Linda Schumacher-Feero, M.D.

Testimony in Opposition

LD 1803

An Act to Amend the Laws Governing Optometric Practice

May 13, 2025

Good afternoon Honorable Donna Bailey and Kristi Mathieson, Chairs and Members of the Committee on Health Coverage, Insurance and Financial Services,

Thank you for the opportunity to speak today. I am an ophthalmologist in private practice in Augusta with over 25 years of experience. I have practiced side by side with three optometrists every day for more than a dozen years. As a physician with an ethical duty to do no harm, I am testifying today in opposition to LD 1803. I appreciate the contributions my optometric colleagues bring to eyecare, but they have not been trained to think and act as surgeons. The legislature last approved updates to the laws governing optometry in 2023. In the intervening time, there have not been any substantive changes in the education and training of optometrists that would justify the purported need to "modernize outdated laws."[1,2] Instead, we are being subjected in Maine to the first attempt of a national push by the American Optometric Association (AOA) to expand the profession of optometry into the surgical arena, a sphere in which they have wholly inadequate training. Over the last 30 years, there have been roughly 300 attempts by optometrists to expand their practice in 47 states, Puerto Rico and Washington D.C. The AOA began the decade long Our Future Practice Initiative in 2018 to provide guidance, administrative, financial and operational support to state optometric societies wanting to gain the ability to perform in-office surgery and specifically laser surgery.[3] The result has been a slew of copycat bills introduced across the country in 13 states last year and in 12 states this year. Since the onset of the AOA Initiative, 9 states (AK, MS, WY, CO, VA, WA, SD, MT, WV) have bought what they are selling. Despite this onslaught, there are no states in either New England or in the northeast who permit optometrists to perform invasive surgery.

The AOA template bill, just like LD 1803, has an exclusionary list of a handful of surgeries, allowing optometrists to perform over 150 different surgeries on and around the eye, not one of which they have been adequately trained to perform on patients from infants to medically complicated senior citizens. The template, like LD 1803, also removes the legislature and any other guardrails that prevent future surgical expansion by making the board of optometry, whose members are not surgeons, solely responsible for determining minimum criteria for optometrists to be allowed to perform surgery and going forward, what surgeries they will be allowed to do. Patient safety is further compromised by the lack of any reporting requirements for complications.

Part of the strategy is to submit similar legislation in subsequent legislative cycles until the state legislators pass a version of the AOA template bill. Among our close neighbors,

Vermont defeated this bill in the 2019-2020 legislative cycle. The bill was resurrected but died in committee in 2024 and is back for a third try, but has yet to be heard in committee (S 64). A bill based off the same template was peddled in New Hampshire in 2024 and was defeated there as well. This year's version limits surgery to lasers only (HB 349). The House has sent the bill for review in the fall special session. Now the Maine Optometric Association (MOA) is going to try advance the AOA agenda IN Augusta.

The MOA designed this bill based on Colorado's 2022 legislation. LD 1803 with its exclusionary list permits more than 150 different surgeries on and around the eye (see attached list of CPT codes), has no limitations on operating on minors, and makes the board of optometry, which has no surgeon members, the sole body able to determine requirements for optometrists to perform surgery and the sole body able to add or remove surgical procedures from the optometrist's purview. The MOA has already amended the bill prior to the public hearing, adding pharmaceutical and specific surgical procedures that they want to perform, despite being unable to provide a coherent reason why they needed to perform some of them when they met with the leadership of the Maine Society of Eye Physicians and Surgeons (MSEPS) two weeks ago. This suggests that some of the procedures in the amended bill are there simply to give them something to "compromise" on and drop from the bill. Like the states of AK, KY, OK and WY, this bill has no adverse event reporting mechanism so that it is easy for optometrists to hide their complications and claim in defiance of common sense that they never have any.

On the federal level, the AOA is lobbying to allow optometrists to perform laser surgery within the facilities of the Veterans Health Administration (VHA), the largest integrated health care system in the nation. Despite what is claimed by optometry, only ophthalmologists are authorized to perform laser surgery at VA facilities, even in those states that permit optometrists to perform laser surgery. This policy has been in place since 2004, and has been reaffirmed three times since then, most recently in 2020. The current language of VHA Directive 1121-2 states "Therapeutic laser eye procedures in VHA are currently performed by only ophthalmologists and ophthalmology residents. To independently perform laser eye procedures, ophthalmologists must have completed an accredited ophthalmology residency approved by the Accreditation Council for Graduate Medical Education or the American Medical or Osteopathic Association, have appropriate training and experience in therapeutic laser procedures in accordance with the credentialing and privileging procedures at the VA medical facility, and be board-eligible or board certified by the American Board of Ophthalmology."[4] Those optometrists who have performed laser surgery on patients at a VHA facility after 2004 did so in violation of federal law and could be subject to charges of malpractice and of battery. The Federal Supremacy Project is developing national standards of practice for 50 health care occupations including physicians and optometrists. A hearing on expansion of scope of practice for several professions occurred in the Subcommittee on Health under the Committee on Veteran Affairs in September 2023, but there has been little further public information about this ongoing process.[5]

From my colleagues you have heard about the inadequacy of surgical training among current optometry students and "become a surgeon in 4 days" training courses on model tissues for optometrists who have been in practice for years. If surgery were really so important to the practice of optometrists, would they not demand curriculum changes that devote something more than 5% of the time in school to achieve this? In the last twenty years, 9 new optometry schools have opened and 4 more will be added by 2029. Only one of these new schools is in a state (KY) that permits optometrists to perform lid surgery and lasers. It seems that the decision makers of determining optometric education now and for the next generation of optometrists are not in step with the legislative agenda of the AOA. Furthermore, Maine optometrists are not leaving the state in order to move to states where they can perform surgery (see attachment).

The National Board of Examiners in Optometry (NBEO) offers an optional Injection Skills Examination (ISE) certification for intravenous and intramuscular injections and the Laser and Surgical Procedures Examination (LSPE) which covers 3 laser surgeries: Selective Laser Trabeculoplasty(SLT), Laser Peripheral Iridotomy(LPI) and YAG Capsulotomy as well as eyelid excision surgery and suturing. These exams have a written as well as skills portion. The NBEO is in North Carolina which does not permit optometric surgery and all the skills testing is performed on synthetic models of eyes and skin. There are zero national competency examinations and certifications for optometrists that require the performance of surgery on even a single live patient. This means that when an optometrist claims they have been "trained" to perform a surgery, they mean they have listened to lectures about surgery, have watched other optometrists "perform" SLT, LPI, YAG capsulotomy, chalazion or eyelid lesion removal on a simulated patient and may have performed a simulated surgery themselves. There is no guarantee that this "trained" optometrist has performed surgery of any kind on a human being before being turned loose on the public. Would you offer up your mother, your spouse or yourself as the first person on whom an optometrist gets to demonstrate his level of surgical skill?

The Accreditation Council for Graduate Medical Education (ACGME), determines professional education standards for physicians, including ophthalmologists, to deliver safe, high-quality medical care. Simulation-based training in ophthalmology is not required by the ACGME but is encouraged to allow resident physicians to practice complex procedures repeatedly, build confidence, and improve technical skills in a safe, controlled environment before they are performed on live humans. All national surgical requirements for ophthalmologists are for procedures performed on live humans. If an ophthalmology resident tried to claim they were a "trained" surgeon based on only the experience that optometry students receive, they would not graduate and would never be credentialed to write a prescription for eyeglasses, much less be allowed to touch a human being with a scalpel or a laser.

Optometrists are trained to provide primary eye care. Before you consider allowing them to become surgeons because they claim an access problem, perhaps you should look at whether there is an access problem for primary eye care that is greater than the current wait time for in-office surgical care. In my practice in Augusta, there are 3 full time

optometrists and myself, the sole surgeon. The average wait time to obtain a routine eye examination with an optometrist is 8 weeks. In my practice, the surgeries that would be permitted by LD 1803 account for 5% of the work I do. The average wait time from a request for consultation to completion of the surgery is 3 weeks. In Augusta, the greatest eye care access issue is for routine examinations, not for in-office surgery and I doubt very much that Augusta is unique. Will the optometrists provide data on current wait times for routine care in their practices? Analysis of states that have permitted optometric surgery indicates that there is no increase in the density of optometrists in those states. Furthermore, the Medicare database indicates that optometrists who practice in Maine are not leaving the state to move to others where they can perform surgery.[6] What is their plan to ensure that they do not create a worse access problem by taking time away from primary eye care to perform surgery?

In a recent American Medical Society survey in 2021, Maine residents, more than any other state were opposed to allowing optometrists to perform surgery, at 85% (see attachment). In the interest of protecting the sight of the people of Maine, I urge you to oppose LD 1803.

Thank you for your time, attention, and consideration. I am happy to answer any questions you may have.

Linda Schumacher-Feero, M.D.

Attachments:

1. List of CPT codes permitted by LD 1803
2. Maine Licensed Optometrists are not Leaving the State to Perform Surgery
3. Maine Toplines

References:

1. It's time to modernize eye care legislation in Maine. S Brenner and B. Farrin. Portland Press Herald. 4 April 2025. https://www.pressherald.com/2025/04/04/opinion-its-time-to-modernize-eye-care-legislation-in-maine/
2. Modernizing eye care laws will improve access for Maine patients. J Quint. Portland Press Herald. 12 May 2025. https://www.pressherald.com/2025/05/12/modernizing-eye-care-laws-will-improve-access-for-maine-patients-opinion/
3. AOA Focus Winter 2024. https://aoa.uberflip.com/i/1530442-aoa-focus-winter-2024/0?
4. VHA DIRECTIVE 1121(2). VHA Eye and Vision Care. https://www.va.gov/OPTOMETRY/docs/VHA_Directive_1121-2_VHA_Eye_and_vision_Care_10-02-2019_Amended_08-19-2020.pdf
5. https://www.congress.gov/event/118th-congress/house-event/LC72861/text
6. Scope of practice expansion is not associated with increased optometry workforce density. T.J. Johnson, C. Carpenter, O. Omotowa, C. Wu, P. Singer and C Stagg. Investigative Ophthalmology & Visual Science June 2024, Vol.65, 6430.

CPT Code	Description
	Procedure that is currently permitted in Maine
11102	Tangential biopsy of skin
11103	Tangential biopsy of skin, each additional lesion
11104	Punch biopsy of skin
11105	Punch biopsy of skin, each additional lesion
11106	Incisional biopsy of skin
11107	Incisional biopsy of skin, each additional lesion
11200	Removal of skin tags up to 15
11201	Removal of skin tags each additional 10
11310	Shaving of epidermal and dermal lesions diameter 0.5 cm or less
11311	Shaving of epidermal and dermal lesions diameter 0.6-1 cm
11312	Shaving of epidermal and dermal lesions diameter 1.1-2 cm
11313	Shaving of epidermal and dermal lesions diameter over 2 cm
11440	Excision benign lesion 0.5 cm or less
11441	Excision benign lesion 0.6-1 cm
11442	Excision benign lesion 1.1-2 cm
11443	Excision benign lesion 2.1-3 cm
11444	Excision benign lesion 3.1-4 cm
11446	Excision benign lesion over 4 cm
11900	Intralesion injection up to 7 lesions
11901	Intralesion injection more than 7 lesions
11960	Insertion of tissue expander
12011	Repair of superficial wound 2.5 cm or less
12013	Repair of superficial wound 2.6 to 5 cm
12014	Repair of superficial wound 5.1 to 7.5 cm
12015	Repair of superficial wound 7.6 to 12.5 cm
12016	Repair of superficial wound 12.6 to 20 cm
12017	Repair of superficial wound 20.1 to 30 cm
12018	Repair of superficial wound over 30 cm
12020	Closure of superficial wound dehiscence
12021	Closure of superficial wound dehiscence with packing
12051	Repair of intermediate wounds 2.5 cm or less
12052	Repair of intermediate wounds 2.6-5 cm
12053	Repair of intermediate wounds 5.1-7.5 cm
12054	Repair of intermediate wounds 7.6-12.5 cm
12055	Repair of intermediate wounds 12.6-20 cm
12056	Repair of intermediate wounds 20.1-30 cm
12057	Repair of intermediate wounds over 30 cm
13151	Repair complex wound 1.1 -2.5 cm
13152	Repair complex wound 2.6-7.5 cm
13153	Repair complex wound each additional 5 cm
14060	Adjacent tissue transfer for defect 10.1-30 square cm

15120	Split-thickness autograft first 100 square cm
15121	Split-thickness autograft each additional100 square cm
15260	Full thickness graft 20 square cm or less
15261	Full thickness graft each additional 20 square cm
15576	Formation of direct or tubed pedicle with or without transfer
15630	Delay of flap or sectioning of flap
15769	Graft of autologous soft tissue harvested by direct extension: derma, fat , fascia
15773	Grafting of autologous fat harvested by liposuction to eyelids 25 cc or less injected
15774	Grafting of autologous fat harvested by liposuction to eyelids each additional 25 cc injected
15788	Epidermal facial peel
15789	Dermal facial peel
17000	Destruction of single premalignant lesion:laser, electrosurgery, cryosurgery, chemosurgery, surgical curettage
17003	Destruction of premalignant lesion 2-14:laser, electrosurgery, cryosurgery, chemosurgery, surgical curettage
17110	Destruction of benign lesion up to 14:laser, electrosurgery, cryosurgery, chemosurgery, surgical curettage
17111	Destruction of benign lesion 15 or more:laser, electrosurgery, cryosurgery, chemosurgery, surgical curettage
64612	Chemodenervation of muscles innervated by the facial nerve, unilateral (botox for blepharospasm)
65205	Removal of foreign body superficial conjunctiva
65210	Removal of foreign body embedded conjunctiva, subconjunctival or scleral nonperforating
65220	Removal of foreign body cornea without a slit lamp
65222	Removal of foreign body cornea with a slit lamp
65270	Repair of conjunctival laceration by direct closure
65272	Repair of conjunctival laceration by rearrangement
65275	Repair of laceration of cornea, nonperforating
65286	Application of tissue glue to wounds of cornea or sclera
65290	Repair of wound, extraocular muscle, tendon or Tenon's capsule
65400	Excision of corneal lesion
65410	Biopsy of cornea
65430	Cornea scraping for smear or culture
65435	Removal of corneal epithelium
65436	Removal of corneal epithelium with chelating agent (EDTA)
65450	Destruction of corneal lesion by cryotherapy, photocoagulation or thermocauterization
65600	Multiple corneal stromal punctures
65710	Anterior lamellar corneal transplant
65757	Preparation of corneal endothelial allograph prior to transplantation
65760	Keratomileusis (removal of a wedge of cornea to correct refractive error)
65767	Epikeratoplasty (suture of a corneal wedge to change refractive error)
65771	Radial keratotomy (to change refractive error)
65772	Corneal relaxing incisions (for refractive error)
65775	Corneal wedge resection (for refractive error)

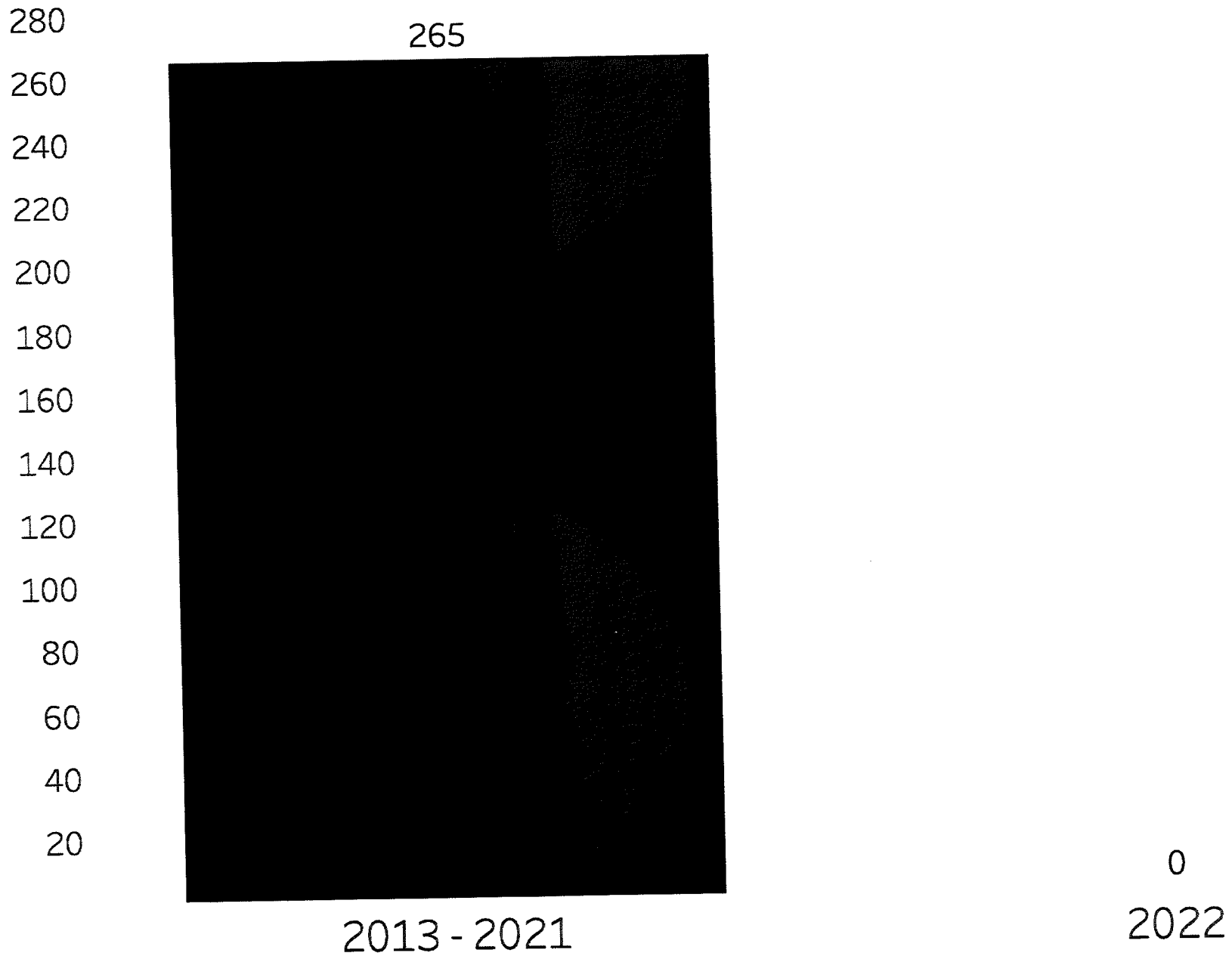
65778	Placement of amnionic membrane on the ocular surface without sutures
65779	Placement of amnionic membrane on the ocular surface with sutures
0402T	Collagen cross-linking of the cornea including removal of the corneal epithelium
65780	Placement of amnionic membrane in multiple layers
65800	Paracentesis of anterior chamber with removal of aqueous
65815	Paracentesis of anterior chamber with removal of blood
65855	Laser trabeculoplasty
65860	Severing adhesions of anterior segment by laser
66710	Transscleral cyclophotocoagulation of the ciliary body
66761	Laser iridotomy
66762	Photocoagulation iridoplasty
66770	Destruction of cyst or lesion or the iris or ciliary body without excision
0730T	Trabeculotomy by laser
66821	Laser discission of opacified posterior lens capsule
66999	Unlisted procedure of anterior segment of the eye
67031	Severing of vitreous strands, membranes or opacities by laser
67025	Injection of vitreous substitute
67028	Intravitreal injection of a pharmacologic agent (steroid, Ozurdex)
0699T	Injection, Posterior chamber of the eye, medication
67299	Unlisted retinal or vitreous procedure
0936T	Photobiomodulation of the retina per session
67345	Chemodenervation of extraocular muscle (botox)
67399	Unlisted procedure, ocular muscle
67415	Fine needle aspiration of orbital contents
67500	Retrobulbar injection of medication
67505	Retrobulbar injection of alcohol
67515	Injection of medication into Tenon's capsule
67516	Suprachoroidal space injection of pharmacologic agent
67700	Drainage of eyelid abscess
67710	Severing of tarsorrhaphy
67715	Canthotomy
67810	Incisional biopsy of lid including the margin
67800	Excision chalazion
67801	Excision multiple chalazia same lid
67805	Excision multiple chalazia different lids
67820	Epilation of trichiasis by forceps
67825	Epilation of trichiasis by laser, cryotherapy or electrosurgery
67830	Incision of lid margin
67840	Excision of lesion of eyelid with or without closure
67850	Destruction of lesion of the lid margin up to 1 cm
67875	Temporary tarsorrhaphy
67880	Construction of intramarginal adhesions, median tarsorrhaphy or canthorrhaphy
67912	Correction of lagophthalmos by implantation of upper eyelid weight
67914	Suture repair of ectropion

67915	Thermocauterization of ectropion
67916	Repair of ectropion by excision of tarsal wedge
67917	Ectropion repair via tarsal strip operation
67921	Suture repair of entropion
67922	Thermocauterization of entropion
67923	Entropion repair by excisional tarsal wedge
67924	Entropion repair by tarsal strip operation
67930	Suture of recent lid wound involving lid margin, tarsus or palpebral conjunctiva, partial thickness
67935	Suture of recent lid wound involving lid margin, tarsus or palpebral conjunctiva, full thickness
67938	Removal of embedded foreign body from eyelid
67950	Canthoplasty
67999	Unlisted eyelid procedure
68020	Incision and drainage of conjunctival cyst
68040	Expression of conjunctival follicles
0207T	Automated evacuation of meibomian glands using heat and intermittent pressure, unilateral
0563T	Manual evacuation of meibomian glands
#0563T	Evacuation of meibomian glands using heat delivered via wearable open eyelid treatment device and manual expression, bilateral
68135	Destruction of conjunctival lesion
68200	Subconjunctival injection
68399	Unlisted conjunctival procedure
68530	Removal of foreign body from lacrimal passage
68705	Cautery repair of punctal ectropion
68760	Closure of punctum by laser or thermocauterization
68761	Closure of punctum by plug
0444T	Placement drug-eluting device under the eyelid
68801	Dilation of lacrimal punctum
68810	Probing of nasolacrimal duct
68815	Probing of nasolacrimal duct with tube or stent insertion
68816	Probing of nasolacrimal duct with balloon catheter dilation
68840	Probing of lacrimal canaliculi
68841	Inserting of drug eluting implant into lacrimal canaliculus
68850	Injection of contrast medium for dacryocystography
68899	Unlisted lactrimal procedure

Maine Licensed Optometrists are Not Leaving the State to Perform Surgery

FACT: Of the 265 optometrists that filed Medicare Part B claims in Maine between 2013 and 2021, there is no record of any filing a claim for laser surgery elsewhere in 2022.

(Data Source: Medicare Part B Claims Data, Records are available for those filing >10 claims for a code)



AMA
AMERICAN MEDICAL ASSOCIATION

Maine Toplines

The survey was conducted among 300 Maine voters, conducted between January 27th and February 1st, 2021. The margin of error is +/- 6.5 at the 95% confidence interval.

68% of Maine voters say it is very important to them for a physician to be involved in diagnosis and treatment decisions.

Expectations extend across parties, with 64% of Republicans, 72% of Democrats, and 65% of independents saying it is very important.

56% or more of Maine voters oppose the different changes to scope of practice we tested.

Maine voters are most concerned about allowing optometrists without medical degrees to perform eye surgery, with total opposition at 85% among Mainers (67% strongly oppose).

70% of Maine voters say patients are most likely to be harmed from scope of practice changes.

This includes 73% of Republicans, 70% of Democrats, and 66% of independents.

32% of Maine voters believe these changes will most benefit non-physician health care practitioners.

Twenty percent (20%) say for-profit health care providers are most likely to benefit and 19% say health insurance companies.

66% of Maine voters think these changes would make our health care system worse.

This includes majorities across parties, with the strongest sentiment among Republicans (70% worse). Sixty-five percent (65%) of Democrats and 60% of independents say these changes would make our health care system worse.