

The Journal welcomes letters to the editor. If found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with Journal style. All letters that reference a recently published Journal article are sent to the original authors for their reply. If no reply is published, the authors have not responded by date of publication.

FLUID RESUSCITATION

To the Editor:

Bisonni et al performed a valuable analysis with their meta-analysis of clinical trials comparing colloid and crystalloid use in fluid resuscitation (Bisonni RS, Holtgrave DR, Lawler F, Marley DS. *Colloids versus crystalloids in fluid resuscitation: an analysis of randomized controlled trials. J Fam Pract* 1991; 32:387-90). Most studies were too small to be able to detect a clinically significant difference. Their analysis shows that colloid therapy is not more effective than crystalloid.

However, they misinterpret the meaning of cost-effectiveness. Colloid should not be used because it works no better than crystalloid. Cost-effectiveness has nothing to do with it. Cost-effectiveness analysis is useful when it is expected that one treatment may be more effective than another treatment and has different costs associated with it. If treatments are found to be equally effective, then one just compares the price, like any good shopper. Therefore, there is cost-effectiveness associated with crystalloid use because it is the standard treatment: there is no reasonable alternative to not giving fluid. There is no cost-effectiveness associated with colloid because it is not a more effective treatment. In this problem, a cost-effectiveness study would be in order if colloid were demonstrated to be marginally better than crystalloid but at great cost. For example, if one additional life could be saved per 100 patients by giving colloid to all of them rather than crystalloid, then the marginal cost-effectiveness of colloid would be 100 times \$1200 (the price of colloid) or \$120,000 per life saved.

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The preceding letter was referred to Drs Bisonni et al. Drs Holtgrave, Bisonni, and Lawler respond as follows:

We thank Dr Mark for his interest in our paper. We disagree with Dr Mark, but our disagreement is caused simply by a different use of terminology. Dr Mark notes (as have others¹) that it is never proper to calculate a *marginal* cost-effectiveness ratio when one policy is less costly and more beneficial than the alternative. We absolutely agree, and that is why we presented no *marginal* cost-effectiveness ratios in our paper. (A marginal cost-effectiveness ratio is a fraction: the numerator is the difference in cost between two competing policies, and the denominator is the difference in health benefits between the policies.) Rather, we presented a cost-effectiveness ratio for colloids and another for crystalloids. The cost-effectiveness ratio is just the cost of one policy divided by the health benefits for that policy. This usage of the term is consistent with that in the literature.² The cost-effectiveness ratio has also been called the "average" cost-effectiveness ratio.³ We presented cost-effectiveness ratios (what some might call average cost-effectiveness ratios) to dramatize the point that crystalloids are drastically cheaper per life saved—a point of interest to the clinician reader. As Dr Mark states, to have presented *marginal* cost-effectiveness ratios would have been inappropriate, but we did not present *marginal* cost-effectiveness ratios.

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Frank Lawler, MD
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References

1. Ganiats TG. Cost-effectiveness concepts and the CE plane. *Med Decis Making* 1991; 11:147.

2. Sox HC, Blatt MA, Higgins MC, Marton KI. *Medical decision making*. Stoneham, Mass: Butterworth, 1988.
3. Detsky AS, Naglie G. A clinician's guide to cost-effectiveness analysis. *Ann Intern Med* 1990; 113:147-54.

REVISED BILLING CODES

To the Editor:

The international classification of health problems in primary care (ICHPPC-2) has been a useful tool used by physicians in the United States and elsewhere for coding problems in the family practice office. It has become less useful in the United States in recent years because of insurance requirements for more specific coding. Several years ago this journal published a version of ICHPPC-2 that is compatible to ICD-9-CM (From J, Schneeweiss MB. *Use of the International Classification of Health Problems and Primary Care (ICHPPC-2) for reimbursement. J Fam Pract* 1980; 10:609-20). While an improvement over the original ICHPPC-2 for use in billing, it has limited benefit regarding today's need for ICD-9 codes to be more specific and include five digits.

Such an abbreviated coding scheme can still serve clinical practices well, if a few precepts are remembered: (1) Some procedures, including radiographs, fracture repair, and joint aspirations, may require more specific codes than exist in ICHPPC-2 when used for billing in the United States. (2) Hospital visits, especially for newborn care and deliveries with perinatal complications, need more specific codes than those found in ICHPPC-2. (3) A few additional codes for specific diseases may be used to clarify specific aspects of care for billing. The most frequently used new codes in our practice were employed to separate insulin-dependent diabetes (250.01)

from non-insulin-dependent diabetes (250.00) and, since our office has an extensive nursing home practice, to add senile dementia (290.0), separating it from IPPCHP-2's "organic psychosis" code. Our office has used this revised code during the past year without specific objections from insurance providers (including Medicare) to its codes. (4) Remember that Medicare will require specific diagnoses to go with specific procedures for billing. For example, in the patient who has multiple health problems, including congestive heart failure, diabetes, and hypertension, the chest radiograph and serum potassium and blood sugar tests must be, if ordered for a visit, specifically related to one of the diagnoses (ie, the potassium for diagnosis of hypertension, the blood sugar for diabetes,

and the chest x-ray for congestive heart failure).

A copy of the revised ICHPPC-2 code for billing used by our offices may be obtained from the author at the listed address as a means for decreasing the use of the 1100-page ICD9-CM code books for routine office use in family medicine and other primary care practice. This conversion format may save most offices time until the ICD-10 has begun to be used for billing purposes, perhaps in 1996 or beyond.

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Corrections

In Letters to the Editor in the May issue of the Journal (*J Fam Pract* 1991; 32:454) under the heading Pharmacology Rounds, the letter should have listed Juman Hijab, MD, MPH, as the second author. He is also with the Department of Family Medicine, Memorial Hospital of Rhode Island, Pawtucket.

In the June issue of the Journal, Dr Agrawal's medical degree (MD) was inadvertently omitted from the title and author line of his paper, "Risk Factors for Gastrointestinal Ulcers Caused by Nonsteroidal Anti-inflammatory Drugs (NSAIDs) (*J Fam Pract* 1991; 32:619-624).

Manuscript Submission

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