AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE MEETING

Hyatt Suites on Michigan
November 20-21, 1992

MINUTES

I. Call to Order

The AMA/Specialty Society Rvs Update Committee (RUC) was called to order by Grant V. Rodkey, MD, Chairman, at 8:05 a.m. on Friday, November 20, 1992. The following RUC members and alternates were in attendance:

Grant V. Rodkey, MD
Robert K. Anzinger, MD
Larry Bedard, MD*
Robert Berenson, MD
Robert Florin, MD*
John O. Gage, MD
Tracy R. Gordy, MD
Michael Graham, MD
Kay K. Hanley, MD*
W. Benson Harer, MD
James G. Hoehn, MD
Allan D. Jensen, MD
Charles F. Koopman, Jr, MD*
George F. Kwass, MD
Donald T. Lewers, MD
J. L. Lichtenfeld, MD*
Michael D. Maves, MD
David L. McCaffree, MD
Kenneth A. McKusik, MD
George E. Miller, MD
James M. Moorefield, MD
L. Charles Novak, MD
Eugene S. Ogrod, II, MD
Byron Pevehouse, MD
Arnold M. Rosen, MD*
Chester W. Schmidt, MD
Gregory A. Slachta, MD
Ray E. Stowers, MD
John P. Tooker, MD*
Richard Tuck, MD
John Tudor, Jr, MD
Joe R. Wise, Jr, MD*
* RUC Alternate

Opening Comments

Noting that it was the RUC's first anniversary, Doctor Rodkey wished the members a Happy Birthday. He introduced Marc Stone, MD, who will serve as an observer from the Health Care Financing Administration (HCFA), and Kay Hanley, MD, who will serve as Doctor Lewers' alternate representing the American Medical Association.

Barry Eisenberg described the new Department of Payment Systems which was created by the AMA to staff the RUC. He introduced the department director, Sandra L. Sherman, and the department professional staff, Sherry Smith and Richard Lewis. Barry commented that the creation of a separate department shows "an AMA commitment commensurate with the task at hand."

II. Approval of June 25-28 Minutes

A motion was made and seconded to approve the minutes from the June 25-28, 1992, RUC meeting. The three alternative procedures for conducting RUC meetings discussed on pages 4-5 (IV.) were revisited with final adoption of the third alternative: "Open process with the potential to call for Executive Session if desirable." Also, an editorial correction was made in the list of attendees [Isadore Cohn]. **The minutes were approved as corrected.**

III. Calendar of Meeting Dates

The current RUC cycle will consist of three more meetings to develop relative value recommendations for coding changes for CPT 1994:

!	January 27-29, 1993	Phoenix, AZ
!	April 30-May 2, 1993	Chicago, IL
!	June 25-27, 1993	Chicago, IL

IV. List of AMA Staff Contacts by Specialty

The Department of Payment Systems has been organized so that each specialty on the Advisory Committee has a specific staff contact at the AMA. A copy of the list was provided to the RUC for information.

V. Health Care Professionals Advisory Committee

Barry Eisenberg discussed the letters of invitation sent on November 2, 1992, to the following societies:

American Academy of Physician Assistants
American Nurses Association
American Occupational Therapy Association
American Optometric Association
American Physical Therapy Association
American Psychological Association
American Speech-Language Hearing Association
National Association of Social Workers

Each of these societies has been invited to nominate representatives to two Health Care Professionals Advisory Committees (HCPAC), one for the CPT Editorial Panel and another for the RUC. These committees will facilitate participation of non-MD/DO professionals in both the CPT and RUC processes. Responses received to date from the organizations have been positive. After the first of the year, a joint orientation will be conducted for the committee members.

VI. Update on CPT Editorial Panel

Doctor Gordy summarized the Editorial Panel's first two meetings (July 31, August 1-2 and October 23-25) for CPT 1994. Panel Actions thus far include new codes for skull base surgery, magnetic resonance angiography (MRA), artif-icial insemination, and revisions to the stomach excision codes. The Panel will meet again in February and April and may be considering a coding proposal by the American College of Surgeons affecting about 500 general surgery codes.

CPT staff are currently working on identifying a specific deadline for submission of coding proposals for CPT 1994. Advisors have been notified that the cut-off date for AMA staff's completion of agenda items for CPT 1994 is March 5, 1993.

The Panel agreed with Doctor Todd's recommendation to invite the above mentioned organizations to appoint representatives to the HCPAC. The Panel was also informed that the American Podiatric

Association has accepted the AMA's invitation to appoint a representative to the HCPAC. Doctor Pevehouse asked if establishing the HCPAC would mean no longer limiting CPT codes to physicians but, rather, expanding them to include allied health fields. Doctor Gordy responded that, to his knowledge, this was not the case. There are no plans to create sections in CPT for allied health.

Doctor Gordy also announced that Angus M. McBryde, MD has been appointed as the Panel's RUC alternate in the event that he is unable to attend a meeting.

VII. 1993 Medicare Payment Schedule

Doctor Rodkey announced that the Federal Register was provided on computer tape to the AMA just two days before the RUC meeting, so data available for the meeting marked a considerable effort on the part of AMA staff. He also indicated that Doctor Stone would be willing to discuss the payment schedule and respond to questions. Sandy Sherman discussed the 1993 Medicare payment schedule, highlighting several points:

- for about 75% of new and revised codes, work RVUs are at or above the level recommended by the RUC;
- where the work RVUs are below the RUC's recommendation, many of them are still based on the RUC recommendation and/or extremely close to the RUC recommendation;
- considerable space is devoted to HCFA's response to the RUC's recommendations;
- the Rule confirms the direction that the RUC is taking in revising the survey instrument, particularly the keener focus on reference services and on providing detailed rationales for RUC recommendations;
- HCFA projected that RVS refinements would increase Medicare expenditures by $450 million, so to maintain budget neutrality it reduced all of the relative values by 2.8% (this reduction did not reflect any "behavioral offset"); and
- the AMA is very concerned about the budget neutrality reduction and the multiple conversion factors.

She also indicated that, because the planned publication date for the Rule would mean that the 60-day comment period would end before the RUC's late January meeting, a separate meeting might be needed to develop comments.

Doctor Stone thanked the RUC for inviting him and informed them of the publication date for the Rule of November 25, 1992. He then outlined HCFA's refinement process for the work RVS:

- 791 codes were reviewed by multidisciplinary panels of physicians appointed by specialties societies and carrier medical directors. Most panels consisted of 13 physicians in 4 groups.

- Following discussion of each code, panel members were asked to rate the relative value of work for that code. Ratings were individual, it was not a consensus process.

- Statistical tests were used to determine if there was agreement between at least three of the four groups. If the rating was similar to the interim value, the interim value was retained. If the rating was significantly different from the interim value, the interim value was revised. In situations where there was not agreement between the four groups in the panel, the code was sent to a review panel.

Of the codes considered in this process, interim values were retained for 50%, 45% were increased, and 5% were decreased.

Doctor Stone also commented that HCFA was struck by the reasonableness of the RUC's results and found very little reason to even question over half of the RUC recommendations. HCFA accepted 55% "as is" and many of the rest were accepted with only minimal changes. These minor changes were generally made in order to make the recommendations more uniform across other specialties. He agreed with the staff's estimate that 75% of the RUC relative value recommendations were accepted as they were or increased. Furthermore, he found nothing inherently wrong with how the process is evolving.

There was considerable discussion about the 2.8% reduction. It was clear that the same budgetary result could have been achieved without rescaling the entire RVS. However, HCFA felt that the differential conversion factor updates would make it difficult to reduce the conversion factor, so they reduced the RVS. Doctor Stone commented that the end result is ultimately the same. Doctor Gage expressed his concern that the RUC spent hours to come up with reasonable work values only to have HCFA alter them. Doctor Novak emphasized the problem of using the RVS for budget neutrality, stating that physicians need a basis that will remain the same; for example, they would like to know that the work RVU for an appendectomy will be the same year after year. Doctor Hoehn commented that HCFA appeared to be "playing with the hard data rather than the soft data" -- the RUC had deliberated long hours over the recommendations and HCFA changed them.

Doctor Stone asked if it would be helpful to go back to the original RVS and adjust the conversion factor instead. Doctor Gage replied that it should definitely be reversed, but Doctor Novak said they should just be sure not to repeat it. After hearing so much opposition, Doctor Stone stated that HCFA would be very reluctant to make such a reduction in the RVS again.

Doctor Rodkey concluded the discussion by saying that it was evident there was much work to be done in developing comments on the Rule. He asked if the RUC would like a face-to-face meeting before submitting a critique to HCFA. A decision on this topic was deferred until Saturday to provide an opportunity for the members to review the material that had been distributed. Later, the committee decided to meet on **Sunday, January 10, 1993, from 10:00 am to 2:00 pm in Atlanta to develop its comments**. It will include only the principle RUC members, so Advisory Committee and staff input should be obtained beforehand. Also, written comments should be provided to the AMA for distribution to the RUC prior to the meeting. [Later, advisor attendance was left as optional and specialty staff attendance was left to the discretion of the RUC member.]

VIII. Legal Analysis of Antitrust Issues and the RUC

Edward Hirshfeld, AMA Associate General Counsel, spoke to the RUC regarding antitrust issues and the legality of the RUC process. He confirmed his continuing support for the conclusion of his 1991 memorandum on this issue, that "the activities are legal and that no antitrust violation will occur if the proposed process is properly managed. The activities are legal because they qualify for an exemption from antitrust liability under the Noerr-Pennington doctrine". *[Note: Mr. Hirshfeld's memorandum, Antitrust Aspects of Proposed Process to Develop Annual Update Recommendation for the RBRVS, may be found in its entirety in Tab 11 of the November RUC agenda book.]*

Regarding the Federal Trade Commission's letter to the American Academy of Orthopedic Surgeons (AAOS), Mr. Hirshfeld explained that there had been some concern from the FTC that the AAOS contract

with Abt Associates violated the consent decree with the FTC. However, this was not the case, and when the FTC sent the letter to AAOS, they did not fully understand the Abt contract.

He also stressed the importance of fairness at all levels of the recommendation process, including the specialty society RVS committees. Procedures should be fair and open and no entity should be denied the chance to present their views. He added that the bylaws of the RUC should protect against any such violation. Staff asked for Mr. Hirshfeld's assistance in preparing a set of guidelines for complying with the law that could be provided to all participants in the RUC process.

Questions were also raised regarding the potential risk of legal action and the possibility of insuring against such risk. Mr. Hirshfeld agreed to explore the insurance issue, but stated that the antitrust risk for the RUC is extremely low. The RUC is operating under the umbrella of the Noerr-Pennington exemption and is not engaging in price-fixing. The only risk would be if the process is abused, that is, if deliberate attempts to exclude any group from the process should occur.

IX. Research Subcommittee Report

Doctor Kwass introduced the subcommittee's recommendations concerning two major issues: revision of the survey instrument and cross specialty relationships in the RVS. *[Note: The subcommittee's report, Survey Instrument Revisions and Cross Specialty Relationships in the RVS, may be found in Tab 6 of the November RUC agenda book.]* The subcommittee met by conference call in September to discuss standardization and modification of the survey instrument. Doctor Tudor commented that the report does not clearly reflect the strength of the discussion on issues of sample size and use of alternative methodologies.

Standard Reporting Form

There was some concern over the need for new information (e.g., length of hospital stay) required on the standardized form. In discussing this point, Doctor Stone stated that HCFA needed additional information in order to assess the validity of a recommendation, as well as to facilitate informed payment policy decisions.

A motion was made to accept the standard reporting form. This motion was seconded and approved.

There was also some discussion of the "consensus" recommendation form, but consideration was deferred until after discussion of the development of consensus recommendations.

Sample Size for the Mail Survey (Step 1)

Doctor Kwass commented that the two consultants had felt that a small sample is often valid and that a large mail survey may not be necessary, and he suggested it might be reasonable to leave that part of the process flexible. However, Doctor Tudor expressed concern with bias in the process. **Doctor Berenson agreed, and made a motion that the RUC require specialty societies to obtain a minimum of 30 survey responses for each code.** This motion was seconded and was put to a hand vote after further discussion. The vote resulted in a 12-12 tie. Doctor Rodkey cast the tie-breaking vote in favor of the motion. **The motion was approved and a minimum of 30 respondents will be required.** The RUC also indicated it would revisit this issue after gaining some experience with the requirement, and, if a specialty society was unable to obtain 30 responses, it would consider the society's explanation.

Key Reference Services (Step 2)

A motion was made to approve Step 2. This motion was seconded and approved.

Description of "Typical" Patient or Service (Step 3)

Concern arose over the emphasis on Medicare patients found in the second paragraph. **Doctor Lichtenfeld moved to strike the second paragraph with its references to Medicare, and the motion was seconded.** He argued that addition of this language could lead to bias in survey results. Responding to a question from Doctor Novak concerning the "downside risk" of retaining the paragraph, Ms. Sherman noted that the Harvard study had been sharply criticized for using patient vignettes that did not describe Medicare patients, and that the RUC could face similar criticism. **This motion was not approved.** Paragraph two will remain.

Doctor Hoehn moved that Step 3 be approved. This motion was seconded and approved.

Summarizing Survey Data (Step 5)

A motion was made to approve Step 5. This motion was seconded and approved.

Alternatives to the Survey Median (Step 6)

Doctor Tudor requested an editorial change to distinguish between the *instructions* to specialty societies and the *survey instrument* itself. **A motion was made to approve Step 6. The motion was seconded and Step 6 was approved with an editorial change in the second sentence; "survey instrument" will be replaced with the phrase "instructions to specialty societies".** This change will also be made in other places where it is appropriate.

Intercode Work Relationships (Step 7)

After some discussion over whether this step should be considered mandatory or remain optional, **a motion was made to maintain Step 7 as an optional step. This motion was seconded and Step 7 was approved.**

Multiple Societies Surveying the Same Code (Step 8)

A motion was made to approve Step 8. This motion was seconded and approved with some discussion.

Doctor Tudor then moved to include an additional sentence in the instructions to specialty societies stating that consideration should be given to Step 8 when developing the survey. This motion was seconded and approved.

A question arose concerning joint recommendations and the minimum sample size requirement approved in Step 1 as to whether the minimum sample was 30 respondents *per code* or 30 *per society* in a joint recommendation. **A motion was made that the minimum requirement include 30 responses per specialty society (e.g., for 2 societies the sample mininum would be 60 respondents). This motion was not approved, so the requirement is for 30 responses per code.**

Terminology and Other Changes

There was some discussion of whether "RVW" or "work RVUs" should be used. The RUC did not express a preference.

Cross Specialty Issues

The subcommittee met on October 9 to discuss the issue of cross-specialty relationships in the Medicare RVS. The subcommittee's report discussed a consultant's assessment of the methodology used by Abt Associates in producing the orthopaedic trauma recommendations submitted by the AAOS at the RUC's June meeting. There was considerable discussion around this section of the report concerning whether the RUC should require specialties to use the RUC's survey instrument. A suggestion was made that the RUC should allow for some variation in methods, but that the proposed variations should be submitted to the Research Subcommittee for approval. **After a lengthy discussion of how such review and/or approval might be accomplished, a motion was made that the final sentence of page 2, para. 2, should read: "If a specialty society wishes to develop/use an alternative methodology, this**

methodologies must first be provided for review and comment by the RUC Research Subcommittee prior to its use in developing recommendations." This motion was seconded and approved. In addition to the motion, the RUC asked staff to prepare a list of standard methodological requirements for all specialties for consideratin at the January 29-31 meeting.

Three recommendations concerning the cross-specialty reference list were presented by the subcommittee. *[Note: These recommendations may be found on the final page of the subcommittee's report in Tab 6 of the November RUC agenda book.]*

Recommendation 1.

A motion was made to approve Recommendation 1. This motion was seconded and approved.

Recommendation 2.

Recommendation 2 involves encouraging specialties to augment their RVS committees with physicians from related disciplines and generalists. A number of questions were raised regarding the purpose of the recommendation. Doctor Rodkey stated that the purpose considered by the subcommittee was to create a more open process and provide additional perspectives and information. Doctor Berenson stated that having a generalist present would enhance the validity of recommendations and avoid group think. He suggested that it be done on a trial basis. Doctor Gage also expressed support for the recommendation, citing the use of multidisciplinary panels in HCFA's refinement process. Overall, there was mixed support for the recommendation.

Doctor Hoehn moved to refer Recommendation 2 back to the Research Subcommitttee for further evaluation. This motion was seconded and approved. Recommendation 2 was referred back to the subcommittee.

Recommendation 3.

A motion was made to approve Recommendation 3. This motion was seconded and approved.

X. Relative Value Recommendation

LAPAROSCOPY FOR VARICOCELE CORRECTION
Tracking Number: D1
Presentation: William F. Gee, MD;
American Urological Association

Note: The presentation materials for this recommendation may be found in Tab 8 of the November RUC agenda book.

Doctor Gee presented the AUA's recommendation of 6.60 RVW for CPT code 55XXX. He noted that according to the definition (time, mental effort, technical skill, and stress), this procedure was clearly more work than the key reference service, 55530. An advantage to this procedure is that the patient will not need an extended hospital stay, but can go back to work the next day.

Doctor Harer commented that the overnight stay and high RVU recommendation was probably due to the fact that the procedure was new. The level of difficulty would decrease as the physicians grew more confident with the procedure. He compared this to OB/GYN's experience with the new laparoscopy procedures. Doctor Novak questioned the code's global period of 90 days when OB/GYN laparoscopies are typically set at 10 days. Doctor Gee stressed that the lengthy pre and post-service time was necessary since patient discussion was very intensive and included both the patient and his partner.

Doctor Rodkey called for a ballot vote. Results: The AUA recommendation was not accepted. The following Facilitation Committee was appointed: Doctor Gage, Chairman; Doctor Harer; Doctor Berenson; and Doctor Slachta. The Facilitation Committee met Saturday morning, and Doctor Gage then reported that it had arrived at a recommendation of 5.88 work RVUs for code 55XXX. They also suggested the recommendation ask HCFA to change the global period from a 90-day to a 10-day global period. Doctor Slachta, speaking for the AUA, accepted the recommendation. **A ballot vote was taken and the Facilitation Committee's recommendation was accepted unanimously (21 to 0).**

XI. Presentations

Note: Presentation materials were distributed at the meeting for insertion into Tab 9 of the November RUC agenda book.

NEONATAL INTENSIVE CARE
Bernard Feldman, MD;
American Academy of Pediatrics
Andrew Costarino, MD;
Society of Critical Care Medicine

Staff noted that the NIC codes were adopted by CPT in June and are included in CPT 1993. However, they have not yet been assigned work RVUs and HCFA has deferred action until the RUC develops its recommendations. The AAP and SCCM were planning to present their recommendations at the January RUC meeting. *[Note: Both societies have requested that RUC action on these codes be deferred until the April or June RUC meeting.]*

There was some discussion regarding the difficulty of surveying for and developing recommendations on these codes because of the bundling of procedures with evaluation and management and their "per day" definition.

SKULL BASE SURGERY
John P. Leonetti, MD
Thomas Origitano, MD, PhD
North American Skull Base Society

The new skull base surgery codes have been accepted by CPT and the RUC will be considering their relative value recommendations at its January meeting.

Following the two presentations, Doctor Rodkey asked whether this new process of having clinical presentations prior to considering recommendations had been effective. Responding to a question of whether there were criteria for such presentations, staff replied that they thought it would be helpful

whenever a brand new section of codes was added to CPT. Doctor Moorefield said he found the process "invaluable," and Doctor Rodkey stated that, in appropriate cases, this process will continue.

XII. Correspondence

Doctor Rodkey recognized the RUC and the remarkable progress it made in developing well-regarded recommendations in a very compressed timeframe. He further commented that the RUC is a mechanism by which every physician has an opportunity to represented by a family of specialties. He emphasized that the RUC is an open process. The National Medical Association has been invited to participate in the process and we are hoping to receive a positive response.

He also recognized that strains among groups are inevitable when strong opinions exist, however, we have developed a democratic forum and the 2/3 majority vote offers great protection to any minority group. Doctor Rodkey also informed the committee that Doctor Todd had attended the staff briefing on Thursday and expressed the extreme importance of organized medicine working together on this process for the interest of medicine and the public. Doctor Todd noted that he has been impressed by the public spirit of every member of the committee.

The Chair indicated that this might be a reasonable time to discuss whether the RUC should continue in the same direction. He also invited the group to discuss the letters which had been exchanged between Doctor Todd, the ASIM/ACP/AAFP/AAP, and the STS/AAOS/AUA/AANS/ACNP/SNM/AAO/ASPRS/ACR/AAO-HNS.

Several RUC members indicated that the correspondence be received as information only, without further discussion. Doctor Berenson noted that the RUC may take time to reflect its direction after reviewing HCFA's response to its recommendations. Doctor Ogrod suggests that some compromise may be necessary to maintain the adhesiveness of the committee. Doctor Tudor would like the process to continue to be observed. Doctor Moorefield said he thought the RUC would not be well-served by a rancorous discussion of the letters. Doctor Lewers commented that the RUC is being looked at by many groups as a template for solving problems in medicine today and he is proud to be a part of this committee.

XIII. Development of a Cross-Specialty List of Reference Services

Discussion regarding development of a cross-specialty reference list began with voting on the staff recommendations in the report, Methodologies for Developing a Cross-Specialty List of Reference Services: Options for the RUC, in Tab 10 of the agenda book.

Step 1: Define List Criteria

Doctor Kwass commented on the final sentence of bullet three (page 2). He voiced the importance of the concept of the "Golden Ruler". The rationality of the ruler depends upon the acceptance of relativity across all of the ranges of RVWs. All services must be considered appropriately valued in relation to other services on the ruler. Doctor Stone agreed.

Doctor Ogrod suggested that the criterion in bullet five (page 2) read "The list should emphasize..." rather than "The list should be comprised of...".

Sandy Sherman stressed the importance of the cross-specialty list as an illustration of the RUC's process. It would help to document the careful consideration of each recommendation and prevent those who do not attend the RUC meetings from regarding the Committee as simply a "rubber stamp". Doctor Gage spoke in favor of cross-specialty referencing, referring to the process as "multi-knowledgeable".

Doctor Stone commented on HCFA's cross-specialty list. Its principal reference list was developed from the Harvard results, and any codes that were objected to by specialties were taken off the list. The secondary reference set contained all codes which were not contested in comments on the 1992 RVS. HCFA used the reference set very loosely, without formal approval or consultation. Ms. Sherman stated that the AMA has talked with HCFA staff and they are anxious to see the outcome of the RUC's efforts on this issue.

Doctor Rodkey asked Doctor Stone about HCFA's plans to reconsider other areas of physician reimbursement, including practice costs, and whether there was a role for the RUC for this process. Doctor Stone said it would require more discussion because of the economic and accounting aspects of this component of the RVS. Doctors Ogrod and Berenson suggested that the RUC stick with its initial charge of work RVUs for the present.

Doctor Moorefield moved to accept Recommendation 1. This motion was seconded and approved. Recommendation 1 was accepted with one editorial change.

Step 2: Specialty Societies Select Potential Reference Services

There was some discussion of whether or not the specialty reference lists should be considered initially as potential candidates for the cross-specialty list of reference services. Doctor Kwass stated that the issue came down to which group [the RUC or the specialty society] should have the prerogative of proposing the initial pass of reference services. Ms. Sherman responded that the Combined Specialty Reference Service List, included in Tab 10, was comprised of lists prepared by the specialty societies.

Many RUC members expressed interest in having their specialty societies reevaluate and revise their respective reference lists before continuing the process further. There was concern that these initial lists had been developed for a different purpose and might not be suitable for the cross-referencing process.

Doctor Kwass proposed an amendment to Recommendation 2 which would read: "Each specialty reference list be referred back to each specialty society for reassessment and resubmission of a list of services for consideration on the intra-specialty list." This would be inserted as the middle paragraph of Recommendation 2.

Doctor Ogrod then proposed that the lists be resubmitted with documentation. After some discussion, it was decided that it would be appropriate to accept

the specialty reference lists without justification. This motion was withdrawn.

Doctor Kwass suggested each specialty submit six codes for the list, but Doctor Moorefield pointed out that the original proposal would be more suitable since certain specialties may have a disproportionate number of codes and, thus, would require more reference services. In addition, staff pointed out that not all codes submitted by the specialties were likely to be approved by the RUC.

The motion was to accept Recommendation 2 as amended by Doctor Kwass. This motion passed and Recommendation 2 was accepted as amended.

Step 3: RUC Review of Potential Reference Services

The consistent interpretation of code descriptors by physicians was addressed in Option A and Option B of Recommendation 3. **A motion was made that both options be included but Option A be encouraged.** In other words, Option A will be preferred without precluding Option B.

A vote was taken to accept Recommendation 3 as amended. This motion passed and Recommendation 3 was accepted as amended.

Step 4: Determine Acceptance or Rejection of Rated Services

The editorial change made in Recommendation 1 also applies to the first paragraph of Step 4; that is, "should be" will now read "emphasize".

A motion was made and seconded to approve Recommendation 4. This motion was approved and Recommendation 4 was accepted without further discussion.

IX. Final Comments

Doctor Berenson commented that in the future a process may be needed for revisiting the relative values for new codes, and asked the Research Subcommittee to explore this issue. Doctor Rodkey accepted this suggestion but asked that Doctor Berenson direct it to Doctor Kwass in written form.

In closing, Doctor Rodkey acknowledged the terrific work of the specialty societies and AMA staff and expressed the RUC's appreciation.

The meeting was adjourned at 10:10 a.m. on Saturday, November 21, 1992.