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Editor's Note

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I am reading a book called The 5000 Year Leap by W. Cleon Skousen - a discussion of the 28 Principles of Freedom our founding fathers realized were critical to the success and prosperity of the fledgling union known as the United States of America. It is certainly timely reading as we head towards the culmination of this election season. Early in my reading one quote really stood out: "The choice before us is plain..... I am rather tired of hearing about our rights and privileges as American citizens. The time is come, it now is, when we ought to hear about the duties and responsibilities of our citizenship." (Peter Marshall, The Rebirth of America, 1986)

Well a statement like that is kind of like preaching to the choir if it happens to be directed at members of the TPMA. I can think of no other organization or group of people that I have ever been a part of that gives more freely of their time, their knowledge and their resources than our association! In my mind, our membership treats "duties and responsibilities" as synonymous with "rights and privileges". I like that; I respect that; and I enjoy being a part of that. As you read through many of the reports in this newsletter the responsibility we have to our profession and to the citizens we serve will clearly shine through.

In another quote early on in the book, Patrick Henry said: "I have but one lamp by which my feet are guided; and that is the lamp of experience. I know of no way of judging the future but by the past." So during these last few days before our local elections, let's all get out there and support a local candidate or a local issue. We all need to participate now to help assure that years from now when we look back, we can appreciate our future prosperity has been the direct result of our commitment and actions of the past (right now, today!!).

Please take care and have a productive 4th quarter doing what we all do best!



President's Message

Martin Sloan, DPM

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TSBPME Meeting Report



As of 8:30a.m. Monday morning we have still been unable to reach an agreement with TOA/TMA on the proposed legislation. During Public Comments TOA/TMA was asked to report on the progress as well as TPMA. Both sides indicated that no agreement had been reached yet.

The TSBPME asked us to meet together (with representatives of TSBPME) to see what still needs to be resolved before an agreement can be reached. To make a long story short, and after a two hour meeting, there are several issues that we jointly have agreed to try to resolve and a TOA/TMA/TSBPME and TPMA conference call has been scheduled for either November 19th or 24th depending on schedules. At that time we will try to resolve and fine tune the outstanding issues, and reach an agreement that can be presented to the TSBPME at a special called meeting shortly thereafter. If everything goes well with the negotiations, we should be able to present a unified front to the TSBPME at a meeting in early December whereby we will agree to the terms of Legislation as well as the terms and conditions of the Settlement Agreement so the TSBPME can sign on to the agreement in a specially called meeting (around December 8th or so is the tentative plan).

Although it did not happen today, we are supportive of the TSBPE Board members and to the representatives of TOA/TMA for their willingness to reach a potential settlement. But we are on a short fuse to get this accomplished and have relied on advice of our legal representatives to let it work if possible. We are still bound by our confidentiality agreement and will tell you more as the negotiations develop.

Upcoming Conference

TPMA & Dallas County
Winter Conference
January 22-24, 2010
Dallas, Texas





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Report on the APMA Podiatry Contractor Advisory Committee Meeting

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The APMA Podiatry Contractor Advisory Committee and Private Insurance Advisory Committee met in Bethesda, Maryland on October 15th – 17th. The meeting provided the profession with very useful information we can use going forward.

The first lecturer we heard was from Supervisory Special Agent (SSA) Larry Guerin of the FBI Healthcare Fraud Unit. Agent Guerin had been posted in Dallas and now serves as part of the White Collar Fraud Unit in Washington, DC. Other divisions of that unit are Asset Forfeiture and Money Laundering Unit, Economic Crimes Unit (non-healthcare fraud) and the National Mortgage Fraud Team.

SSA Guerin explained that when the FBI receives a complaint the agent investigating sends a memo to their headquarters within 30 days describing the issues. Currently he said there are 250 field agents and an additional 200 support staff in the Health Care Fraud Unit. The FBI has no monetary thresholds for cases as per national FBI policy. However some regions may have limits that are in place for cases that those regions must meet before investigations will continue.

SSA Guerin said that healthcare fraud is the deliberate submittal of false claims to private or public healthcare insurance plans. Health care fraud continues to plague the US with losses exceeding \$130 billion annually and podiatry is on their radar. His figures noted that Medicare pays \$968 million for nail debridement each year. SSA Guerin then said that from his reviews only 1 in 4 cases sampled had documentation and 7.35% of sampled documents had inadequate documentation. He finished his talk by relating the last podiatry case he worked while stationed in Dallas.

Again this year we heard from Julie Kass, a lawyer with the APMA consulting firm of Ober/ Kaler. She spoke to the group about the possible decrease in Medicare fees, the newest changes to the Stark rules and the changes to False Claims Act and Voluntary Disclosure Programs.

CMS will publish in November the 2010 Medicare fees as determined by the Secretary of the Department of Health and Human Services (DHHS). She anticipated that those fees will go from a unit value of \$36.066 in 2009 to \$28.3208 in 2010 or a 21.5% reduction unless Congress fixes this problem. The rule should also reduce payments for high cost imaging services and require providers of the technical component of advanced imaging services to be accredited.

Of great importance to physicians is the elimination of all consultation code billing to the Medicare program. Physicians will now be required to bill these consulta-

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tion visits as new patient or established evaluation and management out-patient visits, hospital visits or nursing home visits. The reason for this change is that "transfer of care" issues for consultations are not being correctly adjudicated by all Medicare jurisdictions. She said the rules should increase office visits fees by 6% and the hospital and nursing home visits fees by 2% next year.

Beginning in 2010, a physician signature is not required on requisitions for clinical laboratory testing. However there must be evidence the physician ordered the test that would typically be found in the medical record. However, beginning in 2010 the physician must sign the orders for X-rays, CT, MRI and technical component of pathology services.

The Stark rules involve several changes. The first is the "stand in the shoes" exceptions to the self-referral issues. The other are issues dealing with office space and equipment leasing. The new rules amends four compensation exceptions: office space lease arrangements, equipment lease arrangements, fair market value compensation arrangements, and indirect compensation arrangements. You should discuss how these Stark rules will affect your practice by talking about these issues with your health care attorney.

Then Ms. Kass discussed the Fraud Enforcement and Recovery Act of 2009 (FERA) that increased the scope of False Claims Act (FCA). She then mentioned this new law states that failure to return overpayments could subject a provider to penalties under the FCA including treble damages.

Mr. Howard Sollins, also from Ober/Kaler, spoke about the importance of using the correct place-of-service (POS) code on your insurance forms. He said the POS code will determine which ancillary services can be provided. His example was if you can have your assistant go to a patient's apartment in an assisted living center. In this example, no billing can occur because assistants cannot bill "incident to" a physician's service in POS 12 without the doctor being present.

He also reported that POS 24 (Ambulatory Surgery Center - ASC) can only be used when the ASC has an agreement with CMS under Medicare rules to participate as an ASC and meets the conditions of an ASC. This means the ASC is now regarded as a distinct legal entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization. These POS problems are included in the 2009 work plan of the Office of the Inspector General (OIG) of the DHHS.

We received an updated report about the Recovery Audit Contractors. This federal program is now nationwide. The contractor for Texas is Connolly Consulting. They went "live" this past March 1st. The RAC are paid on a contingency basis. For our region, they will receive approximately 9% of their collections.

We learned the RAC can ask for 10 medical records every 45 days if you are a solo practitioner, 20 medical records every 45 days if you have 2-5 professionals in the practice, 30 medical record if there are 6-15 professionals in the practice and 50 medical records every 45 days if there are 16 or more professionals in the practice. The RAC can continue to request medical records every 45 days

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until they feel there is no further overpayment of monies is found. Since the RAC can go back 3 years, the clock is already running. We were told since the feds are doing this program, we should expect the private carriers to do the same if overpayments are found. The feeling is if there is miscoding and overpayments from Medicare those are also occurring on the private side as well.

The RAC web site should have an issues "tab" so you can see what they are problems they are looking at. You need to get your RAC response process in place now so you'll be prepared to answer them should you get a demand letter. No one is exempt from the RAC process. Be proactive and go through a mock audit. We were told the errors are: 35% - incorrect coding; 7% - no documentation; and 40% - medically unnecessary services.

Keven West, JD talked to the group about Medicare audits. He recommended everyone use the defense offered as part of their medical malpractice coverage. Mr. West said podiatry has been and continues to be a highly audited medical specialty. He said the most commonly audited codes are: 11720/11721, all the E/M Codes with or without the -25 modifier, 11730, 1104x series, 11060/11061, 1105x series, and 9924x series.

David Freedman, DPM of Silver Spring, Maryland presented this year's BMAD data report. As had been found in the past, nationally 11721 remains podiatry's most billed code in 2008 followed by 99213, 99212, 11056, 99203, 11720, 11730, 11750, 99202, and 11040. In 2008 Texas podiatrists billed 99213 followed by 11721, 99203, 99212, 11750, 99202, 11730, 11056, 99214, and 11720.

Paul Kesselman, DPM spoke to the group about DME coverage. He recommended that practices give their patients the 26 Medicare Standards even though only 21 of those standards affect physician suppliers. The newest 5 have to do with accreditation and surety bond coverage.

He then spoke about "Closet Arrangements" where a vendor stocks your office with DME items and supplies. In this arrangement, when you need to dispense DME, that company will bill out DME when you give the item or supply to the patient and the company with a prescription for the DME. Medicare now says the person doing the dispensing must also be doing the billing. The closet arrangements are no longer an appropriate arrangement as deemed by Medicare. He expects private insurers will also soon follow the same rules. In addition, if you dispense DME items from ASC or hospital, that is the dispensing site. Under these rules they are now responsible. So he expects the widespread practice of physicians dispensing DME at the time of surgery when performed in the ASC or hospital to cease.

Dr. Kesselman recommended if you have an on-site inspection for DME to get a picture ID and phone numbers so you can call the issuing agency to get verification. He then spoke about going to the Pricing, Coding Analysis, and Coding contractor (PDAC) instead of listening to suppliers and salesmen on billing DME supplies. Inevitably physician suppliers are given the wrong information concerning coding and billing DME items. The PDAC reviews all DME items sent them and provides the manufacturer with a letter about the correct coding.

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That letter is available and downloadable from the PDAC.

He reminded us that surgical dressings are not covered for nails or warts because those sites are not full thickness wounds (Waggoner Grade III or IV). Dr. Kesselman's recommendation was to bill the patient cash for those items.

Regarding Diabetic Therapeutic Shoe Program, Dr. Kesselman advises physician suppliers to use their own name and NPI number in CMS 1500 block 17 and 17a. He states it is incorrect to use the referring physician's name in those blocks. Doing so may result in denials based on claim reviews.

Next Dr. Kesselman had a lengthy discussion concerning the Provider Enrollment, Chain and Ownership System (PECOS). Every physician must be in the PECOS system. If you have filled-out a CMS 855 in the past 3- 5 years you may already be in the system. However if you have not recently filled-out a CMS 855 or made any changes to your Medicare enrollment, you might need to go through the PECOS process. It will also be important that your referring physicians are also in PECOS. Medicare is conducting a match on every claim filed. Right now check your explanation of Medicare benefits to see if there is a warning message about PECOS. You will be receiving error messages during Phase 1 until December 31st indicating there is a problem. However beginning with Phase 2 on January 1, 2010, claims will be denied if you or the referring physician is not in PECOS.

Those error codes are:

N264 (missing/incomplete/invalid ordering physician provider name); and
N265 (missing/incomplete/invalid ordering physician primary identifier).

APMA will be providing information about the PECOS system and what each office needs to do to be sure of compliance. Once that document comes out, time will be of the essence so don't wait. Read it and follow its instructions explicitly and quickly. So watch for that information from APMA.

PIAC REPORT

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I had the privilege of representing Texas, along with Dr. Paul Kinberg, at the CAC-PIAC meeting sponsored by APMA in Bethesda, Maryland from Oct. 15-17. Dr. Kinberg has provided a report on the Medicare (CAC) portion of the meeting, which was clearly the majority of the meeting. I will provide a report on the PIAC portion, which deals with private insurance payors.

A very interesting presentation was given by Eileen Quenell, health & welfare consultant for Towers Perin Human Capital Group. She differentiated between "fully insured plans" which offer no flexibility regarding benefits. With these plans, the risk is retained by the insurer. They

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must provide state mandated benefits and have standard plan offerings. This is in comparison with "self insured plans" which offer much greater flexibility in providing benefits. In other words, if the employer wants it, the plan can provide it.

When an employer sits down to design a plan, simplicity rules. They want comprehensive benefits, with extensive provider networks with optimal discounts. Most of the time they take the recommendations of the insurance company when making these decisions. Generally, employers review plans every 3 years and/or if they are changing vendors. Here lies an opportunity for APMA; we need to somehow partner with the vendor (or with the employer) to make sure that podiatry coverage is offered with the same benefits as other medical/surgical specialties. She described this opportunity as "getting a seat at the table". It has been determined that the only real means to control health care costs is improving the health status of the public. A focus is being put on employees to be personally accountable for their own health. Podiatry has an opportunity to involve itself in assisting employers in establishing walking programs for employees, weight control through exercise, smoking cessation in preventing PAD, diabetes foot care education, etc.

She identified the "Big 4" insurance companies as BC/BS, Aetna, UHC, and Cigna. She felt that Cigna would be the most receptive to new ideas. She emphasized that the bottom line for employers is its ROI or "return on investment". They want to see results!

Our own Dr. Kinberg gave a report as Chair of the APMA Coding Committee. He announced that the American Academy of Professional Coders is writing a "certification" exam on behalf of APMA. If anyone has the desire to become certified in coding, this would be the opportunity. More information regarding this will be forthcoming in the next few months.

He indicated that there is now a code that some insurers are accepting for plaster impressions when fabricating orthotics. That code is S0395 and it should be billed with left & right modifiers. It is being accepted by Cigna, BC/BS and UHC. On the topic of orthotics, a meeting was going to be held by representatives of APMA to discuss proper coding for orthotics, specifically referring to the L30XX codes. I am sure a report on that will be sent out to membership in the near future.

An excellent presentation was given by Dr. Frank Case, a podiatrist practicing in California, on the "Essentials of Appeals". He emphasized that everyone should read the contracts before signing them. Contracts need to have specific provisions for timely filing, penalties, & timeliness in receipt of payments. Also, if a practitioner follows the guidelines regarding predeterminations of benefits and pre-authorizations, then the services must be paid by the insurer.

He discussed the "pros & cons" of contracting with insurance companies/health plans. He discussed the "appeals process" itself. He prefaced his remarks by saying that this information may pertain to California only and that every state

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may have its own set of rules when it comes to filing an appeal. In general, he recommends:

1. Calling the insurer- record the person's name, date & time of call and get a tracking number for the conversation.
2. Get to know supervisors/managers- they can help get claims paid.
3. Record the discussion if dealing with a "repeat offender"; if continue to get claim denials despite preauthorizations, etc.
4. Get patient involved- 3 way call.
5. Send letter to health plan when receiving EOB in dispute ASAP. Letter should explain clearly why you are disputing the payment or lack thereof.
6. With letter, send copy of original HCFA 1500 and copy of EOB.
7. Provide supporting documentation- ie. Progress notes, op report, etc.
8. Don't appeal if you can't justify your billing!!

Health plans will pay if:

1. You can demonstrate that they violated your contract with them.
2. You can demonstrate that they violated state law and/or accepted coding guidelines.
3. You can demonstrate that they previously paid for the same service/procedure on other patient claims.

If they still don't pay:

1. Request letter indicating criteria used for denial or modification of claim
2. Request re-review by Board Certified DPM
3. Send letter to state board of insurance.
4. Send letter to state podiatry society
5. Legal – arbitration or lawsuit

Kelli Black, an attorney who is a consultant to APMA, gave a presentation on "participating in provider networks". She differentiated between primary and secondary networks. In primary networks, providers are considered "preferred" and members (patients) are given financial incentives (lower copays, etc) to see physicians in that network. Providers will typically sign up for these networks to increase patient volume in return for providing services at a "discounted" or lower fee. Physicians will be listed as "preferred providers" in plan directories. Primary networks may be contracted directly by the health plan or they may be rented or leased from an network administrator, such as a PPO.

Secondary networks, are plans that access discounts when their members receive services from providers not in the plan's primary network. Secondary networks are a mechanism used by insurers to control expenses when members obtain services "out of network". A contract with a network administrator obligates the physician to participate in such networks. Any contract that does not obligate the network or its contracted health plan to provide for some sort of "patient steerage" mechanism, such as lower cost sharing, may open the physician to participation in a secondary network.

Some health plans will educate members that if they see "non preferred" providers in their secondary network, the members cost sharing will be less. The member's insurance card may include the logo of the secondary network and

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members may be directed to a secondary website to look up secondary network providers.

If the amount of payment to the provider is not sufficient, participation in a secondary network will never be desirable. Physicians are generally obligated to hold patients harmless and are prohibited from balance billing. On the other hand, physicians who are part of a secondary network may be paid more promptly than if the physician has no relationship with the plan.

The difference between a secondary network and a "silent PPO" is a contract. Silent PPOs take discounts they are not entitled to take. Growing number of states have laws outlawing "silent PPOs" or calling for transparency with secondary networks.

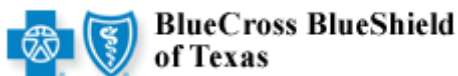
If a physician is truly "out of network" there is no contractual obligation with the plan or network administrator to participate in the plan's primary or secondary network. In these cases, the physician is regulated only by state & federal law. Unless the law states otherwise, the physician can bill patient for unpaid charges and there is no "hold harmless" obligation.

When considering new health plans or networks follow these guidelines:

1. Go online and look at type of "products" the plan/network offers to health plans. If it includes "repricing" or secondary networks, proceed with caution.
2. If you wish to participate in primary network only, make sure that the contract obligates the plan/network administrator to make you a preferred provider by including you in the plan directories to provide patient steerage.
3. When examining a contract, determine to whom you are agreeing to provide discounted services. The contract may say that you are obligated to provide services to members of the PPO or that you are obligated to provide services for "all payors or members of "payors". The narrower and clearer the definition, the better.
4. Make sure the assignment clause is as narrow as possible to avoid allowing the network to inappropriately assign its ability to pay at discounted rates to other organizations.
5. Ensure that you can terminate without cause and avoid particularly long waiting periods to terminate the agreement. Make sure termination date is not tied to renewal dates; you want to see clear 60-90 day period.
6. Keep all copies of contracts. Refer to the contract to make sure organization is in compliance with the agreement.
7. If terminating an agreement/contract, do it in accordance with the termination provisions and obtain proof of receipt of termination notice (send certified with return receipt).

I hope this information is helpful to TPMA membership. As always, it is an honor to be of service and thank you for the opportunity.

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Title: Non-Operative Spinal and Musculoskeletal Ultrasound

Number: RAD602.016

Effective Date: 09-01-2009

Legislation:

ILLINOIS: None

NEW MEXICO: None

OKLAHOMA: None

TEXAS: None

FEDERAL (applies to all Plans): None

Contract:

Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there is any exclusion or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Coverage:

Non-operative diagnostic spinal ultrasound (SUS) **may be considered medically necessary** to evaluate congenital anomalies of the spine and spinal cord (e.g., spinal bifida, spinal dysraphism [SD]) in newborns and infants two years of age or younger. Non-operative musculoskeletal ultrasound **is considered experimental, investigational and unproven** for other musculoskeletal indications including but not limited to:

- back pain;
- radicular symptoms (e.g., disk herniation, spinal stenosis and muscle nerve root pathology);
- muscle injury (e.g., contained and complete muscle ruptures and partial tears);
- tendon injuries (e.g., shoulder, elbow, knee, ankle and Achilles tendon);
- bursae and synovial sheath pathology;
- ligament injury;
- peripheral nerve lesions or nerve entrapment syndromes (e.g., median nerve compression at the carpal tunnel, ulnar nerve compression at the elbow or at Guyons canal);
- congenital anomalies for an individual over the age to two years;
- inflammation;
- foreign bodies.

Codes:

CPT Codes: HCPCS Codes:

76800, 76880, 76885, 76886 None

ICD-9 Diagnosis Codes: ICD-9 Procedure Codes:

Refer to the ICD-9-CM manual Refer to the ICD-9-CM manual

Description:

Ultrasound imaging, also called ultrasound scanning or sonography, involves exposing a part of the body to high-frequency sound waves to produce pictures of the inside

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of the body. The ultrasound transducer functions as both a loudspeaker to create the sounds and a microphone to record them. When the transducer is pressed against the skin, it directs a stream of audible, high-frequency sound waves into the body. As the sound waves echo from the body's fluids and tissues, the sensitive microphone in the transducer records tiny changes in their pitch and direction. These signature waves are instantly measured and displayed by a computer, which then creates a real-time picture on the monitor. Because ultrasound images are captured in real-time, they can show the structure and movement of the body's internal organs, as well as blood flowing through blood vessels. Ultrasound imaging is a noninvasive medical test that helps physicians diagnose medical conditions, and ultrasound exams do not use ionizing radiation.

Diagnostic musculoskeletal ultrasound is a versatile technique for examining soft-tissue pathology. Ultrasound has the advantage of being readily available and inexpensive, and providing detailed information on superficial skeletal structures. Although musculoskeletal ultrasound has been performed since the 1970s, use has not been in high demand due to the constraints of an ultrasound system's spatial resolution. The new generation of real-time ultrasound coupled with advances in transducer technology now allows improved superficial skeletal soft tissue resolution. However, the performance of ultrasound on the musculoskeletal system requires a thorough knowledge of anatomy. The use of diagnostic ultrasound is also equipment and operator dependent with a steep learning curve. Ultrasound images of the musculoskeletal system may be useful to help diagnose and treat:

- tendon tears, such as tears of the rotator cuff in the shoulder or Achilles tendon in the ankle;
- abnormalities of the muscles, such as tears and soft-tissue masses;
- bleeding or other fluid collections within the muscles, bursae and joints;
- small benign and malignant soft tissue tumors;
- early changes of rheumatoid arthritis.

In newborns and infants, various tumors and vascular disorders, especially vascular malformations, can be detected with spinal ultrasound (SUS). In newborns up to six months of age, spinal cord lesions can be detected with SUS because the posterior elements are membranous rather than bony. Beyond this age, these elements calcify and generally SUS would then need to be complemented with another imaging modality. Early evaluation and differentiation of spinal dysraphism (SD) (e.g., neural tube defects) is possible. Spinal dysraphism is a general term used to describe a collection of congenital abnormalities that include defects in the vertebrae and underlying spine or nerve roots. Spinal dysraphism may include myelocoele, meningocele, myelomeningocele, and spina bifida. Spina bifida may be associated with various cutaneous abnormalities, such as lipoma, hemangioma, cutis aplasia, dermal sinus, or hairy patch, and it is often associated with low-lying conus and other spinal cord anomalies. SUS can evaluate the subcutaneous structures and allow for recognition of abnormal spinal canal development, including spinal cord abnormalities. Even in older children, the presence of abnormal skull dimples, pores, or hair tufts can be evaluated for underlying spinal dysraphism. Rarely, SUS can be useful in evaluating spinal neoplasm or syrinx development.

Rationale:

There is sufficient evidence in published peer reviewed literature to support the use of spinal ultrasound (SUS) for specific indications. Intraoperative spinal ultrasound is a useful modality, aiding in diagnosis and treatment planning of several spinal conditions. The use of non-operative ultrasound on newborns and infants is effective in diagnosing suspected occult (OSD) and non-occult spinal dysraphism (SD), spinal cord tumors, vascular malformations and birth-related trauma. There is insufficient evidence in the peer-reviewed medical literature establishing the value of nonoperative spinal/paraspinal ultrasound in adults.

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In 1998 Nazarian and colleagues performed sonographic studies on a control group of 23 asymptomatic patients and 59 patients with neck pain (n=15), low back pain (n=21) and both neck and low back pain (n=23). Of the four radiologists reading the images, the scores for assessment did not differ significantly. For soft tissues adjacent to the lumbar spine, no relationship was found between symptoms and sonographic appearance by any of the four radiologists. For cervical spine facets, a significant relationship between echogenicity and cervical pain was seen by only one reader. However, the odds ratio indicated that when this reader detected an abnormal facet the patient was four times less likely to have pain. For both cervical and lumbar spine facets, findings also indicated poor agreement and unreproducibility. The authors concluded that paraspinal ultrasonography is neither a sensitive nor a specific modality for evaluating patients with back pain and should be considered investigational.

In a March 2003 review article Dick and colleagues discussed the role of spinal ultrasound in children. The authors stated that spinal ultrasound is used in diagnosing occult and non-occult SD, evaluating spinal cord tumors and vascular malformations and in cases of birth-related trauma. Spinal dysraphism, the most common congenital abnormality of the central nervous system, covers a spectrum of congenital disorders. Spinal ultrasound can be used as a screening test to detect OSD in neonates with either SD-associated syndromes, such as anorectal and urogenital malformations, including the VATER group (i.e., vertebral defects, anal atresia, tracheoesophageal fistula, radial defects and renal anomalies) or cutaneous markers (e.g., atypical dimples, skin tag or tail, hemangiomas, hairy patches). Infants with simple midline dimples of >5 mm in diameter within 2.5 centimeter of the anus do not need spinal ultrasound. The authors suggest that SUS be used as the primary screening tool, reserving Magnetic resonance imaging (MRI) for cases where SUS is equivocal or has revealed a definite abnormality.

A retrospective study by Hughes and colleagues evaluated the role of SUS in detecting OSD in neonates and infants, and the degree of agreement between ultrasound (US) and MRI findings. Eighty-five consecutive infants had SUS over 31 months. Of these, 15 patients (mean age 40 days) had follow-up MRI. Six out of 15 (40%) ultrasound examinations showed full agreement with MRI, 47% had partial agreement, and 13% had no agreement. US failed to visualize four of four dorsal dermal sinuses, three of four fatty filum terminales, one of one terminal lipoma, two of four partial sacral agenesis, three of four hydromyelia and one of 10 low-lying cords. The authors stated that agreement between US and MRI was good, particularly for the detection of low-lying cord (90%) and recommends US as a first-line screening test for OSD. They stated that if US is abnormal, equivocal or technically limited, MRI is advised for full assessment.

The American Academy of Neurology's (AAN) Therapeutics and Technology Assessment Subcommittee developed a statement on spinal ultrasound (1998, reaffirmed October 2003) in response to numerous inquiries from neurologists questioning the utility of spinal ultrasound in evaluating back pain and radicular disorders. After conducting a literature search and collecting expert opinion, the AAN concluded that it could not recommend the procedure for use in the clinical evaluation of such patients. As part of the AAN's 1998 research and included in the AAN's 1998 document, the American College of Radiology (ACR) submitted the following adopted statement on spinal ultrasound: "Over the past several years interest has developed in the use of ultrasound technology for the evaluation of the spine and paraspinal regions in adults. While diagnostic ultrasound is appropriately used intra-operatively; in the newborn and infants for the evaluation of the spinal cord and canal, and for multiple musculoskeletal applications in adults, there is currently no documented scientific evidence of the efficacy of this modality in the evaluation of the paraspinal tissues and the spine in adults."

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The American Chiropractic Association (ACA) ratified the following policy, titled "Diagnostic Ultrasound of the Adult Spine", in May 1996 and this position has not been updated:

"Diagnostic Ultrasound has been shown to be a useful modality for evaluating certain musculoskeletal complaints. Fetal, pediatric and intra-operative applications have been published in the scientific literature. The quality of ultrasound images is extremely dependent on operator skill. The resolution abilities of the equipment may have an impact on diagnostic yield and accuracy. Consequently, the importance of training to establish technologic as well as interpretive competency cannot be understated. The application of diagnostic ultrasound in the adult spine in areas such as disc herniation, spinal stenosis and nerve root pathology is inadequately studied and its routine application for these purposes cannot be supported by the evidence at this time."

The American Institute of Ultrasound in Medicine (AIUM) Official Statement titled Non-operative Spinal/Paraspinal Ultrasound in Adults (2002) states: "There is insufficient evidence in the peerreviewed medical literature establishing the value of non-operative spinal/paraspinal ultrasound in adults. Therefore, the AIUM states that, at this time, the use of non-operative spinal/paraspinal ultrasound in adults (for study of facet joints and capsules, nerve and fascial edema, and other subtle paraspinal abnormalities) for diagnostic evaluation, for evaluation of pain or radiculopathy syndromes, and for monitoring of therapy has no proven clinical utility. Nonoperative spinal/paraspinal ultrasound in adults should be considered investigational."

Musculoskeletal diagnostic ultrasound is a rapidly developing imaging technology widely used in both industrialized and developing countries. For certain diagnostic applications, ultrasound has replaced commonly used radiographic imaging techniques as the method of choice and it has also made possible new areas of diagnostic investigation. Moreover, equipment for ultrasound imaging tends to be cheaper and more widely available than imaging equipment requiring the use of ionizing radiation. This combination of factors has resulted in the proliferation of diagnostic ultrasound units, and in some cases their use by individuals without proper training, or under conditions of inadequate control. Imaging of superficial soft tissue structures is not yet widely practiced by the general medical community in the United States.

In the French Journal de Radiologie, Mouterde et al made the following statement regarding contrast enhanced ultrasound in musculoskeletal diseases:

"Contrast-enhanced US can be used for the study of musculoskeletal diseases but this application still belongs to clinical research. Despite a theoretical value for the identification of microvascularity, the technical limitations of musculoskeletal US are challenging the use of contrast enhanced US. This can explain the slow development of this application and the reason why it remained limited to the assessment of Doppler signal intensity increase. However, the recent availability of real time contrastenhanced US imaging and quantification data is very promising. The majority of published papers involves rheumatoid arthritis and demonstrates the value of this technique to improve diagnosis, stage the activity of the disease and follow the patients under therapy. These preliminary studies are extending to other disorders (inflammatory arthritides as well as degenerative disorders). Structures other than articular synovium are undergoing investigations (bone, enthesis). New applications are being developed such as contrast-enhanced US of muscular diseases. This new imaging technique appears to have great potentials for the assessment of musculoskeletal diseases."

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Taggart et al. states in an article in *Rheumatology* that despite the increasing use of musculoskeletal ultrasound (MUS) as a clinical tool in rheumatology, there is no consensus as yet with regard to the standards required to achieve a basic level of competence in the use of this imaging technique. A number of sonographers worldwide are developing curricula and standardizing teaching methods in order to improve training in MSUS for rheumatologists. In the meantime, clinicians are devising informal means of training in order to acquire these new skills. The development of recognized training programs and international standards of competency are important goals on the way to achieving more widespread acceptance of MSUS as a useful tool in everyday clinical practice.

Joshua, et al. reported in a retrospective review of the performance characteristics of power Doppler ultrasound as a diagnostic and monitoring tool in the assessment of musculoskeletal disease through a systematic review of the literature. The study concluded that although the majority of research reports of power Doppler ultrasound assessment of the musculoskeletal system evaluated validity, less than half reported reliability and responsiveness. Further work is needed to evaluate power Doppler ultrasound assessment of the musculoskeletal system before it can be used to guide clinical decisions or be used as an endpoint in clinical trials.

Pricing:

None

References:

Goodkin R., Haynor, D.R., et al. Intraoperative ultrasound for monitoring anterior cervical vertebrectomy. *Journal of Neurosurgery* (1996 April) 84(4):702-4.

Gibbon, W.W. *Musculoskeletal Ultrasound*. Baillieres Clinical Rheumatology (1996 November) 10 (4):561-88.

Rhodes, D.W., and P.A. Bishop. A review of diagnostic ultrasound of the spine and soft tissue. *Journal of Manipulative and Physiological Therapeutics* (1997 May) 20(4):267-73.

WHO—T raining in diagnostic ultrasound: essentials, principles and standards. Report of WHO study group. *World Health Organization Technical Report Series* (1998) 875:i-46; back cover.

Review of the literature on spinal ultrasound for the evaluation of back pain and radicular disorders. Report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology. *Neurology* (1998) 51:343-44. (Reaffirmed 2003 October 17).

Nazarian, L.N., Zegel, H.G., et al. Paraspinal ultrasonography: lack of accuracy in evaluating patients with cervical or lumbar back pain. *Journal of Ultrasonic Medicine* (1998) 17(2):117-22.

Maiuri, F., Iaconetta, G., et al. Intraoperative sonography for spinal tumors. Correlations with MR findings and surgery. *Journal of Neurosurgery and Science* (2000 September) 44(3):115-22.

Hara, Y., Tamaki, N., et al. A new technique for intraoperative visual monitoring during spinal surgery: angiofiber and endoscopic ultrasonography. *Journal of Clinical Neuroscience* (2001 July 8) 8(4):347-50.

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Woydt, M., Vince, G.H., et al. New ultrasound techniques and their application in neurosurgical intraoperative sonography. *Neurology Research* (2001 October) 23(7):697-705.

Nonoperative spinal/paraspinal ultrasound in adults—AIUM. Laurel, Maryland: American Institute of Ultrasound Medicine (2002 June). <www.aium.org>.

Lerch K., Volk, M., et al. Ultrasound-guided decompression of the spinal canal in traumatic stenosis. *Ultrasound in Medicine and Biology* (2002 January) 28(1):27-32.

Woydt, M. Intraoperative Sonography in Neurosurgery. University of Würzburg, Department of Neurology. Würzburg, Germany (2000) (Accessed January 2007). <<http://healthcare.siemens.com>>.

Woydt, M., Vince, G.H., et al. New ultrasound techniques and their application in neurosurgical intraoperative sonography. *Neurological Research* (2001 October) 23(7):697-705.

Nonoperative Spinal/Paraspinal Ultrasound in Adults—Official statement. (2002 June) Laurel, Maryland: American Institute of Ultrasound in Medicine (Accessed 2007 October) <<http://www.aium.org>>.

Diagnostic ultrasound of the adult spine—ACA, Arlington, Virginia: American Chiropractic Association. (Accessed 2007 January) <<http://www.amerchiro.org>>.

Dick, E.A., and R. de Bruyn. Ultrasound of the spinal cord in children: its role. *European Radiology* (2003 March) 13(3):552-62.

Iacopino, D.G., Conti, A., et al. Assistance of intraoperative microvascular Doppler in the surgical obliteration of spinal dural arteriovenous fistula: cases description and technical considerations. *Acta Neurochirurgica (Wien)* (2003 February) 145(2):133-7; discussion 137.

Goetz, C. editor. *Textbook of Clinical Neurology*, 2nd ed. Philadelphia, Pennsylvania: Elsevier (2003).

Hughes, J.A., De Bruyn, R., et al. Evaluation of spinal ultrasound in spinal dysraphism. *Clinical Radiology* (2003 March) 58(3):227-33.

Wang, M.Y., Levi, A.D., et al. Intradural spinal arachnoid cysts in adults. *Surgical Neurology* (2003 July) 60(1):49-55; discussion 55-6.

Vertebral subluxation in chiropractic practice—Council on Chiropractic Practice Clinical Practice Guidelines. Arlington, Virginia: American Chiropractic Association (2003) 1:201. (Accessed 2007 January) <www.worldchiropracticalliance.org>.

Treatment of degenerative lumbar spinal stenosis—Evidence Report/Technology Assessment. Rockville, Maryland: Agency for Healthcare Research and Quality (Accessed January 2007) <www.spinalstenosis.org>.

Matsuyama, Y., Kawakami, N., et al. Cervical myelopathy due to OPLL: clinical evaluation by MRI and intraoperative spinal sonography. *Journal of Spinal Disorders and Techniques* (2004 October) 17(5):401-4.

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Simanovsky, N., Stepensky, P., et al. The use of ultrasound for the diagnosis of spinal hemorrhage in a newborn. *Pediatric Neurology* (2004 October) 31(4):295-7.

Non-operative spinal/paraspinal ultrasound in adults—Position statement. Reston, Virginia: The American College of Radiology (2005).

Regelsberger, J., Fritzsche, E., et al. Intraoperative sonography of intra- and extra-medullary tumors. *Ultrasound in Medicine and Biology* (2005 May) 31(5):593-8.

Unsgaard, G., Rygh, O.M., et al. Intra-operative 3D ultrasound in neurosurgery. *Acta Neurochirurgica (Wien)* (2006 March) 148(3):235-53; discussion 253.

Taggart, A., Filippucci, E., et al. Musculoskeletal ultrasound training in rheumatology: the Belfast experience. *Rheumatology (Oxford)* (2006 January) 45(1):102-5.

Joshua, F., Edmonds, J., et al. Power Doppler ultrasound in musculoskeletal disease: a systematic review. *Seminars in Arthritis and Rheumatism* (2006 October) 36(2):99-108.

Brushoj, C., Henriksen, B.M., et al. Reproducibility of ultrasound and magnetic resonance imaging measurements of tendon size. *Acta Radiologica* (2006 November) 47(9):954-9.

ACR—ACR Practice Guideline for the performance of the musculoskeletal ultrasound examination. *American College of Radiology* (2007 Resolution 29).

Mouterde, G., Carrotti, M., et al. Contrast-enhanced ultrasound in musculoskeletal diseases. *Journal of Radiology* (2009 January) 90(1 Part 2):148-55.

Policy History:

9/1/2009 Policy updated with literature review. Title changed to Non-Operative Spinal and Musculoskeletal Ultrasound. Policy revised to state non-operative musculoskeletal ultrasound will be experimental, investigational and unproven. Non-operative spinal ultrasound will remain conditionally medically necessary. CPT coding updated.

5/1/2007 Revised/updated entire document

2/27/2004 New medical document

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Help-line Assists Hospitals and DPMs with Residency Start-up and Expansion

Is your hospital a good candidate for a residency program, or does it already have a program you would like to expand? With nearly 240 podiatric residency programs in the nation's hospitals, there is room for growth. Unlike allopathic and osteopathic residencies, podiatric residency programs currently are not capped for graduate medical education (GME) reimbursement. To help facilitate expansion, APMA is offering members and their respective hospitals assistance in establishing residencies or expanding existing ones in concert with the Council on Podiatric Medical Education (CPME) and the American Association of Colleges of Podiatric Medicine's Council of Teaching Hospitals (COTH). In an effort to simplify the process, the organizations have created a help-line, 1-800-372-0775, to assist individuals in developing podiatric medical and surgical residency programs in their hospitals.

"In order to keep up with growing patient demand, we need to expand the number of new podiatric residencies offered to students," said APMA Immediate Past President Ross Taubman, DPM. "Providing hospitals with tools to make forming a new podiatric residency program easier, such as the help-line, is a step in the right direction."

Experienced APMA staff and podiatric physicians will work directly with APMA members or hospital representatives to explain the residency development process. If you are interested in receiving more information, call the help-line 24 hours a day at 1-800-372-0775.

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THERAPEUTIC SHOE FITTER COURSES SUPPORT TPMF PROJECTS

The TPMF has partnered with Dr. Comfort to host therapeutic shoe fitting courses in local areas around the state. This course meets the National ABC requirement to sit for the national certification exam and is open to assistants, DPMs or anyone specializing in shoe fitting.

To register, go to www.txpmf.org and select Donor Opportunities or email krista@txpma.org. Future courses are scheduled for: December 1-2, 2009 in San Antonio and February 19-20, 2009 in Dallas.

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A big thank you to the 12 mission volunteers and all of our donors for a successful mission trip to San Miguel! We made a big impact this trip seeing over 300 patients, providing 8 surgeries, 24 pairs of custom orthotics and 3 travel grants for residents/ students. The volunteers treated 3 orphanages, 4 villages and indigent families at the CASA Hospital with surgery and clinic. We also distributed shoes, socks, toys, shirts & pants to the orphanages and villages. The next Mission Trip will be at the end of June 2010 - plan now to take part of this terrific experience. October Mission Volunteers were:

Javier LaFontaine, DPM & wife Pilar
Joe Morgan, DPM, Greenville, TX Program
Ashley Marcol, DPM - Detroit Resident
Tu Dao, DPM
Don Robinson, DPM
Jason Miller, DPM
Neeta Hamukh, Ohio College, 4th Year Student
Steve Brancheau, DPM
Jennifer Williams - BAKO Pathology
Nelda Falknor
Jessica Falknor



HOLIDAY SHOE DRIVE FOR THE BORDER CHILDREN WILL BE DECEMBER 11 - MCALLEN

The TPFM needs your help now for the "Comforting Little Feet" Holiday Shoe Drive. Last year, 1000 children received shoes, candy and a toy at the holiday event. \$21 can buy 3 pairs of shoes for these children! Donations are subject to tax deductibility. Send new shoes or monetary donations by November 25, 2009 to: TPFM, 918 Congress, Ste. 200, Austin, TX 78701 or email krista@txpma.org to volunteer.

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