounts to patients on copayments & deductibles as a business practice.

When offering discounts or reduced fees to patients that are unable to afford care, the OIG is very clear on their position:

"The OIG has never excluded or attempted to exclude any provider or supplier for offering discounts to uninsured or underinsured patients"[9] The OIG also does not see a conflict with the Federal anti-kickback statute when offering discounts to uninsured patients, and extends this to Medicare and underinsured patients: "As discussed below, the statute and regulations offer means to reduce or waive coinsurance and deductible amounts to provide assistance to underinsured patients with reasonably verified financial need."

To clarify the OIG's opinion on discounts for uninsured or underinsured:

"... it has been suggested that hospitals are reluctant to give discounts to uninsured patients because the OIG requires hospitals to engage in vigorous collection efforts against uninsured patients. This misperception may be based on some limited OIG audits of specific

hospitals' compliance with Medicare's bad debt rules. No OIG rule or regulation requires a hospital to engage in any particular collection practices. " ibid [Underline added]

And:

"Hospitals have the ability to provide discounts to uninsured and underinsured patients who cannot afford their hospital bills and to Medicare beneficiaries who cannot afford their Medicare cost-sharing obligations. Nothing in the OIG rules or regulations prohibits such discounts, and the OIG fully supports the hospital industry's efforts to lower health care costs for those unable to afford care. While every case must be evaluated on its own merits, it is important to note that the OIG has never brought a case based on a hospital's bona fide discounting of its bill for an uninsured or underinsured patient of limited means. " ibid [Underline added]

The next question based on the above is what would constitute a financial hardship. Again, the OIG is clear on this:

"*The fraud and abuse laws clearly permit the waiver of all or a portion of a Medicare cost-sharing amount for a financially needy beneficiary. Importantly, under the fraud and abuse laws, the "financial need" criterion is not limited to "indigence," but can include any reasonable measures of financial hardship.*" ibid The OIG clarifies that this provision does not extend to the routine waiver of copays or to advertising this fact.

And, importantly in the Chiropractic Board's duty to come up with a hardship definition:

"The OIG recognizes that what constitutes a good faith determination of "financial need" may vary depending on the individual patient's circumstances and that hospitals should have flexibility to take into account relevant variables. These factors may include, for example:

- *the local cost of living;*
- *a patient's income, assets, and expenses;*
- *a patient's family size; and*
- *the scope and extent of a patient's medical bills.* " ibid

The above references are very clear in allowing a provider to reduce or waive patient fees, including coinsurance, based on financial hardship considerations. They also allow the provider latitude in determining what a financial hardship is for an individual patient. Aside from financial hardship, providers can also offer fee or coinsurance reductions based on common sense business decisions. The OIG recognizes that providers have a substantial cost associated with collections and that reasonable efforts to reduce collection costs can be beneficial to both the patient and provider.

On February 8, 2008, the OIG posted an opinion "regarding a proposed arrangement by which a health care system would provide prompt pay discounts to Federal health care program beneficiaries and other insured patients".[10] The OIG was asked to review:

"*Under the Proposed Arrangement, the Health System would offer to Medicare, Medicaid and other Federal health care program beneficiaries, along with all other insured patients, a discount for prompt payment of their cost-sharing amounts and amounts owed for non-covered services for which the patients received an advanced beneficiary notice (the "Prompt Pay Discount"). The Prompt Pay Discount is designed to reduce the Health System's accounts receivables and costs of debt collection, and to boost its cash flow. The Health System has certified that the amount of fees discounted to patients under the Proposed Arrangement would bear a reasonable relationship to the amount of collection costs that would be avoided.*" ibid

"*The Health System has certified that it would not publicly advertise the Prompt Pay Discount opportunity. Instead, the Health System would only notify patients of the Prompt Pay Discount at certain times during the Health System's ordinary course of dealing with patients. These times would include: when the patient registers for outpatient services and the patient pays his or her cost-sharing amount; when the Health System sends written statements to a patient by mail; and when financial arrangements are made between the Health System and the patient, or his or her appointed financial counselor, after admission for inpatient health services.*" ibid

The OIG's analysis concluded that:

"*Under the Proposed Arrangement, the Health System has certified that it would adhere to all these conditions. It would not claim the Prompt Pay Discount as debt or otherwise shift the burden to the Medicare or Medicaid programs, other third-party payers, or individuals. The Prompt Pay Discount would be offered by the Health System without regard to the reason for the patient's admission, length of stay, diagnostic-related group, or ambulatory payment classification. The Prompt Pay Discount, moreover, would not be part of a price reduction agreement between the Health System and any third-party payer. In sum, to the extent that the Prompt Pay Discount is granted with regard to inpatient hospital services, it complies with the safe harbor for waivers of beneficiary coinsurance and deductible amounts owed by patients.*" ibid The opinion also clearly extends to outpatient services.

State Considerations & Regulations

State laws obviously vary greatly. A general review of State statutes, including Wisconsin, indicate that very few have specific regulations pertaining to what individual businesses or other healthcare providers can and cannot do in offering payment or discount options to the public as long as the public interest is upheld (with the exception of the new Chiropractic regulations). Chiropractic boards have been active in coming up with regulations for chiropractors disproportionately to the other healing arts, including medical, dental, orthodontics, massage, acupuncture, and podiatry. This fact still mystifies me.

Minnesota recently clarified their position on this matter and the MN CEB has had to go back and forth between legislative sessions to try to clarify their intent as their attempts to restrict discounts violated Minnesota consumer laws.[11] They finally settled on a regulation that protected the consumer without infringing on the individual rights of the business owner (chiropractor):

"Section 1. Minnesota Statutes 2006, section 148.10, is amended by adding a subdivision to read:

"Subd. 1a. Free or discounted examination or treatment. (a) Free or discounted examinations must provide sufficient information to allow for a diagnosis and initiation of treatment, with the exception of examinations clearly identified as for the purpose of screening. Free or discounted chiropractic treatments shall be comparable to similar nondiscounted chiropractic treatments.[ibid]

Managed Care Contract Considerations

I have reviewed and have before me, managed care contracts from across the country, including Wisconsin-based insurers including HFN, Humana, WPPN, Anthem BC/BS, ChiroCare WI, HSM, Cigna, Multi-Plan/Health EOS/PHCS, Coventry, and BadgerCare. Each contract uses generally similar language to stipulate how contracted providers will handle patient portions (copayments, deductibles and/or co-insurance).

While each agreement is unique, the general provisions call for the provider to accept a reduced or predetermined fee amount in exchange for access to network patients. The provider usually agrees that *"... the Member* [the patient] *shall be liable only for actual copayments and/or deductibles as determined by Payor* [the insurance company] *in accordance with the Member contract."*[12] Or that "*You* [the provider] *may charge Participants* [patients] *applicable Copayments, Coinsurance and Deductibles in accordance with the process set out in the Administrative Guidelines."*[13]

It is important to recognize that a managed care agreement is just that – i.e. an agreement or contract between the insurance company and the healthcare provider or organization. The contract does not supersede or supplant either state or federal regulations nor board regulations

for a specific provider. Anthem Blue Cross clarifies this point in that *"... in no event shall Plan or the Covered Individual be required to pay more than they would have paid had the Plan been the primary payor. Further, this provision shall not be construed to require Provider to waive Coinsurance, Copayments and Deductibles in contravention of any Medicare rule or regulation, nor shall this provision be construed to supersede any other Medicare rule or regulation."*[14] It is also important to recognize that these agreements are not necessarily written in the best interest of the provider or patient (consumer).

Most every contract specifies that it is the provider's responsibility under the contract to make a reasonable effort to collect from the patient any portion defined under the plan as co-insurance. None of the contacts contain specific provisions for how the provider may collect the patient balance or what actions must be done. From my review, none specify that the provider must collect the entire amount of the co-insurance from the patient or that this amount must be collected prior to services being rendered or prior to billing the services to the insurer. On the contrary, Medicaid directs that *"Under the Standard Plan, Providers **cannot** deny services if a member fails to make his or her copayment."*[15] [original emphasis]

Summary Considerations

The Board of Chiropractic Examiners for the State of Wisconsin must come up with clear and concise guidelines for practitioners that a) protects the public interest while b) not unduly restricting or interfering with an individual provider's rights to conduct his or her practice independently and within his or her scope of practice.

In coming up with guidelines, the following factors should be considered:

A. It is appropriate and customary for Chiropractors to have treatment or care plans and to present these to the patient along with sufficient information/education for the patient to make an informed choice. Part of this process, in a well-run office, should include presenting personal payment considerations and options for the patient as part of their decision making process.

B. Nothing in a proposed payment plan can be in conflict with regulatory agencies or contracts that the office or the chiropractor is enrolled or engaged.

C. Payment Plans should be written with clear terms understandable to the patient and the office and not interfere with the right to health care in the state of Wisconsin. Generally, all patients (insured, uninsured and underinsured) have a financial responsibility to the provider for services rendered.

D. On any prepayment plan, there must be a clear exit clause that the patient or the chiropractor can request should either party wish to terminate before the end of the agreement. The terms of this clause must be clearly defined and be understood by all parties before beginning a care plan.

E. And lastly, all care recommended and rendered must be clinically justified and appropriately documented, as covered by the current WI CEB Rules & Regulations.

I am respectfully providing the CEB with a copy of this letter in the hopes that it will be useful in determining enforcement and regulatory actions by the Board and in determining what a "patient's financial hardship" is defined as per Section 446.02(10)(a)(1).

With the above in mind, I would like to ask about some scenarios that are incredibly common in offices we represent and around the State. I realize that some of these are pretty picky, but they are common and have caused confusion within the profession. The WCA has provided some informational meetings, but have prohibited non-WCA members from attending[16]. I ask that you provide your opinion on the legality of each of these actions based on the current legislation and the items referenced above:

Situation 1:

A mother and daughter are both under care in an office. Anthem Blue Cross is the mother's primary insurance. Each has a $25.00 per visit copay and is being seen three times per week initially for a total of 24 visits each. After determining that the weekly visit costs (3 X $25 X 2 = $150 per week) would inhibit the patients from receiving care, the chiropractor agrees to accept the mother's copay and waives the daughter's. The chiropractor bills his normal fees to Anthem and collects his contracted rate ($33.39) less the copayment, for a total reimbursement of $8.39 for the daughter's care. Is this legal or is the chiropractor subject to discipline?

My understanding under Section 446.02(10)(a)(2) is that if the chiropractor waives all of the copayment, the chiropractor may not seek payment from the insurer even in a financial hardship (as the regulation reads that all points of 446.02(10)(a)(1-2b) must be met).

Situation 2:

A Medicaid patient is unable or unwilling to pay his $1.00 copayment. Per Medicaid guidelines, the chiropractor cannot refuse treatment, so provides care and bills Medicaid for the full amount of the office visit. Medicaid reimburses the chiropractor at their contracted rate for the visit ($24.14). Is this legal or has the chiropractor now violated the law or board regulations?

Again, as per the above scenario, my understanding is that the chiropractor must treat the patient but may not bill for the services rendered nor collect from Medicaid ("If the chiropractor waivers all or a portion of the patient's copayments … due to the chiropractor, the chiropractor may not seek payment from the insurer").

Situation 3:

A patient presents with a problem that requires $1,000 of care over one month. The patient has an 80/20 indemnity health insurance plan and so owes $200 for his portion. The patient's insurance pays $800 of the bill. The office balance bills the patient for his portion several times over six months, makes calls and finally agrees to accept $100 from the patient to settle the outstanding balance (waiving or reducing the remaining $100 balance). The office does not refund any money to the insurance company. Is this legal or has the chiropractor now broken state law or Board regulations?

My understanding of the wording of the law indicates that if the chiropractor waives or reduces part of the patient payment due, the chiropractor must refund the insurer for all payments received that are related to the dates on which the patient's payment was waived or reduced (446.02(10)(a)(2)(b)).

Situation 4:

The chiropractor presents a care plan to the patient covering 18 visits over two months. The patient has a $30 copayment per visit. The chiropractor offers a "prepayment discount" of 20% on the patient portion if the patient wants to handle their copayments upfront rather than paying each visit or being billed at the end of care. The patient pays their copay of $540 (18 visits X $30) less a billing discount of $108. The chiropractor bills and collects from the insurer without giving the insurer a 20% discount on the total bill (because the chiropractor still has to bill, wait for and justify payment from the insurer). The chiropractor has a clear written policy for prepayments and refunds on unused care. Obviously the federally, Medicare and the OIG allows this. Has the chiropractor violated the law or board regulations?

My understanding, and it is confusing at best, is that the chiropractor would not be able to do this because the patient was not a financial hardship case (as all points of the regulation must be met), even though it is in the patient and provider's best interest.

Situation 4(a):

On the above case, assuming the patient was a financial hardship, the chiropractor should have passed the "reduced" fee on to the insurer per the wording of the regulation. In the case of a contracted rate (which the vast majority of insurers use), must the chiropractor deduct what the patient didn't pay (i.e. if the office visit was $60, does the chiropractor bill $54, less the $6 of the copayment the provider did not collect)? Or does the chiropractor bill $48, less the 20% the patient didn't pay? Or must the chiropractor use his or her "contracted rates" – i.e. the chiropractor bills $60, but the contracted rate is $33.32 for the office visit, less the $30 copay owed by the patient resulting in the insurer owing $3.32 for that date of service? Chiropractors

around the state are unclear on how to bill this "reduced" fee proportional to the discount given the patient.

Can you or the board please clarify how this law will be implemented and how to correctly calculate how to accurately report to the insurer the correct fee charged?

My clients sincerely want to provide the best possible service to their patients. They want to adhere to the laws of the State and be in compliance with Federal, State and Board regulations. The problem is that there is a lack of clarification on these regulations and they conflict with extant federal opinions and provider agreements.

One or all of the four scenarios above are happening in 95% of the chiropractic offices in this State on a daily basis. I think that the wording of the new regulation is poor at best and misguided. I need clarification from the legal counsel of the WI CEB on these points.

It is our opinion that the actions of the chiropractors in the above four situations were in the best interest of the public, conforms to Federal and State regulations, and allows individual providers freedom to practice within their scope. If this is not the case, please let me know.

It is very possible that I have completely misread and am confused on the specific regulations cited. I would be more than grateful to know that. But I also know that most every chiropractor I have spoken with is also confused on the practical application of these points in their clinics. A confusing law is a bad law.

Please feel free to contact me with questions or comments. I would be happy to appear before the Chiropractic Board or the Department of Regulation and Licensing to further clarify my concerns and better understand the new regulations. I can also bring several concerned, upset practicing DCs, including members of the WCA, that share the above concerns and want to follow the new regulations.

Sincerely,

David Michel
Petty, Michel & Associates

Cc: Angela Arrington
Bureau Director – Wisconsin
Chiropractic Examining Board
1400 E. Washington Avenue
Madison, WI 53708

Cc: Celia M. Jackson, Wisconsin Secretary Department of Registration and Licensing
Wendy Henrichs, DC, Chairperson, Chiropractic Examining Board
James Koshick, DC, Secretary, Chiropractic Examining Board
Mania Moore, Member, Chiropractic Examining Board
Steven Silverman, DC, Vice Chairperson, Chiropractic Examining Board
Kathleen Schneider, Member, Chiropractic Examining Board
Steven Conway, DC, Member, Chiropractic Examining Board

1. "... protect the citizens of Wisconsin by ensuring the safe and competent practice of licensed professionals. We serve the public and the professionals we regulate by fairly administering education, experience, and examination requirements, setting professional practice standards, and ensuring compliance by enforcing occupational licensing laws ..." (ref: Wisconsin Department of Regulation and Licensing, http://drl.wi.gov/section.asp?linkid=3&locid=0)

2. "At OCABR, we are committed to protecting consumers through consumer advocacy and education. We also work to ensure that the businesses our agencies regulate treat all Massachusetts consumers fairly." (ref: Massachusetts Office of Consumer Affairs, http://www.mass.gov/?pageID=ocautilities&L=1&sid=Eoca&U=welcome)

3. "The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452 (as amended), is to protect the integrity of Department of Health and Human Services (HHS) programs, as well as the health and welfare of the beneficiaries of those programs. The OIG has a responsibility to report both to the Secretary and to the Congress program and management problems and recommendations to correct them. The OIG's duties are carried out through a nationwide network of audits, investigations, inspections and other mission-related functions performed by OIG components." (ref: US Department of Health and Human Services, Office of the Inspector General, http://oig.hhs.gov/organization.asp)

4. "Implementation of the chiropractic benefit requires an appreciation of the differences between chiropractic theory and experience and traditional medicine due to fundamental differences regarding etiology and theories of the pathogenesis of disease. Judgments about the reasonableness of chiropractic treatment must be based on the application of chiropractic principles. So that Medicare beneficiaries receive equitable adjudication of claims based on such principles and are not deprived of the benefits intended by the law, carriers may use chiropractic consultation in carrier review of Medicare chiropractic claims." (ref: CMS, Medicare IOM 100-2, Chapter 15, Section 240, page 191)

5. "Treatment Plan: The treatment plan should include the following: Recommended level of care (duration and frequency of visits); Specific treatment goals; and Objective measures to evaluate treatment effectiveness (ref: Medicare Guidelines Pub 100-2, Chapter 15, 240.1.5 – Documentation Requirements – Initial Visit)

6. Mercy Guidelines, Chapter 8, Frequency and Duration of Care (Guidelines for Chiropractic Quality Assurance and Practice Parameters)

7. National Health Insurance Corporation (NHIC), Medicare's fiscal intermediary for Massachusetts, etc, delineates accepted treatment durations and frequency of between 12 – 48 visits by diagnosis. (ref: LCD for Chiropractic Service (Manual Spinal Manipulations) (L3172))

8. 56 Fed. Reg. 35952, 35979, July 29, 1991

9. Department of Health & Human Services, OIG Opinion, February 2, 2004: "Hospital Discounts Offered to Patients Who Cannot Afford to Pay Their Hospital Bills"

10. Department of Health & Human Services, OIG Opinion, February 8, 2008: "Re: OIG Advisory Opinion No. 08-03"

11. ref: http://www.mn-chiroboard.state.mn.us/Whats%20new.htm#FREE OR DISCOUNTED SERVICES

12. Wisconsin Coventry Health Care Provider Agreement (ref: CHCNN_Provider_Standard 10/20/08)

13. Wisconsin Cigna Provider Agreement (ref: HP2005MCA.US)

14. Wisconsin Anthem Blue Cross / Blue Shield Provider Agreement (ref: PROFWI Ver 6.2 Professional Base Agreement)

15. Wisconsin Badgercare Plus Provider Information, November 2007, Bulletin 2007-90, Chiropractic Services Under BadgerCare Plus

16. Letter from Russ Leonard, WCA Executive Director, "Special district meetings will be held **for WCA members and their staff only** to discuss these changes …" [original emphasis] (Governor Signs New Chiropractic Laws – Special Meetings to Discuss Changes)