



TOA NEWSLETTER

Texas Ophthalmological Association

September 2019

TOA Name Change

*Look for
a special
communication
next month*

401 W. 15th St.,
Suite 825
Austin, Texas
78701-1667

(512) 370-1504

toa@TexasEyes.org
www.TexasEyes.org
[facebook.com/txoph](https://www.facebook.com/txoph)
twitter.com/txoph

President's Message

*By Mark Gallardo, MD
president@TexasEyes.org*

My five-year-old son has recently gained an interest in Sci-Fi movies and is quite intrigued by *Men in Black*, starring the fabulous Fresh Prince of Bel Air and Tommy Lee Jones. In watching this movie and its sequels, I'm reminded of what the Texas Ophthalmological Association (TOA) does for its members. In *Men in Black*, the world is under constant threat of complete annihilation, yet we, as mere mortal citizens of the world have no idea. The Men in Black are constantly surveying the landscape to look for threats and to intervene, saving the world without as much as a word of their duly deeds. Although we are not under threat of complete demise (though some may disagree) the TOA is somewhat similar in that it is constantly listening to legislative chatter, observing various agencies that can influence our profession and patient care, and working with other societies from within our Great State of TEXAS and beyond.

The TOA is not simply a state society that provides continuing medical education for its members, it's also a council of members that fights for continued fairness for our profession and the welfare of our patients. In terms of politics and policies, we all have our hierarchy of issues that hold a closer place in our heart than others. Some practitioners are focused on fairness of reimbursements while others focus their energy on expressing displeasure in having to complete unnecessary registries like MIPS or PQRS. And, of course, some have identified the containment of scope of practice expansion as their most important topic.

The TOA is continuously working to benefit the overall good for our profession and patient safety both on the local and national stage. Although we try preventing alien invasion and global demise, sometimes we lose a battle or two. We, unfortunately, were recently informed of the Centers for Medicare and Medicaid Services' decision to reduce our reimbursement for cataract extraction by phacoemulsification with intraocular lens implantation (66984) and its complex counterpart (66982) by 15%. This was primarily due to a questionnaire sent out to members of the American Academy of Ophthalmology, which provided CMS with information that suggested there was a decrease in the relative value units (RVU) for the procedures due to decreased "cut time" and number of postoperative visits. Also, our regional Medicare administrative contractor (Novitas) has recently published that they will no longer cover the professional fee for implantation of a second trabecular micro-bypass stent (0376T) and they felt that the work required to implant a second was negligible. Though I was not speaking as an official executive council member for TOA, I did give a formal presentation, as a private practitioner, to the Novitas committee explaining the difficulty of not just implanting trabecular microbypass microstents in general, but also how implanting two stents exponentially increases the difficulty of the procedure and surgical time. We have yet to hear their decision, but time will tell. Though we had a few setbacks in reimbursement, there were several other areas with positive outcomes.

Eyecare Patients Prevailed in 2019

For those ardent observers of scope of practice expansion, during this last legislative session we saw all arms of medicine in a number of states engrossed in aggressive scope expansion battles. In our great state we were certainly not immune from bills that would have not only created a surgical optometrist but would have given the



The Right Eyecare for All Texans

This coalition continues its work.
Encourage everyone around you
to join at SafeVisionTexas.org.

“...none of the optometric scope bills was even granted a hearing. This fact alone reflects the huge success of our advocacy.”

Texas Optometry Board full authority to determine its licensees' future scope of practice without legislative input or oversight. House Bill 3505 represented an aggressive and unprecedented attempt to dilute the Texas Medical Board's ability to regulate surgery. Additionally, House Bill 1798 and Senate Bill 1223 would have allowed optometrists to practice beyond their training, education and experience – well into the areas of medicine and surgery.

Through grassroots efforts and diligent work by our 2019 president, **Sanjiv Kumar, MD**, our executive council, TOA members and concerned citizens, these bills did not advance. In fact, none of the optometric scope bills was even granted a hearing. This fact alone reflects the huge success of our advocacy.

Lawmakers, especially new ones, are often confused about the vast differences between the training, education and experience of ophthalmologists and optometrists. TOA is a founding member of Safe Vision Texas coalition, which was instrumental in educating lawmakers and the public on the dangers inherent in giving surgical and medical privileges to non-physicians. All of these elements came together resulting in the defeat of these dangerous bills.

YOUR advocacy made a huge difference for patients. Every phone call, email and letter on behalf of your patients made an impact. I would like to personally thank those TOA members who took the extra step of joining the “white coat invasion,” locking arms with other Texas physicians during the TMA First Tuesday advocacy days: **Charlotte Akor, MD; Michelle Berger, MD; John Bishop, MD; Keith Bourgeois, MD; Harrison Bowes, MD; Marie Bui, MD; Lindsay Davis, MD; Sidney Gicheru, MD; Victor Gonzalez, MD; Robert Gross, MD; Davinder Grover, MD; Jerry Hunsaker, MD; Ronald Kuffel, MD; Sanjiv Kumar, MD; Chevy Lee, MD; Mark Mazow, MD; Steven McKinley, MD; Jacob Moore, MD; Wanda Northum, MD; Jack Pierce, MD; H. Miller Richert, MD; Rajiv Rugwani, MD; Halsey Settle, MD; Timothy Sipos, MD and Ann Stout, MD.**

Legislative Win for Ophthalmic Surgical Personnel

In other news, TOA played a central role in defeating a bill that could have kept your ophthalmic surgical tech out of the surgical suite, even within physician-owned ASC's. A 2001 Texas law created a licensure provision for surgical assistants. However, the law also created an exemption if a surgical assistant is working under a surgeon's delegation. There was an attempt this 2019 Texas Legislative Session to eliminate that exemption, requiring all surgical assistants to become licensed. The passage of a law such as this could be devastating to your ability to use ophthalmic surgical technicians. It could also impact medical students assisting during a surgery. The TOA worked with other surgical groups to voice these concerns and the bill ultimately failed. Moving forward, the TOA will continue to educate stakeholders about the unique and valuable role of ophthalmic technicians.

A Very “Scopy” Session with More on the Horizon

TOA joined the House of Medicine to advocate for patient safety across the specialties. Several allied health provider groups pursued scope expansions during the 2019 Texas legislative session. The chiropractors sought to define their scope to include the “neuromusculoskeletal system,” which would have given them the authority to treat the nervous system. Advanced practice registered nurses sought full independent practice and prescribing authority. Psychologists pushed

for independent prescribing authority. These bills were defeated. A new law was implemented on September 1 that allows patients to have limited direct access to physical therapists as long as a detailed disclosure is signed by the patient.

We expect to see a slew of aggressive scope of practice efforts again during the 2021 Texas Legislative Session.

North Carolina Teeth Whitening and Scope of Practice in Texas?

The Texas Legislature passed SB 1995 which will give the governor the ability to establish a division (overseen by what some are calling a super-regulator) that will review the rules of each state agency featuring a governing board consisting of individuals who are governed by the agency. This would include the Texas Medical Board, Optometry Board, Chiropractic Board etc.

According to the bill's analysis, "The bill establishes that for purposes of its provisions a rule affects market competition if the rule would, if implemented or readopted, create a barrier to market participation in Texas or result in higher prices or reduced competition for a product or service provided by a license holder in Texas."

The bill's sponsor, Sen. Brian Birdwell (R-Granbury), referenced the North Carolina Dental Board's ruling on teeth whitening in which the US Supreme Court ruled in 2015 that the North Carolina State Board of Dental Examiners was not immune from the US Federal Trade Commission's authority when it restricted teeth whitening to dentists. However, some policy experts have stated that the Supreme Court ruling does not apply to scope of practice laws that are developed by state legislatures.

Could SB 1995 take away the Legislature's authority to determine which licensing provisions are appropriate for patient safety?

The 2021 Legislative Session as Already Begun

I know that it starts to sound like a broken record, but we need every member of TOA to contribute to EYE-PAC. When you get your 2020 dues statement next month, please do contribute at least the recommended \$300. Right now, only 20% of members participate. Testifying or writing an op-ed is not within everyone's skill set but giving to EYE-PAC is the least you can and should do to protect patients.

One of our former TOA presidents, **Victor Gonzalez, MD** wrote in his president statement, "Like many Texans, I am always reminded of the words of Judge Gideon Tucker when this biennial season rolls around: 'No man's life, liberty or property are safe while the legislature is in session.'" And while I agree with this statement, we can help secure our goals while the legislature is not in session. We can do a lot of important work during this period by reaching out to each of our local representatives and senators to establish a relationship and ongoing dialogue. These relationships can provide us with the proverbial seat at the table at times of adversity and provide for more epicurean legislative sessions.

Get involved. Talk to your legislatures. Contribute to our PACs. Join the Men in Black.



*Only 20%
of TOA
members give
to EYE-PAC*

We can do better than that. Give generously with your 2020 dues.

Message from the Chair, TOA Liaison Committee to Third Party Payors and Peer Review Agencies

*John Haley, MD
answers coding and
reimbursement questions
from TOA members at
coding@texaseyes.org.*

*He volunteers his time
to provide this valuable
service.*

By John Haley, MD

Disclaimer: The comments below reflect my personal views derived over forty years with all my many well-connected medical associations and activities. The comments below do not represent the views of the TOA.

It had been a quiet several months for Medicare payment policy changes until the proposed final rule for the Medicare Fee Schedule was released recently. And I am sure you are aware by now that allowable cuts of about 15% (\$100) for 66984 (CAT/IOL) and \$50 for 66982 (complex cataract) were proposed along with a few other surprises. The final rule does not usually come out until November to be implemented January 1, 2020.

As few have been in this business for as long as I have and really do not know the history of Medicare reimbursement, I think a short historical review is in order. In 1966 the AMA introduced the CPT (Current Procedural Terminology) system which defines all our fees. Then we were paid on the reasonable charge system where we built a Medicare profile based on historical charges. That of course got out of hand very quickly and surgeons really profited as patients will always pay more for the perceived value of surgery over cognitive care. This led to cataract surgical fees of \$2,400 in that era. So, the solution was payment by the Resource-Based Relative Value Scale (RBRVS) which began in 1991. The AMA formed the Specialty Society Relative Value Scale Update Committee (RUC) to include all specialties to determine the relative value of physician work for every CPT code and service. As you can imagine, this RUC process has become very time consuming and contentious.

Work value is based on physician time, technical skill, physical effort and judgment and stress caused by potential risk to the patient (basically time and intensity). Ophthalmology has played the game well. Our strong leaders have gotten involved with the process and we have been relatively very successful. However, the sheer volume of cataract surgery has for years made it a target. Recall that the fee schedule in Medicare is revenue neutral and if relative values are increased in one procedure, they must be decreased in others as there is a fixed monetary pie. The real purpose of RBRVS was to shift payment to primary care and cognitive services away from surgery or procedural services. That shift has been very successful and continues to this day.

The RUC continually revalues work values of all services as they do continue to change and usually become overvalued as efficiency increases. In the case of cataract surgery, most of us remember the good old days of \$2,400 procedures plus many add-on diagnostic tests and assistant fees but we forget that we had considerably more difficult cases then with large incisions, no viscoelastics – early design of IOLs, poorly functional phaco with much longer, more complicated surgical time and post-op complications. So, as our procedures have gotten safer, easier and more consistent the relative values have decreased. We have experienced a long period of work value cuts every few years.

Now, what triggered these most recent proposed cataract changes? The Centers for Medicare & Medicaid Services (CMS) has a policy that if any procedure is

done with another surgical code in more than 50% of the cases then a new combined code must be developed by CPT and valued by RUC. Endocyclophotocoagulation is performed 75% of the time with cataract surgery but the volume is relatively low; regardless, this triggered formation of a new combined code which triggered a RUC review of the whole cataract family - always bad news that RUC gets more difficult each year. ASCRS and AAO sent out surveys to determine surgical time, intensity, post-op visits, etc. for each procedure. The bottom line is that cataract surgery is getting faster and time went down by one minute to 20 minutes. Post-op visits went from over four to three in the ninety-day global fee period. Cataract is still valued at the top for intensity and risk – still right up there with carotid endarterectomy and cardiac bypass. Like it or not, most of us would agree that the intraservice time and post-op visits are what we really perform. Therefore, this is reasonable.

There were many outcries on our various chat sites over more cuts to cataract surgery, and soon we will be doing them below costs. Our chat sites and meetings continue to find ways to cut out post-op visits and make cataract surgery faster and more efficient. Be careful in this search as you now know where that will lead RBRVS. But that is how the RBRVS is supposed to work. Equal pay for equal work. This is a problem for all of medicine, not just the ophthalmologists, 3% of the medical herd. Many of us feel we are due higher per minute pay due to our quick, intense, very successful, patient-pleasing surgery and perhaps without RBRVS we would come out way ahead. Then of course the rest of medicine would hate us as they did when we were once the fat cats of medicine, sending limousines for patients and paying optoms for referrals. So, life is a balancing act. The good news from the proposed rule is that the E/M codes will be somewhat increased in value. There is a proposal to not increase the post-op visit codes in surgical fees but that will be vigorously fought by our organization as it is unjust.

So finally, I think it has come to the time surgical cases per hour pay about the same as a well-run, efficient, office-based practice. Remember, you must take out the pre-op and post-op care to determine what you are actually paid for your surgical time. Example, if 66984 goes to \$550 that means about \$385 is the surgical fee and \$165 is pre- and post-op care (co-management becomes even more of a problem). So, figure how many you can do per hour and compare with hourly office visits and I think they are now equivalent. Of course, one can play games with use of premium IOLs, but they increase pre- and post-op chair time and many times create unrealistic expectations with the current lenses. Or you can play games that are unethical or quasi legal. I recently had an older friend in Colorado who went to one of the new private equity practices because of the powerful marketing. He was given a choice of either \$3,000 for a guaranteed 20/20 vision monofocal or \$8,000 for guaranteed happiness with

a multifocal package. Some are now charging noncovered pre-op diagnostic packages to improve questionable post-op results. None of these practices passes the smell test for me but to each his own.

For me, I just try to be efficient in both surgical and office spheres. Then your income basically is determined on how many hours you work efficiently, not on the surgical case mix. That is a change in thinking over the last 10 years but that is where we are, and you know we are all still doing just fine if you want to work hard.

It does however frustrate me to see what the Fed pays for marginally useful meds like Omidria® and Dextenza® which is as much as we will be paid to perform the cataract surgery. And then there are the outrageous funds paid to run the Medicare Advantage plans. But big pharma, device manufacturers, hospitals and insurance companies all have found ways to raise big PAC money and therefore control their destinies. Our Doc groups can get very few to donate to our political PACs or political campaigns. Less than 18% of our members contribute to ASCRS, AAO, AMA and TOA PACs. And I see no stomach for that to improve. That is the cost of doing successful U.S. business and we as a profession are slow to learn. Some cry to form Doc unions but proper politics is the way to go IMO. ASCRS Director of Government Relations Nancey McCann and AAO Chief Executive Officer David W. Parke II, MD have written and spoken very wisely in their magazines and broadcasts regarding the changes.

On our chat sites and in our conversations, there are many ideas out there, but none seems to have legs for society. This cannot be a one-way deal to increase doc income. Doc unions? Not going to happen. It's hard to get 18% to contribute to anything political. Pass legislation to allow balance billing? Not going to happen. There is no political will to turn doctors loose in billing and think of us as elderly patients (I am getting there). When you are a medical consumer, the last thing you want is to compare and negotiate fees when you are sick with a serious illness. No, it will not happen here or anyplace else in the world. Just imagine if all docs put just 1% of gross income into our political PAC and get to be close with at least one Congressman or Senator. Our collective voice would be as loud as the voices of big pharma and big hospital. But most wait for the few to do it all, therefore it will not happen.

Many badmouth Medicare and our insurance companies as they control us. Yes, but they have made us relatively wealthy. My father, an internist in Dallas for over 40 years told stories before Medicare and before insurance and no one could afford anything but very basic office care. No one could afford hospital workups or elective surgery. The doctor got paid in chickens and gifts and rarely could collect what we now consider an entitlement to high fees. Medicare and insurance made it possible for most to afford reasonable

Continued on page 6

New!

***TOA Job Board
for those seeking to
hire staff, ophthalmic
personnel, sell
equipment, etc.***

TexasEyes.org

care and we docs have prospered. Now we need to tweak the system and I feel that is beginning. Obamacare was a start but was greatly limited by political reality. Now we must do better. Let the political debate begin.

New Draft MIGS LCD:

Novitas recently released a new draft MIGS LCD for comment. The draft is on novitas-solutions.com for you to review. Several doctors including our president Mark Gallardo have commented. Overall, the policy seems reasonable to me and will be released in several months in final form. There will likely be a few changes in the final policy.

As to reimbursement for the MIGS, if the device has a category 1 CPT code then the RUC sets the relative value (see cataract above). However, most MIGS devices have a category 3 emerging technology code which is valued by the Medicare carriers. More and more often the various MACs are talking and trying to standardize their policies and valuations based on an informal RBRVS approach. Therefore, the allowables have really decreased over the initial introduction of iStent. Remember, the category T codes are paid at 100% of allowable when performed with cataract surgery. To get a true RUC valuation the companies must seek out a permanent CPT category 1 code when literature requirements are met. But RUC review is a mixed blessing as we see with cataract above. And the additional surgical MIGS procedure will then be paid at 50% in addition to cataract surgery. When you now think that the MIGS are underpriced, just wait until the RUC acts on the fees and reduced by 50% when combined with cataract surgery. All of a sudden, the fees appear in line with the system.

Note that the LCD process has been overhauled by CMS and all coding parameters are not put into the LCD but listed in associated articles. The articles can be more easily amended and revised as changes occur.

Rush to Quality:

In 2015, Congress and CMS decided that the current RBRVS system, which encourages increasing volume was not solving the problem of increasing costs and decreasing quality and was flawed and developed the new value-based payment systems: MIPS and Alternative Payment Models (APM). MIPS has allowed us to keep our fee-for-service system as there are no APM's that fit ophthalmology. However, all roads continue to lead toward value-based payments. There is still a very strong push for the assumption of risk by all providers. Everyone continues to try and find a way – *any* way to decrease the cost of Medicare (but they are forced politically to overlook the ASC-Hospital advantage, the obscenely priced drugs, high cost of medical devices and regular hospital fee increases - only the providers fees are totally controlled). These systems favor large systems at the expense of small practice and community hospitals and impose new layers of quality reporting. However, to date these quality systems have done little to improve care or moderate costs.

While surgeons in general do not consider RBRVS a fair system, cataract surgeons feel we already offer a quality product that should be rewarded on its own merit, but then what do you do with some of our other specialties? Do patients feel the same about glaucoma surgery? How far would balance billing go in the clinical evaluation of glaucoma suspects and even trab surgery? Not real popular with the public. At least for ophthalmology the reporting systems are a non-issue with a good EMR and the Iris® Registry.

We continue to rapidly evolve as the Feds move the cheese. The next election is getting interesting as several new health care systems are being discussed. Who knows where all this will end up. But we are nimble, we have good, effective, patient popular treatments that essentially all aging citizens will need so keep positive.

Question/Answers from the Texas Herd

Question: We have been getting denials from multiple insurance companies for 0509T pattern ERG. The company has provided us with appeal paperwork, further appeals have been denied.

Answer: After multiple attempts in the CPT process, Diopsys has failed to get a category 1 CPT code for pattern ERG. They simply do not have the required literature to show pattern ERG effectiveness. Pattern ERG currently is a Category 3 code, emerging technology and most carriers will not pay for same.

Question: How long must I keep medical records?

Answer: Per the Texas Administrative Code, Texas Medical Board requires retention for seven years with some exceptions below:

(b) Maintenance of Medical Records.

- (1) A licensed physician shall maintain adequate medical records of a patient for a minimum of seven years from the anniversary date of the date of last treatment by the physician.
- (2) If a patient was younger than 18 years of age when last treated by the physician, the medical records of the patient shall be maintained by the physician until the patient reaches age 21 or for seven years from the date of last treatment, whichever is longer.
- (3) A physician may destroy medical records that relate to any civil, criminal or administrative proceeding only if the physician knows the proceeding has been finally resolved.
- (4) Physicians shall retain medical records for such longer length of time than that imposed herein when mandated by other federal or state statute or regulation.
- (5) Physicians may transfer ownership of records to another licensed physician or group of physicians only if the physician provides notice consistent with §165.5 of this chapter (relating to Transfer and Disposal of Medical Records) and the physician who assumes ownership of the records maintains the records consistent with this chapter.
- (6) Medical records may be owned by a physician's employer, to include group practices, professional associations, and non-profit health organizations, provided records are maintained by these entities consistent with this chapter.
- (7) Destruction of medical records shall be done in a manner that ensures continued confidentiality.

Note that Medicare Advantage requires retention for 10 years:

Medicare Advantage health insurers are required to ensure all contracts with physicians contain "accountability provisions." Among these required provisions is a mandate that the physician will "maintain records a minimum of 10 years." Specifically, records and information related to services provided under a Medicare Advantage agreement must be kept at least 10 years from the final date of the Centers for Medicare & Medicaid Services (CMS) contract period in effect at the time the records were created. It is very important to review any contracts the practice may have with Medicare carriers to determine the necessary retention period.

Question: One of the Medicare Advantage HMOs changed its payment policy January 1 for physician-administered drugs to only pay 65% of the Medicare allowable. We are prohibited by their contract from collecting the other 35% from the patient so we eat the loss. We were never notified of this change until our claims were paid 4-5 months later. This is a real problem with \$1,800 Eylea. Our one-eyed patient only responds to Eylea so what do we do? We have not been able to even talk with a medical director or person in charge about this matter.

Answer: First, I am not sure that is legal as MA plans are required to offer the same benefits as regular Medicare. The problem is communication with the MA plan. No one seems to be in charge so one cannot ever talk to them. Letters go unanswered so what to do? MA plans do have oversight, but it is not with the regular Medicare carriers. Oversight is with regional CMS offices. I have the CMS oversight officer name and address if you need it for complaints. The only other organization that can help is the TMA's socioeconomic committee that regularly meets with the MA plans and private insurance companies. Submit a "Hassle Factor" log at www.texmed.org/Hassle/. This shows the value of our Texas and national societies. Unless we have powerful groups, we have no recourse with many of the insurance companies.

Continued on page 8

C O D **Q**uest
2020

**You Can't
Afford to Miss
Codequest
2020!**

**2020 Registration will
open in December.**

**TOA educated over
1,000 physicians and
staff in 2019.**

**Pay your dues to
take advantage of
discounts for you and
your entire staff.**

San Marcos
Saturday, Feb. 1
plus fundamentals course

Lubbock
Friday, March 27

Dallas
Saturday, March 28

Houston
Saturday, April 4

Question/Answers from the Texas Herd (cont.)

Question: May our practice sell compounded eyedrops to patients directly from our office, with a small handling fee?

Answer: No. the Texas Administrative Code indicates that only in exceptional circumstances may a physician supply drugs to patients other than to meet their immediate needs. And even in these exceptional circumstances, it is a violation of the Code to profit (i.e. handling or delivery fee) from the delivery of the drug.

Texas Administrative Code, Title 22, Part 9, Chapter 169:
Authority of Physicians to Supply Drugs

Rule 169.4: Providing, Dispensing, or Distributing Drugs
Except as otherwise provided in §169.5 of this chapter, a physician may provide, dispense, or distribute drugs for use or consumption by the patient away from the physician's office or after the conclusion of the physician-patient encounter only in quantities as are necessary to meet the patient's immediate needs. A physician shall comply personally with all appropriate labeling and record keeping requirements under state or federal law or shall oversee compliance by persons acting under his or her direction and supervision. A physician who provides, dispenses, or distributes drugs to a patient to meet his or her immediate needs may not charge a fee separate from that charged for medical services provided to the patient.

169.5: Exceptions

Under the following circumstances, a physician may dispense or distribute drugs in quantities greater than those necessary to meet a patient's immediate needs.

(1) A licensed physician who practices medicine in a rural area, as defined in Section 169.2(10) of this chapter, may maintain a supply of dangerous drugs in his or her office to be dispensed in treating his or her patients and may be reimbursed for the cost of supplying those drugs without violating the Texas Pharmacy Act, Title 3 Subtitle J Tex. Occ. Code Ann. A physician desiring to dispense dangerous drugs in compliance with this subsection and §§158.001-.003 of the Act, shall notify the board and the Texas State Board of Pharmacy that he or she practices in a rural area.

(2) If a physician believes that a patient's prescribed treatment regimen should include certain drugs, the physician may supply them to the patient by means of pharmaceutical samples. No charge may be made by a physician for such samples. A patient's immediate needs as defined in this chapter shall not affect or limit the quantity of pharmaceutical samples a physician may provide to the patient.

In Memorium

Richard Levacy, MD of Beaumont passed away March 2019.

Virginia Connally, MD of Abilene passed away March 2019 at age 106.

Chester Vaughn, MD of Tyler passed away September, 2018.

Sheldon Braverman, MD of San Antonio passed away November, 2018.

Jack Cooper, MD of Dallas passed away June, 2019.

Sam V. Stone, Jr, JD

Samuel Vaughan Stone, Jr., passed away peacefully on April 26, 2019 surrounded by family. Sam served as TOA's general counsel for over 40 years and guided the association through many legislative and regulatory storms. Sam's dedication to quality eye care along with his tremendous institutional knowledge was invaluable.

Sam was born on January 21, 1934 to Samuel Vaughan Stone and Berenice Barton Hufstutler Stone in Georgetown, Texas. He was a graduate of Georgetown High School (#71, All District Tackle and still proud they beat their nemesis, the Taylor Ducks), the University of Texas, and the University of Texas School of Law. Sam served in the Army for two years as Lieutenant in the Military Police. Much to his relief, he received an honorable discharge in 1960.

Sam is survived by his children: Samuel Vaughan Stone, III and his wife Beryl, William Morgan Stone and Frances Berenice Stone; his grandchildren Olivia Stone, Will Stone, and Katherine Stone; his brother and sister-in-law Mike and Carolyn Stone; numerous nieces and nephews and grand nieces and nephews and cousins. Sam is also survived by his two former wives, one who gave him his children and the other who showed him the world.

Sam had a distinguished legal career spanning many decades representing the Texas Academy of Family Physicians, the Travis County Medical Society, the Texas Physicians Assistants Association, the Texas Ophthalmologists Association, the Texas Librarians Association and many other professional organizations. He occasionally represented his children as well in their younger days.

Sam will be remembered by his family and many loving friends for his quick wit, love of good conversation and good scotch, and holding court at Tarry House or Headliners.

“Sam was a great guy who helped the TOA over so many years. He will be missed.”—David Shulman, MD





Congressional Advocacy Day and AAO Council Report

By Robert D. Gross, MBA, MD, FACS, AAO Councilor

The Texas Ophthalmological Association was well represented at this year's American Academy of Ophthalmology's Congressional Advocacy Day and Mid-Year Forum, April 10-13 in Washington DC. Councilors **Galen Kemp**, **Chevy Lee** and I were joined by TOA President **Sanjiv Kumar**; Past President **John Haley**; TOA members **Jeremiah Brown**, **Jane Edmond**, **Sidney Gicheru**, **Mark Mazow**, **Aaron Miller** and **Jack Pierce**.

Our Texas Advocacy Ambassadors were:

- **Jed Assam, MD** - University of Texas Medical Branch
- **William Burkes, MD** - Texas Tech University HSC
- **Richard Jones, MD** - UT Health San Antonio
- **Kyle MacLean, MD** - UT Health San Antonio
- **Aditya Mehta, MD** - The San Antonio Uniformed Services Health Education Consortium
- **Martin Mullen, MD** - UT Southwestern Medical Center
- **Hamza Pasha, MD** - University of Texas Medical Branch
- **Claudia Prospero Ponce, MD** - Houston Methodist
- **Jacob Reynolds, MD** - Texas Tech University HSC
- **Mahdi Rostamizadeh, MD** - Valley Retina
- **Michael Simmons, MD** - UT Southwestern Medical Center
- **Timothy Sipos, MD** - Baylor Scott & White Eye Institute
- **Meghan Saumur, MD** - Baylor College of Medicine
- **Elaine Zhou, MD** - Baylor College of Medicine

TOA's broad support for resident participation was recognized by the AAO at this meeting. We were one of two recipients of the AAO's Platinum Participation Award, a reflection of the emphasis TOA places on early involvement in our profession by our ophthalmologists in training. Our thanks also to the residency programs for their support.

AAO Congressional Advocacy Day took place on April 11th. We met with numerous congressional and senate staff with emphasis on seeking support for AAO positions such as seeking relief from onerous prior authorization requirements under Medicare Advantage plans, step therapy, increasing prices and decreasing availability of ophthalmic medications, and support for increasing appropriations for eye research. Our Advocacy Ambassadors were very effective in our conversations with legislative staff on Capitol Hill.



The Mid-Year Forum and AAO Council meeting included extensive discussion of several key issues facing ophthalmology and our patients. There were symposia covering the increasing cost of pharmaceuticals, the use of social media as a means of communication with our patients and for marketing, private equity purchases of ophthalmology practices, the IRIS Registry, and emergency planning and disaster preparedness – including cybersecurity and active shooter planning. Excellent resources on emergency preparedness, disaster planning and cybersecurity are available at www.aao.org/MYF19-EPDP.

The AAO Council considered a number of Council Advisory Recommendations (CARs). CARs approved for referral to the AAO Board of Trustees included recommendations on issues such as transition of care for disabled pediatric patients, CME for cybersecurity training, recommendations for driving fitness, and measures to address workforce shortages in ophthalmic technical personnel.

TOA is increasing its number of scholarships for residents and fellows to attend next year's Congressional Advocacy Day, April 23, 2020. TOA also thanks the programs for allowing time off to these ambassadors and future leaders. Any AAO member may attend Congressional Advocacy Day.



Members Honored by AAO

Senior Achievement Award

Karl G. Csaky, MD
Dallas

Brian E. Flowers, MD
Fort Worth

Achievement Award

R. Galen Kemp, MD
Waxahachie

Oluwatosin U. Smith, MD
Colleyville

Kimberly G. Yen, MD
Houston

Secretariat Awards

The following awards recognize individuals for their contributions and volunteer activities that support the AAO and the profession:

From the Senior Secretary for Ophthalmic Practice

Sandra Schnable, CPC, CCS-P, OCS, OCSR, CEMA, Midland.

Although Ms. Schnable is not an ophthalmologist, she provides tremendous support to Codequest and to the residents training at Texas Tech University HSC Department of Ophthalmology.

From the Secretary for Annual Meeting

Mitchell P. Weikert, MD
Houston

Annual Meeting a Success

Follow us
on Social
Media!



@txoph



@txoph

Under the direction of **Mark Gallardo, MD**, the 2019 Annual Meeting in May in Dallas featured high-caliber continuing medical education and an excellent resident competition.

Thank you to the members of the Education Committee: **Mark Gallardo, MD, chair; Sanjiv Kumar, MD; and James P. McCulley, MD, FRCOphth(UK), FACS.**

Ophthalmologists continue to play an important role in the House of Medicine at the local, state and national levels. Within the Texas Medical Association, many TOA members serve in leadership roles. It is remarkable for such a small specialty to be so visible within the House of Medicine. Here is a listing of those members serving within the TMA:

Officer – Secretary/Treasurer

Michelle A. Berger, MD

Board of Trustees:

Keith A. Bourgeois, MD, member-at-large

Council on Legislation:

Victor H. Gonzalez, MD, member

Council on Practice Management Services:

Johnathan Warminski, MD, member

Texas Delegation to the AMA:

Lyle Thorstenson, MD, delegate

Michelle A. Berger, MD, Texas delegation vice chair

Interspecialty Society Committee:

Jack W. Pierce, MD, committee chair

Shashi Alloju MD, alternate delegate

TMA Past Presidents:

Alan C. Baum, MD (2000)

Robert M. Tenery, Jr., MD (1994)

TMA House of Delegates:

Audrey E. Ahuero, MD; Charlotte M. Akor, MD; Michelle A. Berger, MD; Robert Gerald, MD; Robert D. Gross, MD; Lindsey D. Harris, MD; Jerry D. Hunsaker, MD; Chevy C. Lee, MD; Jacob Moore, MD; Jack W. Pierce, MD; Ryan Rush, MD; Todd Shepler, MD; Alexander P. Sudarshan, MD; Rosa A. Tang, MD; Johnathan Warminski, MD and Dan A. Willis, MD

TMA House of Delegates (ex-officio):

Alan C. Baum, MD; Michelle A. Berger, MD; Keith A. Bourgeois, MD; Victor H. Gonzalez, MD; Robert M. Tenery, Jr., MD.

TMA House of Delegates (Alternate Delegates):

Garvin H. Davis, MD; Shashi K. Dharma, MD; Jonathan Grady, MD; A. Melinda Rainey, MD; Ann E. Ranelle, DO; H. Miller Richert, MD; Halsey Settle, III, MD; and Frank Terrell, MD.

TexPac Board of Directors:

Audrey Ahuero, MD (District 7); Jake Moore, MD (District 20);

Jerry Hunsaker, MD (District 20); Carlos Manrique de Lara, MD; (District 21); Chevy Lee, MD (District 27); Victor Gonzalez, MD (District 27)



Advocacy is a Year-Round Sport!

Do you know the names of your state representative and state senator?

It's always a great time to get involved in advocacy. Attending a fundraiser for your local lawmakers or candidates at this time of the year can spur valuable relationships.

TOA may not contribute to political campaigns; that is the role of EYE-PAC. Contact Rachael Reed at exec@texaseyes.org to learn how to get involved in your district.



Dr. Wanda Northum with
Sen. Bryan Hughes



Drs. Mark Mazow and Robert Gross
with Rep. Julie Johnson

SAVE
the
DATE

TexMed
2020 and
TOA Annual
Meeting

May 1-2
Fort Worth



The Annual Meeting
is free for TOA
members.

TOA Change of Officers

Congratulations to **Sanjiv R. Kumar, MD** for his service and leadership as the 2018-2019 TOA president. Dr. Kumar put patient safety first time and again as he guided us through the 2019 Texas legislative session. His steadfast leadership and devotion to quality eye care helped defeat the dangerous scope of practice bills that patients faced. Thank you, Dr. Kumar!

Mark Gallardo, MD of El Paso was inaugurated as the 63rd President of the TOA on Saturday, May 18 during the Annual Business Meeting. Dr. Gallardo has been part of TOA's success for many years, serving on the Executive Council continuously since 2010. Dr. Gallardo, a glaucoma specialist, is a strong advocate for patient safety.

The TOA Business Meeting was held as part of the Annual Meeting. New members of the Executive Council were elected by members present. Below is a list of the full roster of officers and councilors:



- | | |
|---------------------|---|
| President: | Mark J. Gallardo, MD, El Paso (automatic) |
| President-Elect: | Mark Mazow, MD, Dallas |
| Secretary: | Lindsey Harris, MD, Houston |
| Treasurer: | H. Miller Richert, MD, Abilene |
| Past President: | Sanjiv R. Kumar, MD, San Antonio (automatic) |
| Councilors: | Jacob Moore, MD, Corpus Christi |
| | Ryan Rush, MD, Amarillo |
| | Marie Bui, MD, Austin |
| | Davinder Grover, MD, Dallas |
| | Mark Mazow, MD, Dallas |
| | Ann Ranelle, DO, Fort Worth (new to EC) |
| | Ximena De Sabra, MD, Austin |
| | Charlotte Akor, MD, Abilene |
| | Zev Shulkin, MD, Dallas (new to EC) |
| AAO Councilors: | R. Galen Kemp, MD, Waxahachie |
| | Robert Gross, MD, Dallas |
| | Chevy Lee, MD, McAllen |
| | Sidney K. Gicheru, MD, Dallas (as of Jan. 1, 2020) |
| AAO Alt. Councilor: | Rajiv Rugwani, MD, Waxahachie |
| TMA Delegate: | Jack W. Pierce, MD, Austin |
| TMA Alt. Delegate: | Sashi Alloju, MD, Dallas (new to EC) |

Committee on Legislative Activities: David Shulman, MD, Chair
Liaison Committee to Third Party Payors: John Haley, MD, Chair

2019 Award Winners

Congratulations to the winners of the 2019 Barry Uhr, MD, Memorial Prize in Comprehensive Ophthalmology. The memorial prize was established by the TOA Foundation in 2011 to honor former TOA President, Barry Uhr, MD, of Dallas.

Before his passing in 2010, Dr. Uhr practiced comprehensive ophthalmology in Dallas for almost 40 years, but his care for patients extended far beyond direct patient care. He served as President, officer and longtime legislative committee member of TOA, President of Dallas County Medical Society, President of Dallas Academy of Ophthalmology, member of the Board of Trustees of the AAO, TexPac board, and several OMIC committees.

1st Prize

Complications of Resident-Performed Intravitreal Injections

Keerthana Bolisetty, MD,
UT Southwestern Medical Center, Dallas, TX

2nd Prize

Military Ophthalmologists Deployed to Iraq and Afghanistan

Grant Justin, MD, Uniformed Services Health Education
Consortium (SAUSHEC) Ophthalmology Residency, San Antonio, TX

*Special Thanks to the TOA Foundation for
supporting the TOA Annual Meeting*

The John Henry & Anna Marie Fish Memorial Fund

Dr. & Mrs. Gary Edd Fish, MD

Dr. & Mrs. John Ronald Fish, MD

Dr. & Mrs. Kenton Henry Fish, MD

The Eyecare Consortium of Texas Scientific Educational Fund

Eyecare Consortium of Texas

New World Medical, Inc.

*...and the many TOA members who have
contributed to the TOA Foundation.*



Special Recognition

2019 Distinguished Service Award: Jerry Hunsaker, MD

The Distinguished Service Award is the TOA's highest honor. It is a peer recognition award given to those who have exhibited a lifelong dedication to ophthalmology patients and to the profession. Each year, the sitting president selects the awardee. Sanjiv Kumar, MD presented the award to Jerry Hunsaker, MD with the following words:

“Today, I have the honor of presenting this award to Jerry Hunsaker, MD of Corpus Christi.

Dr. Hunsaker served as TOA President 1998-1999 and is one of the original board members of the TOA Foundation. He is an “EYE-PAC for life” member. He served as Texas Medical Association’s TEXPAC’s Board Chair from 2013-2014 and is still active with that organization.

Dr. Hunsaker has always had advocacy in his blood. You’ll frequently find him and his wife Keely Hunsaker, DDS (past president of the TMA Alliance and current member of TEXPAC leadership) at TMA’s First Tuesday lobby days and the various TMA meetings. As usual, they came to every First Tuesday this year.

But more importantly, the Hunsakers practice grassroots advocacy the best way, the smart way – they understand that the care and feeding of political relationships is a year-round job. They maintain genuine relationships with their local lawmakers including Rep. Todd Hunter and Sen. Chuy Hinojosa. If you walk around the Capitol with the Hunsakers, you will quickly see that these are true friendships. The lawmakers trust them. We are so lucky have both Jerry and Keely Hunsaker representing our eyecare patients.

Dr. Hunsaker is here today with his family.”

Welcome New Members

Provisional

Elvia Canseco, MD, Houston
P. Christi Carter, MD, Marble Falls
Joel H Goffman, MD, Houston
Naina Gupta, MD, Dallas
James Harkins, MD, Waco
Jay Joseph, MD, Allen
Rishav Kansal, MD, Richardson
Albert P. Lin, MD, Houston
Morgan Micheletti, MD, Houston
Sarah N. Mirza, MD, Dallas
Anhtuan Nguyen, MD, San Antonio
Amenze Oriaiifo, MD, San Marcos
Michael Rolfsen, MD, Waco
Colin J. Scott, MD, Sunnyvale
Bryce Shutt, MD, Waco
Kevin Talbot, MD, Beaumont
Huy Tran, MD, Arlington
Ivan Vrcek, MD, Dallas
Joshua Wiggins, MD, JD, Texarkana

Out-of-State

Ho-Seok Sa, MD, PhD, Seoul, Korea
Benjamin Haden, MD, Springfield, MO
Elena Kiang, MD, Sarasota, FL
Sohail Khan, MD, Augusta, GA

Resident

Jed Assam, MD, Galveston
Peter Bealka, MD, Waco
Buck Bennett, MD, Fort Worth
Keerthana Bolisetty, MD, Dallas
Trenton Bowen, MD, Dallas
William Burkes, MD, Lubbock
Amy Cadis, MD, Temple
Cameron Carr, MD, Dallas
Sylvia Casas de Leon, MD, Fort Worth
Stephan Y Chiu, MD, Dallas
S. Serdar Dogan, MD, Dallas
Bobby W. Douglas, MD, Temple
Kourtney Dwyer, MD, Temple
Parsha Forouzan, MD, MS, Dallas
Darron Fors, MD, Dallas
Ankur Gupta, MD, MBA, Dallas
Spencer Hayes, MD, Austin

Brian Heiniger, MD, Dallas
Bennett Hong, MD, Galveston
Andrew D. Johnson, MD, Temple
Richard Jones, MD, San Antonio
Zachary Keenum, MD, Dallas
Ross Kennamer-Chapman, MD, Fort Worth
Bradley Langston, MD, Dallas
Emma McDonnell, MD, Dallas
Aditya Mehta, MD, Lackland AFB
Joseph Merck, MD, Temple
Andrew Mueller, MD, Dallas
Martin Mullen, MD, Dallas
Hamza Pasha, MD, Galveston
Kishan Patel, MD, Austin
Varun Reddy, MD, Dallas
Donovan Reed, MD, San Antonio
Meghan Saumur, MD, Houston
Adriane Schiano, MD, Dallas
David Seamount, MD, Dallas
Michael Simmons, MD, Dallas
Ashish Singh, MD, Dallas
Timothy Sipos, MD, Temple
Connor Smith, MD, Fort Worth
Timothy Soeken, MD, Fort Sam Houston
Sean Wadley, MD, Temple
Jana Waters, MD, Temple
James Wilhite Jr, MD, Temple
Katherine Williams, MD, Houston
Elaine Zhou, MD, Houston

Fellow

Hussam Banna, MD, Dallas
Jinghua Chen, MD, PhD, Dallas
Pedro Davila, MD, Dallas
Evan Levy, MD, Dallas
Shaam Mahasneh, MD, Dallas
Orwa Nasser, MD, MPH, Dallas
Amenze Osa, MD, Dallas
Corey Parish, MD, Dallas
Andrew B Pazandak, MD, Dallas
Stacy Scofield-Kaplan, MD, Dallas

False Advertising in Your Community?

We occasionally hear from members who observe instances of false advertising or misrepresentation of health care providers in local publications. An example of this would be a mid-level provider listed as a physician or surgeon in a newspaper or phone book. While these listings might be accidental, it is important that members of the public see accurate information about the various providers in their community.

TOA can communicate with the involved parties so that you don't have to. We will explain the law regarding professional identification, specifically the requirements of Chapter 104 Healing Art Practitioners, under Title 3 Health Professions of the Occupations Code, and the Texas Medical Act.

Contact Rachael Reed in the executive office at exec@TexasEyes.org or at (512) 370-1518 for more information

New Consent Form for 2020

Member Benefit:

Submit your questions regarding Texas Regulatory Laws & Practice Acts to andrea@aschwablaw.com

The Texas Medical Disclosure Panel (TMDP) has adopted changes to informed consent forms, which will take effect at the beginning of 2020. Ophthalmologists will use the new Disclosure and Consent for Medical Care and Surgical Procedures form. Links to the forms in English and Spanish can be found at www.TexasEyes.org under “quick links” on the home page. Beginning Jan. 1, a patient must sign the new version of the applicable form before a physician provides the care or procedure to have it presumed in a court proceeding that the physician obtained informed consent.

The presumption physicians receive in court by having a patient sign the form is rebuttable in a court of law; if the patient did sign the applicable form prior to the care or procedure, the patient would have to prove in court that the information he or she received was insufficient. But if the physician does not get the patient’s signature on the informed-consent form beforehand, and the patient alleges that the physician didn’t make the required disclosures, the physician has the burden of proving he or she obtained proper informed consent.

In 2018, The Texas Medical Disclosure Panel (TMDP) approved changes to the lists of medical care and surgical procedures that require disclosure of specific risks and hazards. Effective August, 2018, physicians providing these eye care services (list A, below) must disclose each of these specific risks and hazards to their patients or persons authorized to consent for their patients and to establish the general form and substance of such disclosure. List B names procedures requiring no disclosure of specific risks and hazards.

Texas Administrative Code

TITLE 25 HEALTH SERVICES
PART 7 TEXAS MEDICAL DISCLOSURE PANEL
CHAPTER 601 INFORMED CONSENT

RULE §601.2

Procedures Requiring Full Disclosure of Specific Risks and Hazards – List A

(f) Eye treatments and procedures.

(1) Eye muscle surgery.

(A) Additional treatment and/or surgery.

(B) Double vision.

(C) Partial or total blindness.

(2) Surgery for cataract with or without implantation of intraocular lens.

(A) Complications requiring additional treatment and/or surgery.

(B) Need for glasses or contact lenses.

(C) Complications requiring the removal of implanted lens.

(D) Partial or total blindness.

(3) Retinal or vitreous surgery.

(A) Complications requiring additional treatment and/or surgery.

(B) Recurrence or spread of disease.

(C) Partial or total blindness.

(4) Reconstructive and/or plastic surgical procedures of the eye and eye region, such as blepharoplasty, tumor, fracture, lacrimal surgery, foreign body, abscess, or trauma.

(A) Blindness.

(B) Nerve damage with loss of use and/or feeling to eye or other areas of face.

(C) Painful or unattractive scarring.

(D) Worsening or unsatisfactory appearance.

(E) Dry eye.

(5) Photocoagulation and/or cryotherapy.

(A) Complications requiring additional treatment and/or surgery.

(B) Pain.

(C) Partial or total blindness.

(6) Corneal surgery, such as corneal transplant, refractive surgery and pterygium.

(A) Complications requiring additional treatment and/or surgery.

(B) Pain.

(C) Need for glasses or contact lenses.

(D) Partial or total blindness.

(7) Glaucoma surgery by any method.

(A) Complications requiring additional treatment and/or surgery.

(B) Worsening of the glaucoma.

(C) Pain.

(D) Partial or total blindness.

(8) Removal of the eye or its contents (enucleation or evisceration).

(A) Complications requiring additional treatment and/or surgery.

(B) Worsening or unsatisfactory appearance.

(C) Recurrence or spread of disease.

(9) Surgery for penetrating ocular injury, including intraocular foreign body.

(A) Complications requiring additional treatment and/or surgery.

(B) Possible removal of eye.

(C) Pain.

(D) Partial or total blindness.

RULE §601.3

Procedures Requiring No Disclosure of Specific Risks and Hazards--List B

(f) Eye.

(1) Administration of topical, parenteral (such as IV), or oral drugs or pharmaceuticals, including, but not limited to, fluorescein angiography, orbital injection or periocular injections.

(2) Removal of extraocular foreign bodies.

(3) Chalazion excision.

Proud to be an Eye Physician

Ophthalmology is one of the very best specialties in medicine. Our eye physicians and surgeons tend to be leaders in their communities and life-long learners.

This new series will demonstrate the diverse interests and activities of our members.



An interview with M. Kelly Green, MD

Dr. Green is a comprehensive ophthalmologist practicing in the hill country community of Marble Falls.

You joined TOA in 2006 as an intern. What motivated you to join at the very beginning of your career?

I was acquainted with several Austin area eyeMDs who told me about the importance of advocacy and the TOA. I also knew that Dr David Shulman and my dad, fellow ophthalmologist Dr Robert Green felt that TOA was doing important work to preserve patient safety in Texas

Tell us about your time in the Peace Corps in West Africa.

I left the US three weeks after college graduation! I taught high school physics and chemistry (in French) in Bénin, West Africa. I also worked on a well-building project and an educational seminar for local women. I learned a lot about another culture. It has made me a better physician, and a better employer. My experiences in Bénin gave me the skills that allow me to see things from many perspectives and to be aware of cultural differences. I also learned a lot about myself and how I deal with stress. It was quite a fascinating two years.

Why did you choose ophthalmology as your specialty and would you choose it again?

My Med school anatomy professor calls ophthalmology the “Queen of all the specialties!” I agree. We must work to maintain that status. We are the guardians of vision. We must remain steadfast in our refusal to bow to the lure of money, and instead provide superb medical and surgical eye care for our trusting patients.

You clearly have a passion for teaching and service – are you still teaching?

Yes, I am a clinical professor at UT Health San Antonio’s Dept of Ophthalmology. Just a few months ago, I spoke with the residents there about the importance of advocacy. I am honored to serve as an Oral Board Examiner for the American Board of Ophthalmology. Our practice welcomes high school

health career students to shadow us in clinic. One of my personal mentees is now a neurology resident. A major part of what we do every day IS education – it’s part of why I love being a physician.

You are a staunch advocate for patient safety. What would happen if we didn’t engage in the political process?

Well first of all, we MUST engage. It would be tantamount to abandoning our sweet patients if we were not to advocate for their safety. Legislators simply have too much to do and to learn. We must be there, in their offices, in their districts, alerting them to the dangers of legislating medical privileges. Medical privileges are properly obtained through 8 years of medical education, not by legislation. Our patients are counting on us to do this work.

What is your best piece of advice for that brand-new ophthalmologist?

Be true to your Hippocrates oath and be true to your patients. If you always do what is best for the patient, you cannot err. Our patients love and trust us. We must maintain our integrity at all times & resist the draw of purely financial success at all cost.

What do you enjoy doing when you’re not at work?

I play with my kids! My husband and I play soccer, build legos and ride bikes. We pick pears and blackberries on our little piece of land in the country. As a retired Ironman triathlete, I now plod along, jogging whilst pushing that gigantic double BOB stroller.

What would you choose for a superpower?

This is a hard one. I think I would like to be able to read minds. It might get kind of loud, but it would be so interesting!



Texas Ophthalmological Association
401 W. 15th Street, Ste. 825
Austin, TX 78701

Address Service Requested

PRESORTED
FIRST-CLASS MAIL
U.S. POSTAGE PAID
AUSTIN, TEXAS
PERMIT NO. 1787

Upcoming Events

December 7-8, 2019

TMA Advocacy Retreat
Austin

February 1, 2020

Codequest
San Marcos

March 27, 2020

Codequest
Lubbock

March 28, 2020

Codequest
Dallas

April 4, 2020

Codequest
Houston

April 23-25, 2020

AAO Congressional Advocacy Day
and Mid-Year Forum
Washington, DC

April 30, 2020

TOA Executive Council Meeting
3 pm
*Any TOA member may attend
Fort Worth*

May 1-2, 2020

TOA Annual Meeting
& TexMed
Fort Worth

Go to www.TexasEyes.org or contact TOA at 512-370-1504.