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# THE Ortho File

Vol. 4, No. 2 ❖ The Official Newsletter of the South Carolina Orthopaedic Association ❖ Winter 2004

## South Carolina Patient Access in Jeopardy; Medical Liability Reform Immediate Need

**P**atient access to South Carolina doctors is in jeopardy. Without sound and effective medical liability reform, many patients will have trouble getting health care services. You can make a difference by supporting favorable action this

General Assembly session through advocacy of medical liability tort reform.

Is the problem that serious? Consider these supporting points:

- A recent report released by the GAO — a non-partisan investigative arm of the U.S. Congress determined that states with high medical liability insurance premiums have experienced reduced access to hospital-based services -particularly emergency surgery and newborn deliveries.
- A recent survey by the *Medical Liability Monitor*, an independent newsletter that covers the medical liability insurance industry, reports that more than half of the internists, general surgeons and OB/GYNs
- Because medical liability premiums continue to skyrocket, orthopaedic surgeons – and many medical specialists – are being forced to give up certain procedures, move to other states where medical liability insurance is more affordable, retire early or give up their practices altogether.
- Trauma centers are closing down throughout the country – in Pennsylvania, New Jersey, West Virginia, Mississippi, Missouri and Florida – because physicians have

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had double-digit rate increases of up to 49 percent between 2002 and 2003. The highest rates were found in Florida (Miami), Michigan, Illinois, Texas and Pennsylvania.

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# SCOA Members Asked to Support Tort Reform – Grassroots Activism Key to Positive Legislative Action

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left the area or stopped practicing medicine altogether as a direct result of the cost or availability of medical liability insurance.

For example: In October 2001, a group of 18 physicians who perform approximately 80% of the orthopedic surgeries in Delaware County -just outside Philadelphia —announced that they would stop doing surgery and answering trauma calls; In Pennsylvania only two medical liability insurers remain, down from ten only five years ago.

According to Kenneth E. Thorpe, Robert W. Woodruff Professor and chair of the Department of Health Policy and Management, Emory University, the United States is in the midst of its third "crisis" in medical malpractice, with the last four years witnessing rising medical malpractice premiums, declining profits, and a reduction in the number of liability carriers offering insurance (See Exhibit 1).

*Enacting legislative "caps" – either state-by-state or at the federal level is a common sense approach to maintaining access to quality care for all patients. This is the underlying rationale which has been incorporated into the Medical Malpractice and Patient Safety Reform Act.*

Following are the most salient points which are cited as central to the reason for seeking passage of this type of legislation:

- Caps are enacted by legislators to limit the size of settlements that juries can award plaintiffs.
- In 1975, California enacted a \$250,000 cap on non-economic damages. Since that time, medical liability insurance premiums have increased only 167 percent in California compared to 505 percent nationally. As a result the

number of physicians and access to medical care has remained stable.

- A recent study by the U.S. Department of Health and Human Services (HHS) concluded that limiting awards for non-economic damages could reduce healthcare costs by 5 to 9 per-cent, saving an estimated \$108 billion in healthcare costs nationally every year.
- The U.S. General Accounting Office (GAG), a non-partisan investigative arm of the U.S. Congress, found in a new report that growth in medical malpractice premiums is slower in states that have limits on non-economic damages.
- A report issued by the U.S. Department of Health and Human Services' (HHS) Agency for Healthcare Research and Quality confirms that states that limit non-economic damages to \$250-

300 thousand have more physicians per capita.

All of us must take action to protect access to medical services. To learn how you can make a difference consider some of the below supporting points for action:

- Lawmakers need to hear from people outside of the medical profession that access to medical care is in jeopardy.
- Lawmakers listen to their constituents -tell them you fear not being able to access a physician when you need medical care.
- Grassroots activism has made the difference in states that have achieved reform!
- Your voice matters!

*Please take action today to contact your South Carolina State Representative or Senator, especially those Judiciary Committee members listed on Page 3 who are presently considering HB 4464.*

## EXHIBIT 1

### Trends in Medical Malpractice Premiums, As Percentage Change, 1998-2002

Year	Premiums Earned(%)	OB-GYN Premiums (%)	Internal Medicine Premiums (%)	General Surgery Premiums (%)
1998	9.1	0.3	- 2.9	1.0
1999	3.9	2.1	5.1	1.1
2000	5.3	4.8	7.3	7.0
2001	14.1	10.3	9.9	12.0
2002	23.2	14.2	20.0	21.9

*SOURCES: Premiums earned: National Association of Insurance Commissioners data; and premium increases for physician specialties: tabulations from the Medical Liability Monitor, 8 October, 2002.*

# Medical Malpractice and Patient Safety Reform Act: HB 4464

- **Medical Claims Review** – Establishes a Medical Claims Review office (MCRO) in the Dept. of Insurance, which shall convene a panel to review all claims against healthcare providers for damages allegedly resulting from medical malpractice. Revenues to fund the MCRO would be generated from fees assessed by the licensing boards of each profession to its licensees.
- **Mandatory Claims Adjusting** – After a claim for damages is filed against a healthcare provider, the provider's insurance carrier shall commence a full evaluation of the potential liability. The carrier has 180 days to make a final disposition of the claim by adjusting, compromise or claim rejection.
- **Healthcare Provider Data** – The SC Budget & Control Board shall develop procedures for providing information to the Board of Medical Examiners that identifies healthcare providers and their outcome data; Dept. of Insurance and the Dept. of Health & Environmental Control that identifies hospitals and their outcome data; and, public in a manner that is readily available and understandable.
- **Mediation** – (1) Mandatory mediation before a medical malpractice action is brought to trial. (2) If both parties agree, binding arbitration will be provided.
- **Expert Witness** – If a judge finds an expert healthcare provider in a medical malpractice action engaged in any unjustifiable conduct when testifying as an expert, the judge shall report to the state entity that licenses the expert's profession. The state entity is authorized to investigate the reported conduct, hold hearings, and impose sanctions.
- **Damages for Pain & Suffering** - Cap set at \$300,000 for pain and suffering, not economic damages. The cap excludes (1) permanent disability; (2) disfigurement or scarring; (3) paralysis; and (4) loss of limb or any organ.
- **Comparative Faulty (Joint & Several Liability)** – Each defendant is liable to the claimant only for the defendant's proportionate share of the recoverable damages.
- **BOME Investigations** – The Board of Medical Examiners is authorized to set licensure fees sufficient to generate revenue to enhance capabilities by increasing investigative staff and conducting inquiries, which result from opinions provided by the Medical Claims Review Office.
- **Deductibles** – An insurer issuing a medical malpractice insurance policy shall offer as part of the policy or as an optional endorsement to the policy, deductibles and policy limits optional to the policyholder.
- **JUA/PCF Board** - A person serving on the JUA or PCF Boards is prohibited from being employed in any manner and this prohibition continues for one year after the person ceases to be a member of the Board.
- **Frivolous Lawsuits** – Every lawsuit filed must be signed by an attorney constituting that the attorney read the document and believes there is good grounds to support it and that it is not frivolous.
- **Transfer to PCF** – The Patients Compensation Fund will be managed by its board and will no longer be under the State's Treasurer's Office.

*The SCOA is not an official sponsor of this legislation, but does support the passage of a comprehensive medical liability tort reform bill.*

## South Carolina Senate Judiciary Committee

McConnell, Glenn F.Chm.(R) .....	212-6610	Knotts, Jr., John M. (R) .....	212-6032
Anderson, Ralph (D) .....	212-6108	Kuhn, John R. (R) .....	212-6008
Cromer, Ronnie W. (R) .....	212-6124	Malloy, Gerald (D) .....	212-6148
Elliott, Dick (D) .....	212-6000	Martin, Larry A. (R) .....	212-6340
Fair, Michael L. (R) .....	212-6420	Mescher, William C. (R) .....	212-6320
Ford, Robert (D) .....	212-6124	Moore, Thomas L. (D) .....	212-6156
Glover, Maggie Wallace (D) .....	212-6116	Rankin, Luke A. (D) .....	212-6132
Gregory, Chauncey K. (R) .....	212-6330	Richardson, Scott H. (R) .....	212-6040
Hawkins, John D. (R) .....	212-6024	Ritchie, James H. (R) .....	212-6008
Hutto, C. Bradley (D) .....	212-6140	Verdin, III. Daniel B. (R) .....	212-6016
Jackson, Darrell (D) .....	212-6048	Waldrep, Jr. Robert L. (R) .....	212-6230



**Medtronic**  
SOFAMOR DANEK

**Michael F. DeMane** *President*

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February 10, 2004

**PAUL BIGGERS, PH.D.**

SOUTH CAROLINA ORTHOPAEDIC ASSOCIATION

1501 Peter Pan Road

P.O. Box 171

Lookout Mountain, GA 37350

Dear Dr. Biggers:

There are many victims from South Carolina's growing medical liability crisis, but those impacted the most are patients. Across the state and nation, patients are finding it harder to get access to vital medical services, such as spine surgery. Excessive litigation is making medical liability insurance either unaffordable or unobtainable at any price. As a result, more doctors are curtailing services, being forced to leave litigious states or abandoning the practice of medicine. South Carolina faces the same fate unless meaningful medical liability reform can be enacted by the state legislature this year.

*What can you do to make a difference?* Help us make the case that reform to bring reasonable caps on non-economic damage awards, constraints on outrageous attorneys fees and contingencies, and other means to stabilize medical malpractice premiums will provide relief and most importantly ensure continued patient access to needed care. Ultimately, effective liability reform improves medical care, decreases its cost, and reduces the need for defensive medicine. As legislative opportunities arise, know that Medtronic Sofamor Danek will be working at your side to make meaningful reform a reality. You can act now by calling or writing your elected state and federal representatives, educate your patients on the access implications, and reach out to other opinion leaders and stakeholders in your community and encourage their active engagement. Together, we can make a difference.

Sincerely,

Michael F. DeMane

# SC Trauma Care Gets Legislative Attention – Grassroots Support Critical for Passage in 2004

**T**rauma care in South Carolina is in crisis. Every orthopaedic surgeon who takes call has experienced the frustration of increasing liability costs, disruptions to practice, confusing rules regarding care and transfer of patients (EMTALA), and the challenges of providing the best care possible to victims of injury.

A bill has been put forth to the SC House and Senate which has the potential to stabilize the system and provide a framework for administration, regulation, and hopefully, financial support of the trauma system.

Senator Harvey Peeler (R-Cherokee) is sponsoring Senate bill S.713 and Representative Denny Neilson (D-Darlington) and numerous other House members are sponsoring House bill H.4262 to rescue our fragile South Carolina Trauma System. In 2001 Level I and II centers lost \$18.3 million on unreimbursed trauma care. Hospitals in Aiken and Georgetown have dropped their Level III designation. The time is right to do something to improve trauma care in our state.

The proposed legislation does several important things. First, it establishes a Trauma Fund to pay for the trauma system. The funds will be used to pay for the administration of the system and grants to participating providers. The legislation does not include a funding mechanism. The funding source will be determined as part of future legislation.

Second, the bill requires reorganization within DHEC to give trauma greater visibility and authority over the trauma system. It authorizes DHEC to designate trauma centers and to develop a trauma advisory committee which will include physicians involved in trauma care. Currently trauma is under the EMS com-

mittee which is not satisfactory. The reorganized section will have the authority to designate, regulate, inspect, and fine trauma centers. Many issues such as transfer protocols, regionalization, back transfers, bypass rules, etc will be dealt with by creating new regulations authorized by this bill.

Third, the bill authorizes DHEC to dissolve the trauma system if the legislature fails to create a funding source to run the system. This obviously is the "Big stick" to get the legislature to do something to fund the system.

The success of passage of this bill hinges on grassroots support. What does this bill mean to the average orthopaedic surgeon taking call in South Carolina? I think it has the potential to mean a lot. First, for the first time ever, there may be a way to get tax payer dollars to support the trauma system and the people who take care of trauma victims. I believe a good trauma system is just as legitimate as police and fire protection. It is a public service for the good of all citizens and is worthy of tax payer support.

Second, many nagging issues about provision of trauma care can be cleared up by carefully crafted regulations. Trauma centers will have to be designated and maintain the necessary levels of quality care. This will be a plus for us when hospitals are constantly looking for ways to curb costs and cut needed staff and expenses. Issues related to transferring patients and EMS transport protocols may be able to be made more clear and explicit.

I urge you to support this bill and contact your Senator and Representative to support the bill. You can learn more by receiving the Trauma

Scorecard and visit [www.scstatehouse.net](http://www.scstatehouse.net). Click on Legislative Resources and search for H.4262 or Senate bill S.713. You can send your trauma news to Melanie Lux at 803-376-1603 or [melanielux@sc.rr.com](mailto:melanielux@sc.rr.com). You can contact DHEC EMS Division at 803-5454-4204 or SCHA at 803-796-3080.

*Prepared by  
Langdon A. Hartsock, MD, FACS  
Medical Univ. of South Carolina*

## Ways & Means Committee

**Harrell, Robert W., Jr. .... 734-3144  
Chairman**

**Battle, James A., Jr. .... 3001**

**Cobb-Hunter, Gilda Y. .... 2809**

**Cooper, Daniel T. .... 3014**

**Cotty, Bill ..... 4851**

**Clyburn, William ..... 3033**

**Davenport, G. Ralph, Jr. .... 3098**

**Edge, Tracy R. .... 3013**

**Harvin, C. Alexander, III ..... 3135**

**Hinson, Shirley R. .... 2951**

**Keegan, Thomas G. .... 3063**

**Kennedy, Kenneth ..... 2986**

**Kirsh, Herb ..... 3071**

**Koon, Larry L. .... 2963**

**Limestone, Harry B., III ..... 2967**

**Littlejohn, Lanny F. .... 3007**

**McCraw, E. DeWitt ..... 2992**

**McGee, James G., III ..... 3039**

**Neilson, Denny W. .... 3097**

**Quinn, Richard M., Jr. .... 3138**

**Rice, Rex F. .... 3035**

**Smith, J. Roland ..... 3109**

**Trotter, Teddy N. .... 3036**

**Vaughn, Lewis R. .... 3141**

**Young, Annette D. .... 2953**

*\*All members area code 803*

# SC General Assembly Considers Prompt Pay Bills State One of Only Three Without Similar Statutes

**S**outh Carolina is one of only three states (Idaho and Nebraska are the others) that do not have a prompt pay statute or regulation.

States have time limits that vary from 15 days to 45 days. The most popular limits are 30 days for both paper and electronic claims: nine-teen states have 45 days for both: eight states have 30 days for elec-tronic claims and 45 days for paper. So the proposed limits in the SC bills are not the best, but not out of the ball park.

The re-occurring issues that negatively affect the usefulness of existing prompt pay statutes for doctors in the 47 states are: 1) how do you define a clean claim? 2) who is covered by the bill? and 3) how severe is the punishment to the insurers for violating the Act and how vigorously does the state enforce the Act (if the state has the power)?

There are currently three prompt pay bills in the SC legislature.

## HB 4472

HB 4472 applies to all insurers including HMOs and third party administrators (this is very good; in fact all three bills are very broad). The bill defines "clean claim" as "an eligible electronic or paper claim for reimbursement submitted as required on a standardized HCFA 1500 or UB 92 claim form, or the successor of each or as either may be amended from time to time, or other forms or formats as may be required under the Health Insurance Portability and Accountability Act of 1996, for health care services rendered by an eligible provider to an insured person that has no material defect or impropriety including, but not limited to, any lack of required substantiating documentation or coding, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under the terms of

the policy or the insurer's published filing requirements."

The bill states that insurers must accept 1500 forms and all correspondence regarding claims must be dated (to help prevent insurers from arguing that they received a claim or letter after they actually did). The meat of the bill states "A clean claim submitted electronically or on paper is due and payable within forty-five days from the date received by the insurer."

An insurer has 15 days to dispute a non-clean claim and inform the provider what is wrong or missing from the claim. Portions of claims that are clean must be paid within the 45 day limit. Claims not paid within the 45 day limit automatically begin to accrue late interest at 12%. The bill goes on to provide that providers can recover in a court action for enforcement of this law "the amount of overdue claims plus reasonable court costs, attorney's fees, and additional compensatory damages as the court may award" for claims not paid within 90 days of receipt. The bill goes on to say that the state may prosecute insurers for violating the act as an unfair trade practice. The bill also prevents retaliation against providers for enforcing the law.

## SB 644

SB 644 contains much of the same language as HB 4472 but does include a section requiring insurers to acknowledge receipts of claims within two working days (notice does not have to be sent if the claim is paid in its entirety within 15 days). SB 644 also prohibits insurers from demanding submission of claims within 180 days of the date of service. Under SB 644 clean paper claims must be paid within 45 days and clean electronic claims must be paid within 30 days. Capitation payments must be paid with 30 days from when provider must begin providing services (in

HB 4472 it is 45 days) .The court cost recovery provisions in SB 644 apply after 60 days. SB 644 also includes language outlawing "all products" clauses. So SB 644 is a better bill than HB 4472 because the time frame is shorter and the acknowledgment requirement is helpful to make sure claims aren't lost.

## SB 766

SB 766 defines clean claim as "a nonelectronic claim by a provider" ...if the claim is submitted using "...Form 1500"....An electronic claim by a provider, other than an institutional provider, is a 'clean claim' if the claim is submitted using the Professional 837 (ASC X12N 837) format. The bill goes on to add "The director may promulgate regulations that specify the information that must be entered into the appropriate fields on the applicable claim form for a claim to be a clean claim" and "An otherwise clean claim submitted by a provider that includes additional fields, data elements, attachments, or other information not required by this section is considered to be a clean claim for the purposes of this chapter. SB 766 requires providers to submit claims within 95 days of service. "If a provider fails to submit a claim in compliance with this subsection, the provider forfeits the right to payment unless the failure to submit the claim in compliance with this subsection is a result of a catastrophic event that substantially interferes with the normal business operations of the provider. The period for submitting a claim under this subsection may be extended by contract."

To prevent insurers claiming a claim was never received the bill assumes that a faxed claim was received on the date of the transmission acknowledgement, a mailed

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# Prompt Pay Legislation Offers Good and Bad Solutions SCOA Encourages Grassroots Advocacy for Action

*Continued from Page 6*

claim on the fifth day after dropping it in the mailbox, and if sent electronically "on the date of the electronic verification of receipt by the insurer or the insurer's clearinghouse.

The insurer has 45 days for paper claims and 30 days for electronic claims to: pay the entire claim, pay the clean portion or notify the provider why the claim (or parts thereof) cannot be paid. If the insurer wishes to audit the claim it must pay the claim at 100% within 30/45 days and "shall indicate on the explanation of payment statement in the manner prescribed by the director by regulation that the clean claim is being paid at one hundred percent of the contracted rate, subject to completion of the audit."

If an insurer needs additional information from a treating provider to determine payment, the insurer, not later than the thirtieth calendar day after the date the insurer receives a clean claim, shall request in writing that the provider provide an attachment to the claim that is relevant and necessary for clarification of the claim. The request must describe with specificity the clinical information requested and relate only to information the insurer can demonstrate is specific to the claim or the claim's related episode of care.

The insurer's claims payment processes must: (1) use nationally recognized, generally accepted Current Procedural Terminology codes, notes, and guidelines, including all relevant modifiers; and (2) be consistent with nationally recognized, generally accepted bundling edits and logic.

A provider may recover reasonable attorney's fees and court costs in an action to recover payment. If the insurer doesn't pay the claim on time they must pay the claim plus "fifty percent of the difference between the

billed charges, as submitted on the claim, and the contracted rate." If the claim is 46-91 days late the penalty is "one hundred percent of the difference between the billed charges, as submitted on the claim, and the contracted rate." If the claim is more than 91 days late the penalty is one hundred percent of the difference between the billed charges, as submitted on the claim, and the contracted rate plus 18% interest.

The bill goes on to say that "An insurer may recover an overpayment to a provider if:

1. Not later than the one hundred eightieth day after the date the provider receives the payment, the insurer provides written notice of the overpayment to the provider that includes the basis and specific reasons for the request for recovery of funds; and
2. The provider does not make arrangements for repayment of the requested funds on or before the forty-fifth day after the date the provider receives the notice."

The bill goes on to state that a provider "may request a description and copy of the coding guidelines, including any underlying bundling, recoding, or other payment process and fee schedules applicable to specific procedures that the provider will receive under the contract."

Since HB 4472 is similar to SB 644, the two Senate bills are further reviewed...

**Time period to pay:** 45/30 days in both

**Time period to file:** SB 644 can't require filing before 180 days; SB 766 must file within 95 days.

**Definition of clean claim:** SB 644 a claim with "no material defect or impropriety." SB 766 a clean claim is

one in the proper format with all required fields filled out.

**Enforcement:** SB 644 -12% interest and court costs if needed.

SB 766 a percent of the difference between the billed charges, as submitted on the claim, and the contracted rate and court rate and court costs if needed.

I think both bills have pluses and minuses. For instance, the definition of clean claim in SB 644 is subjective allowing the payers more easily to game the system, while SB 766's is objective. However, SB 766 requires that all claims be filed within 95 days which may be onerous to providers. On enforcement both bills allow recovery of attorney fees and court costs which is necessary to make judicial enforcement financially feasible (only one or two states have such language now). However the penalty under SB 766 is based on billed charges and the contracted rate.

SB 766, though, in the non-prompt pay sections would require insurers to supply fee schedules and bundling and downcoding info. This is an issue that physicians in many states are pushing now.

While most states have enforcement based on interest, like SB 644. I think the interest penalty is more appropriate as a penalty, if you are late paying something you pay interest on the unpaid amount.

I doubt that insurers wrote any of these bills. They all have many good aspects and things that could be improved. All in all, if forced to choose I would say SB 644 is the best one currently.

*Prepared by*

*M. David Mitchell, MD  
SCOA President-Elect*

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ADDRESS CORRECTION REQUESTED



## *South Carolina Orthopaedic Association* **INVITATION FOR MEMBERSHIP**

*Please send an application for membership, with requirements, to:*

Name \_\_\_\_\_

Office Address \_\_\_\_\_  
\_\_\_\_\_

Telephone ( \_\_\_\_\_ ) \_\_\_\_\_

**Categories of Membership:** Please check (✓) the below abbreviated category which would qualify you for membership:

- Active** membership is for candidates who are certified by the American Board of Orthopaedic Surgery or its equivalent thereof; for twelve months immediately prior to induction have devoted his or her medical practice exclusively to orthopaedic surgery or been actively engaged in the teaching of orthopaedic surgery or research related to the musculoskeletal system in South Carolina; and maintain a full, unrestricted and unlimited license to practice medicine in South Carolina.
- Associate** membership may be conferred upon distinguished physicians who have retired from active practice of orthopaedics and have not previously been a member of SCOA or a distinguished member of an allied health profession whose activities and contributions are related to orthopaedic surgery.
- Emeritus** membership is for candidates over age 65 and are retired from active practice of Orthopaedics.
- Inactive** membership is for candidates who are unable to maintain an active practice due to illness or disability.
- Honorary** membership is for guest speakers at SCOA sponsored meetings or others as determined by the membership.
- Candidate** membership is for residents enrolled in an approved orthopaedic training program.

*Requests for membership applications should be mailed to the below address:*

South Carolina Orthopaedic Association • P.O. Box 171 • Lookout Mountain, TN 37350  
Fax to: (888) 508-7262 or [www.scoanet.org](http://www.scoanet.org)