DECEMBER 2001

REPORT TO THE CONGRESS

Paying for Interventional Pain Services in Ambulatory Settings

MEDPAC Medicare Payment Advisory Commission

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Executive summary

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Medicare's payment policies should strive to establish rates that approximate the prices that would prevail in the long run in competitive local health care markets to ensure that: 1) beneficiaries have access to high-quality care; and 2) taxpayers and beneficiaries are not unnecessarily burdened through the taxes and the premiums they pay to finance the program. The Congress asked MedPAC to report on the barriers to payment and coverage for interventional pain services furnished in hospital outpatient departments (HOPDs), ambulatory surgery centers (ASCs), and physicians' offices. This report gives our response to this question.

Medicare's policies for paying for interventional pain services are inconsistent across ambulatory care settings. Consequently, the Commission recommends that the Secretary evaluate payments for ambulatory services to ensure that financial incentives do not inappropriately affect decisions regarding where care is provided. The Commission also found that payments for interventional pain services in ASCs probably do not reflect current costs because the rates are based on old charge and cost data. The Commission recommends that the Secretary evaluate payment rates for ASCs using recent charge and cost data from a sample of ASCs and update the list of procedures that are covered when performed in ASCs. With respect to care furnished in physicians' offices, the practice expense allocation for interventional pain services performed in physicians' offices is lower than the amounts paid for the same services under the HOPD and ASC payment systems. Beginning in January 2002, Medicare will recognize pain management as a specialty group. Consequently, the Commission recommends that the Secretary recalculate the practice expense payments for interventional pain procedures when data become available on the practice expenses of physicians specializing in pain management.

Finally, MedPAC found inconsistences in coverage policies across localities because Medicare's contractors each set policies within a specified geographic area. In addition, the limited number of randomized controlled studies evaluating interventional pain services is hindering the ability of contractors to establish policies in this clinical area. The Commission recommends that the Secretary sponsor additional research about the effectiveness of interventional pain services to strengthen the evidence basis for Medicare's coverage decisions. ■

Paying for Interventional Pain Services in Ambulatory Settings

RECOMMENDATIONS

1 The Secretary should evaluate payments for services provided in hospital outpatient departments, ambulatory surgical centers, and physicians' offices to ensure that financial incentives do not inappropriately affect decisions regarding where care is provided.

*** YES: 15 • NO: 0 • NOT VOTING: 0 • ABSENT: 2**

2 The Secretary should evaluate payment rates for ambulatory surgical centers (ASCs) using recent charge and cost data from a sample of ASCs. He also should update the list of procedures that are covered when performed in ASCs.

*** YES: 15 • NO: 0 • NOT VOTING: 0 • ABSENT: 2**

3 The Secretary should recalculate the practice expense payments for interventional pain procedures when data become available on the practice expenses of physicians specializing in pain management.

*** YES: 15 • NO: 0 • NOT VOTING: 0 • ABSENT: 2**

4 The Secretary should sponsor additional research about the effectiveness of interventional pain services to strengthen the evidence basis for Medicare's coverage decisions.

*** YES: 15 • NO: 0 • NOT VOTING: 0 • ABSENT: 2**

***COMMISSIONERS' VOTING RESULTS**

The Medicare Payment Advisory Commission (MedPAC) examined the consistency and appropriateness of payment for interventional pain services across ambulatory settings—hospital outpatient departments (HOPDs), ambulatory surgical centers (ASCs), and physicians' offices. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) required that MedPAC report on the barriers to payment and coverage for outpatient interventional pain management procedures.

Based on our evaluation and the findings of a study conducted by Project HOPE on behalf of MedPAC, we found no hard evidence that access is compromised (Mohr and Milet 2001). MedPAC's analysis of trend data shows, with a few exceptions, that spending for interventional pain services has generally kept pace with or exceeded spending growth for all physician services. However, it is possible that some of these services, such as spinal punctures or trigger point injections, may have been administered as adjuncts to surgical procedures rather than for the management of chronic pain. As such, these data may confound evaluation of the use of interventional pain services. Medicare's newly created pain management specialty for physician services should improve efforts to monitor trends in the use of these services.

We highlight three conclusions based on our analysis of Medicare's policies for paying for interventional pain services in ambulatory settings:

- Payment rates for some interventional pain services vary greatly across ambulatory settings. The Commission reiterates our March 1999 recommendation that the Secretary evaluate payments for services provided in HOPDs, ASCs, and physicians' offices to ensure that financial incentives do not inappropriately affect decisions regarding where care is provided.

- Payment rates for services furnished by ASCs are probably not consistent with their costs because the rates are based on dated charge and cost data. In addition, certain interventional pain services are not paid for when performed at ASCs. This lack of payment may be due to delays by the Centers for Medicare & Medicaid Services (CMS) in updating the list of covered procedures in ASCs. Consequently, the Commission recommends that the Secretary evaluate ASC payment rates and update the list of ASC-approved procedures.

- Physician practice expense allocations for interventional pain services are, on average, lower than the rates paid to ASCs and HOPDs. We do not know if payments are adequate or if the cost of providing these services in offices is lower than that in facilities. CMS recently recognized pain management as a physician specialty, but it is too soon to tell whether this will affect the physician practice expense allocation for interventional pain services. The Commission recommends that the Secretary recalculate practice expense payments for interventional pain services when data become available on the expenses of physicians specializing in pain management.

MedPAC also examined the effect of Medicare's coverage policies on access. Substantial variation exists in the local medical review policies (LMRPs) made by Medicare's contractors about coverage of interventional pain services in ambulatory settings. The paucity of information in the medical literature about the use of interventional pain services has contributed to the inconsistencies in these policies. Consequently, MedPAC recommends that the Secretary sponsor additional research about the effectiveness of interventional pain services to strengthen the evidence basis for Medicare's coverage decisions.

TABLE 1

Interventional pain services considered in MedPAC's analysis

Interventional pain procedures
- Facet joint blocks and neurolysis (diagnostic and therapeutic)
- Sympathetic blocks and neurolysis
- Intercostal nerve blocks and neurolysis
- Trigeminal nerve blocks and neurolysis
- Other nerve blocks
- Epidural injections
- Trigger point injections
- Other neurolytic injections
- Percutaneous lysis of epidural adhesions
- Discography
- Annuloplasty
- Implantable drug delivery systems
- Spinal cord stimulation (implantable transcutaneous electrical nerve stimulation)
- Chemodenervation of muscles

Procedures performed adjunct to interventional procedures
- Fluoroscopic guidance
- Arthrography
- Epidurography
- Myelography
- Catheter placement
- Spinal puncture
- Arthrocentesis

Source: Data compiled by MedPAC.

What is interventional pain management?

Pain is widespread among Medicare beneficiaries, many of whom suffer from osteoarthritis, joint disease, and other chronic medical conditions. Between 25 and 50 percent of the noninstitutionalized elderly suffer from significant pain at some time, and estimates of the rate for nursing home residents reach as high as 80 percent (American Geriatric Society Panel on Chronic Pain in Older Persons 1998, Magni et al. 1993, Mobily et al. 1994).

Interventional pain management procedures consist of minimally invasive procedures such as needle placement of drugs in targeted areas, ablation of targeted nerves, and some surgical techniques such as diskectomy and the implantation of intrathecal infusion pumps and spinal cord stimulators. (See Table 1 for the interventional pain procedures considered in MedPAC's analysis.) Many clinicians believe that these procedures are useful in diagnosing and treating chronic, localized pain that does not respond well to other treatments. Researchers estimate that 10 to 20 percent of persons suffering from pain will not find adequate relief from less invasive care (Krames 1999).

Improving Medicare's payment policies across ambulatory care settings

Because the basis for payment varies across ambulatory settings, large differences exist in the payment rates for many types of services, including interventional pain services. Payments in ASCs are generally higher than those in other settings, while physician practice expenses are generally lower. For example, in 2001, the payment to hospitals for a trigeminal nerve block was $166.80; by comparison, the ASC rate for the same procedure was $323.00, and the practice expense payment under the Medicare's physician schedule was $97.56 when the procedure was provided in the office setting.

Variations in payment could lead to shifting of care to inappropriate settings. MedPAC examined the issue of potential shifts among ambulatory settings by calculating the share of spending, by setting, for physicians' services in 1995 and 1999. The results, detailed in Table 2 (page 6), show the potential for shifting services among ambulatory care settings. For example, in the case of trigeminal nerve blocks and facet joint blocks, the data suggest that procedures have shifted to HOPDs and ASCs from physicians' offices. The data also show the potential for shifting of spinal cord stimulation and spinal puncture services to HOPDs from physicians' offices. Finally, data suggest that for intercostal nerve blocks and neurolysis and other nerve blocks, decreasing shares for services in HOPDs are offset by increasing spending shares for physicians' offices.

The Commission is concerned that financial considerations could lead to undesirable shifts of services. If care is shifted among settings, it should occur for clinical reasons and not because of payment rates. Consequently, we reiterate our recommendation from March 1999:

RECOMMENDATION 1

The Secretary should evaluate payments for services provided in hospital outpatient departments, ambulatory surgical centers, and physicians' offices to ensure that financial incentives do not inappropriately affect decisions regarding where care is provided.

The Secretary's evaluation should focus primarily on services commonly provided in more than one ambulatory setting and should include both an analysis of the payments and costs and an analysis of the appropriateness of care performed in particular settings. In the event that inappropriate payment differences are found, the Secretary should begin to develop a means of recalibrating payment amounts to reduce their potential impacts on choice of setting.

In addition to affecting program spending, shifts in site of care can have unintended consequences on beneficiary coinsurance. Beneficiary coinsurance is 20 percent for services provided in physicians' offices and ASCs. By contrast, MedPAC estimated that the average coinsurance for HOPD services was just under 50 percent of total payment for services in 2001 (MedPAC 2001a).

Improving payment policies for services provided in ambulatory surgical centers

ASC payment rates probably do not reflect current ASC costs because the rates are based on old charge and cost data. Medicare pays ASCs based on a fee schedule, which sets payment rates (median charges adjusted to costs) for eight procedure groups.[1] CMS last conducted a survey of ASC's costs and charges in the late 1980s.

In addition, Medicare only pays for certain interventional pain procedures when they are performed in ASCs. CMS has not updated the list of these covered procedures since 1998.

[1] ASC payment rates are adjusted to reflect geographic differences in input prices.

TABLE 2

Share of physicians' expenditures for interventional pain services by site of care, 1995 and 1999

Type of service	Share of physicians' expenditures 1995	1999
Chemodenervation of muscles		
• HOPD	12.7%	13.0%
• office	87.3	86.6
• ASC	0	<1.0
Discography		
• HOPD	51.6	52.3
• office	46.5	43.1
• ASC	1.9	4.7
Facet joint blocks		
• HOPD	22.9	64.7
• office	72.1	23.4
• ASC	5.0	11.9
Implantable drug delivery systems		
• HOPD	0	<1.0
• office	100	99.8
Intercostal nerve blocks/neurolysis		
• HOPD	12.3	8.1
• office	83.7	91.4
• ASC	4.0	<1.0
Spinal cord stimulation		
• HOPD	80.1	97.5
• office	19.9	0
• ASC	0	2.5
Spinal puncture		
• HOPD	68.5	76.1
• office	31.5	23.6
• ASC	0	<1.0
Sympathetic blocks and neurolysis		
• HOPD	5.5	15.7
• office	81.1	81.2
• ASC	13.4	3.1
Trigeminal nerve blocks		
• HOPD	26.8	33.8
• office	73.2	61.1
• ASC	0	5.5
Trigger point injections		
• HOPD	1.6	1.3
• office	98.4	98.7
Other nerve blocks		
• HOPD	7.8	3.7
• office	91.6	95.7
• ASC	<1.0	<1.0
Other neurolytic injections		
• HOPD	23.5	24.5
• office	72.9	74.5
• ASC	3.5	1.0
All other services		
• HOPD	24.8	21.3
• office	71.9	75.9
• ASC	3.4	2.7

Note: HOPD (hospital outpatient department), ASC (ambulatory surgical center). Groups of interventional pain procedures accounting for less than $1 per $1,000 in physician spending are not shown.

Source: MedPAC analysis of Medicare Part B 5 percent physician/supplier file.

RECOMMENDATION 2

The Secretary should evaluate payment rates for ambulatory surgical centers (ASCs) using recent charge and cost data from a sample of ASCs. He also should update the list of procedures that are covered when performed in ASCs.

CMS should proceed with its 1998 proposal to conduct a new rate survey, and, in accordance with the BIPA, should collect data from 1999 or later. CMS is statutorily required to conduct a rate survey every 5 years. Past surveys have collected data from a sample of ASCs about charges for individual procedures and total costs and charges.

In addition, CMS should proceed with its 1998 proposal to update the list of procedures that are covered when performed in ASCs. The agency is required by statute to review the list at least every two years. CMS also should revisit its 1998 proposal to modify the methods used to approve procedures, including using site-of-service volumes as one of the factors (but not the main factor) in its approval process.

Improving payment policies for physician services

Generally, the practice expense allocation for interventional pain services performed in physician offices is lower than the amounts paid for the same services under the HOPD prospective payment system and the ASC fee schedule. It is unclear, however, whether practice expense allocations are adequate, because data on the costs of providing these services in office settings are lacking. Beneficiaries' access to high-quality care in office settings could be adversely affected if payment amounts are not adequate.

The practice expense allocation for interventional pain services is a function of the mix of specialty groups who perform these services and their hourly practice expenses.[2] CMS calculates the practice expense allocations for each procedure by weighting the average of the direct and indirect costs of the specialties performing the service by the frequency with which each specialty performs the procedure. The agency calculates practice expense allocations separately for care delivered in facility and non-facility (office) settings. CMS estimates practice expenses for each physician specialty by using data obtained from the American Medical Association's Socioeconomic Monitoring System (SMS) survey. Because some specialties are not adequately represented in the SMS data, CMS allows specialty groups to submit their own cost data.

Current mean practice expenses differ substantially among the specialty groups recognized by Medicare that perform interventional pain procedures, ranging from $27 per hour for anesthesiology, to $59 for neurology and $88 for physical medicine (HCFA 1998a). The average practice expense allocation for a given procedure will decrease the extent to which a greater number of physicians with lower practice expenses perform the procedure.

[2] Medicare requires physicians participating in Medicare to describe the kind of medicine they practice by designating one primary and one secondary medical specialty.

RECOMMENDATION 3

The Secretary should recalculate the practice expense payments for interventional pain procedures when data become available on the practice expenses of physicians specializing in pain management.

Beginning in January 2002, Medicare will recognize pain management as a specialty group. A Medicare-recognized specialty of pain management is justified, given the high prevalence of pain among beneficiaries and the varying techniques used to treat pain. Physicians performing interventional pain services are trained in a variety of specialties, including anesthesiology, neurology, and physical medicine. The American Board of Anesthesiology provides a subspecialty board certification in pain management and approximately 3,000 physicians have achieved this certified status. A pain management specialty will enable researchers to monitor trends in the use of and payments for pain management services. In addition, this specialty designation is consistent with the specialty taxonomy that has been developed under the Health Insurance Portability and Accountability Act.

At issue is whether this new specialty will affect the adequacy of the practice expense allocation for interventional pain services. We have no way to ascertain how this new specialty designation will affect payments until data becomes available on: 1) the practice expenses of the physicians who will identify themselves under the new specialty designation; and 2) the mix of physician specialties that will ultimately perform these services. It typically takes two to three years for CMS to collect sufficient data to calculate the practice expense allocation for a new specialty. First, physicians must identify themselves under a new specialty to their carriers. Then they must bill enough services so that they are adequately represented in the claims data. Practice expense data may need to be collected from physicians specializing in pain management to supplement data from the SMS survey. Finally, it takes a full billing year for claims to be used in CMS's reevaluation of the practice expense allocation. When sufficient data do become available, the agency should re-analyze the adequacy of the practice expense allocation for interventional pain services.

Improving payment policies for services provided in hospital outpatient departments

Certain aspects of the design of the HOPD prospective payment system may result in inaccurate payment for interventional pain services. It appears that the method CMS used to establish the relative values, which measure the expected costliness of a unit in each classification category (APC) compared with the overall average costliness of all units, may result in inaccurate payments for certain services, including fluoroscopy. Specifically, CMS used only single-procedure claims to calculate the median cost for services within an APC, which resulted in 55 percent of the outpatient claims being excluded.[3] The agency excluded multiple-procedure claims to minimize the risk of improperly assigning costs to the wrong service.

[3] Single-procedure claims are those for which the procedure code to be grouped to an APC is the only code that appears on the bill, other than incidental services. Multiple-procedure claims included more than one procedure code that could be mapped to an APC. Multiple-procedure bills were used in other analyses done by CMS, including the impact analysis (Health Care Financing Administration 1998b).

Unfortunately, the lack of claims data about the experience of hospitals under the new outpatient payment system to date substantially limits MedPAC's ability to draw definitive conclusions about the appropriateness of this system for interventional pain services. Nonetheless, CMS's recent proposal to revise the HOPD prospective payment system by adding several new APCs for interventional pain procedures and by paying for some procedures previously not paid in HOPDs, such as the refilling of ambulatory pain pump reservoirs, should address some of the concerns raised by interested parties about the new payment system. These changes are expected to affect the majority of interventional pain management procedures by creating a wider range of payment amounts and groups that are clinically coherent.

Improving Medicare's coverage policies

Inconsistencies in coverage policies occur across localities because Medicare's contractors who implement local coverage policies—fiscal intermediaries (FIs) for hospital services, carriers for outpatient services provided in physicians offices and ASCs, and durable medical equipment regional carriers (DMERCs) for DME services—each can set policies within a specified geographic area. Variation occurs despite recent efforts by CMS that require its contractors to: 1) develop evidence-based LMRPs, 2) establish an open and public process for developing LMRPs, 3) share information among one another, and 4) post all draft and final LMRPs on their websites. CMS requires that its contractors employ at least one medical director who assists in developing LMRPs and meets with interested parties about draft LMRPs. Medical directors from the carriers and FIs participate in clinical work groups, and a committee on chronic pain management was formed in the mid-1990s.[4] In addition, the agency encourages contractors that operate in two or more states to develop uniform LMRPs across all jurisdictions to the extent possible. Finally, the four DMERCs are required by Medicare to develop and use one set of coverage policies.

The disparities among coverage decisions in different geographic areas may be affecting access to certain interventional pain services. For example, several carriers have issued different LMRPs about the number of paravertebral facet joint blocks that can be provided during an encounter and the indications for which this procedure may be performed. MedPAC's review of the medical literature suggests that the limited number of randomized controlled studies evaluating interventional pain services is hindering the ability of Medicare's contractors to establish policies in this clinical area.

RECOMMENDATION 4

The Secretary should sponsor additional research about the effectiveness of interventional pain services to strengthen the evidence basis for Medicare's coverage decisions.

[4] Meetings of these clinical work groups are not required to take place in public settings.

Additional research about the use of interventional pain services will assist Medicare's contractors implementing evidence-based LMRPs. Conducting carefully controlled studies is especially important in the area of pain management, because pain tolerance is highly individualized and may have a psychological component. Researchers have shown that pain interventions can have a large placebo effect, further reinforcing the importance of strong study designs. Many of the existing clinical studies that evaluate interventional pain services are case series without controls. Indeed, the Cochrane Collaboration recently called for the conduct of larger, better-designed studies to improve understanding of the effectiveness of injection therapy for subacute and chronic low back pain.[5] Some public-private initiatives are aiming to fill this informational gap. For example, the National Comprehensive Cancer Network and the National Cancer Institute have several ongoing studies in cancer pain management. However, there appear to be fewer research initiatives in the treatment of nonmalignant pain.

Additional research about the use of interventional pain services could address concerns raised by groups interviewed on behalf of the Commission that some of the current LMRPs do not reflect conventional pain management practice. Some groups also were concerned that LMRPs were imposed without consulting with experts in the area of interventional pain medicine, and that physicians specializing in pain management could not sit on carrier advisory committees (CACs). CMS requires that carriers establish CACs in each state to make local coverage decisions after reviewing scientific evidence in a public forum, and that CACs consider evidence obtained from its members as well as from outside sources. The agency has clarified its policy to its contractors that physicians without a Medicare-recognized specialty can sit on CACs. Finally, groups may formally request that CMS make a national coverage decision about services with widely varying local coverage policies. CMS officials have invited provider groups that offer interventional pain services to submit requests for national coverage decisions, but none have been submitted.

The Secretary might consider the use of provisional coverage as one way to advance research on interventional services. Under provisional coverage, investigational procedures may be covered if beneficiaries receive treatments at facilities that follow a rigorous study protocol to evaluate the outcomes of care. Final coverage decisions are made once the data are analyzed. The concept of provisional coverage also could be used to evaluate the effectiveness of procedures that are currently considered standards of care, but for which limited evidence about effectiveness exists. Such a policy might need to be introduced at a national level to ensure an adequate sample of beneficiaries and consistency in the methods used to collect and evaluate data.

CMS could also pursue further research about the effectiveness of interventional pain services by jointly sponsoring clinical trials with the National Institutes of Health (NIH). Beginning in September 2000, Medicare began covering the routine costs of qualifying clinical trials, as well as reasonable and necessary items and services used to diagnose and treat complications arising from participation in clinical trials. A recent example of such a collaboration by NIH and CMS is their task force to design a clinical trial to evaluate the efficacy and costs of daily dialysis. As the Medicare population ages, it is important to better understand what does and does not work in treating and managing pain.

[5] The Cochrane Collaboration is a non-profit organization based in the United Kingdom that aims to improve health care decisionmaking by performing systematic reviews of the effects of health care interventions (Nelemans et al. 2000).

In addition to further clinical research on the effectiveness of interventional techniques, MedPAC believes the development of cross-specialty guidelines in pain management also may make an important contribution. Many pain specialty groups have developed their own guidelines, but they are not always in agreement. A consensus development panel that cuts across the various specialty groups involved in pain management could help move specialty groups toward clinical consistency in areas where differences exists. Such endeavors could also benefit Medicare contractors as they develop LMRPs.

Additional research about the use of interventional pain services also could help address a concern raised by some clinical experts about the quality of these services when they are performed in physicians' offices. Some clinical experts interviewed on behalf of the Commission voiced a concern that these procedures are being performed in physicians' offices that lack the necessary sterile environment or imaging equipment, such as fluoroscopy, required to safely guide some spinal injections to the proper locations. Although complications are rare, inappropriate needle placement may result in paralysis or death for some of these procedures. Nonetheless, the Commission could find no evidence in the medical literature showing that patient outcomes were affected when interventional pain services were furnished in physician offices compared with other ambulatory settings.

Ultimately, the Commission believes that CMS should move to a standard nationwide system of claims processing, which would eliminate LMRPs and require that CMS make nationwide decisions about the coverage of medical services. This conclusion is based on the Commission's analysis of the complexity of LMRPs discussed in our December 2001 report on reducing Medicare complexity and regulatory burden (MedPAC 2001b). Eliminating LMRPs would reduce much of the current complexity, inconsistency, and uncertainty in the current coverage process program and eliminate the associated burden on beneficiaries and providers. ■

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Commissioners' voting on recommendations

In the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), the Congress required MedPAC to call for individual Commissioner votes on each recommendation, and to document the voting record in its report. The information below satisfies that mandate.

Recommendation 1

The Secretary should evaluate payments for services provided in hospital outpatient departments, ambulatory surgical centers, and physicians' offices to ensure that financial incentives do not inappropriately affect decisions regarding where care is provided.

Yes: *Braun, Burke, DeBusk, Feezor, Hackbarth, Loop, Muller, Nelson, Newhouse, Newport, Raphael, Reischauer, Rosenblatt, Rowe, Stowers*
Absent: *Smith, Wakefield*

Recommendation 2

The Secretary should evaluate payment rates for ambulatory surgical centers (ASCs) using recent charge and cost data from a sample of ASCs. He also should update the list of procedures that are covered when performed in ASCs.

Yes: *Braun, Burke, DeBusk, Feezor, Hackbarth, Loop, Muller, Nelson, Newhouse, Newport, Raphael, Reischauer, Rosenblatt, Rowe, Stowers*
Absent: *Smith, Wakefield*

Recommendation 3

The Secretary should recalculate the practice expense payments for interventional pain procedures when data become available on the practice expenses of physicians specializing in pain management.

Yes: *Braun, Burke, DeBusk, Feezor, Hackbarth, Loop, Muller, Nelson, Newhouse, Newport, Raphael, Reischauer, Rosenblatt, Rowe, Stowers*
Absent: *Smith, Wakefield*

Recommendation 4

The Secretary should sponsor additional research about the effectiveness of interventional pain services to strengthen the evidence basis for Medicare's coverage decisions.

Yes: *Braun, Burke, DeBusk, Feezor, Hackbarth, Loop, Muller, Nelson, Newhouse, Newport, Raphael, Reischauer, Rosenblatt, Rowe, Stowers*
Absent: *Smith, Wakefield*

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