

Osteopathic Medicine in the United States

Osteopathic medicine in the United States is a complete system of medical training, much like the allopathic (MD) training in the US or the British system of medical education, with all of the specialties and subspecialty training available to its graduates. In addition to the usual course of medical study, osteopathic medical students spend additional time studying the musculoskeletal system as it relates to functional ability, as well as osteopathic manual medicine treatment methods to aid in the restoration of their patients' health. Disease prevention is a central tenet of this philosophy. There is an emphasis on treating the whole person – body, mind and spirit, rather than just the presenting symptoms.

While osteopathic medicine has its own basic board examinations (NBOME/COMLEX), hospitals, specialty training programs and specialty board examinations, American osteopathic physicians (DO) may choose to sit for the USMLE, complete allopathic graduate medical education programs and take allopathic specialty board exams. Because of our additional training, there is presently no pathway for our MD colleagues to be admitted to our training programs or sit for our exams. DOs & MDs are the only two types of complete physicians in the United States. Our medical education system is recognized as on par with allopathic (MD) training by our colleagues, medical institutions, professional organizations, educational accreditation bodies, testing examiners, licensing/regulatory authorities, the US government and military. Below you will find the documentation with hyperlinks (CTRL + Click to follow link) to support these statements.

The **[Federation of State Medical Boards \(FSMB\)](#)** is a national not-for-profit organization representing the seventy medical boards of the United States and its territories, including fourteen state boards of osteopathic medicine. The President & CEO of the FSMB is Humayun J. Chaudhry, DO, MS, FACP, FACOI.

The following documents demonstrate the parity of US-osteopathic medical education, basic board examination, specialty training, and specialty board certification with its allopathic – MD counterpart system:

[Essentials of a Modern Medical and Osteopathic Practice Act:](#) As early as 1914, the FSMB and its member boards recognized the need for what was to become A Guide to the Essentials of a Modern Medical and Osteopathic Practice Act. First published in 1956 and now updated every three years, its purpose is to (1) serve as a guide to those states that may adopt new medical practice acts or amend existing laws; and to (2) encourage the development and use of consistent standards, language, definitions and tools by boards responsible for physician regulation. Essentials of a Modern Medical Practice Act applies equally to practice acts that govern physicians who have acquired the M.D. or D.O. degree in the same statute or in separate statutes.

[Elements of a Modern State Medical and Osteopathic Board:](#) A companion document to the Essentials of a Modern Medical Practice and Osteopathic Act, the Elements is intended to nurture creativity by encouraging the public, state legislators, medical boards, medical societies and others who have an interest in the regulation of the medical profession to reexamine existing practice acts as they relate to the composition, structure, functions, responsibilities, powers and funding of medical boards. It is not an effort to provide a template for a complete medical practice act, but rather, includes only those portions of an act that focus most directly on the medical board itself.

The **[US Department of Education](#)** recognizes the American Osteopathic Association, Council on Osteopathic College Accreditation [COCA]: The dates specified for each entry are the date of initial listing as a recognized agency, the date of the Secretary's most recent grant of renewed

recognition, and the date of the agency's next scheduled review for renewal of recognition by the National Advisory Committee on Institutional Quality and Integrity. (Note: S = Spring meeting and F = Fall meeting)

American Osteopathic Association, Commission on Osteopathic College Accreditation

1952/2006/S2011

Scope of recognition: the accreditation and preaccreditation ("Provisional Accreditation") throughout the United States of freestanding, public and private non-profit institutions of osteopathic medicine and programs leading to the degree of Doctor of Osteopathy or Doctor of Osteopathic Medicine.

Title IV Note: *Only freestanding schools or colleges of osteopathic medicine may use accreditation by this agency to establish eligibility to participate in Title IV programs.*

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The **American Medical Association** [AMA] states that:

Who is eligible to be a member of the AMA?

Membership in the AMA is open to:

1. **Physicians who possess a U.S. doctor of medicine degree (MD) or doctor of osteopathic medicine (DO), or a recognized international equivalent.**
2. Resident physicians who are attending an accredited residency or fellowship program in the United States, Puerto Rico, Guam or the Virgin Islands.
3. **Medical students enrolled in educational programs provided by a college of medicine or osteopathic medicine accredited by the Liaison Committee on Medical Education or the American Osteopathic Association leading to a MD or DO degree.** This includes those students who are on approved sabbatical, provided that the student will be in good standing upon returning from the sabbatical.

On the AMA page for **Requirements for Becoming a Physician** it states:

The education of physicians in the United States is lengthy and involves undergraduate education, medical school and graduate medical education. (The term "graduate medical education" [GME] includes residency and fellowship training; the American Medical Association does not use the term "postgraduate education.")

Note: For more information on careers in all health care fields, including medicine, refer to the AMA's **Health Care Careers Directory**, which lists information about 81 health care careers and more than 8,000 accredited educational programs in those fields.

- **Undergraduate education:** Four years at a college or university to earn a BS or BA degree, usually with a strong emphasis on basic sciences, such as biology, chemistry, and physics (some students may enter medical school with other areas of emphasis).
- **Medical school** (undergraduate medical education): Four years of education at one of the U.S. medical schools accredited by the Liaison Committee on Medical Education (LCME). Four years at one of the LCME-accredited U.S. medical schools, consisting of preclinical and clinical parts. After completing medical school, students earn their doctor of medicine degrees (MDs), although they must complete additional training before practicing on their own as a physician. **(Note: Some physicians**

receive a **doctor of osteopathic medicine [DO] degree** from a college of osteopathic medicine.)

In the Glossary of Terms of its **Bylaws, the AMA** defines the following:

Academic Physician – an individual who possesses the **United States degree of doctor of medicine (MD) or doctor of osteopathic medicine (DO), or a recognized international equivalent, and who holds a faculty appointment of any type at a United States medical school with an educational program** as defined in Bylaw 1.11. **Educational program** describes a **Liaison Committee on Medical Education (LCME) or American Osteopathic Association (AOA) accredited program** in which medical students are enrolled.

According to **AMA Policy**:

D-405.989 Definition of a Physician

1. Our American Medical Association Commissioners to The Joint Commission will be urged to request and continue to work to have The Joint Commission's "Glossary" **definition of physician limited to Doctors of Medicine and Osteopathy.**
2. Our AMA Commissioners to The Joint Commission will be urged to request The Joint Commission delete any changes made and all references to the Social Security Act definition of physician added to the Elements of Performance with their July 1, 2009 change in the "Glossary" definition of physician.
3. **Our AMA will advocate with the American Osteopathic Association Health Facilities Accreditation Program, DNV and other potential deeming authorities to maintain a definition of physician as a Doctor of Medicine or Osteopathy.**
4. **Our AMA will, in conjunction with the Federation, aggressively pursue revision of the Social Security Act and state law definitions of physician to be limited to Doctors of Medicine and Osteopathy.** (Res. 821, I-09)

G-635.053 AMA Membership Strategy: Osteopathic Medicine

Our AMA's membership strategy on osteopathic physicians (DOs) includes the following: Our AMA: (1) encourages all state societies to accept DOs as members at every level of the Federation;

(2) encourages state societies with schools of osteopathic medicine to support development of Medical Student Sections at those schools; Both the MSS Governing Council and existing MSS chapters in states with osteopathic schools should assist in this effort;

(3) encourages that DO members of our AMA continue to participate in the Member-Get-a-Member program;

(4) will provide recruiters with targeted lists of DO nonmembers upon request;

(5) will include DOs, as appropriate, in direct nonmember mailings; and

(6) will expand its database of information on osteopathic students and doctors. (BOT Rep. I-93-11; Consolidated: CLRPD Rep. 3, I-01; Reaffirmed: Res. 809, I-05; Reaffirmed: BOT Rep. 35, A-08)

D-405.991 Clarification of the Title "Doctor" in the Hospital Environment

1. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement standards for an identification system for all hospital facility staff who have direct contact with patients which would require that an identification badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a Doctorate, and those with other types of credentials.
2. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement new standards that require anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition (H-405.969, **“that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine”**) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.
3. Our AMA will request the American Osteopathic Association (AOA) to (1) expand their standards to include proper identification of all medical staff and hospital personnel with their applicable credential (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), and (2) Require anyone in a hospital environment who has direct contact with a patient presenting himself or herself to the patient as a "doctor", who is not a "Physician" according to the AMA definition (AMA Policy H-405.969 .. **that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine**) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree. (Res. 846, I-08; Modified: BOT Rep. 9, I-09)

D-295.939 Independent Regulation of Physician Licensing Exams

Our AMA will: (1) continue to work with the National Board of Medical Examiners to ensure that the AMA is given appropriate advance notice of any major potential changes in the examination system in support of Policy H-295.893, "Voting Rights for AMA-MSS NBME Representatives;" (2) continue to collaborate with the organizations who create, validate, monitor, and administer the United States Medical Licensing Examination; (3) continue to promote and disseminate the rules governing USMLE in its publications; (4) continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP); and **(5) work with American Osteopathic Association and National Board of Osteopathic Medical Examiners to stay apprised of any major potential changes in the Comprehensive Osteopathic Medical Licensing Examination (COMLEX)**. (CME Rep. 10, A-08)

H-275.934 Alternatives to the Federation of State Medical Boards Recommendations on Licensure

Our AMA adopts the following principles:**(1) Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Parts 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Part 1 of COMLEX. There should be provision made for students who have not completed Step 2 of the USMLE or Part 2 of the COMLEX to do so during the first year of residency training.**

(2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., **have passed all licensing examinations (USMLE or COMLEX)**, and must be certified by their residency program director as ready to advance to the next year of

GME and to obtain a full and unrestricted license to practice medicine. The candidate for licensure should have had education that provided exposure to general medical content.

(3) There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. **To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Part 1 of COMLEX.**

(4) Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians.

(5) Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements.

D-275.985 Clinical Skills Assessment Exam and College of Osteopathic Medicine Licensing Exam-Physical Exam Implementation

Our AMA will: (1) study mechanisms for providing feedback to medical students on their performance on the proposed United States Medical Licensing Exam Clinical Skills Assessment Examination (CSAE) and College of Osteopathic Medicine Licensing Exam-Physical Exam (COMLEX-PE) including but not limited to written narrative feedback, and access to video recording of the exam for possible review with their medical school and communicate these findings to the National Board of Medical Examiners (NBME) and National Board of Osteopathic Medical Examiners (NBOME);

(2) encourage medical schools to develop mechanisms to assist medical students to meet financial obligations associated with the requirements for participation in the CSAE and COMLEX-PE;

(3) encourage medical schools to avoid linking passage of the CSAE and COMLEX-PE to graduation requirements for at least the first five years after the implementation of the proposed exam;

(4) in conjunction with the National Resident Matching Program, the American Osteopathic Association, the Accreditation Council for Graduate Medical Education, and other interested organizations, study the potential impact of the CSAE and COMLEX-PE on undergraduate and graduate medical education and report back at the 2004 Annual Meeting;

(5) strongly encourage the NBME and NBOME to develop policies to ensure adequate capacity for registration and administration of the proposed CSAE and COMLEX-PE in order to accommodate all students testing for the initial time as well ensuring students failing the exam can retest within 60 days; (6) monitor in an ongoing fashion, the proposed implementation of the CSAE and COMLEX-PE and its impact on the medical education continuum; and

(7) involve all interested groups at the AMA in any AMA deliberations regarding the CSAE as well as utilization of this or a similar test for recertification purposes, to ensure that the perspectives of all physicians are reflected. (Res. 324, A-03)

H-275.944 Board Certification and Discrimination

(1) Where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes, the AMA oppose discrimination that may occur against physicians involved in the board certification process including those who are in a clinical practice period for the specified

minimum period of time that must be completed prior to taking the board certifying examination. (2) Our AMA reaffirms and communicates its policy of opposition to discrimination against member physicians based solely on lack of American Board of Medical Specialties or equivalent American Osteopathic Board certification. (3) Our AMA continues to advocate for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not. (Sub. Res. 701, I-95; Appended: Res. 314, I-98; Appended: Sub. Res. 301, I-99; Reaffirmed: Sub. Res. 722, A-00; Reaffirmed: CME Rep. 7, A-07)

H-255.974 Preservation of Opportunities for US Graduates and International Medical Graduates Already Legally Present in the US

In the event of reductions in the resident workforce, the AMA will advocate for a mechanism of resident selection which promotes the maintenance of resident physician training opportunities for all qualified graduates of United States Liaison Committee on Medical Education and American Osteopathic Association accredited institutions; and the AMA adopts the position that it will be an advocate for IMGs already legally present in this country. (Res. 324, A-97; Reaffirmed: CME Rep. 10, A-99; Reaffirmed: CME Rep. 2, A-09)

H-295.892 Potential Implications of Attending Non-LCME/AOA Accredited Medical Education Programs

Our AMA encourages efforts to educate all prospective medical students about the potential implications of attending any non-Liaison Committee on Medical Education/American Osteopathic Association accredited medical education program. (Res. 322, I-98; Reaffirmed: CME Rep. 2, A-08)

D-295.323 Creation of Domestic For-Profit Medical Schools

Our AMA, in collaboration with the Association of American Medical Colleges, the Liaison Committee on Medical Education, and the Commission on Osteopathic College Accreditation, will study new and emerging models of medical school organization and governance, including for-profit models and how medical school accreditation standards can protect the quality and integrity of the education, with a report back to the House of Delegates at the 2011 Annual Meeting. (Res. 310, A-09)

H-275.923 Maintenance of Certification / Maintenance of Licensure

Our AMA will:

1. Continue to work with the Federation of State Medical Boards (FSMB) to establish and assess maintenance of licensure (MOL) principles with the AMA to assess the impact of MOC and MOL on the practicing physician and the FSMB to study the impact on licensing boards.
2. Recommend that the American Board of Medical Specialties (ABMS) not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
3. Encourage rigorous evaluation of the impact on physicians of future proposed changes to the MOC and MOL processes including cost, staffing, and time.
4. Review all AMA policies regarding medical licensure (Appendix A); determine if each policy should be reaffirmed, expanded, consolidated or is no longer relevant; and in collaboration with other stakeholders, update the policies with the view of developing AMA Principles of Maintenance of Licensure in a report to the HOD at the 2010 Annual Meeting.
5. Urge the National Alliance for Physician Competence (NAPC) to include a broader range of practicing physicians and additional stakeholders to participate in discussions of definitions and assessments of physician competence.

6. Continue to participate in the NAPC forums.

7. Encourage members of our House of Delegates to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.

8. Continue to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major CME credit systems that comprise the foundation for post graduate medical education in the US, including the Performance Improvement CME (PICME) format; and continue to develop relationships and agreements that may lead to standards, accepted by all US licensing boards, specialty boards, hospital credentialing bodies, and other entities requiring evidence of physician CME.

9. Collaborate with the American Osteopathic Association and its eighteen specialty boards in implementation of the recommendations in CME Report 16-A-09, Maintenance of Certification / Maintenance of Licensure. (CME Rep. 16, A-09)

D-310.962 Evaluation of Increasing Resident Review Committee Requirements

Our AMA will work with and monitor the Accreditation Council for Graduate Medical Education and American Osteopathic Association in studying residency/fellowship documentation requirements for program accreditation and the impact of these documentation requirements on program directors and residents with recommendations for improvement. (Res. 315, A-08)

D-295.934 Encouragement of Interprofessional Education Among Health Care Professions Students

Our AMA: (1) recognizes that interprofessional education and partnerships are a priority of the American medical education system; and (2) will explore the feasibility of the implementation of Liaison Committee on Medical Education and American Osteopathic Association accreditation standards requiring interprofessional training in medical schools. (Res. 308, A-08)

H-310.916 Funding to Support Training of the Health Care Workforce

Our American Medical Association will insist that **any new GME funding to support graduate medical education positions be available only to Accreditation Council for Graduate Medical Education (ACGME) and/or American Osteopathic Association (AOA) accredited residency programs, and believes that funding made available to support the training of health care providers not be made at the expense of ACGME and/or AOA accredited residency programs.** (Res. 913, I-09)

American Association of Medical Colleges

Parity as related to Graduate Medical Education Training in Federal Dollars

Federal Register /Vol. 75, No. 148 /Tuesday, August 3, 2010 / Proposed Rules

XVII. Proposed Changes Relating to Payments to Hospitals for Direct Graduate Medical Education (GME) and Indirect Medical Education (IME)

Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements for Accreditation of Graduate Medical Education Programs recognizes DO parity with resident selection for its programs:

INSTITUTIONAL RESPONSIBILITIES FOR RESIDENTS (page 4)

II.A. Eligibility and Selection of Residents: The Sponsoring Institution must have written policies and procedures for resident recruitment and appointment and must monitor each program for compliance. These eligibility requirements must address the following:

II.A.1. Resident eligibility: Applicants with one of the following qualifications are eligible for appointment to programs:

II.A.1.a) Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).

II.A.1.b) Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).

II.A.1.c) Graduates of medical schools outside the United States and Canada who meet one of the following qualifications:

II.A.1.c).(1) Have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment, or,

II.A.1.c).(2) Have a full and unrestricted license to practice medicine in a US licensing jurisdiction in which they are training.

II.A.1.d) Graduates of medical schools outside the United States who have completed a Fifth Pathway** program provided by an LCME accredited medical school.

The **American Board of Medical Specialties** (ABMS) member boards may certify osteopathic physicians who have successfully completed an ACGME accredited residency training program. ABMS also recognizes that osteopathic physicians may also be certified by their respective osteopathic specialty board of examiners:

Osteopathic boards and ABMS

Osteopathic boards fall under the umbrella of the American Osteopathic Association (AOA). For more information about osteopathic medicine, visit the **American Osteopathic Association** Web site.

The **ABMS 2009 Certificate Statistics** states the following on page 9:

Initial or General Certification is awarded to approved candidates who meet the requirements for certification in a defined field of medical practice (see Table 2A). It recognizes special knowledge and ability demonstrated during medical residency training and on examinations which are typically taken following the completion of a residency program. Candidates for General Certification are evaluated on the following areas:

1. Completion of a predoctoral medical education (MD, DO or other approved credential)
2. Completion of appropriate training in an accredited residency program
3. Possession of a valid and unrestricted license to practice medicine in at least one U.S. state, territory or in Canada
4. Demonstration of clinical competence and professionalism through documentation of performance provided by the residency training director or faculty
5. Successful completion of written and/or oral examinations administered by the Board which focuses on knowledge, judgment and diagnosis

...Each Board is responsible for establishing the content of the board certification exams. Exams are developed by physicians who are subject matter experts in specific areas of medicine. This is done to assure that the exam is a thorough, relevant and fair assessment of medical knowledge and clinical judgment. Depending on the Board, certification is valid for 6-10 years. In order to recertify, physicians participate in another process called ABMS Maintenance of Certification® (MOC) which is described on page 42.

ABMS recognizes AOA Category 1A Continuing Medical Education as meeting the **Standards for ABMS Maintenance of Certification** for DOs or MDs for ABMS certifying boards.

The **Utilization Review Accreditation Council (URAC)** states that for **accreditation purposes its requirements state:**

CORE 10 – Senior Clinical Staff Requirements

The *organization* designates at least one senior clinical *staff* person who has:

- a. Current, unrestricted clinical license(s) (or if the license is restricted, the organization has a process to ensure job functions do not violate the restrictions imposed by the state licensure board);
- b. Qualifications to perform clinical oversight for the services provided; and
- c. Post-graduate experience in direct patient care; and
- d. Board certification (if the senior clinical staff person is an M.D. or D.O.).

CORE - 11 - Senior Clinical Staff Responsibilities

A senior clinical *staff* person:

- a. Provides guidance for all clinical aspects of program;
- b. Is responsible for clinical aspects of program; and
- c. Has periodic consultation with practitioners in the field.

Question: With regards to Core Standard 10 and 11, in the interpretive guide it indicates URAC generally expects that the organization providing general health services, products or management, that the senior clinical staff is a MD or DO. We are sitting for accreditation for case management only. We do have a medical director, but he is contracted to provide services as needed. We provide case management services; we are not an insurance company nor do we approve or deny services (i.e., perform utilization review). Do we need to have an MD or DO on staff in the Senior Clinical position?

Response: For Case Management organizations, it is not required that the senior clinical staff person be a physician; however, the case management standards require that the case managers have access to a physician that has experience to the type of program under consideration.

The senior clinical staff person for a Utilization Management program must be an MD or DO for general health and welfare review programs. In addition, *board eligible* does not meet Core 10(d). Though the senior clinical staff person may not work full time, work remotely, or may be a contracted individual instead of an employee, it is incumbent upon the organization to provide evidence that this individual is qualified pursuant to Core 10 and fulfills the accountabilities identified in Core 11.

Citations in the United States Code (USC)
& Code of Federal Regulations (CFR)

1. Social Security Administration's recognition of osteopathic postdoctoral training for coverage of in-patient hospital services under Medicare [42 USC §1395x \(b\)](#)

[TITLE 42](#) > [CHAPTER 7](#) > [SUBCHAPTER XVIII](#) > [Part E](#) > § 1395x

§ 1395x. Definitions

For purposes of this subchapter—

(a) Spell of illness

The term “spell of illness” with respect to any individual means a period of consecutive days—

- (1)** beginning with the first day (not included in a previous spell of illness)
 - (A)** on which such individual is furnished inpatient hospital services, inpatient critical access hospital services or extended care services, and
 - (B)** which occurs in a month for which he is entitled to benefits under part A of this subchapter, and
- (2)** ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital or critical access hospital nor an inpatient of a facility described in section [1396r \(a\)\(2\)](#) of this title or subsection (y)(1) of this section.

(b) Inpatient hospital services

The term “inpatient hospital services” means the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital—

- (1)** bed and board;
- (2)** such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients; and
- (3)** such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by others under such arrangements; excluding, however—
- (4)** medical or surgical services provided by a physician, resident, or intern, services described by subsection (s)(2)(K) of this section, certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist; and
- (5)** the services of a private-duty nurse or other private-duty attendant.
Paragraph (4) shall not apply to services provided in a hospital by—
- (6)** **an intern or a resident-in-training under a teaching program approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, or, in the case of services in a hospital or osteopathic hospital by an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association, or in the case of services in a hospital or osteopathic hospital by an intern or resident-in-training in the field of podiatry, approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association; or**
- (7)** a physician where the hospital has a teaching program approved as specified in paragraph (6), if
 - (A)** the hospital elects to receive any payment due under this subchapter for reasonable costs of such services, and
 - (B)** all physicians in such hospital agree not to bill charges for professional services rendered in such hospital to individuals covered under the insurance program established by this subchapter.

2. Social Security Administration’s legal definition of “physician.” [42 USC §1395x \(r\)](#)

[TITLE 42](#) > [CHAPTER 7](#) > [SUBCHAPTER XVIII](#) > [Part E](#) > § 1395x

§ 1395x. Definitions

(r) Physician

The term “physician”, when used in connection with the performance of any function or action, means

- (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section [1301 \(a\)\(7\)](#) of this title),
- (2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions,
- (3) a doctor of podiatric medicine for the purposes of subsections (k), (m), (p)(1), and (s) of this section and sections [1395f \(a\)](#), [1395k \(a\)\(2\)\(F\)\(ii\)](#), and [1395n](#) of this title but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them,
- (4) a doctor of optometry, but only for purposes of subsection (p)(1) of this section and with respect to the provision of items or services described in subsection (s) of this section which he is legally authorized to perform as a doctor of optometry by the State in which he performs them, or
- (5) a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of subsections (s)(1) and (s)(2)(A) of this section and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided. For the purposes of section [1395y \(a\)\(4\)](#) of this title and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section [1395y \(a\)\(4\)](#) of this title) are furnished.

[TITLE 42](#) > [CHAPTER 7](#) > [SUBCHAPTER XI](#) > [Part A](#) > § 1301

§ 1301. Definitions

(a) When used in this chapter—

- (1) The term “State”, except where otherwise provided, includes the District of Columbia and the Commonwealth of Puerto Rico, and when used in subchapters IV, V, VII, XI, XIX, and XXI of this chapter includes the Virgin Islands and Guam. Such term when used in subchapters III, IX, and XII of this chapter also includes the Virgin Islands. Such term when used in subchapter V and in part B of this subchapter of this chapter also includes American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands. Such term when used in subchapters XIX and XXI of this chapter also includes the Northern Mariana Islands and American Samoa. In the case of Puerto Rico, the Virgin Islands, and Guam, subchapters I, X, and XIV, and subchapter XVI of this chapter (as in effect without regard to the amendment made by section 301 of the Social Security Amendments of 1972) shall continue to apply, and the term “State” when used in such subchapters (but not in subchapter XVI of this chapter as in effect pursuant to such amendment after December 31, 1973) includes Puerto Rico, the Virgin Islands, and Guam. Such term when used in subchapter XX of this chapter also includes the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. Such term when used in subchapter IV of this chapter also includes American Samoa.
- (2) The term “United States” when used in a geographical sense means, except where otherwise provided, the States.
- (3) The term “person” means an individual, a trust or estate, a partnership, or a corporation.
- (4) The term “corporation” includes associations, joint-stock companies, and insurance companies.

(5) The term “shareholder” includes a member in an association, joint-stock company, or insurance company.

(6) The term “Secretary”, except when the context otherwise requires, means the Secretary of Health and Human Services.

(7) The terms “physician” and “medical care” and “hospitalization” include osteopathic practitioners or the services of osteopathic practitioners and hospitals within the scope of their practice as defined by State law.

3. Social Security Administration’s recognition of AOA-accredited hospitals. [42 USC §1395bb](#)

[TITLE 42](#) > [CHAPTER 7](#) > [SUBCHAPTER XVIII](#) > [Part E](#) > § 1395bb

§ 1395bb. Effect of accreditation

(a) Accreditation by American Osteopathic Association or other national accreditation body

(1) If the Secretary finds that accreditation of a provider entity (as defined in paragraph (4)) by the American Osteopathic Association or any other national accreditation body demonstrates that all of the applicable conditions or requirements of this subchapter (other than the requirements of section [1395m \(j\)](#) of this title or the conditions and requirements under section [1395rr \(b\)](#) of this title) are met or exceeded—

(A) in the case of a provider entity not described in paragraph (3)(B), the Secretary shall treat such entity as meeting those conditions or requirements with respect to which the Secretary made such finding; or

(B) in the case of a provider entity described in paragraph (3)(B), the Secretary may treat such entity as meeting those conditions or requirements with respect to which the Secretary made such finding.

(2) In making such a finding, the Secretary shall consider, among other factors with respect to a national accreditation body, its requirements for accreditation, its survey procedures, its ability to provide adequate resources for conducting required surveys and supplying information for use in enforcement activities, its monitoring procedures for provider entities found out of compliance with the conditions or requirements, and its ability to provide the Secretary with necessary data for validation.

(3)

(A) Except as provided in subparagraph (B), not later than 60 days after the date of receipt of a written request for a finding under paragraph (1) (with any documentation necessary to make a determination on the request), the Secretary shall publish a notice identifying the national accreditation body making the request, describing the nature of the request, and providing a period of at least 30 days for the public to comment on the request. The Secretary shall approve or deny a request for such a finding, and shall publish notice of such approval or denial, not later than 210 days after the date of receipt of the request (with such documentation). Such an approval shall be effective with respect to accreditation determinations made on or after such effective date (which may not be later than the date of publication of the approval) as the Secretary specifies in the publication notice.

(B) The 210-day and 60-day deadlines specified in subparagraph (A) shall not apply in the case of any request for a finding with respect to accreditation of a provider entity to which the conditions and requirements of sections [1395i-3](#) and [1395x \(j\)](#) of this title apply.

(4) For purposes of this section, the term “provider entity” means a provider of services, supplier, facility, clinic, agency, or laboratory.

(b) Disclosure of accreditation survey

The Secretary may not disclose any accreditation survey (other than a survey with respect to a home health agency) made and released to the Secretary by the

American Osteopathic Association or any other national accreditation body, of an entity accredited by such body, except that the Secretary may disclose such a survey and information related to such a survey to the extent such survey and information relate to an enforcement action taken by the Secretary.

(c) Deficiencies

Notwithstanding any other provision of this subchapter, if the Secretary finds that a provider entity has significant deficiencies (as defined in regulations pertaining to health and safety), the entity shall, after the date of notice of such finding to the entity and for such period as may be prescribed in regulations, be deemed not to meet the conditions or requirements the entity has been treated as meeting pursuant to subsection (a)(1).

(d) State or local accreditation

For provisions relating to validation surveys of entities that are treated as meeting applicable conditions or requirements of this subchapter pursuant to subsection (a)(1), see section [1395aa \(c\)](#) of this title.

4. Provides for AOA certification of medical staff within the Centers for Medicare & Medicaid Services [CMS] [42 CFR § 412.96 \(c\)\(2\)\(B\)\(ii\) and \(c\)\(3\)\(ii\)](#).

Title 42: Public Health [PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES](#) [Subpart G—Special Treatment of Certain Facilities Under the Prospective Payment System for Inpatient Operating Costs](#)

§ 412.96 *Special treatment: Referral centers.*

(a) *Criteria for classification as a referral center: Basic rule.* CMS classifies a hospital as a referral center only if the hospital is a Medicare participating acute care hospital and meets the applicable criteria of paragraph (b) or (c) of this section.

(b) *Criteria for cost reporting periods beginning on or after October 1, 1983.* The hospital meets either of the following criteria:

(1) The hospital is located in a rural area (as defined in subpart D of this part) and has the following number of beds, as determined under the provisions of §412.105(b) available for use:

(i) Effective for discharges occurring before April 1, 1988, the hospital has 500 or more beds.

(ii) Effective for discharges occurring on or after April 1, 1988, the hospital has 275 or more beds during its most recently completed cost reporting period unless the hospital submits written documentation with its application that its bed count has changed since the close of its most recently completed cost reporting period for one or more of the following reasons:

(A) Merger of two or more hospitals.

(B) Reopening of acute care beds previously closed for renovation.

(C) Transfer to the prospective payment system of acute care beds previously classified as part of an excluded unit.

(D) Expansion of acute care beds available for use and permanently maintained for lodging inpatients, excluding beds in corridors and other temporary beds.

(2) The hospital shows that—

(i) At least 50 percent of its Medicare patients are referred from other hospitals or from physicians not on the staff of the hospital; and

(ii) At least 60 percent of the hospital's Medicare patients live more than 25 miles from the hospital, and at least 60 percent of all the services that the hospital furnishes to Medicare beneficiaries are furnished to beneficiaries who live more than 25 miles from the hospital.

(c) *Alternative criteria.* For cost reporting periods beginning on or after October 1, 1985, a hospital that does not meet the criteria of paragraph (b) of this section is classified as a referral center if it is located in a rural area (as defined in subpart D of this part) and

meets the criteria specified in paragraphs (c)(1) and (c)(2) of this section and at least one of the three criteria specified in paragraphs (c)(3), (c)(4), and (c)(5) of this section.

(1) *Case-mix index.* CMS sets forth national and regional case-mix index values in each year's annual notice of prospective payment rates published under §412.8(b). The methodology CMS uses to calculate these criteria is described in paragraph (h) of this section. The case-mix index value to be used for an individual hospital in the determination of whether it meets the case-mix index criteria is that calculated by CMS from the hospital's own billing records for Medicare discharges as processed by the fiscal intermediary and submitted to CMS. The hospital's case-mix index for discharges (not including discharges from units excluded from the prospective payment system under subpart B of this part) during the most recent Federal fiscal year that ended at least one year prior to the beginning of the cost reporting period for which the hospital is seeking referral center status must be at least equal to—

(i) For hospitals applying for rural referral center status for cost reporting periods beginning on or after October 1, 1985 and before October 1, 1986, the national or regional case-mix index value; or

(ii) For hospitals applying for rural referral center status for cost—reporting periods beginning on or after October 1, 1986, the national case-mix index value as established by CMS or the median case-mix index value for urban hospitals located in each region. In calculating the median case-mix index for each region, CMS excludes the case-mix indexes of hospitals receiving indirect medical education payments as provided in §412.105.

(2) *Number of discharges.*

(i) CMS sets forth the national and regional number of discharges in each year's annual notice of prospective payment rates published under §412.8(b). The methodology CMS uses to calculate these criteria is described in paragraph (i) of this section. Except as provided in paragraph (c)(2)(ii) of this section for an osteopathic hospital, for the hospital's cost reporting period that began during the same fiscal year as the cost reporting periods used to compute the regional median discharges under paragraph (i) of this section, its number of discharges (not including discharges from units excluded from the prospective payments system under subpart B of this part or from newborn units) is at least equal to—

(A) For hospitals applying for rural referral center status for cost reporting periods beginning on or after October 1, 1985 and before October 1, 1986, the number of discharges under either the national or regional criterion; or

(B) For hospitals applying for rural referral center status for cost reporting periods beginning on or after October 1, 1986, 5,000 discharges or, if less, the median number of discharges for urban hospitals located in each region.

(ii) For cost reporting periods beginning on or after January 1, 1986, an osteopathic hospital, recognized by the American Osteopathic Healthcare Association (or any successor organization), that is located in a rural area must have at least 3,000 discharges during its cost reporting period that began during the same fiscal year as the cost reporting periods used to compute the regional median discharges under paragraph (i) of this section to meet the number of discharges criterion.

(3) *Medical staff.* More than 50 percent of the hospital's active medical staff are specialists who meet one of the following conditions:

(i) Are certified as specialists by one of the Member Boards of the American Board of Medical Specialties or the Advisory Board of Osteopathic Specialists.

(ii) Have completed the current training requirements for admission to the certification examination of one of the Member Boards of the American Board of Medical Specialties or the Advisory Board of Osteopathic Specialists.

(iii) Have successfully completed a residency program in a medical specialty accredited by the Accreditation Council of Graduate Medical Education or the American Osteopathic Association.

(4) *Source of inpatients.* At least 60 percent of all its discharges are for inpatients who reside more than 25 miles from the hospital.

(5) *Volume of referrals.* At least 40 percent of all inpatients treated at the hospital are referred from other hospitals or from physicians not on the hospital's staff.

(d) *Payment to rural referral centers.* Effective for discharges occurring on or after April 1, 1988, and before October 1, 1994, a hospital that is located in a rural area and meets the criteria of paragraphs (b)(1), (b)(2) or (c) of this section is paid prospective payments for inpatient operating costs per discharge based on the applicable other urban payment rates as determined in accordance with §412.63, as adjusted by the hospital's area wage index.

5. Recognition that osteopathic physicians can be appointed as commissioned officers in the US Public Health Service. [42 USC §209d](#)

[TITLE 42](#) > [CHAPTER 6A](#) > [SUBCHAPTER I](#) > [Part A](#) > § 209d

§ 209d. Appointment of osteopaths as commissioned officers

Graduates of colleges of osteopathy are eligible for licensure to practice medicine or osteopathy in a majority of the States of the United States, or approved by a body or bodies acceptable to the Secretary, shall be eligible, subject to the other provisions of this Act, of the appointment as commissioned officers in the Public Health Service.

6. Eligibility of Colleges of Osteopathic Medicine to receive grants from the federal government to run programs in family medicine, general internal medicine and general pediatrics. [42 USC § 293k](#)

[TITLE 42](#) > [CHAPTER 6A](#) > [SUBCHAPTER V](#) > [Part C](#) > § 293k

§ 293k. Family medicine, general internal medicine, general pediatrics, general dentistry, pediatric dentistry, and physician assistants

(a) Training generally: The Secretary may make grants to, or enter into contracts with, any public or nonprofit private hospital, school of medicine or osteopathic medicine, or to or with a public or private nonprofit entity (which the Secretary has determined is capable of carrying out such grant or contract)—

(1) to plan, develop, and operate, or participate in, an approved professional training program (including an approved residency or internship program) in the field of family medicine, internal medicine, or pediatrics for medical (M.D. and D.O.) students, interns (including interns in internships in osteopathic medicine), residents, or practicing physicians that emphasizes training for the practice of family medicine, general internal medicine, or general pediatrics (as defined by the Secretary);

(2) to provide financial assistance (in the form of traineeships and fellowships) to medical (M.D. and D.O.) students, interns (including interns in internships in osteopathic medicine), residents, practicing physicians, or other medical personnel, who are in need thereof, who are participants in any such program, and who plan to specialize or work in the practice of family medicine, general internal medicine, or general pediatrics;

(3) to plan, develop, and operate a program for the training of physicians who plan to teach in family medicine (including geriatrics), general internal medicine or general pediatrics training programs;

(4) to provide financial assistance (in the form of traineeships and fellowships) to physicians who are participants in any such program and who plan to teach in a

family medicine (including geriatrics), general internal medicine or general pediatrics training program;

(5) to meet the costs of projects to plan, develop, and operate or maintain programs for the training of physician assistants (as defined in section 295p of this title), and for the training of individuals who will teach in programs to provide such training; and

(6) to meet the costs of planning, developing, or operating programs, and to provide financial assistance to residents in such programs, of general dentistry or pediatric dentistry.

For purposes of paragraph (6), entities eligible for such grants or contracts shall include entities that have programs in dental schools, approved residency programs in the general or pediatric practice of dentistry, approved advanced education programs in the general or pediatric practice of dentistry, or approved residency programs in pediatric dentistry.

(b) Academic administrative units

(1) In general

The Secretary may make grants to or enter into contracts with schools of medicine or osteopathic medicine to meet the costs of projects to establish, maintain, or improve academic administrative units (which may be departments, divisions, or other units) to provide clinical instruction in family medicine, general internal medicine, or general pediatrics.

7. Requirements for appointment of osteopathic physicians as commissioned officers in the Armed Forces Medical Corps. [10 USC § 532 \(b\)\(1\)&\(2\)](#)

[TITLE 10](#) > [Subtitle A](#) > [PART II](#) > [CHAPTER 33](#) > § 532

§ 532. Qualifications for original appointment as a commissioned officer

(a) Under regulations prescribed by the Secretary of Defense, an original appointment as a commissioned officer (other than as a commissioned warrant officer) in the Regular Army, Regular Navy, Regular Air Force, or Regular Marine Corps may be given only to a person who—

(1) is a citizen of the United States;

(2) is able to complete 20 years of active commissioned service before his sixty-second birthday;

(3) is of good moral character;

(4) is physically qualified for active service; and

(5) has such other special qualifications as the Secretary of the military department concerned may prescribe by regulation.

(b)

(1) Original appointments in the Regular Army in the Medical Corps or Dental Corps, and original appointments in the Regular Air Force with a view to designation of an officer as a medical or dental officer, may be made in the grades of first lieutenant through colonel. Original appointments in the Regular Navy in the Medical Corps or Dental Corps may be made in the grades of lieutenant (junior grade) through captain. Such appointments may be made only from persons who are qualified doctors of medicine, osteopathy, or dentistry.

(2) To be eligible for an original appointment as a medical officer, a doctor of osteopathy must—

(A) be a graduate of a college of osteopathy whose graduates are eligible to be licensed to practice medicine or surgery in a majority of the States;

(B) be licensed to practice medicine, surgery, or osteopathy in a State or in the District of Columbia;

(C) under regulations prescribed by the Secretary of Defense, have completed a number of years of osteopathic and preosteopathic education equal to the number of years of medical and premedical education prescribed for persons entering recognized schools of medicine who become doctors of medicine and who would be

qualified for an original appointment in the grade for which that person is being considered for appointment; and (D) have such other qualifications as the Secretary of the military department concerned prescribes after considering the recommendations, if any, of the Surgeon General of the armed force concerned.

8. Appointment of osteopathic physicians within the Veterans Administration and Department of Veteran's Affairs. 38 USC § 7402 (b)(1)(A)

TITLE 38 > PART V > CHAPTER 74 > SUBCHAPTER I > § 7402

§ 7402. Qualifications of appointees

(a) To be eligible for appointment to the positions in the Administration covered by subsection (b), a person must have the applicable qualifications set forth in that subsection.

(b)

(1) Physician.— To be eligible to be appointed to a physician position, a person must—

(A) hold the degree of doctor of medicine or of doctor of osteopathy from a college or university approved by the Secretary,

(B) have completed an internship satisfactory to the Secretary, and

(C) be licensed to practice medicine, surgery, or osteopathy in a State.

(2) Dentist.— To be eligible to be appointed to a dentist position, a person must—

(A) hold the degree of doctor of dental surgery or dental medicine from a college or university approved by the Secretary, and

(B) be licensed to practice dentistry in a State.

(3) Nurse.— To be eligible to be appointed to a nurse position, a person must—

(A) have successfully completed a full course of nursing in a recognized school of nursing, approved by the Secretary, and

(B) be registered as a graduate nurse in a State.

(4) Director of a Hospital, Domiciliary, Center, or Outpatient Clinic.— To be eligible to be appointed to a director position, a person must have such business and administrative experience and qualifications as the Secretary shall prescribe.

(5) Podiatrist.— To be eligible to be appointed to a podiatrist position, a person must—

(A) hold the degree of doctor of podiatric medicine, or its equivalent, from a school of podiatric medicine approved by the Secretary, and

(B) be licensed to practice podiatry in a State.

(6) Optometrist.— To be eligible to be appointed to an optometrist position, a person must—

(A) hold the degree of doctor of optometry, or its equivalent, from a school of optometry approved by the Secretary, and

(B) be licensed to practice optometry in a State.

(7) Pharmacist.— To be eligible to be appointed to a pharmacist position, a person must—

(A) hold the degree of bachelor of science in pharmacy, or its equivalent, from a school of pharmacy, approved by the Secretary, and

(B) be registered as a pharmacist in a State.

(8) Psychologist.— To be eligible to be appointed to a psychologist position, a person must—

(A) hold a doctoral degree in psychology from a college or university approved by the Secretary,

(B) have completed study for such degree in a specialty area of psychology and an internship which are satisfactory to the Secretary, and

- (C) be licensed or certified as a psychologist in a State, except that the Secretary may waive the requirement of licensure or certification for an individual psychologist for a period not to exceed two years on the condition that that psychologist provide patient care only under the direct supervision of a psychologist who is so licensed or certified.
- (9) Social Worker.— To be eligible to be appointed to a social worker position, a person must—
- (A) hold a master’s degree in social work from a college or university approved by the Secretary; and
 - (B) be licensed or certified to independently practice social work in a State, except that the Secretary may waive the requirement of licensure or certification for an individual social worker for a reasonable period of time recommended by the Under Secretary for Health.
- (10) Marriage and Family Therapist.— To be eligible to be appointed to a marriage and family therapist position, a person must—
- (A) hold a master’s degree in marriage and family therapy, or a comparable degree in mental health, from a college or university approved by the Secretary; and
 - (B) be licensed or certified to independently practice marriage and family therapy in a State, except that the Secretary may waive the requirement of licensure or certification for an individual marriage and family therapist for a reasonable period of time recommended by the Under Secretary for Health.
- (11) Licensed Professional Mental Health Counselor.— To be eligible to be appointed to a licensed professional mental health counselor position, a person must—
- (A) hold a master’s degree in mental health counseling, or a related field, from a college or university approved by the Secretary; and
 - (B) be licensed or certified to independently practice mental health counseling.
- (12) Chiropractor.— To be eligible to be appointed to a chiropractor position, a person must—
- (A) hold the degree of doctor of chiropractic, or its equivalent, from a college of chiropractic approved by the Secretary; and
 - (B) be licensed to practice chiropractic in a State.
- (13) Peer Specialist.— To be eligible to be appointed to a peer specialist position, a person must—
- (A) be a veteran who has recovered or is recovering from a mental health condition; and
 - (B) be certified by—
 - (i) a not-for-profit entity engaged in peer specialist training as having met such criteria as the Secretary shall establish for a peer specialist position; or
 - (ii) a State as having satisfied relevant State requirements for a peer specialist position.
- (14) Other Health-Care Positions.— To be appointed as a physician assistant, expanded-function dental auxiliary, certified or registered respiratory therapist, licensed physical therapist, licensed practical or vocational nurse, occupational therapist, dietitian, microbiologist, chemist, biostatistician, medical technologist, dental technologist, or other position, a person must have such medical, dental, scientific, or technical qualifications as the Secretary shall prescribe.

9. Recognition that Colleges of Osteopathic Medicine can contract with the Secretary of Veteran’s Affairs to provide “scarce medical specialist services.” [38 USC § 7409 \(b\)\(1\)](#)

[TITLE 38](#) > [PART V](#) > [CHAPTER 74](#) > [SUBCHAPTER I](#) > § 7409

§ 7409. Contracts for scarce medical specialist services

- (a) The Secretary may enter into contracts with institutions and persons described in subsection (b) to provide scarce medical specialist services at Department**

facilities. Such services may include the services of physicians, dentists, podiatrists, optometrists, chiropractors, nurses, physician assistants, expanded-function dental auxiliaries, technicians, and other medical support personnel.

(b) Institutions and persons with whom the Secretary may enter into contracts under subsection (a) are the following:

- (1) Schools and colleges of medicine, osteopathy, dentistry, podiatry, optometry, and nursing.**
- (2) Clinics.
- (3) Any other group or individual capable of furnishing such scarce medical specialist services.

10. Eligibility of osteopathic physicians to participate in Federal Health Service programs.
5 USC § 7901(e)

[TITLE 5](#) > [PART III](#) > [Subpart F](#) > [CHAPTER 79](#) > § 7901

§ 7901. Health service programs

- (a)** The head of each agency of the Government of the United States may establish, within the limits of appropriations available, a health service program to promote and maintain the physical and mental fitness of employees under his jurisdiction.
- (b)** A health service program may be established by contract or otherwise, but only—
- (1)** after consultation with the Secretary of Health, Education, and Welfare and consideration of its recommendations; and
 - (2)** in localities where there are a sufficient number of employees to warrant providing the service.
- (c)** A health service program is limited to—
- (1)** treatment of on-the-job illness and dental conditions requiring emergency attention;
 - (2)** preemployment and other examinations;
 - (3)** referral of employees to private physicians and dentists; and
 - (4)** preventive programs relating to health.
- (d)** The Secretary of Health, Education, and Welfare, on request, shall review a health service program conducted under this section and shall submit comment and recommendations to the head of the agency concerned.
- (e) When this section authorizes the use of the professional services of physicians, that authorization includes the use of the professional services of surgeons and osteopathic practitioners within the scope of their practice as defined by State law.**
- (f)** The health programs conducted by the Tennessee Valley Authority are not affected by this section.