September 10, 2018

Ms. Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services Hubert
H. Humphrey Building, Room 445-G
200 Independence Ave, SW
Washington, DC 20201
Submitted online via regulations.gov

Re: Medicare Program; Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program; Proposed Rule (CMS-1693-P)

Dear Administrator Verma:

The American Society of Retina Specialists, The Retina Society) and Macula Society (hereafter retina societies) appreciate the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) proposed rule (CMS-1693-P), published on July 27, 2018 in the Federal Register, regarding the Medicare Physician Fee Schedule and the Quality Payment Program (QPP) implementing MIPS and APMs under the Medicare Access and Chip Reauthorization Act (MACRA).

MEDICARE PHYSICIAN FEE SCHEDULE

The retina societies support CMS' "Patients Over Paperwork" initiative and appreciates your outreach to the physician community. While we are solidly behind your goal of reducing administrative burdens for physicians and other health care professionals so that they can devote more time to patient care, we think the current proposal needs further refinement to attain that objective.

The retina societies offer comments in the following areas:

- Delay implementation of the Evaluation and Management Proposal to allow time for the AMA workgroup to submit an alternative proposal
- Cover remote screening of new patients under arrangements in which high quality images can be taken and transmitted to the specialist for interpretation
- Oppose proposal to reduce payment for new Part B Drugs
- Support the RUC values for CPT codes 67500, 67505, 67515, 92X71, and 92X73

<u>Evaluation and Management (E/M) Proposals</u>

We support the goal of reducing E/M documentation requirements and agree that the current E/M coding needs refinement. However, we feel offering an all-or-nothing approach that collapses E/M services (Level 2-5) into a single, blended payment rate in return for some potential documentation relief for only Medicare patients is a false choice. We are particularly concerned that this proposal

would likely have the unintended consequence of limiting access to care for patients with complex medical conditions.

While we appreciate CMS' desire to improve E/M coding, creating a blended single code with add-on codes for some specialties not only fails to simplify coding but also results in a significant redistribution of funds across specialties. We are troubled that the complexity code GCGOX is only available for some specialties and ophthalmology is not on the list. **At the very least, if CMS moves forward with this proposal we ask that CMS accept our request for a separate provider/supplier code for retina specialists and add retina specialists to the GCGOX list.** The extended time code for more than 30 minutes does not make sense as it results in the same payment regardless of how much extra time the patient takes. Finally, we think the extra $5 primary care add-on code also adds a new level of coding complexity**. In sum, we question how these add-on codes are an improvement over the current 5 levels of E/M.**

As it stands now, we believe that overall this proposal prioritizes time over risk and complexity as the most important payment factor. Collapsing the codes penalizes physicians who treat patients with complex medical conditions, devaluing services that require additional fellowship training. The proposed system would compensate an E/M visit for a contact lens or intraocular pressure check the same as a visit for a new onset proliferative diabetic retinopathy with vitreous hemorrhage or malignant ocular melanoma. This hardly appears logical.

Moreover, the E/M proposal creates a new Indirect Practice Expense Index (IPCI) solely for office visits further cutting reimbursement to many specialists. **We join the AMA in opposing this proposal as the development of an E/M Practice Expense/Hour and resulting IPCI distorts the relativity of the RBRVS. We are concerned that the new office visit IPCI has massive unintended and unexplained payment effects across the physician fee schedule.**

While we appreciate the Administration's effort to comprehensively review supply and equipment pricing, we ask CMS to confirm that all physicians, not just those in hospitals and large practices, are able to access supply and equipment at inputs used to calculate the proposed revised PE RVUs. Based on our preliminary review, we are particularly concerned that the pricing proposal for injectable fluorescein is too low. Current invoices are included as requested for your review. If these issues are not addressed, this will only further exacerbate the problem of lower payment rates for solo and small group practices making it even more difficult to treat the sickest patients.

CMS is also proposing to pay for the G-codes by reducing modifier 25 reimbursement by 50 percent to the lowest cost service when an E/M and a procedure occur on the same day. This will discourage physicians from performing procedures on the same day as an office exam. CMS simply indicates it is recognizing gained efficiencies when both an E/M and procedure occur during the same encounter. Without documenting the calculations used to arrive at the 50 percent figure, CMS justifies the proposed modifier 25 reimbursement reduction policy as an extension of the Multiple Procedure Payment Reduction (MPPR). Current use of the MPPR is a recognition of efficiencies gained when multiple procedures occur during the same encounter, and an inability to remove duplicative cost during the valuation process. However, resources used to provide the separately identifiable E/M service are significantly different from those used in performing the procedure. Further, since 2010 the AMA RUC and CMS removed any "efficiencies" by reducing all three major portions of the code value, namely physician work/time, direct PE, and indirect PE

for procedures commonly performed with an E/M. **We oppose this new multiple procedure payment reduction policy as it disregards work already performed by RUC and CMS, and would result in an excessive, unjustified reduction in reimbursement.**

While well intended, the quid pro quo documentation changes may not be practical to implement. Since the proposal only applies to original Medicare, physicians would need to follow the current documentation guidelines for Medicare Advantage and other commercial plans. Having different E/M documentation standards based on insurance means physicians will need to either continue documenting to meet the highest standards or invest in an electronic health record upgrade adding additional expense at a time of decreasing reimbursement. Since most EHR vendors will not be able to update systems by January 1, the proposal likely will lead to more administrative burden as physicians will need to manage multiple E/M documentation requirements. Finally, physicians will need to document to show medical decision making for audits and medical legal reasons, so the value of the documentation reduction is minimized.

Given the significant impact of this proposal, we urge CMS to delay implementation for at least a year to allow the AMA workgroup, which is supported by the medical community, to have adequate time to develop a proposal that accomplishes both goals – a reduction in documentation requirements and a nuanced E/M coding system that recognizes distinctions in complexity of services and differences in resources. Once a new E/M code system is developed, then this work group is well positioned to help CMS value the codes, establish payment rates, and define documentation requirements for different levels of E/M services.

Communication Technology-Based Services

As stated in previous comment letters, we support CMS' intent to expand coverage of telehealth and remote patient monitoring services in the Medicare program. As our members are on the cutting edge of developing imaging technologies suited for these services, we appreciate CMS' request for input as it updates and broadens its guidance in this important and evolving area of medicine.

Our members are increasingly seeing patients with advanced eye disease that could be prevented or treated earlier with the convenience of remote patient monitoring. Since technology, such as ForeseeHome, is available to remotely monitor established patients, we encourage CMS to expand coverage for remote monitoring, which would allow the earlier identification of disease progression in a less costly care setting. For new patients, however, this is not as easy.

One such population this is particularly relevant to is the growing diabetic population and its related comorbidity of diabetic retinopathy, a potentially blinding eye condition. Diabetic blindness leads all causes of blindness in working age US adults and therefore has significant and high direct medical and indirect societal costs in play. New telemedicine technology is allowing screening of diabetic patients for diabetic retinopathy and in certain arrangements this can be performed on new patients never seen before by that physician. Typically, a camera is installed at a primary care office and the nurse takes a non-mydriatic fundus image that is sent to a retina specialist to interpret. Unfortunately, technology is not available to enable patient-transmitted information conducted via pre-recorded ''store and forward'' video. As a result, we are concerned that a patient-transmitted image would be inadequate to diagnosis diabetic retinopathy and other ophthalmic pathology. **Therefore, we recommend that telemedicine for diabetic retinopathy screening be handled as distinct from patient-transmitted information.**

Reduced Payment for new Part B Drugs

We oppose CMS' proposed cut to WAC-based drug payment. Reducing payment to WAC plus 3 percent during the first two quarters that a Part B drug is launched is a cut to physician reimbursement and does not impact drug pricing. We also believe this proposal will have the unintended consequence of discouraging innovation as physicians will be reluctant to use new drugs during the launch period as the add on will not cover the administrative costs associated with the buy and bill model.

Proposed Valuation of Injection – Eye (CPT codes 67500, 67505, and 67515)

67505

For CPT code 67505, we support the RUC recommended work RVU of 1.18 rather than the CMS work RVU of 0.94. We note that a valid survey carefully summarized data from physician experts for this procedure and the 25th percentile indicated a much higher work RVU of 1.30, higher than that of code 67500 (work RVU = 1.18). CMS notes that when the family of codes were valued in 2005, code 67505 has a higher intensity than CPT code 67500. Now, CMS is proposing a lower work RVU for CPT code 67505 due to its lesser intensity because the procedure is performed on a blind eye. In fact, code 67505 has a higher intensity than CPT Code 67500, not because of potential vision loss, but because of the risk of death if the absolute alcohol is injected accidentally into the optic nerve sheath. In addition, the risk of globe perforation and resulting infection leading to a need for enucleation, which CPT code 67505 is designed to avoid, is still present. The RUC supports the same work RVU as CPT code 67500 based on the clinical consideration of the procedure risk. CMS states that this comparison of current values and times supports the view that CPT code 67500 should continue to be valued higher than CPT code 67505 due to its greater intensity. Further, CMS states that "At the recommended identical work RVUs, CPT code 67500 has almost triple the intensity of CPT code 67505." We are confused by this statement because the RUC recommendation for CPT code 67505 does have less total time and slightly *higher* intensity (26 minutes total time and IWPUT = 0.156) than CPT code 67500 (33 minutes total time and IWPUT = 0.125). Therefore, CPT code 67505 has a lower total time and a higher intensity than the base code, justifying the recommended work RVU of 1.18.

We ask that CMS carefully consider this critical clinical information when determining proposed and final work values instead of selecting a cross-walk that does not match the clinical work and intensity. Therefore, we strongly advocate against using an arbitrary crosswalk to code CPT code 31575 *Laryngoscopy, flexible; diagnostic* (work RVU = 0.69 and 5 minutes intra-service time), as it is inappropriate given the clinical considerations. CMS also uses an intra-service time ratio in justifying the crosswalk to CPT code 31575 and states that the RUC-recommended total time of 26 minutes for CPT code 67505 was approximately 21 percent lower than the RUC-recommended total time for CPT code 67500 of 33 minutes, and the total time ratio between the two codes produces a suggested work RVU of 0.93 which is almost identical to the 0.94 value of the proposed crosswalk code. We disagree with the CMS approach of calculating intra-service time ratios to account for changes in time and instead support the RUC survey process as the basis for this recommendation. **The retina societies urge CMS to accept the RUC recommended work RVU of 1.18 for CPT code 67505.**

67515

For CPT code 67515, we support the RUC-recommended work RVU of 0.84 rather than the proposed CMS work RVU of 0.75. For CPT code 67515, CMS disagrees with the RUC recommended work RVU of 0.84 and is proposing a work RVU of 0.75 based on a direct crosswalk to CPT code 64450 *Injection, anesthetic agent; other peripheral nerve or branch* (work RVU = 0.75 and 5 minutes intra-service time). CMS states that CPT code 64450 is a more accurate crosswalk because it has a more similar intra-service time to CPT code 67515 (3 minutes intra-service time). We disagree with this crosswalk and believes that appropriate crosswalks should consider potential impact to patients' vision. However, CPT code 64450 Injection, anesthetic agent; greater occipital nerve (work RVU = 0.94 and 5 minutes intra-service time) appears to be a better crosswalk because the higher work value appropriately reflects the skill needed to be certain that the needle is not in the eye and that the medication is injected into an extremely specific space between the Tenon capsule and the sclera.

CMS also uses an intra-service time ratio with the first code in the family, CPT code 67500, to justify the valuation of 0.75. We agree with the RUC that it is not appropriate for CMS to calculate intra-service time ratios to account for changes in time and note that the RUC unanimously approved a work RVU of 0.84. **The retina societies urge CMS to accept the RUC recommended work RVU of 0.84 for CPT code 67515.**

Proposed Valuation of Electroretinography (CPT codes 92X71 and 92X73)

92X71

For CPT code 92X71, we support the RUC-recommended work RVU of 0.80 rather than the proposed CMS work RVU of 0.69. For CPT code 92X71, CMS proposes a work RVU of 0.69 based on a direct crosswalk to CPT code 88172 *Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site* (work RVU = 0.69). CMS states it believes that 88172 is a more accurate comparison code than the RUC's reference services. We do not agree that the survey results should be overlooked in lieu of an inappropriate comparison code that fails to account for the clinical aspects of the physician work and intensity related to the service. Given that a low number of providers perform full-field ERGs, the specialty societies sought and obtained permission to target those who perform this procedure. The RUC recommended work RVU of 0.80 is based on the survey 25th percentile for experts performing this procedure. We strongly urge CMS to accept the process that the RUC used to reflect valid data results in establishing is recommendation for the work RVU for CPT code 92X71. The RUC noted that the decrease in intra-service time of deleted code 92275 from when it was last surveyed in 1995 is because the physician no longer participates in the acquisition of the data or performing the test on the patient, which is the technician's work. However, the intensity and complexity of the physician work has increased significantly since 1995. Now there are more potential diagnoses and genotypes, which have increased the physician's cognitive work. The intra-service physician work includes reviewing numerous tracings and data, formulating a diagnosis, prognosis and potential therapeutic options. The physician reviews over 100 images and although the devices are sophisticated at collecting and presenting a desired output, the device does not indicate diagnostic suggestions. There is significant physician work involved in interpreting the

waveforms to arrive at a diagnosis of a typically rare disease with serious implications for the patient. The RUC determined that the physician work is not the same as it was with 92275 and the recommended decrease in work RVUs appropriately addresses the decrease in physician time to perform this service. **The retina societies urge CMS to accept the RUC-recommended work RVU of 0.80 for CPT code 92X71.**

92X73

For CPT code 92X73, we support the RUC recommended work RVU of 0.72 and disagrees with the CMS work RVU of 0.61. CMS proposes to take the incremental difference of 0.08 RVUs between 92X71 and 92X73 to arrive at a work RVU of 92X73. We urge CMS to use valid methods of evaluating services instead of using an increment or decrement to estimate work RVU. The RUC recommendations were based on the standard methodology using survey data, not on an incremental difference in work RVUs between 92X71 and 92X73. The RUC used magnitude estimation valuing these services compared to the physician work, time, intensity and complexity and we strongly urge CMS to use the input of the experts in valuing this service. The RUC provided appropriate references services supporting a work RVU of 0.72 for CPT code 92X73. The RUC compared 92X73 to similar service 92235 *Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral* (work RVU = 0.75 and 15 minutes intra-service time) and noted that CPT code 92X73 is slightly less intense and complex to perform than 92235, therefore is valued lower. The RUC also referenced similar service, CPT code 77333 *Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)* (work RVU = 0.75 and 20 minutes total time).

CPT code 92X73 requires more physician work than the CMS-proposed CPT code 88387 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); each tissue preparation (eg, a single lymph node)* (work RVU = 0.62) For code 92X73, the physician must consider more specific retinal dystrophy diagnoses with specific genotypes when interpreting the test and formulating advice regarding further testing, patient counseling, and genetic testing to communicate to the referring physician. Thus, the cognitive work is different from reviewing a tissue sample for a marker specific to breast tissue.

CPT code 92100 *Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (eg, diurnal curve or medical treatment of acute elevation of intraocular pressure)* (work RVU = 0.61) is also inappropriate because measuring intraocular pressure is less physician work than reviewing the varied number of uncommon diagnoses for which the test is utilized. The physician reviews approximately 80 images and the device does not indicate diagnostic suggestions. There is significant physician work involved in interpreting the waveforms to arrive at a diagnosis of a typically rare disease with serious implications for the patient. The RUC determined that the recommended decrease in work RVUs appropriately addresses the decrease in physician time to perform this service. The RUC also noted that CPT code 92X73 is appropriately slightly less physician work than the full-field ERG CPT Code 92X71.The survey results appropriately

reflected the intensity and complexity of the physician work for a multifocal exam. **The retina societies urge CMS to accept the RUC recommended work RVU of 0.72 for CPT code 92X73.**

QUALITY PAYMENT PROGRAM

General Comments

We appreciate the Administration's continued outreach to the physician community before and during the comment period on the QPP and proposed rule, including its briefings, webinars, and meetings with the AMA and national medical specialty societies, as it continues the transition to the QPP. We applaud CMS for proposing continued flexibility in the third year of the transition period as well as maintaining opportunities for bonus points. As we noted in previous comments, extending transition year policies to ensure a smooth implementation of the new Program is both valued and appreciated by our members.

We offer our detailed comments on the following aspects of the MIPS Program below:

- Support removal of Part B drugs from MIPS payment adjustment
- Oppose removal of two retina quality measures from the Ophthalmology Specialty Set
- Return to the minimum 90-day reporting period with one year optional for quality for the second and third year performance periods
- Delay the phase out of topped out measures and removal of the cap on points
- Improve risk adjustment and attribution methods in the cost category or reweight to another category

APPLICATION OF PAYMENT ADJUSTMENT TO PART B DRUGS

We applaud CMS for proposing modifications to MIPS consistent with the Bipartisan Budget Act of 2018 to ensure that the MIPS payment adjustments will not apply to Part B drugs and other items furnished by a MIPS eligible clinician. We appreciate that CMS is making this change beginning with the first MIPS payment year as reimbursement of Part B drugs administered to patients serve as a pass-through mechanism to cover acquisition costs and, therefore, should not be impacted by payment adjustments.

QUALITY PERFORMANCE CATEGORY

Overall, we appreciate many of the CMS proposals that maintain consistent requirements for the quality category in the 2019 performance period, and we appreciate that CMS proposes to allow reporting through multiple collection types for a single performance category and to score the physician on the measures with the highest assigned measure achievement points. Yet, to simplify and improve the quality category further, the retina societies support many of the recommendations that the American Medical Association (AMA) submitted in its comment letter regarding the MIPS Program. In particular we support the following recommendations:

- Reduce the number of quality measures a physician must report and shorten the reporting period to 90 days to ease data collection and reporting burdens and facilitate continuous quality improvement

- Make quality reporting more flexible by not requiring the use of any specific type of measure. High priority and outcomes measures should be optional and CMS should recognize the importance of these measures through bonus points
- Provide maximum number of points for reporting on new measures or measures where there is no benchmark. Require EHR vendors, if requested by the physician at no cost to incorporate all available electronic clinical quality measures (eCQMs) in the MIPS measure set since CEHRT only requires a minimum number
- Reduce the Data Completeness Threshold to 50 Percent
- Eliminate the Requirement to Report on All-Payer Data and make it optional.

We offer the following detailed comments below.

<u>Quality Performance Period Recommendation: Change the reporting period to a minimum of 90 days with the 1-year reporting period as optional</u>

We continue to believe that the quality performance category should be a minimum of 90 days with a full year being optional for both 2018 and 2019 reporting years. The move to a 12-month performance period should be more gradual as clinicians fully transition into MIPS. There is precedent for retroactively shortening a federal quality reporting program reporting period, as CMS did in 2015 and 2016 for eligible professionals in the Electronic Health Record (EHR) Meaningful Use program.[1] In addition, the 2017 MIPS program allowed for a reduced reporting period.

We joined the AMA and other specialty societies in April 2018 to ask that the one-year reporting period continue to be optional for various reasons in addition to the transition and alignment of reporting with the other MIPS categories. While we acknowledge that certain reporting options, such as some outcome-based measures, may require a reporting period longer than 90 days to ensure statistical validity, we believe shortening the minimum data collection period to 90 consecutive days will substantially reduce the cost and labor involved in reporting MIPS data to CMS. This would be consistent with CMS' efforts to reduce clinician burden and to put patients over paperwork. As pointed out in the April letter, the paperwork burden associated with full-year quality reporting for 2018 is estimated at 7.6 million hours at a cost of nearly $700 million.[2] And a 2016 *Health Affairs* study found that physician practices in four common specialties spend in a year, on average, 785 hours per physician and more than $15.4 billion on quality measure reporting, the majority of time consisting of "entering information into the medical record only for the purpose of reporting for quality measures from external entities." As many of the options for reporting by retina specialists continue to require manual upload, this is a significant burden.

Further, with the initial MIPS feedback reports midyear, physician practices may need to conduct internal due diligence to identify quality performance variables, explore more clinically relevant reporting metrics and change data capture and input into the EHR, which would require action by third-party vendors who are not subject to the same payment penalties as physicians. If the reporting period were reduced, physicians would have greater flexibility to incorporate the feedback into their current performance and focus more of their attention on improving patient care

[1] See *Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 3 and Modifications to Meaningful Use in 2015 Through 2017; Final Rule* (CMS-3310-FC and CMS-3311-FC) and *Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs* (CMS-1656-FC and IFC).
[2] 82 FR 53925, *Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year*, CMS-5522-FC and IFC.

as opposed to just reporting. We also believe this flexibility would provide time to resolve problems that may occur if a physician updates or switches their EHR during the performance year.

Similarly, QCDR dashboard reports are often delayed by several months, so a shortened reporting period would give physicians the opportunity to review quality data to ensure it is accurate and correctly mapped from their EHRs to QCDRs before it is submitted on their behalf by a registry. While we have confirmed that registry vendors plan to provide physicians with real-time snapshots of their quality data, this is still a work in progress. In fact, many of our members did not receive feedback for the first two quarters of 2017 until mid-July and found that their data was incorrect due to unresolved mapping issues. **A 90-day or 6-month performance period would allow time for these dashboard improvements to be implemented, allow corrections to be made in data mapping, and promote continuous quality improvement**.

Quality Measures Proposed for Elimination: The Retina Societies Opposes Elimination

CMS proposes to remove two ophthalmology measures currently used by retina specialists for reporting in the 2019 performance year for the 2021 payment year and future years:

Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement (Measure 140)

> CMS Rationale: the measure neither assesses a clinical outcome nor one of the defined MIPS high priority areas. The measure's quality action that only requires the provision of counseling of AREDS risk factors, but does not require discontinuation of AREDS if risks/adverse effects are identified.

Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy (Measure 018)

> CMS Rationale: it is duplicative both in concept and patient population as the currently adopted Measure 019: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care. Measure 019 is considered high priority because it promotes communication and care coordination with eligible clinicians managing diabetes care. The numerator of Measure 018 is considered the standard of care as it captures an assessment with no additional clinical action. Measure 018 neither assesses a clinical outcome nor one of the defined MIPS high priority areas.

The retina societies strongly oppose removal of these measures.

CMS indicates that its proposal to remove measures is based upon certain criteria, specifically: whether the removal of the measure impacts the number of measures available to a specific specialty; whether the measure addresses a priority area of the Meaningful Measures Initiative; and whether the measure is linked closely to improved outcomes in patients. Further considerations are given in the evaluation of the measure's performance data, to determine whether there is no longer is variation in performance.

First, the removal of these two measures would certainly impact the number of measures available to retina specialists. Given that there are nine measures relevant to retina specialists, this will leave only seven, reducing the number reportable by Part B Claims from five to four and reporting on six measures would be more difficult for some retina specialists. Further, one of the two measures (Measure 18) is an eCQM, which if removed would leave only four measures of that type. According to CMS' 2018 benchmarking data, neither of these measures are topped out for all reporting options, and measure 18, which is only available for EHR reporting, is not topped out at all. **In general, we strongly believe that maintaining as many options as possible**

for reporting – measure type and collection type— is critical to ensure meaningful and widespread participation at this stage in the Program.

As for Measure 18, the retina societies join PCPI, the measure steward, and the AMA in opposing its removal for various reasons. First, as indicated above, input provided by some PCPI TEP members cautioned that removal of this measure would impact the number of measures available to retina specialists. Second, the CMS benchmarking data indicate that the eCQM measure, only reportable via EHRs, is not topped out for this particular reporting mechanism with 66.8% average performance. Therefore, Measure 18 should not be removed from the program as there is room for improvement in the eCQM collection type. And finally, in its rationale, CMS states that Measure 18 is duplicative of another PCPI eCQM – Measure 019: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care. These measures, however, were developed not as duplicative, but rather as complementary measures to ensure appropriate grading of the level of retinopathy and promote care coordination and ongoing communication with the primary physician. **Accordingly, there are compelling reasons to keep Measure 18 in the ophthalmology measures set so we strongly oppose its removal.**

Measure 140 remains clinically important as patients who are taking the AREDS supplements reduce their risk of developing choroidal neovascularization, a blinding complication of age-related macular degeneration by 25%. This quality measure still has value as patients need regular reminders to ensure adherence to these supplements and continue to reduce the risk of complications. The cost of treating choroidal neovascularization to CMS is substantial since the intravitreal anti-VEGF treatments have to continue indefinitely, so maintaining this measure will help to reduce future CMS costs.

In conclusion, the retina societies believe it is important to maintain as many quality measures and reporting options as possible to ensure full participation as the Program matures**. We join the AMA in opposing the removal of Measures 18 and 140.**

<u>Topped-Out Measures Recommendation: Do not finalize proposal for "extremely topped out" measures and extend the timeline for removal.</u>

In the 2018 Program final rule, CMS finalized the 4-year timeline to identify topped out measures, after which it may propose to remove the measures through rulemaking. After a measure has been identified as topped out for 3 consecutive years through the benchmarks, CMS may propose to remove the measure through notice and comment rulemaking. Therefore, in the 4th year, if finalized through rulemaking, the measure would be removed and would no longer be available for reporting during the performance period. Further, CMS finalized that QCDR measures would not go through the comment and rulemaking process like MIPS quality measures, but QCDR measures that consistently are identified as topped out according to the same timeline would not be approved for use in year 4 during the QCDR self-nomination review process.

For all measures other than an initial six identified by CMS, the timeline would apply starting with the benchmarks for the 2018 MIPS performance period. **Thus, as CMS finalized its timeline, the first year any topped out measure (other than the initial 6) could be proposed for removal would be in rulemaking for the 2021 MIPS performance period, based on the benchmarks consistently being topped out in each of the 2018, 2019, and 2020 MIPS performance periods.** If the measure benchmark is not topped out during one of the 3 MIPS performance periods, then

the lifecycle would stop and start again at year 1 the next time the measure benchmark is topped out.

Despite this 4-year timeline, CMS is now proposing that once a measure has reached an extremely topped out status (for example, a measure with an average mean performance within the 98th to 100th percentile range), it may propose the measure for removal in the next rulemaking cycle, regardless of whether or not it is in the midst of the topped-out measure lifecycle. Further, CMS now indicates that QCDR measures are not approved or removed from MIPS through the rulemaking timeline or the topped-out cycle, so CMS indicates that it would exclude QCDR measures from the topped-out timeline that was finalized in the CY 2018 Quality Payment Program final rule. When a QCDR measure reaches topped out status, as determined during the QCDR measure approval process, it may not be approved as a QCDR measure for the applicable performance period. **We oppose these new proposals. The timeline for removal of measures based upon topped out status should certainly not be shortened; if CMS adjusts the timeline in any way, it should be to lengthen it.**

We maintain our position as commented previously, that the timeline for removal should be longer to allow for the development of new measures to replace topped out measures. Measures development is a lengthy, complex, costly and time-consuming process. Depending on the measure, it can take a minimum of one to three years after stakeholder internal development for a measure to go through field testing, refinement, obtain endorsement and CMS approval. Thereafter, working with EHRs and registries to enable electronic reporting can add additional years to the process. For example, of the seven retina measures that American Academy of Ophthalmology (AAO) started developing with input from the retina societies in 2009, four have been approved as QCDR measures, but none have completed field testing and refinement. Moreover, these four measures are only available for manual reporting so they are not being used by many practitioners. Similarly, the IRIS® QCDR measures submitted and approved in 2018 were not field tested in a sufficient number of practices and are just now going through additional refinement.

If topped-out measures are being removed faster than new measures are being developed and used there will not be enough measures for some specialists to report. CMS should either maintain topped out measures or lengthen the timeline for removal until more measures can be developed and approved. Further, CMS should not penalize physicians for reporting on topped out measures by capping the number of achievement points at seven points. Physicians should be eligible to earn maximum achievement points for reporting such measures until a measure is removed. Capping achievement points adds to the complexity of scoring and disregards the fact that there are multiple factors that go into the decisions for reporting on specific measures.

<u>Removal of Quality Measures for Reasons Other Than Topped-Out Status</u>

CMS underscores its desire to reduce the number of process measures within the MIPS quality measure set as it believes that outcome measures are more valuable than clinical process measures and are instrumental to improving the quality of care patients receive. In the CY 2018 Quality Payment Program quality measure set, 102 of the 275 quality measures are process measures that are not considered high priority. The removal of all non-high priority process measures would impact most specialty sets, nearly 94 percent, so CMS proposes to incrementally remove non-high priority process measures through rulemaking. Beginning with the 2019 performance period, CMS

proposes to implement an approach to incrementally remove process measures where prior to removal, considerations will be given to, but is not limited to:

- Whether the removal of the process measure impacts the number of measures available for a specific specialty.
- Whether the measure addresses a priority area highlighted in the Measure Development Plan.
- Whether the measure promotes positive outcomes in patients.
- Considerations and evaluation of the measure's performance data.
- Whether the measure is designated as high priority or not.
- Whether the measure has reached a topped-out status within the 98th to 100th percentile range, due to the extremely high and unvarying performance where meaningful distinctions and improvement in performance can no longer be made.

As stated above, the retina societies strongly believe that maintaining as many options as possible for reporting –measure type or collection type— is critical to ensuring meaningful and widespread participation at this stage in the Program. We understand that CMS would like to incentivize development of outcome measures and high priority measures, but this should be accomplished at the measure approval stage and by awarding bonus points for reporting such measures. We don't believe it is helpful to remove measures outside of the topped-out timeline merely because the measure is a process measure. As CMS acknowledges, over one third of currently available quality measures are process measures that are not considered high priority. We oppose this proposal.

SCORING FOR QUALITY

Bonus Points and Flexibility for Small Practices

We appreciate that CMS proposes to retain bonus points in the scoring methodology for the quality category for treating complex patients and for end-to-end electronic reporting, and that it will retain the small practice bonus, as well as awarding 3 points (as opposed to 1 point) to small practices for reporting quality measures that do not meet the data completeness requirements. We offer the following specific feedback.

End-to-End Bonus

We appreciate that CMS has further delineated the submission types and clarified that the end-to-end bonus will apply to reporting eCQM, CQM and QCDR measures even if the clinician reports by manually uploading quality data. As proposed, the end-to-end reporting bonus would apply to the subset of data submitted by direct, log in and upload, and CMS Web Interface, not to the claims submission method. CMS notes that this is not a policy change but rather a clarification of current process in light of the proposed terminology changes. We appreciate the clarification given that the QCDR ophthalmology measures used by retina specialists can only be manually uploaded to the IRIS® registry. This bonus is appreciated to reward the effort and expense a practice undertakes to move to electronic reporting and to connect with a registry, yet not penalize them due to the obstacles encountered with the effort that still involves the burden of reporting by manual upload.

With regards to eCQMs, CMS proposes that MIPS eligible clinicians and groups reporting on the quality performance category must use the most recent version of the eCQM specifications in the 2019 reporting year. CMS is proposing this to encourage clinicians to work with their EHR vendors to ensure they have the most recent version of the eCQM. CMS will not accept an older

version of an eCQM as a submission for the MIPS program for the quality performance category or the end-to-end electronic reporting bonus within that category. While we understand that the Secretary is required to encourage the use of CEHRT for quality reporting, we disagree with this proposal for 2019 as the EHR industry needs more time. We believe that eliminating obstacles to complete electronic end-to-end reporting without manual upload should be the primary goal for all involved. Without incentives placed on CEHRT technology vendors this process will be slow and cumbersome.

Small Practice Bonus

Although we value and support retention of the small practice bonus, we question why CMS proposes to include it in the quality performance category score instead of as a standalone bonus. This is yet another change that adds to the confusion of MIPS while the program is still new to clinicians. Given the proposed terminology changes that may help delineate and clarify requirements and other proposed changes it would help to keep the Program simple and minimize changes unless clearly necessary. Moving the small practice bonus to the cost score would add another layer to the scoring in that category that will vary from clinician to clinician based upon the weight of the category. CMS acknowledges that the Quality Payment Program is a large shift for many clinicians and practices, and notes that it is a priority for Program Year 3 among other things to reduce clinician burden and implement the Patients Over Paperwork initiative. As such, **the retina societies believe that CMS should minimize confusion where it can and keep the Program simple by leaving this bonus as an add-on to the final score. As CMS deems necessary, it can be phased out by simply reducing the number of points in the bonus.**

COST PERFORMANCE CATEGORY

We were disappointed that CMS finalized a weight for the cost category at 10% for the 2018 reporting year after initially proposing 0%. This was in part due to concerns that a jump in 2019 to 30% would be too large of a leap. Now, despite new statutory authority providing CMS the flexibility to weight the cost category at no less than 10% and no more than 30% for the 2019, 2020 and 2021 reporting years, CMS proposes a weight of 15% for the cost category in 2019. **We have opposed weighting the cost category until appropriate cost measurement is possible for all physicians. Given the new statutory minimum requirement and the current weight, we believe CMS should keep the category to the minimum weight of 10%.**

As we commented in the past, while we appreciate CMS' efforts to develop new measurement tools such as patient relationship categories and episode-based measures, this work will take time and we believe the weight of the category should remain at very low levels until new episode-based measures cover a large percentage of physicians. In the interim, we continue to have major concerns with the measures carried over from the Value-Based Payment Modifier (VM) to assess performance in the cost performance category. Despite acknowledging problems, CMS continues to use the Total per Capita Costs for All Attributed Beneficiaries (TPCC) and Medicare Spending per Beneficiary (MSPB). We have repeatedly urged CMS to address weaknesses in its methods of adjusting for differences in physician specialty and subspecialty as well as patient risk, and to improve feedback to physicians to avoid inappropriate attribution of hospitalization costs to our members unrelated to their outpatient care for a particular patient.

Without refinements to VM attribution methodologies to distinguish between specialists and subspecialists in the same field, many subspecialists, like retina specialists, may be inappropriately labeled as high-cost utilizers due to inaccurate attribution methodologies. For example,

subspecialists that treat patients that require high-cost drugs or procedures would not be distinguished from physicians in the same specialty who do not provide similar treatment to similar patients, resulting in inaccurate "comparisons" and misleading information provided to patients. The typical patient population cared for by retina specialists is comprised of patients who are generally sicker, older, and have more comorbidities than the average ophthalmology patient. The conditions most commonly treated by retinal specialists include diabetic retinopathy, artery/vein occlusions, and wet age-related macular degeneration. While these conditions have effective pharmacologic treatments, there is no permanent cure necessitating continual monitoring and ongoing care. If not adjusted for, discrepancies in these patient populations, disease processes, and treatments would lead to inaccurate comparisons.

As one step towards ensuring appropriate refinements, we urge CMS to increase granularity when making peer-to-peer comparisons within provider specialties and sub-specialties to more accurately and appropriately capture the quality of care being delivered to Medicare patients. Under current program structure, CMS uses the Composite Performance Score to make broad comparisons regardless of provider specialty and sub-specialty for the purpose of applying adjustments to provider payments. **We urge CMS to use taxonomy codes within this and other subspecialties to track physician performance and ensure relevant comparisons are being made between providers in MIPS.** For example, NUCC recently approved new, voluntary healthcare provider taxonomy codes for ophthalmology subspecialties in retina, oculoplastics, uveitis, and glaucoma subspecialties. We encourage CMS to further define "peer" groups of providers, as in the case of ophthalmology, throughout the QPP and as more specialty specific taxonomy codes become available.

That said, we appreciate that CMS proposes to continue its policy to assign a scoring weight of 0% to the cost category for those clinicians for whom it cannot reliably calculate a score for the cost measure that adequately reflects performance and to redistribute the weight of the category. For specialists, such as retina specialists who do have patients attributed to them under these cost measures, we urge CMS to ensure a transparent and fair review process to confirm attribution is appropriate. If a clinician can demonstrate that CMS cannot reliably calculate a score for the cost measures that adequately captures and reflects their performance, CMS should redistribute the cost score to another performance category.

PROMOTING INTEROPERABILITY PERFORMANCE CATEGORY

We appreciate and support many of the changes that CMS proposes for the Promoting Interoperability category, yet the total overhaul of the category requirements is yet more change to learn and adjust to while many physicians are still learning Program requirements. While CMS has simplified this category, the reweighting process is cumbersome and confusing and we urge CMS to rethink that section. Further, as we have consistently opposed the "all-or-nothing" structure of this category, we urge CMS to award partial credit for physicians who report on some of the required measures. In fact, the category could be further simplified by allowing full credit for physicians who use a QCDR. Finally, we appreciate that the Secretary must provide incentives to CEHRT, and many ophthalmologists with EHR have upgraded to 2015 technology, or are planning to soon, however we recommend CMS not to mandate 2015 CEHRT as that would still be burdensome for some small practices.

We appreciate and support the proposal to remove patient action measures as retina patients are often elderly and have reduced visual acuities so they are unable to use utilize electronic patient

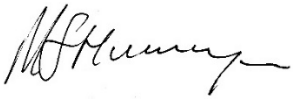
portals. Many do not have routine access to use a computer, thereby limiting our members' ability to meet such requirements. We also appreciate the proposal to modify the "receive a summary of care" measure to score it based on performance within the physician's control, solely on whether he or she completes the clinical data reconciliation when an electronic summary of care is received. Currently, this measure scores a physician on the percentage of electronic summaries of care received from other practitioners out of all referrals. We have consistently opposed measures that hold providers responsible for the actions of patients and other physicians outside of their control. We appreciate the proposals that focus on interoperability rather than the quantity of information exchanged. CMS should finalize these proposals.

CMS should ensure only relevant measures are required, however. We support exclusions for measures not applicable to certain specialties, such as the opioid measures and the public health registry, and immunization reporting measures. These measures are often not relevant to retina specialists and their practice. For example, ophthalmologists rarely prescribe controlled substances. While we recognize these measures are optional for 2019, long term we recommend CMS provide an exclusion for each opioid measure, as they are not applicable to ophthalmologists. Similarly, we recommend exclusions for reporting to public health registries and immunization reporting measures as they are not applicable to retina specialists.

CONCLUSION

The retina societies appreciate the opportunity to provide comments on the 2019 Medicare Physician Fee Schedule and QPP Proposed Rule. We support CMS's initiatives to reduce the regulatory burden on physicians. We reiterate our support for the RUC process in valuing and revaluing codes in 2019. We look forward to partnering with CMS to enhance the E/M coding system, advance telehealth guidance, and make further refinements to the MIPS program. If we may provide any additional information, please contact Jill Blim, ASRS Executive Vice President at jill.blim@asrs.org.

Sincerely,

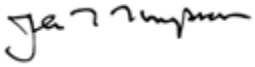


Mark Humayun, MD
President, ASRS

H. Richard McDonald, MD
President, Macula Society

Bernard Doft, MD
President, Retina Society

Antonio Capone, MD
Retina Society Retina-AAO Coordinating Committee Representative



John Thompson, MD
ASRS Retina-AAO Coordinating Committee Representative

Lawrence Singerman, MD
Macula Society Retina-AAO Coordinating Committee Representative

ORDER ONLINE

FAQs

CSOS Setup Instructions

Shipping Info.

Order History

JDE OE REF #3386077

Item Description	NDC#	Qty Ord	Qty Ship	Qty BO	Price	Status	Tracking
AK-Fluor 10% Injection 100mg/mL, 5mL, 12 Vials	17478-0253-10	24	24	0	$585.36 ($24.39 each)	Backorder in S/O Entry	456421144130

SUBTOTAL	$585.36
DISCOUNTS	$0.00
SHIPPING	$0.00
TAX	$0.00
TOTAL	$585.36

AKORN

1925 W. FIELD COURT
SUITE 300 LAKE FOREST IL 60045
Phone: 800-932-5676 - Fax: 847-279-6125
Seller FL License: 261857

Shipped From	Address
305 or 308	5605 Centerpoint Ct, Ste. B Gurnee, IL 60031
310 or 350 or 370	150 S. Wyckles Rd. Decatur, IL 62522
325	13 Edison Street East Amityville, NY11701

Send Payment To:

Akorn Inc.
3950 Paysphere Circle
Chicago, IL 60674

INVOICE

Invoice No	Page
3000591 RI	1 of 1
Invoice Date	
1/31/18	
Due Date	
3/2/18	

Bill To

Ship To

Order Details:

Order No	Order Date	Customer PO Number	Terms	Tracking Number
3221655 SO	1/30/18	Dawn 01302018	Net 30	1ZX340W00369533927

Item Details:

Line	Shipped From	Item Number	Item Description	Quantity	Unit Price	UOM	Lot/Exp Date	Extended Amount
1	308	17478-0253-10	AK-Fluor 10% Injection 100mg/mL, 5mL, 12 Vials	1248.00	22.19	EA	101597A 10/31/2019	27693.12

Visa, Mastercard & American Express Accepted.
Invoices paid beyond terms are subject to a late payment charge.

Sale Amount	27693.12
0 % Sales Tax	.00
BALANCE DUE Payable in U.S. Currency	27693.12

Please detach and return with payment

Customer No.	Ship To No.
14876	21133

Invoice No.	Balance Due
3000591 RI	27693.12

RETINA CONSULTANTS
191 MAIN ST
MANCHESTER CT 06042

RETINA CONSULTANTS
43 WOODLAND ST STE 100
HARTFORD CT 06105-2370

REMIT PAYMENT TO: Akorn Inc.
3950 Paysphere Circle
Chicago, IL 60674

Search GO

Order History

JDE OE REF #3375358
Web Order #32080

Item Description	NDC#	Qty Ord	Qty Ship	Qty BO	Price	Status	Tracking
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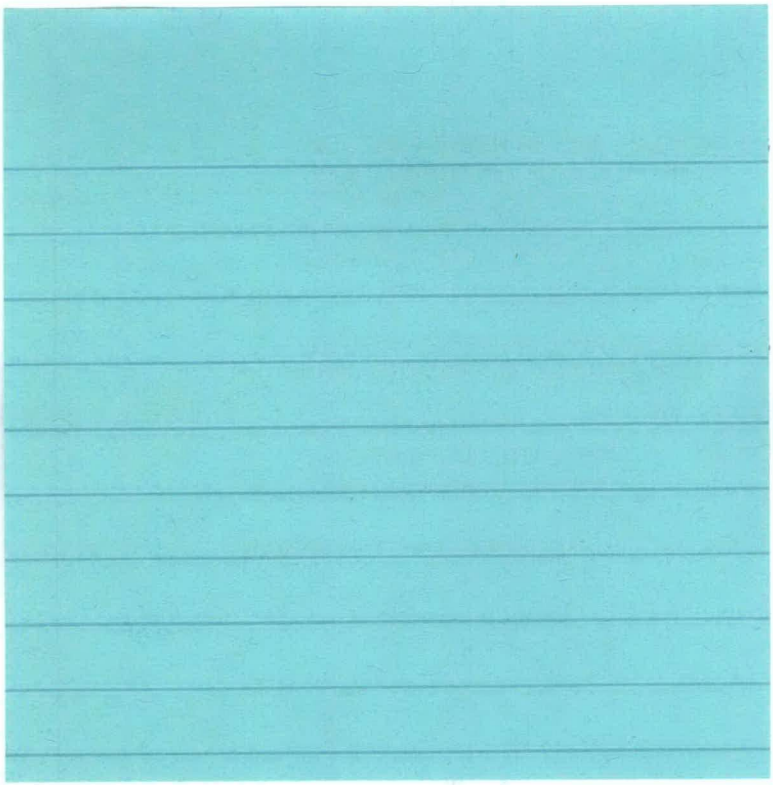
AK-Fluor 25% Injection 250mg/mL, 2mL, 12 Vials	17478-0250-20	120	0	120	$2926.80 ($24.39 each)	Backorder in S/O Entry	NA

SUBTOTAL	$4390.20
DISCOUNTS	$0.00
SHIPPING	$0.00
TAX	$0.00
TOTAL	$4390.20



Besse Medical
AmerisourceBergen Specialty Group

Distributed by ASD Specialty Healthcare, LLC
dba Besse Medical
345 International Blvd, Suite #400A
Brooks, KY 40109
www.besse.com
Phone: 1-800-543-2111
Fax: 1-800-543-8695

DEA# RA0219798
FEIN: 33-0800482

INVOICE

INVOICE NO. 12013183560

DATE	PAGE	ROUTE
08-08-2018	1 of 1	ALPHA

ORDER # / DATE	ACCOUNT NUMBER		LOB / CUSTOMER TYPE	SALESPERSON / DEPT		CUSTOMER PO / TERMS
271779882	A 000211194	C 000211194	RETINA		OPHT01	Martin Boscarino Card
08-08-2018	B 000211194	D 000211194	033			Net 30 Days CC

QUANTITY ORDERED	QUANTITY SHIPPED	QTY. B/O	ITEM NUMBER	CLASS	DESCRIPTION	UNIT PRICE	U/M	EXTENDED PRICE
12	12	0	48188	RX	FLUORESCITE 10% VL 12X5ML UD NDC:00065-0092-65	611.78	EA TAX	7341.36 0.00

This wholesale distributor, or a member of the affiliate of such wholesale distributor, purchased the product directly from the manufacturer, exclusive distributor of the manufacturer, or repackager that purchased the product directly from the manufacturer. The transaction history for the prescription drugs in this invoice is available at www.besse.com. Florida Out-of-State Prescription Drug Wholesaler Permit No. 23 2323.

$50.98 per Vial

Comments:

SUBTOTAL	7,341.36
TOTAL TAX	0.00
AMOUNT DUE	**$ 7,341.36**

Prices on this invoice reflect a discount for payments received by cash, check, money order, EFT or similar means. Payments by credit card will not receive this cash discount.

PLEASE RETURN THIS STUB WITH REMITTANCE. THANK YOU.

CUSTOMER NUMBER	000211194
INVOICE NUMBER	12013183560
INVOICE DATE	08-08-2018
AMOUNT DUE	$ 7,341.36
DUE DATE	09-07-2018

Besse Medical
AmerisourceBergen Specialty Group

Please indicate payment amount and check number in the boxes provided.

CHECK NUMBER	_____
AMOUNT PAID	$_____

Please Remit To:

BESSE MEDICAL SUPPLY
1576 SOLUTIONS CTR
CHICAGO, IL 60677-1005

0002111941201318356000000073413600000090720183

Besse Medical
AmerisourceBergen Specialty Group

Distributed by ASD Specialty Healthcare, LLC
dba Besse Medical
345 International Blvd, Suite #400A
Brooks, KY 40109
www.besse.com
Phone: 1-800-543-2111
Fax: 1-800-543-8695

DEA# RA0219798
FEIN: 33-0800482

INVOICE

INVOICE NO. 12013221476

DATE	PAGE	ROUTE
09-06-2018	1 of 1	ALPHA

ORDER # / DATE	ACCOUNT NUMBER		LOB / CUSTOMER TYPE	SALESPERSON / DEPT		CUSTOMER PO / TERMS
223213293	A 000211194	C 000211194	RETINA	CINRJM	OPHT01	
09-06-2018	B 000211194	D 000211194	033			Net 30 Days CC

QUANTITY ORDERED	QUANTITY SHIPPED	QTY. B/O	ITEM NUMBER	CLASS	DESCRIPTION	UNIT PRICE	U/M	EXTENDED PRICE
25	25	0	21438	RX	AK-FLUOR 10% OPHT 12X5ML NDC:17478-0253-10	290.40	pk TAX	7260.00 0.00

This wholesale distributor, or a member of the affiliate of such wholesale distributor, purchased the product directly from the manufacturer, exclusive distributor of the manufacturer, or repackager that purchased the product directly from the manufacturer. The transaction history for the prescription drugs in this invoice is available at www.besse.com. Florida Out-of-State Prescription Drug Wholesaler Permit No. 23 2323.

$ 24.20 per vial

Comments:

SUBTOTAL	7,260.00
TOTAL TAX	0.00
AMOUNT DUE	**$ 7,260.00**

Prices on this invoice reflect a discount for payments received by cash, check, money order, EFT or similar means. Payments by credit card will not receive this cash discount.

PLEASE RETURN THIS STUB WITH REMITTANCE. THANK YOU.

CUSTOMER NUMBER	000211194
INVOICE NUMBER	12013221476
INVOICE DATE	09-06-2018
AMOUNT DUE	$ 7,260.00
DUE DATE	10-06-2018

Besse Medical
AmerisourceBergen Specialty Group

Please indicate payment amount and check number in the boxes provided.

CHECK NUMBER	_____
AMOUNT PAID	$_____

Please Remit To:

BESSE MEDICAL SUPPLY
1576 SOLUTIONS CTR
CHICAGO, IL 60677-1005

00021119412013221476000000726000000000100620181

AKORN

1925 W. FIELD COURT
SUITE 300 LAKE FOREST IL 60045
Phone: 800-932-5676 - Fax: 847-279-6125
Seller FL License: 261857

Shipped From	Address
305 or 308	5605 Centerpoint Ct. Ste. B Gurnee, IL 60031
310 or 350 or 370	150 S. Wyckles Rd. Decatur, IL 62522
325	13 Edison Street East Amityville, NY11701

Send Payment To:

Akorn Inc.
3950 Paysphere Circle
Chicago, IL 60674

INVOICE

Invoice No	Page
3151706 RI	1 of 1
Invoice Date	
8/7/18	
Due Date	
9/6/18	

Bill To
Acct #: 10592
RETINA CONSULTANTS OF WESTERN NY
6637 MAIN STREET
KHAN MEDI A DO
WILLIAMSVILLE NY 14221
DEA#:
License#:233770

Ship To
Acct #: 10592
RETINA CONSULTANTS OF WESTERN NY
6637 MAIN STREET
KHAN MEDI A DO
WILLIAMSVILLE NY 14221
DEA#:
License#:233770

Order Details:

Order No	Order Date	Customer PO Number	Terms	Tracking Number
3371692 SO	7/31/18	JERRY	Net 30	455403496174

Item Details:

Line	Shipped From	Item Number	Item Description	Quantity	Unit Price	UOM	Lot/Exp Date	Extended Amount
1	305	17478-0253-10	AK-Fluor 10% Injection 100mg/mL, 5mL, 12 Vials	240.00	24.39	EA	061158A 06/30/2020	5853.60

Visa, Mastercard & American Express Accepted.
Invoices paid beyond terms are subject to a late payment charge.

Sale Amount	**5853.60**
0 % Sales Tax	**.00**
BALANCE DUE Payable in U.S. Currency	**5853.60**

Please detach and return with payment

Customer No.	Ship To No.
10592	10592

Invoice No.	Balance Due
3151706 RI	**5853.60**

RETINA CONSULTANTS OF WESTERN NY
6637 MAIN STREET
KHAN MEDI A DO
WILLIAMSVILLE NY 14221

RETINA CONSULTANTS OF WESTERN NY
6637 MAIN STREET
KHAN MEDI A DO
WILLIAMSVILLE NY 14221

REMIT PAYMENT TO: **Akorn Inc.**
3950 Paysphere Circle
Chicago, IL 60674

EyeSupply™

Invoice

6297 W Linebaugh Ave
Tampa, FL 33625 USA
License # 221437
(813) 975-2020 Phone
(813) 975-0213 Fax

Invoice Number: **0000360759**
Date: 1/26/2018
Sales Order: 0000264480
Salesperson: ESI
Customer: 971031
License: 119187

Sold To	Ship To
Retina-Consultants of Western NY 6637 Main St Williamsville, NY 14221 USA	Retina-Consultants of Western NY 6637 Main St Williamsville, NY 14221 USA

Customer P.O.	Ship Via	F.O.B	Terms
	UPS Ground	TAMPA	Net 15

Item	Description	Qty Shipped	Price	Amount
204112	AK-Fluor 10% (lite) 5ml	9.00	408.00	3,672.00
316223	Inf Sets Safety 25g 12in tubing Terumo	2.00	69.95	139.90

ITEMS CURRENTLY ON BACKORDER FROM SALES ORDER 0000264480

ItemID	Description	Ordered	Shipped	Backordered

LAST ITEM

Remit Payment To:

EyeSupply
POBOX 864734
Orlando, FL 32886-4734

Bill To: 971031 / 0000360759
Retina-Consultants of Western NY
6637 Main St
Williamsville, NY 14221 USA

Please return a copy of invoice or include customer no. and invoice data with your check made payable to EyeSupply USA, Inc.

Subtotal	3,811.90
Freight	50.24
Sales Tax	0.00
Trade Discount	-139.90
Payment/Credit Amount	0.00
Balance	3,722.24

***Note**: For drug pedigrees, please call 800-521-5257*

HENRY SCHEIN®

Corporate Office
135 Duryea Road
Melville, NY 11747

Customer Service
1-800-472-4346

Address Service Requested

Invoice

Invoice #	:	49410074
Invoice Date	:	01/15/18
Amount	:	891.02
Terms	:	Statement date + 20 days
Due Date	:	02/23/18

Bill To:

STATE REG#: 036077639

Cust # : [redacted]	Ship Date : 01/15/18	Sls Ord # : 59828981
Cust P O # : EZ20035232018011515092 8	Ship Via : UPS DAVENPORT IOWA ZONE 2	Sls Ord Dt : 01/15/18
		Sls Rep : G764

Item #	Ship	BO	UOM	Description	Unit Price	Amount	Tax Status
1027394	3	0	Gallon	Maxicide w/Activator 2.5% 28 Day	14.4900	43.47	T
2452955	2	0	12/Pk	Ak-fluor 5ml Vials 10%	239.0300	478.06	T
	MN - See message below for DSCSA compliance details NDC#: 17478025310						
1126131	6	0	200/Bx	Alcohol Prep Pads Sterile 2Ply Med	1.7200	10.32	T
	** special contract price ** NDC#: 00404000702						
1118536	4	0	100/Bx	Criterion Glove PF Nitrile LF Medium	7.5300	30.12	T
1127198	6	0	4oz/Bt	Eye Wash Solution Screw-Top 98.3%	2.5500	15.30	T
1026076	1	0	Kit	Maxitest Biological Monitor In Office	281.2900	281.29	T

Please refer to back of paperwork for Disclosures/Terms of Sale
MN - The Drug Supply Chain Security Act (DSCSA) information related to prescrip tion drug products is available on our website www.henryschein.com/pedigree. If you have any problems accessing our website or would like to receive a copy of DSCSA documentation via fax, mail, or email, please contact our customer servi ce department at 1-800-472-4346.
This order has been processed by our Henry Schein, Inc, Midwest Dist Center, 5315 W 74th St Bldg 138, Indianapolis, IN 462685135

Finance Charges of 1.5% per month (18% per annum) are applied to amounts not paid within terms.
No merchandise will be accepted for return without our authorization. All claims must be made within 10 days of invoice.

Sub-Total	858.56
Tax	27.21
Shipping and/or Handling	5.25
Total Amount	891.02

Tax ID # 11-3136595 DUNS # 01-243-0880

Remittance Section

HENRY SCHEIN®

0100003160824494100741100000000008910201151 89

Cust #	:	[redacted]
Invoice #	:	49410074
Invoice Date	:	01/15/18
Amount	:	891.02
Terms	:	Statement date + 20 days
Due Date	:	02/23/18

Please put your account number on the check.

Remit To:

Henry Schein
Dept CH 10241
Palatine, IL 60055-0241

Search GO

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Order History

JDE OE REF #3367455

Item Description	NDC#	Qty Ord	Qty Ship	Qty BO	Price	Status	Tracking
AK-Fluor 10% Injection 100mg/mL, 5mL, 12 Vials	17478-0253-10	144	144	0	$3512.16 ($24.39 each)	Backorder in S/O Entry	455403494609

SUBTOTAL	$3512.16
DISCOUNTS	$0.00
SHIPPING	$0.00
TAX	$0.00
TOTAL	$3512.16

Billing To:

Shipping To:

Shipping Method: Ground

Payment Method: PO# and/or Name: 07252018

✓ RSS

McKESSON

McKesson Medical-Surgical
9954 Mayland Drive Suite 4000
Richmond, VA 23233

Bill To:

Invoice

RCHAP6519

Shipped From:
MCKESSON MEDICAL-SURGICAL
INC(URBANCREST
COLUMBUS #072
3500 CENTERPOINT DRIVE STE A
URBANCREST,OH 43123

District License
Shipped To:

Regulatory License
Payment / Account Balance Inquires 1-800-453-5180
Phone:
Customer Service Phone: 1-800-877-1919

Sales Order Number		**Invoice Number**	
Sales Order Date	**09/06/2018**	**Invoice Date**	**09/06/2018**
PO Number		**Payment Due Date**	**10/02/2018**
Sales Rep Name		**Invoice Amount**	**$1,738.39**

Notes: See back for Terms and Conditions.
Please contact us regarding electronic payment options at MMS.Treasury@ McKesson.com

Invoice Detail

Item Number	Vendor / Vendor Cat #	Description	Ordered	Unit	Shipped	Unit Price	Amount	Sales Tax
682624	Vendor: AKORN NDC Num: & 17478025310	AK-FLUOR, VL 10% 5ML (12/CT) PO LN 1	6	CT	6	289.55	1737.30	.00
	072000783072							
	SHIPPED: 09/06/2018	Columbus						
	Vend Cat#:	FUEL SURCHARGE PO LN 2	1	EA	1	1.03	1.03	.06

McKESSON

McKesson Medical-Surgical
9954 Mayland Drive Suite 4000
Richmond, VA 23233

Invoice

RCHAP6519

Account Number			
Document Number		**Date**	**09/06/2018**
	Terms	**Cycle Statement for 12th**	
Pay This Amount Before	**10/02/2018**		**$1,738.39**

Please contact us regarding electronic payment options at MMS.Treasury@McKesson.com.

Please Remit To:

The amount above to be charged to Credit Card on file per agreed schedule. If your credit card declines or there is no active credit card on file, it's your responsibility to contact us with an alternate form of payment.