Texas Orthopaedic Association

TEXAS ORTHOPAEDIC ASSOCIATION

Connection

February 2014

President's Message

By Patrick Palmer, MD
President, TOA

On behalf of the TOA board of directors, I want to thank everyone for returning their 2014 membership dues. We have been pleased to see such a strong increase of interest in TOA over the past year. In particular, a number of young orthopaedic surgeons who are in the beginning stages of beginning their practices are getting involved in TOA. It's clear that our organization has a strong future.

I wanted to draw your attention to a few items that are of interest to Texas orthopaedic surgeons:

April 10 - 12, 2014 Annual Meeting

Please make plans to join us at the San Antonio Westin Riverwalk for our April 10 - 12 annual meeting. We're pleased that this year's event will be during the first weekend of Fiesta, which is our great annual tradition in San Antonio. Full details and registration (our special hotel rate expires in March) can be found on our Web site (www.toa.org).

A special thank you goes out to San Antonio orthopaedic surgeons Joel Jenne, MD and Matthew Morrey, MD for all of the hard work that they have put into producing the agenda. We have already had an incredible response for our all-day ICD-10 coding seminar on Thursday, April 10. This is a great way for you and your staff to learn more about the October 1, 2014 changes. Plus, it will be one of our final seminars on the ICD-10 changes.

As always, we have a great line-up of speakers on numerous clinical, legal, and business topics. In addition, we're adding a new "Business of Orthopaedics" session on the afternoon of Saturday, April 12. We'll take a look at issues concerning independent practices and employed physicians. This is a hot topic that will be of great interest to everyone.

March 13 Texas Reception in New Orleans

Please join TOA for a reception on Thursday, March 13 in New Orleans to celebrate all of the Texas orthopaedic surgeons who are serving in AAOS leadership. The event will be held from 5:30 p.m. to 6:30 p.m. at SoBu in the French Quarter. Please e-mail TOA (Bobby@toa.org) to RSVP and for full details.

Want to stay connected with orthopaedic news and events in Texas? Subscribe to our bi-monthly e-mail newsletter, eConnect. Contact Bhillert@toa.org if you are not receiving it.

The Primary Is Around the Corner

For the first time in over a decade, Texas will soon have a new governor and many other new faces in key legislative and statewide positions. The March 4 primary will play a major role in determining who the new leaders will be.

Many of us are burned out on the political process. The constant bickering and apparent lack of progress over the past few years has created many cynics of the legislative process. However, the reality is that government laws and regulations touch every aspect of our practices. Whether we are in an independent, hospital-employed, or academic setting, the Texas Legislature plays a key role in the orthopaedic world.

The Texas Orthopaedic Political Action Committee (TOPAC), led by John Gill, MD of Dallas, has been very busy educating candidates about the issues and participating in political fundraisers. The medical community recently became engaged in a north Austin special election for state representative, which featured a chiropractor as a candidate. The chiropractor eventually lost. The Texas Medical Association's political arm sent a mailer to voters informing them that the chiropractor candidate was referring to himself as a "physician" while communicating with voters. The mailer reminded voters that Texas law requires an individual to have a license from the Texas Medical Board to call himself/herself a "physician."

Table of Contents

Thanks to everyone who has renewed their 2014 dues. TOA exists because of support from Texas orthopaedic surgeons.

Upcoming Events

March 10, 2014
TOA Annual Meeting Hotel Reservation Deadline
San Antonio Westin Riverwalk

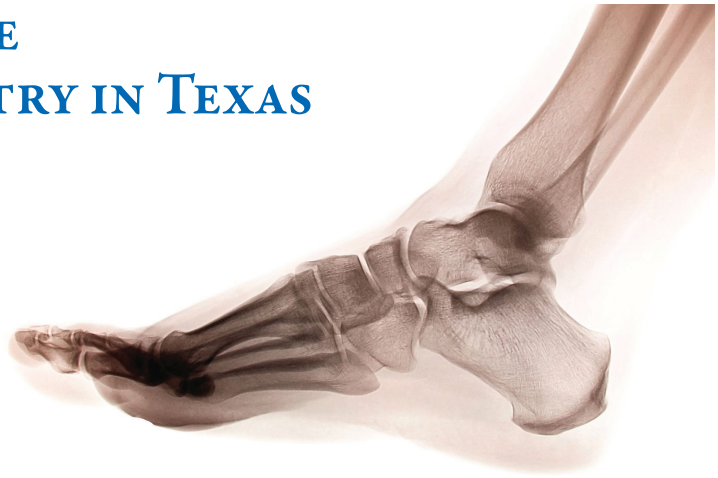
March 13, 2014
TOA Reception at AAOS
New Orleans | 5:30 p.m.
E-mail Bobby@toa.org for details/RSVP

April 10-12, 2014
TOA Annual Meeting
San Antonio Westin Riverwalk
www.toa.org for details

April 30 - May 1
National Orthopaedic Leadership Conference
Washington, DC
Contact Bobby@toa.org for details

Update on the Status of the Scope of Practice of Podiatry in Texas

By Andrea I. Schwab, JD, CPA | Andrea@aschwablaw.com



Notice: The information provided in this article is commentary of a general nature. It is not intended to provide specific legal advice, and should not be used as a substitute for the advice of an attorney.

The scope of practice of podiatry has been the focus of recent case rulings at the appellate and district court levels. This article will examine law concerning the scope of practice of podiatry and the impact the recent rulings may have on that scope.

Practice of Medicine in Texas

There is no inherent right to practice medicine in Texas. In Texas, no one is allowed to practice medicine without a license from the Texas Medical Board.[3] By the power of Article XVI, section 31 of the Texas Constitution and the general police power to protect the public health, the Texas Legislature has specifically defined the practice of medicine, and has prescribed rules and regulations governing the practice thereof, under the Medical Practice Act (MPA).[4] The MPA defines the practice of medicine as follows:

"Practicing medicine means the diagnosis, treatment or offer to treat a mental or physical disease or disorder or a physical deformity or injury by any system or method, or the attempt to effect cures of those conditions, by a person who: (A) publicly professes to be a physician or surgeon; or (B) directly or indirectly charges money or other compensation for those services."[5]

Whether one has publicly professed to be a physician does not depend on whether he or she has made a verbal claim to be a medical doctor, physician, or a surgeon--courts have held that a "public profession" depends on what one does, not only on what one says.[6]

Indeed, the regulation of those who practice medicine is so important to the people of Texas that the Texas Constitution prevents the Legislature, or any state agency, from enacting laws or regulations that allow a person to practice medicine unless that person satisfies the same requirements and standards applicable to all others who practice medicine in Texas.[7] Why, then, can other healthcare providers such as podiatrists legally treat a physical disease or disorder of the human body without a medical license? This is because the Legislature provides in the MPA an ***exemption--a specific carve-out-- for certain individuals*** from compliance with the many regulations of the practice of medicine.[8] One of those exemptions is for licensed podiatrists; the Legislature has exempted from the regulation of the MPA a "licensed podiatrist engaged ***strictly*** in the practice of podiatry as defined by law."[9] Therefore, stated differently, a podiatrist treating patients who is not engaged strictly in the practice of podiatry as defined by law could arguably be practicing medicine, and subject to the MPA as well as to regulation by the Texas Medical Board (TMB).

Practice of Podiatry in Texas

The practice of podiatry in Texas is governed by statue, and that has been the case since 1923.[10] The Texas Legislature has defined podiatry as "the treatment of or offer to treat any disease, disorder, physical injury, deformity, or ailment of the human foot any system or method."[11] Also pursuant to Texas statute, the Texas State Board of Podiatric Medical Examiners (TSBPME) adopts rules to govern the regulation of the practice of podiatry.[12] The TSBPME regulation of the practice of podiatry and rule making authority is not without bounds, however. The board *must* act *"consistent with the law regulating the practice of podiatry"* and the law of this state.[13] Its regulation can be challenged in court. One who seeks to challenge the board's rule making actions must bring a declaratory action in a *Travis County* district court.[14] This statutory authorization allowing a person to challenge the validity or applicability of an agency rule, if it is alleged that the rule or its threatened application interferes with or impairs a legal right or privilege of the plaintiff, is a legislative grant of subject matter jurisdiction.[15] This is precisely what occurred in *Texas Orthopaedic Association* v. *Texas State Board of Podiatric Medical Examiners*, 254 S.W.3d 714 (Tex. App.--Austin 2008, pet. denied). In that case, the TSBPME's rule making was challenged, and the challenged rule was declared invalid by the court of appeals.[16]

Texas Orthopaedic Association v. Texas State Board of Podiatric Medical Examiners (TOA v. TSBPME)

In TOA v. TSBPME, the Texas Orthopaedic Association, et. al., sought a declaratory judgment that a rule promulgated by the TSBPME defining "foot" impermissibly expanded the scope of podiatry. The case was properly brought in a Travis County District court, as required by the Texas Government Code.[17] The TSBPME rule challenged in that case defined "foot" as follows:

"The foot is the tibia and fibula in their articulation with the talus, and all bones to the toes, inclusive of all soft tissues (muscles, nerves, vascular structures, tendons, by ligaments and any other anatomical structures) that insert into the tibia and fibula in their articulation with the talus and all bones to the toes."[18]

Continued next page

The Travis County district court declared that the rule was valid, but the Third Court of Appeals reversed the trial court and invalidated the rule, holding that the *"rule defining 'foot' impermissibly expanded practice of podiatry beyond treatment of foot."*[19] The court wrote in its opinion that the rule authorized podiatrists to treat parts of the body outside the traditional scope of podiatry without satisfying the requirements of the MPA, and that such authorization "exceeds the *limited exemption* given to podiatrists and *would constitute the unauthorized practice of medicine."*[20]

The court also correctly noted that any change to the scope of practice must be made by the Legislature. In a footnote, the appellate court wrote: "The statutory authority currently in place limits podiatrists to the treatment of 'the foot...it is clear that 'the foot' does not include the full portion of the body included within the definition of the Rule...

Compelling arguments might be made as to whether--from a medical standpoint--it is reasonable to allow a practitioner treating the foot to consider and threat other anatomical systems that interact with and affect the foot. ***This is a debate to be had at the legislature."***[21]

Hendrick Medical Center Case

Recently, however, a district court in Abilene (not an appellate court) has issued what may be considered by some as a conflicting opinion.[22] The facts surrounding that case are that in 2011, Hendrick Medical Center (HMC) in Abilene allegedly gave two podiatrists on the medical staff written notice that their podiatry privileges would be administratively reduced by the elimination of all ankle privileges. According to the facts of that case, HMC indicated in the notice that the decision to eliminate ankle privileges was based on its interpretation of the law that defines the scope of the practice of podiatry. The podiatrists and the podiatric medical association filed suit against HMC in

Taylor County District Court, seeking injunctive and declaratory relief regarding their ankle privileges. On October 2, 2013 the district court judge for Taylor County entered an interlocutory declaratory judgment that the following surgical procedures are within the scope of podiatry as defined in the Texas Occupations Code:

1) ankle fusion; 2) pantalar fusion; 3) open reduction-internal fixation (ORIF) of ankle fracture to treat unstable talus; 4) ankle arthrotomy to treat talus; 5) tibial/fibular osteotomy to treat talus; 6) calcaneal osteotomy; 7) cuneiform osteotomy with bone graft; 8) gastrocnemius recession; 9) tendo-Achilles lengthening; 10) detachment and re-attachment of Achilles tendon with resection of posterior calcaneal exostosis; 11) flexor hallucis tendon transfer; 12) tibialis posterior tendon transfer; and 13) decompression posterior tibial nerve.[23]

This ruling has not been appealed, and it therefore remains a trial court declaratory judgment. Generally an appellate court ruling holds a greater precedent value than a trial court judgment.

An interesting aspect of this trial court case is that the plaintiffs sought a declaratory judgment under the Texas Declaratory Judgments Act.[24] That Act requires that *all persons who have any interest that would be affected by the declaration must be made parties to the suit.*[25] Importantly, the Act clearly states that a declaratory judgment *"does not prejudice the rights of a person not a party to the proceeding."*[26] Therefore, it does not appear that the HMC ruling is binding on other individuals or entities not parties to the HMC suit.

Summary

In summary, podiatrists are exempted from the requirements of the MPA and the TMB when they practice *strictly* within the scope of practice of podiatry. The scope of practice of podiatry is defined by the Texas Legislature. The Legislature has vested power in the TSBPME to write rules regulating the practice of podiatry, but if the TSBPME exceeds its rule making authority, a challenge to that rule making must be brought in a *Travis County* district court, and any subsequent judgment by a Travis County district court is appealed to the *Third Court of Appeals in Austin*. The TSBPME's rule defining the foot and authorizing treatment other than the foot was appropriately challenged in Travis County district court, and the Third Court of Appeals invalidated that rule. *The Legislature has not amended the statute that existed when the court of appeals made its ruling, i.e., it has not authorized the treatment by podiatrists beyond the foot.* Therefore, podiatrists who might perform the procedures at issue in the Taylor County case could arguably and potentially be at risk of regulation by the Texas Medical Board for the unauthorized practice of medicine.

Andrea I. Schwab currently practices law with the Law Office of Andrea I. Schwab in Austin, Texas. She has approximately 19 years of legal experience, primarily focused on health law, professional liability litigation, and commerical law. She is also a former Associate General Counsel of the Texas Medical Association, where she advocated for Texas physicians to the Legislature, state agencies, and in litigation. She was involved in drafting and negotiating legislation on many health related issues, including scope of practice.

[3] *TEX. OCC. CODE § 155.001. When the Legislature enacted the Medical Practice Act it made the following specific finding: "[T]he practice of medicine is a privilege and not a natural right of individuals and as a matter of public policy, it is necessary to protect the public interest through enactment of this subtitle to regulate the granting of that privilege and its subsequent use and control[.]" TEX. OCC. CODE § 151.003 (West 2004).*

[4] *TEX. OCC. CODE § 151.001 et seq; TEX. CONST. ART. XVI § 31.*

[5] *TEX. OCC. CODE § 151.002(a)(13).*

[6] *Green v. State, 137 S.W.3d 356 (Tex.App.—Austin 2004, pet ref'd); Kelley v. Texas State Board of Medical Examiners, 467 S.W.2d 539, 542 (Tex.Civ.App.-- Fort Worth 1971, writ ref'd n.r.e.)*

[7] *Article 16, section 31, of the Texas Constitution states the following: The Legislature may pass laws prescribing the qualifications of practitioners of medicine in this State, and to punish persons for malpractice, but no preference shall ever be given by law to any schools of medicine.*

Continued page 12

Member Spotlight: Chad Krueger, MD

Chad Krueger, MD is currently serving as an orthopaedic resident at Brooke Army Medical Center's Orthopaedic Surgery Residency Program in San Antonio and is scheduled to complete his residency in 2015. He serves as a TOA board member.

A native of Maine, Dr. Krueger completed his undergraduate work at the University of Delaware in Newark and finished medical school at the University of Medicine and Dentistry of New Jersey – Robert Wood Johnson School of Medicine.

Q: What led you to your current practice setting?

A: I chose to enter the military for residency for a couple of reasons. First and foremost, I wanted to give back to our country. My family has been involved with the military for generations. I wanted to continue in that honor.

I also signed the contract to join the military at the beginning of what is now the longest combat effort that our country has ever been involved in. I thought that there could be learning and professional opportunities that I could take advantage of because of this conflict. Clearly, I could not have predicted much about what has transpired during my residency. However, I have found military residency to be like most other ventures in life – what you get out of it is directly proportional to the effort you put forth.

Q: What do you believe are some of the most significant to orthopaedics over the past five years?

A: As a resident, it is hard for me to comment on changes that have had a great impact on orthopaedics, as my experience is limited. However, as a member of the military I get a glimpse of a universal-style healthcare system. This system, like any, has many attributes and many failures. However, there appears to be much that could be learned from it as we move forward with the ACA.

Q: There is a lot of uncertainty in the health care industry right now due to the Affordable Care Act, industry consolidation, and other events. What do you believe the orthopaedic landscape in Texas will look like in five years?

A: I foresee more and more residents going into some type of hospital-based employment. The reasoning for this seems to center around the "stability" of such a job and the feeling that an employed position comes with less "headaches" than a private practice.

At the same time, it appears that many of the more senior orthopaedic surgeons are becoming frustrated by the ever-changing medical landscape and may opt to retire a few years early as opposed to adopt to those changes. This may leave Texas with fewer private practice-based orthopaedists but relatively stable number of orthopaedists total. However, this continued change in private practice versus employed orthopaedists could have a large ripple effect on the orthopaedic community and the orthopaedic care that could be provided to patients.

Q: Why do you choose to be involved with advocacy organizations like TOA and AAOS?

A: Organizations such as the TOA and AAOS help me invest in the future or orthopaedic surgery. I want to help orthopaedics grow stronger and stronger with time so that I am able to care for and help patients for years to come. These organizations are basically an investment – a small amount of time, money or effort give now can have a large payoff in the future. There are few things I enjoy more than orthopaedics. I want to make these investments to help me continue to be able to do what I love for years to come.

Q: What are your plans for when you wrap up your residency?

A: After residency I will serve the time I owe to the military as a general orthopaedist for four years. I'm unsure of where I will be stationed, but I'm sure it will be a great experience no matter where I end up.

Having taken a year off from residency to complete a research fellowship, I would like to continue to be involved in research. Similarly, I have really enjoyed my involvement with the Texas Orthopaedic Association, Society of Military Orthopaedic Surgeons, AAOS committees and other orthopaedic/professional organizations. Such involvement has allowed me to develop great relationships with people I would otherwise not have a chance to interact with while also allowing me to develop professionally and personally in ways I'm not sure I would have on my own.

I also take pride in educating junior residents and get a lot of satisfaction from watching other residents find their own passions within orthopaedics. While I certainly do not need to be at an academic institution to continue with those experiences, I do find something exciting/energizing about being at a larger institution. Still, I feel that private orthopaedic offices have a way to influence lives and communities in ways that larger centers can't and I worry about the current trend of graduating residents joining healthcare organizations in large numbers.

So, in summary, you can tell that I'm not entirely sure where my orthopaedic career will take me. However, I look forward to all that orthopaedics has to offer and hope to be able to add to the orthopaedic community in a multitude of ways during my career.

Q: What are some of the biggest differences between military and civilian orthopaedics that you have seen during your residency?

A: There are many specifics about being an orthopaedic surgeon in the military that are different than that of a civilian provider. However, the bottom line is that we still do everything in our power to take care of our patients.

There are certainly some differences between combat-related trauma and civilian trauma, but, at the end of the day, a mangled extremity is still a mangled extremity and gets treated as such. In addition, the majority of our patients present with the same type of disease processes that are seen in most civilian clinics. We have a large population of young, active individuals who sustain sports medicine injuries such as ACL and labral tears and also have plenty of retirees and dependents who rely on us to provide them care for their degenerative joints, carpal tunnel syndromes, herniated discs, etc. We take great pride in caring for the men and women who fight for our country and these men and women tend to be afflicted with many of the same types of orthopaedic diseases that are encountered by the general population.

Member Spotlight: Kyle Dickson, MD

Dr. Kyle Dickson is currently in the Texas Medical Center in the Southwest Orthopaedic Group. He was formerly a Professor and Chairman of Orthopaedic Surgery at the University of Texas Medical School at Houston. His education, extensive training and many years of experience uniquely qualify him to treat complex orthopaedic trauma and orthopaedic reconstructions. Dr. Dickson was a Regent's Scholar at the University of California, San Diego School of Medicine where he received his medical degree. He completed his orthopedic residency at the University of California, San Francisco, followed by a fellowship in Trauma and Pelvic and Acetabular surgery at the University of Southern California. Dr. Dickson went on to complete an AO trauma fellowship in the trauma centers of Hanover, Augsburg, and Bern and completed an Ilizarov fellowship in Lecco, Italy. He became a Tenured Professor of Orthopaedics at Tulane University.

He received an M.B.A. from Tulane's Freeman School of Business. Dr. Dickson is board certified by the American Board of Orthopaedic Surgery and was a past President of both the New Orleans Orthopaedic Society and the Houston Orthopaedic Society. In the field of Orthopaedic Trauma and Complex Reconstructions, Dr. Dickson has published numerous peer reviewed papers, written many text book chapters, and given lectures all around the world.

Q: What led you to your current practice setting?

A: I was in academics for more than 15 years and learned the hard way that contracts with Texas schools go only one way. You have to do what the contract says but they don't. I learned a new term, "sovereign immunity", which means you can't sue the state.

I'm in a hybrid practice now with a group of orthopaedic surgeons with a part-time academic appointment with Baylor College of Medicine and Ben Taub.

Q: What do you believe are some of the most significant changes to orthopaedics over the past five years?

A: To me, the most significant changes started more than five years ago, which was the hospitals hiring or teaming up with physicians. If this is done correctly, it can work well. But when one entity has too much power (for example, hospitals), there can be major conflicts of interest. One major insurer dropped their reimbursement to physicians but not to hospitals. Due to technical fees they can continue to pay their orthopaedists well and force them to continue to see these patients. This will eventually erode their reimbursements and are killing private practice.

Q: There is a lot of uncertainty in the health care industry right now due to the Affordable Care Act, industry consolidation, and other events. What do you believe the orthopaedic landscape in Texas will look like in five years?

A: See my earlier comments about hospital partnerships. I am normally an optimistic person, but I believe that the independence of the physician is continuously being eroded away. Most of these measures aim at trying to bring the bottom up as opposed to really measuring how the patient is doing two years out. Good physicians will still do the right thing for the right reason.

We have witnessed new "quality measures" requiring brace wear for a patient with end stage knee arthritis. A requirement like this by payors has no scientific validity and would make it harder for a physician to do the right thing for a patient.

Q: What advice do you have for orthopaedic residents who may be starting their orthopaedic practice in the near future?

A: It may not be what they expected, but they can still make a huge difference in people's lives and have a huge amount of job satisfaction.

Q: Why do you choose to be involved with advocacy organizations like TOA and AAOS?

A: You can't complain about the system or change the system unless you are willing to get involved either personally or with a monetary donation.

Q: You were recently named the 2014 Verne T. Inman Lecturer at the University of California, San Francisco. What will that entail?

A: It is an honor to be chosen by your alma mater to be part of this very distinguished and one of the oldest lectureships in the country. I'll be lecturing on "Acetabular and Pelvic Nonunions and Malunions: The Good, the Bad and the Ugly" and "In the Eye of Level 5 Hurricane Katrina: Have We Learned anything?" I'm my harshest critic, but maybe I've done some good in orthopedics, after all. Hopefully there are many patients, medical students, residents, and orthopaedists who are a little better because of me.

TOA/TOF/TSSM Annual Meeting Registration Information

Register NOW online at www.toa.org!

ICD-10 Coding Seminar Thursday, April 10 (separate registration fee)

Space will be limited. **$250** fee for TOA members and their staff. Price includes books and lunch.
$600 fee for non-members.

Annual Meeting Registration

$75 registration fee for TOA and TSSM members and their staff prior to March 31st.
$125 registration fee for members after March 31st.
$600 registration fee for non-members.

Hotel Information

Our special rate of **$219** per evening at the Westin Riverwalk will expire on **March 10**. Please visit our web site's 2014 Annual Meeting page to book your room online or by calling 210-224-6500.

Texas Orthopaedic Association

TOA/TOF/TSSM 2014 Annual Meeting

April 10-12, 2014 | San Antonio Westin Riverwalk

Texas Orthopaedic FOUNDATION

Texas Society of Sports Medicine

THURSDAY, APRIL 10, 2014

Time	Event	Speaker
9:00 a.m. – 3:00 p.m.	ICD-10 Coding Workshop: What Physicians & Their Staff Need to Know	Margaret Maley RN, BSN *Karen Zupko & Associates*

This low-cost course will prepare physicians and their staff for the switch to ICD-10 on October 1, 2014. Margaret Maley of Karen Zupko and Associates is one of the nation's leading speakers on orthopaedic coding issues and has been preparing hundreds of orthopaedic surgeons and their staff for ICD-10.

Do not miss this event as it will be one of the final ICD-10 courses that TOA will present! Registration will begin on January 8 at www.toa.org so be sure to register early because space is limited. Your registration fee will include handouts and your lunch.

Participants are encouraged to bring the ICD-10 books with them, which can be purchased at Amazon.com.

FRIDAY, APRIL 11, 2014 - *Speakers and topics subject to change*

Session 1: Total Joints, Young Hips, New Payment Models, Sports Team Coverage & Medical Board Issues

Time	Event	Speaker
7:00 a.m. - 7:30 a.m.	Registration and Breakfast	
7:30 a.m. - 8:00 a.m.	Total Joint Address	Brian S. Parsley, MD - AAHKS President
8:00 a.m. - 8:45 a.m.	Symposium: New Payment Models	Brian S. Parsley, MD; Adam I. Harris, MD & Louis S. Stryker, MD
8:45 a.m. - 9:15 a.m.	Break & Exhibitor Visits	
9:15 a.m. - 9:45 a.m.	Presentation TBA	John J. Callahan, MD
9:45 a.m. - 10:30 a.m.	Symposium: Young Hip	Warren R. Kadrmas, MD; Matthew C. Morrey, MD; Casey D. Taber, MD & Matthew R. Schmitz, MD
10:30 a.m. - 11:15 a.m.	Symposium: Sports Team Coverage - Liabilities and Return to Play	David S. Schmidt, MD; Casey D. Taber, MD; Matthew C. Murray, MD & David E. Haynes, MD
11:15 a.m. - 11:45 a.m.	Texas Medical Board Address	Mari Robinson, JD Executive Director - TMB
11:45 a.m. - 12:00 p.m.	Break for Lunch & Exhibitor Visits	
12:00 p.m. - 1:00 p.m.	Lunch & Legal Discussion: Physician Employment, Stark & TMB Issues - Ethics Hour	Josh Weaver, JD; Ashley Johnston, JD & Dan Ballard, JD
1:00 p.m. - 1:30 p.m.	Break & Exhibitor Visits	

Session 2: Fractures, Shoulders, Benchmarking & Quality Measures

Time	Event	Speaker
1:30 p.m. - 2:00 p.m.	The Evolution of Bundled Payments in Orthopaedics	Michael Zucker | Senior VP & Chief Development Officer - Baptist Health Systems
2:00 p.m. - 2:15 p.m.	What Is the Best Treatment for Fractures of Proximal Humerus in Older Patients?	Charles A. Rockwood, Jr., MD
2:15 p.m. - 3:00 p.m.	Symposium: Current Trends in Fracture Management	Kyle F. Dickson, MD; John S. Early, MD; Daniel S. Stinner, MD & Travis C. Burns, MD
3:00 p.m. - 3:30 p.m.	Break & Exhibitor Visits	
3:30 p.m. - 4:15 p.m.	Symposium: Shoulder Overuse to Old Age	Fred G. Corley, MD; Travis C. Burns, MD; Warren R. Kadrmas, MD & Ralph J. "Bud" Curtis, MD
4:15 p.m. - 5:00 p.m.	Symposium: Benchmarking - Applying it to Your Practice	Kyle F. Dickson, MD; Marc M. DeHart, MD & Maureen A. Finnegan, MD

SATURDAY, APRIL 12, 2014 - *Speakers and topics subject to change*

Session 3: Non-Operative Trends, Orthopaedic Oncology, ICD-10 & Scientific Papers

Time	Event	Speaker
6:15 a.m. - 7:00 a.m.	Past Presidents Breakfast	
6:30 a.m. - 7:30 a.m.	Registration, Breakfast, & Exhibitor Visitation	
7:30 a.m. - 8:30 a.m.	Scientific Presentations	Six Minute Abstract Podium Presentations
8:30 a.m. - 9:00 a.m.	Presentation TBA	Michael J. Yaszemski, MD
9:00 a.m. - 9:45 a.m.	Symposium: Office Based Nonoperative Trends in Orthopaedics	Bernard F. Morrey, MD; Michael J. Yaszemski, MD & Theodore W. Parsons, III, MD
9:45 a.m. - 10:15 a.m.	Break & Exhibitor Visits	
10:15 a.m. - 10:45 a.m.	TOA Presidential Line: Policy Changes on the Horizon	Bobby Hillert; Marc M. DeHart, MD; Patrick M. Palmer, MD; Howard R. Epps, MD & Kyle F. Dickson, MD
10:45 a.m. - 11:15 a.m.	ICD-10: Everything That a Physician Needs to Know in 30 Minutes	Andrew P. Kant, MD
11:15 a.m. - 11:45 a.m.	Musculoskeletal Oncology: What the General Orthopaedic Surgeon CAN Do	Theodore W. Parsons, III, MD
11:45 a.m. - 1:00 p.m.	TOA/TOF/TSSM Business Lunch & Exhibitor Visitation	

Session 4: The Future of Orthopaedics in Texas

Time	Event	Speaker
1:00 p.m. - 2:15 p.m.	Resident Quiz Bowl	Emcees: Kyle F. Dickson, MD & Fred G. Corley, MD
2:15 p.m. - 3:00 p.m.	Remaining Independent vs. Employment	Bernard F. Morrey, MD
3:00 p.m. - 4:00 p.m.	The Future of Orthopaedics: Resident Panel & Networking Session	Howard R. Epps, MD; David E. Haynes, MD; Andrew P. Kant, MD & Bernard F. Morrey, MD

Schedule Overview

Thursday, April 10

All-day ICD-10 Coding Course for Physicians and Staff (separate registration fee)

Friday, April 11

All-day scientific and socieconomic sessions for physicians and other providers.

All-day business sessions for orthopaedic staff.

Join us for the Welcome Reception from 6:30 p.m. to 8:30 p.m.

Saturday, April 12

Morning scientific session and paper presentations for physicians and other providers.

Afternoon session: The Future of Orthopaedics and Resident Quiz Bowl.

CME

Attendees will receive a total of 20.50 *AMA PRA Category 1 Credits*™ for attending all three days, which includes 1 hour of Ethics. The ICD-10 Coding Course on Thursday offers 6 *AMA PRA Category 1 Credits*™, Friday's program offers 7.75 *AMA PRA Category 1 Credits*™ and Saturday's program offers 6.75 *AMA PRA Category 1 Credits*™.

More information concerning CME will be released soon.

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A Review of Medicare's Total Joint Cuts

By Louis Stryker, MD

The day before Thanksgiving 2013, the Centers for Medicare and Medicaid Services (CMS) released the 2014 interim final Medicare Physician Fee Schedule (MPFS). In it, CMS reduced the work relative value units (RVU) for total hip arthroplasty and total knee arthroplasty by 5 percent and 11 percent, respectively. We can still be thankful, however, because these cuts were significantly less than those recommended by the AMA/Specialty Society Relative Value Scale Update Committee (RUC).

These latest cuts represent only the most recent round of reductions in Medicare reimbursement to surgeons for total joint arthroplasty. From 1991 to 2006, Medicare payments for total hip arthroplasty fell 39 percent. Meanwhile, Medicare reimbursement for total knee arthroplasty fell 36 percent.[1] This decline in physician reimbursement reflects an overall progressive devaluation of the role of the physician in caring for total joint arthroplasty patients. From 1991-2007 there was a 24 percent increase in Medicare payments to hospitals for total hip arthroplasty. Similarly, the selling price of implants increased 127 percent from 1996-2005.[2]

Patients, however, still highly value the care and expertise we provide. In a study by Foran et al in 2012, surveyed patients thought surgeons should be paid $14,358 for a total hip arthroplasty and $13,332 for a total knee arthroplasty.[3] The $1,394 we will be paid in 2014 pales in comparison to what our patients think of our worth.

Persistently shrinking reimbursements for total joint arthroplasty heralds a future patient access crisis. Many surgeons already limit Medicare or have left it entirely. A survey of surgeons published in the September 2013 AAHKS Supplemental revealed that the vast majority of surgeons would respond adversely if drastic cuts in Medicare reimbursement were made: 58% would limit Medicare, 21 percent would leave Medicare entirely, 7 percent would retire early and another 6% would quit arthroplasty altogether. The end effect would be further limited access for patients in what is already anticipated to be a crisis due to projected demand for total joint arthroplasty.[4,5]

The cuts recommended by the RUC in May 2013 were much deeper than those adopted by CMS: 10 percent for total hip arthroplasty and 16 percent for total knee arthroplasty. The fact that these cuts did not occur is a testament to the advocacy efforts exposing the flawed process by which these recommendations were reached. CMS specifically cited the advocacy work of specialty societies in deciding to not endorse the RUC recommendations. Currently, those advocacy efforts persist. Of special note, these are the only 2 instances in the entire 2014 MPFS where CMS adopted higher RVU values than those recommended by the RUC. In all other cases, CMS adopted the RUC recommendations or reduced values beyond those recommended by the RUC. A RUC fact sheet boasting that CMS accepts 95 percent of its recommendations further emphasizes the significance of the CMS rejection of these RUC recommendations.[6]

Unrelenting reductions in Medicare reimbursement for total joint arthroplasty with the threat of compromised patient access is a call to action. The significant positive societal and individual impact of total joint arthroplasty is established and recent successful advocacy efforts by surgeons indicate our objections have merit. In addition to our own endeavors however, we as surgeons need to more effectively educate and engage those who stand to lose the most if this trend continues, our patients.

Louis S. Stryker, MD is an Assistant Professor of Adult Reconstruction at the UT Health Science Center San Antonio's Department of Orthopaedics. Born in San Antonio, Dr. Stryker earned a Bachelor of Arts from Texas A&M University, majoring in Biology with a minor in History. He completed his medical degree at The University of Texas Medical School at Houston and was inducted into the Alpha Omega Alpha Honor Medical Society in his third year. Dr. Stryker performed his residency in Orthopaedic Surgery at the Mayo Clinic in Rochester, Minnesota. In addition to his clinical training as a resident, he conducted clinical research and was honored with awards from both the faculty and his colleagues. Dr. Stryker concluded his formal medical training as a fellow in adult reconstruction at the OrthoCarolina Hip and Knee Center in Charlotte, NC.

Dr. Stryker specializes in the reconstruction of the hip and knee and is committed to matching the treatment and procedure to each patient's specific needs. In addition to direct anterior total hip arthroplasty and primary knee replacement surgery, he performs complex reconstructions and revision surgery.

In conjunction with his clinical practice, Dr. Stryker remains active in education, research and leadership in the orthopedic community. He teaches residents, has authored numerous articles and book chapters, and has presented his research at the local, regional and national levels. Dr. Stryker currently serves as a Health Policy Fellow for the American Association of Hip and Knee Surgeons and maintains active membership in a number of professional societies.

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[1] *Orthopedics Data Compendium. August 2006. Available at: http://www.iha.org/pdfs_documents/medical_device/07_OrthopedicsDataCompendium.pdf.*

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[5] *Fehring TK, Odum SM, Troyer JL, Iorio R, Kurtz SM, Lau EC. "Joint Replacement Access in 2016: A Supply Side Crisis." J Arthroplasty 2010 Dec;25(8):1175-81.*

[6] *American Medical Association. What the RUC Is & Is Not. Available at: http://www.ama-assn.org/resources/doc/rbrvs/ruc-is-ruc-is-not.pdf*

Podiatry in Texas Continued from page 4

The Texas Court of Criminal appeals interpreted Article 16, Section 31 as follows: Section 31 is a part of the Constitution of 1876, and has remained unchanged through the years. It is and has been the basis upon which has rested the legislative control over, and definition of, the practice of medicine. It furnishes the direct reason why the courts have steadfastly held that, if one treats or offers to treat, as a business, profession, or avocation, diseases or disorders of the human body -- by any method, system, or means -- he must first qualify himself to do so by taking the same examination that is required of all others doing the same thing, regardless of the system employed. Ex Parte Halsted, 182 S.W.2d 479 (Tex.Crim.App. 1944).

[8] *See TEX. OCC. CODE § 151.052 (emphasis added).*

[9] *TEX. OCC. CODE § 151.052(a)(5) (emphasis added)*

[10] *Act of March 6, 1923, 38th Leg., R.S.; Texas Orthopaedic Association v. Texas State Board of Podiatric Medical Examiners, 254 S.W.3d 714 (Tex.App.--Austin 2008, pet. denied.).*

[11] *TEX. OCC. CODE§ 202.001(a)(4)*

[12] *TEX. OCC. CODE§ 202.151 (The TSBPME "consistent with the law regulating the practice of podiatry, the law of this state, and the law of the United States to govern:...(2) the regulation of the practice of podiatry; and (3) the enforcement of the law regulating the practice of podiatry."*

[13] *Id.*

[14] *See Tex. Gov't Code § 2001.038(b).*

[15] *Combs v. Entertainment Publications, Inc., 292 S.W.3d 712 (Tex. App.--Austin, 2009)___).*

[16] *Texas Orthopaedic Association v. Texas State Board of Podiatric Medical Examiners, 254 S.W.3d 714 (Tex.App.--Austin 2008, pet. denied).*

[17] *Tex. Gov't Code § 2001.038(b).*

[18] *See 26 Tex. Reg. 2385, 2385-2390 (March 23, 2001); Texas Orthopaedic Association v. Texas State Board of Podiatric Medical Examiners, 254 S.W.3d at 718.*

[19] *Texas Orthopaedic Association v. Texas State Board of Podiatric Medical Examiners, 254 S.W.3d at 714-715. The case was appealed to the Texas Supreme Court, but the Supreme Court denied the petition; therefore the Third Court of appeals' invalidation of the rule was left to stand.*

[20] *Id. at 721 (emphasis added).*

[21] *Id. at n. 7 (emphasis added).*

[22] *See Texas Podiatric Medical Association, Cory Brown, DPM, and Martin V. Sloan, DPM v. Hendrick Medical Center, cause no. 25137-B, in the 104th Judicial District Court of Taylor County, Texas.*

[23] *See Interlocutory Judgment on Scope of Podiatry, Oct. 2, 2013, cause no. 25137-B, 104th Judicial District, Taylor County, Texas.*

[24] *See Ch. 37, Tex. Civ. Prac. & Rem. Code.*

[25] *Tex. Civ. Prac. & Rem. Code § 37.006(a).*

[26] *Id.*

Explanation of State Rules Concerning Peer Review Calls

By Andy Kant, MD

TOA realizes that many of our members are extremely frustrated with peer review phone calls. By the rules of the Texas Department of Insurance (TDI), the peer review physician must give a "reasonable opportunity" to the provider of record to discuss the services under review. This must occur during "normal business hours," which is the central time zone. In the case of El Paso, it would be the mountain time zone.

A documented good-faith attempt by definition of the TDI would indicate that a treating physician or consultant would have a "working day" to return the phone call of the peer review physician. Also, obviously if the physician does not answer the returned phone call, is not available, or does not call back once the treating physician or consultant calls, then no true peer review can take place.

The Division of Workers' Compensation (DWC) has a specific fax number and e-mail to which you may send these complaints. If your peer review physician does not provide a "reasonable opportunity" of a "working day" to return the phone call, is not available, does not call back when you return the phone call, or calls outside of normal business hours and then states "I left my phone number with the answering service," then these complaints should be filed directly to the DWC. They will compile the complaints and, if there is a specific utilization review agency or physician who violates these standards, the DWC will take action.

The complaint line to the DWC is fax 512.490.1030. The e-mail is dwc-crcintakeunit@tdi-texas.gov. As you see, the actual intake goes to the Texas Department of Insurance. There are forms that can be filled out, which you can download from the e-mail site. The link to file a complaint can also be accessed through www.tdi.texas.gov/consumer/complfrm.html. The complaint form can be found on this site.

If a peer review physician requests the Texas administrative code for reasonable opportunity, it is rule #19.2003 (28).

Physicians Assistants

*By Joshua Weaver and Ashley Johnston**

Notice: This material is provided for informational purposes only. The material provided herein is general and is not intended to be legal advice. Nothing herein should be relied upon or used without consulting a lawyer to consider your specific circumstances, possible changes to applicable laws, rules and regulations and other legal issues. Receipt of this material does not establish an attorney-client relationship.

Over the past few years, there has been an increase in the use of physician assistants ("PAs") by physicians in Texas and new laws have taken effect governing the use of PAs and the type of arrangements physicians may have with PAs. Physicians should pay careful attention to these laws when employing, supervising, contracting or entering into a business arrangement with PAs. This article discusses some of the general regulatory requirements physicians should keep in mind when employing or supervising PAs, as well as an overview of the laws governing medical practices that are jointly owned by physicians and PAs.

General Requirements for Physician Assistants

Medical Services Provided by a PA

All PAs practicing in Texas must be duly licensed by the Texas Physician Assistant Board. The practice of a PA includes providing medical services delegated by a supervising physician that are within the education, training, and experience of the PA. Medical services provided by a PA may include:

1. obtaining patient histories and performing physical examinations;
2. ordering or performing diagnostic and therapeutic procedures;
3. formulating a working diagnosis;
4. developing and implementing a treatment plan;
5. monitoring the effectiveness of therapeutic interventions;
6. assisting at surgery;
7. offering counseling and education to meet patient needs;
8. requesting, receiving, and signing for the receipt of pharmaceutical sample prescription medications and distributing the samples to patients in a specific practice setting in which the PA is authorized to prescribe pharmaceutical medications and sign prescription drug orders as permitted by law or authorized by PA board rule;
9. signing or completing a prescription as permitted by law; and
10. making appropriate referrals.

These activities may be performed in any place authorized by a supervising physician, including a clinic, hospital, ambulatory surgical center, patient home, nursing home, or other institutional setting.

It is important to note that a PA is the agent of the supervising physician for any medical services that are delegated by that supervising physician. All services performed by the PA must be within the PA's scope of practice and should be delineated by protocols, practice guidelines, or practice directives established by the supervising physician. This is important because a supervising physician may be liable for the negligence and bad acts of his or her PAs, especially if the delegated task was determined to be outside the PA's level of competence. Therefore, it is recommended that a supervising physician ensure that his or her professional liability policy covers the acts or omissions of the PAs.

Supervision of and Delegation to PAs

Each PA must have a supervising physician; however, the PA may have more than one supervising physician. Prior to supervising a PA, the PA and the supervising physician must notify their respective licensing boards of the supervision. Among other things, a supervising physician must notify the medical board of the physician's intent to supervise a PA and submit a statement to the Texas Medical Board that the physician will (i) supervise the PA according to the Texas Medical Board Rules and (ii) retain professional and legal responsibility for the care provided by the PA. The supervising physician must receive approval from the Texas Medical Board to supervise the PA. Each PA and the PA's supervising physician shall ensure that (i) the PA's scope of function is identified; (ii) delegation of medical tasks is appropriate to the PA's level of competence; (iii) the relationship between the PA and the supervising physician and the access of the PA to the supervising physician are defined; and (iv) a process is established for evaluating the PA's performance. Additionally, the PA must notify the Texas Physician Assistant Board of any changes in, or additions to, the person acting as the supervising physician within thirty (30) days of the change or addition. There are limits on how many PAs any one physician may supervise depending upon the location, but generally, a physician may supervise up to five (5) PAs or their full-time equivalents. The Texas Medical Board considers full time as no more than 50 hours per week.

Continued next page

The supervising physician oversees the activities of, and accepts responsibility for, medical services provided by the PA. Supervision of a PA by a supervising physician must be continuous; however, the supervision does not require the constant physical presence of the supervising physician where PA services are being performed. If a supervising physician is not present, the supervising physician and the PA must be, or must be able to easily be, in contact with one another by radio, telephone, or another telecommunication device. Additionally, except at a site serving medically under served populations as defined by law, a PA shall not practice at a site where that PA's supervising physician is not present at least 10 percent of the site's listed business hours.

A physician may delegate to a qualified and properly trained person acting under the physician's supervision any medical act that a reasonable and prudent physician would find within the scope of sound medical judgment to delegate if, in the opinion of the delegating physician (1) the act (A) can be properly and safely performed by the person to whom the medical act is delegated; (B) is performed in its customary manner; and (C) is not in violation of any other law; and (2) the person to whom the delegation is made does not represent to the public that the person is authorized to practice medicine. The Texas Board of Physician Assistants retains ultimate authority to determine whether an act constitutes the practice of medicine and whether a medical act may be properly or safely delegated by physicians.

Prescriptive Authority Agreements

In 2013, the Texas Legislature passed "Senate Bill 406," which amended the law in Texas as it relates to the delegation of prescriptive authority. In most circumstances, supervising physicians must enter into "Prescriptive Authority Agreements" with PAs and advance practice registered nurses ("APRN"). This law became effective on November 1, 2013 and so it is important to note that the law is already effective.

A Prescriptive Authority Agreement must meet certain minimum requirements in order to comply with Texas law. Generally, a Prescriptive Authority Agreement:

1. must be in writing and signed and dated by the parties;
2. state the name, address, and all professional license numbers of the parties;
3. state the nature of the practice, practice locations or practice settings;
4. identify the types or categories of drugs or devices that may be prescribed or the types of categories of drugs or devices that may not be prescribed;
5. provide a general plan for addressing consultations and referrals;
6. provide a plan for addressing patient emergencies;
7. state the general process for communication and the sharing of information between the physician and the APRN or PA;
8. if alternate physician supervision is to be utilized, designate one or more alternate physicians who may (A) provide appropriate supervision on a temporary basis in accordance with the Prescriptive Authority Agreement and Texas law; and (B) participate in the prescriptive authority quality assurance and improvement plan meetings required by Texas law; and
9. describe a prescriptive authority quality assurance and improvement plan and specify methods for documenting the implementation of the plan that includes the following: (A) chart review, with the number of charts to be reviewed determined by the parties; and (B) periodic face-to-face meetings between the parties.

The periodic face-to-face meetings between the APRN or PA and the physician must:

1. include the sharing of information relating to patient treatment and care, needed changes in patient care plans, and issues relating to referrals and must include discussion of patient care improvement; and
2. be documented and occur on at least a monthly basis for at least a year initially and then eventually, depending on the PA's experience and history, occur quarterly with monthly meetings by means of a remote electronic communications system.

Each party to a Prescriptive Authority Agreement must retain a copy of the Prescriptive Authority Agreement until at least the second anniversary of the date the agreement is terminated. In the event a party to a Prescriptive Authority Agreement becomes the subject of an investigation by the Texas Medical Board, Texas Board of Nursing or the Texas Physician Assistant Board, the individual shall immediately notify the other party to the Prescriptive Authority Agreement. Additionally, the Prescriptive Authority Agreement and any amendments must be reviewed at least annually, dated, and signed by the parties. The law requires the Texas Medical Board to maintain a searchable online list of physicians, APRNs and PAs who have entered into a Prescriptive Authority Agreement.

Jointly-Owned Practices

In 2011, Texas passed a law that allows PAs to jointly own a professional association or professional limited liability company ("business entity") with a licensed physician so long as the PAs do not own a majority of the entity, either individually or collectively and so long as the PAs do not interfere with the practice of medicine by a physician owner or interfere with the supervision of PAs by a physician owner. The law is clear that a person not licensed as

a physician may not practice medicine or direct the activities of a physician in the practice of medicine.

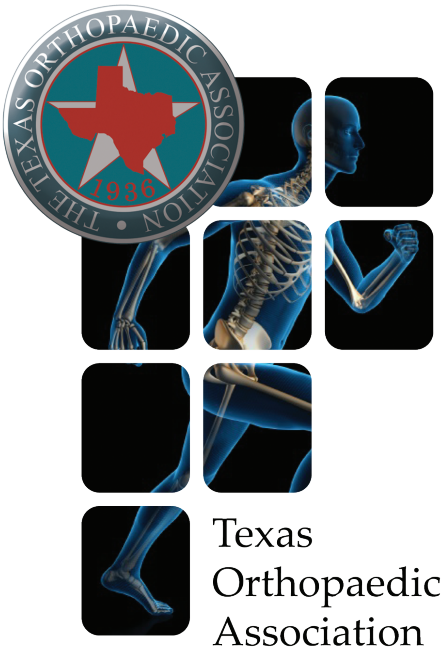
If physicians choose to jointly own an entity with PAs, only physicians can organize, control and manage the business entity. No PA may serve as an officer of the business entity. Further, no PA may own a larger percentage of the business entity than any physician. There are other requirements regarding jointly-owned practices between physicians and PAs. Therefore, it is recommended that you consult with competent health care counsel prior to entering into any jointly-owned arrangement.

A PA who jointly owns an entity with a physician shall report the ownership annually to the Texas Physician Assistant Board.

Summary

Any physician who employs or contracts with a PA should ensure that his or her relationship with the PA complies with Texas law. Among other things, the physician should make sure that the PA's duties are within the scope of the PA's expertise, a Prescriptive Authority Agreement is entered into if required, and the PA is properly supervised. Further, if a physician wishes to jointly own an entity with a PA, the physician should take great care to ensure that the entity is formed and operated in accordance with Texas law.

**About the authors: Josh Weaver and Ashley Johnston are health care attorneys who advise doctors, hospitals, surgery centers and other health care providers on day-to-day operational and regulatory matters. Both Ashley and Josh are Board Certified in Health Law by the Texas Board of Legal Specialization. Josh can be reached at (214)661-5514 and his e-mail address is jweaver@polsinelli.com. Ashley can be reached at (469)320-6061 and her e-mail address is ajohnston@grayreed.com.*



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