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MEDICARE CPT CODES

To the Editor:

The unfair and frustrating Medicare rules for reimbursing primary care consultations were reviewed in the June issue of *The Journal of Family Practice*.¹

Medicare has announced a revised policy effective for consultation services provided on or after June 28, 1993.² Medical providers who have seen a patient within the last 3 years now may use the *Physicians' Current Procedural Terminology* (CPT)³ consultation codes. There is no limit on how often a consultation may be billed, as long as the criteria for using the codes are met.

Primary care physicians may use the consultation codes when reporting preoperative clearance services for their patients.² The new Medicare billing requirements for these services are outlined in the table that accompanies this letter. If a physician is asked to provide a preoperative consultation, and then assumes a portion or all of the patient's management during the postoperative period, the preoperative services can be billed with a consultation code and the postoperative services billed with subsequent hospital care codes.

Outpatient visits can be reported as consultations if all the criteria are met. The request for an outpatient consultation should be documented in the form of a letter or written request from the surgeon or referring physician, or with the consultant's documentation referencing the specific request.

These policy changes represent a significant effort by Medicare to comply with CPT billing guidelines and to over-

turn the detrimental policy that had been in effect for the last year. Primary care physicians should express appreciation to Ed Langston, MD, and Dan Johnson of the American Academy of Family Physicians, and all other groups who lobbied for these changes.

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1. Zuber TJ. Primary care physician consultations [editorial]. *J Fam Pract* 1993; 36: 605.
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3. American Medical Association. *Physicians' current procedural terminology 1993*. Chicago: American Medical Association, 1993.

CHIROPRACTIC BY FPs

To the Editor:

As a family physician who has used spinal manipulation in his practice for 27 years and has taught basic techniques for 10 years, I wish to comment on the paper on chiropractic by Curtis and Bove¹ and the editorial by Cherkin.²

Neither attempted to suggest the obvious answer, that family physicians learn manipulative skills. These are not difficult to learn. After the equivalent of 10 days' training 27 years ago I began

using these techniques. Although my colleagues wondered at first, a number referred patients to me within a year. Patients found my techniques gentler than most chiropractors.

I was concerned about injury and did a 3-year study on the experience of 676 consecutive patients who had received previous spinal manipulation.³ The principles still hold true today. This study from primary care was ignored by your authors. Two years ago a woman from a western state who was terribly injured by an unwise chiropractic neck manipulation phoned me at home in British Columbia, Canada. She had been researching chiropractic injury and had come across the study. Uneven treatment still occurs.⁴

Family physicians should be trained in these skills because they have a wider understanding of illness and a broader therapeutic approach. Currently the training of medical students in physical medicine is poor.

Historically, leading physicians recommended that doctors learn manipulative skills. In 1867 James Paget⁵ adjured doctors, "learn then to imitate what is good and avoid what is bad in the practice of the bone-setters." Advice that our profession ignored. Earlier, Hippocrates had advised the physician or, as he put it, "some person who is strong and not uninstructed . . ." to manipulate the spine.

In over 35 years of practicing medicine I have seen family physicians take decreasing responsibility in managing patients. I am saddened that your authors did not encourage learning more active participation in neck and back pain management, a common problem in family practice.

When will we learn from history?

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3. Livingston MCP. Spinal manipulation

Medicare Billing Requirements for Preoperative Clearance

1. The surgeon must request the consultant's opinion or advice for the evaluation and management of a *specific problem*.
2. The surgeon's request and the need for consultation must be documented in the medical record (in the progress notes, or orders section, or on a consultation form).
3. The consultant's opinion and actions (services) must be documented in the medical record and be available to the surgeon before surgery.
4. The consultant's opinion and services must be communicated to the surgeon (with documentation indicating communication).
5. The consultant must meet the CPT description for the level of consultation reported with documentation of the history, examination, and medical decision making in the medical record.

Adapted from Booth CR. Memorandum FQA-541. Health Care Financing Administration, Department of Health and Human Services, March 24, 1993.

causing injury. A three year study. Clin Orthop 1971; 81:82-6.

- Livingston MCP. Some facets of alternative medicine, today and yesterday. West J Med 1985; 143:269-70.
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The preceding letter was referred to Dr Cherkin and to Drs Curtis and Bove, who respond as follows:

I agree with Dr Livingston that there may be some merit in having family physicians learn manipulative skills. In fact, I had hoped to conduct a study to determine if family physicians who received a brief session of training in manipulative skills achieved better outcomes in their patients with back pain. Unfortunately, I happen to live in the only state in the country in which medical doctors are prohibited by law from performing spinal manipulation.

Without convincing evidence that family physicians who take a brief course in manipulation actually provide more effective care, it seems premature to conclude that manipulative skills should be incorporated into medical training. Furthermore, one must wonder why many osteopathic general practitioners do not use the manipulative skills they spent years learning. Before we can follow Paget's advice to "imitate what is good and avoid what is bad in the practice of the bone-setters," we first need a better idea of what is good and what is bad.

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Many thanks for your letter of May 11 with an enclosure from Dr Livingston. Dr Livingston comments that in our article we did not adequately address the issue of training family physicians to undertake manipulative therapy. We acknowledge this; we purposely avoided reviewing this issue.

In the United States, osteopathic physicians and a few family physicians and orthopedists do use spinal manipulation. In other countries (UK, Germany, France) family physicians receive CME training in these skills, probably because

there are very few chiropractors and osteopathic physicians.

We feel that including manipulation in a family medicine training program would be useful. However, the time spent to become proficient in these techniques is significant and should not be taken lightly. Many medical journals advertise weekend courses in manipulation; these are looked on with disfavor by leaders in all fields that use manual manipulation. These courses usually teach non-specific long-lever techniques. The New Zealand Report, a major independent governmental inquiry into chiropractic and manipulation, concluded that these courses were inadequate and recommended that they be stopped.¹

Dr Livingston states that manipulation techniques are easy to learn and use, and that his techniques are "gentler than [the techniques of] most chiropractors." While we have no grounds to address the latter claim, the former contrasts with his own published statement: "Medical and paramedical personnel would do well to either study spinal manipulation thoroughly or avoid it. I have yet to see serious damage done by adequately trained personnel."²

It appears that the medical and chiropractic communities agree that to develop proficiency in manipulation takes substantial time. The previously mentioned New Zealand Report stated that, based on all available international evidence, a medical school graduate would require 12 months of full-time training "to acquire a degree of diagnostic and manual skill sufficient to match chiropractic standards."¹ And from other well-known experts in the field come the following comments:

"It is not easy to practice manual medicine well. The ability to sense blockage in joint movements comes very gradually. At first one despairs of ever being able to localise; as the ability to sense grows, there is another challenge to overcome, that is your lack of confidence that the diagnosis is correct."—J. Bourdillon³

"... to learn when to manipulate and when not, and what sort of manoevers to use, is a diagnostic problem involving years of study."—James Cyriax⁴

"... prolonged training under guidance is indispensable."—Robert Maigne⁵

Some questions that arise from Dr Livingston's comments include:

1. What is adequate training in manipulation for family physicians?

2. Where are the data that show that primary care physicians are as effective in manipulative skills as chiropractic and osteopathic providers?

3. Do the relatively straightforward and unsophisticated long-lever techniques often used by primary care physicians match up, in terms of outcome, with the short-lever and specific methods of chiropractors?

There are almost no data to answer these questions. The final issue, of course, has to do with "turf" and how this would play out if primary care physicians received training.

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CHEST PAIN AND MI

To the Editor:

The article by Drs Green and Ruffin is very interesting, but it highlights a standard of care that is neither efficient nor cost-effective.¹ I appreciate that women have not been adequately represented in research studies regarding coronary artery disease, and they are treated less aggressively than men when presenting with chest pain. This needs further study. However, the authors have unwittingly focused on a standard of care that

leaves much to be desired. I would like the authors to ask themselves a simple question: Of what value is the Acute Ischemic Heart Disease Predictive Instrument (HDPI) in warranting admission to a coronary care unit (CCU) when only 8 (16%) of 50 female patients and only 8 (19%) of 43 male patients had a myocardial infarction? The authors point out that the HDPI "is a seven-factor regression formula developed to improve CCU utilization practices." Even more remarkable, the authors have found merit in using this instrument in primary care. I suggest that the HDPI does just the opposite: It fosters inappropriate and unnecessary utilization of CCU admissions.

The basis for this inappropriateness is substantial. In my office-based practice I have evaluated hundreds of patients presenting with chest pain. However, my approach to evaluating chest pain is substantially different than those espoused by the authors. In my office I have electrocardiographic, echocardiographic, and treadmill equipment. When a patient presents with chest pain I take a history and perform a physical examination, and I obtain a patient profile consisting of coronary artery disease risk factors. In patients who are at risk for heart disease, the first test I perform is an electrocardiogram. However, what constitutes an abnormal electrocardiogram is often inconstant. In one study only 19% of patients presenting to the emergency room with chest pain had normal electrocardiograms.² In another study only 14% had normal electrocardiograms.³ As a result, the majority of electrocardiograms show either nonspecific ST or T-wave changes or are considered abnormal according to varying criteria and definitions. Ironically, despite the high proportion of electrocardiograms that are nonspecific or abnormal, only 20% of patients who are admitted to the CCU actually have heart attacks.⁴ This again attests to the unwarranted use of the HDPI.

A better approach to patients presenting with chest pain is to perform a resting echocardiogram to assess for wall motion abnormalities. The presence and location of abnormal wall motion at rest is associated not only with a strong probability of a myocardial infarction (MI), but also with complications associated with this disease. If the electrocardiogram does not show evidence of a prior MI or severe ischemic heart disease, and the resting echocardiogram shows normal wall motion, I perform a stress test to

assess for ischemic changes. If the stress test discloses ischemic changes in the absence of chest pain, or the patient develops chest pain with no demonstrable ischemic changes, then I perform a post-exercise echocardiogram or stress echocardiogram.⁵⁻⁷ A single cardiac enzyme determination plays no role in this office-based scheme.⁸ The results are immediate, and both the patient and the family can be spared the anxiety-provoking experience of a hospital admission. By utilizing this strategy, I have been able to decrease coronary care unit admissions to zero. Furthermore, I have referred fewer than 20 patients for coronary angiography. In the several hundreds of patients who have been tested, none have had complications and none have died from a missed MI. In my experience, and in that of others,⁷ the majority of these patients have entities such as left ventricular hypertrophy, mitral valve prolapse, pericarditis, supraventricular tachycardia, cholelithiasis, reflux esophagitis, a hiatal hernia, ulcer disease, and other medical conditions that do not justify a CCU admission. Very few of these patients have coronary artery disease, which is consistent with the large proportion of patients who are admitted to CCU and do not have heart attacks. With regard to cost, I have seen one of these admissions to the CCU to "rule out MI" that cost \$6,000, only to find that the patient had a normal heart.

I market this strategy in my *Healthwatch* newsletter, and I have taught other family physicians this hands-on approach. I recommend that the authors use their research talents to determine who actually benefits from a CCU admission. According to their study, only 7 (7%) of 93 patients seemed to have benefited from a CCU admission to treat complications from an MI. The new paradigm should be, if a patient is admitted to a CCU and does not have a complication from a myocardial infarction, then he or she did not benefit from a CCU admission. We would all benefit from such an endeavor.

Charles J. Godreau, MD
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8. Lee T, Goldman L. Serum enzyme assays in the diagnosis of acute myocardial infarction: recommendations based on quantitative analysis. *Ann Intern Med* 1986; 105: 221-33.

The preceding letter was referred to Drs Green and Ruffin, who respond as follows:

We have reviewed the comments offered by Dr Godreau. He raises several interesting points, but we are quite concerned about his proposals for dealing with them.

The concern that current practices in utilization of coronary care units (CCUs) are excessive is widely shared, including by us. The purpose of tools such as the Heart Disease Predictive Instrument (HDPI) and its successor, the ACI-TIPI, is precisely to reduce such utilization. Both tools have been well tested on large patient populations (thousands of patients) across widely varying settings, from tertiary care centers to small community hospitals. When applied appropriately, the instruments effectively reduce the overuse of the CCU that Dr Godreau deplores without sacrificing patient safety. Such tools have not, in any study, fostered inappropriate use of the CCU.

Dr Godreau regards a situation in which 15% to 20% of admissions sustained myocardial infarction (MI) as excessive. We disagree. First, 28% of men and 36% of women placed in the CCU (as opposed to admitted to the floor) sustained MI. Second, evaluations of various admission rates suggest that false-

positive rates of 70% to 80%, surprising though that may seem, are optimal, and lower rates will result in inadequate sensitivity and excessive adverse outcomes.¹

Dr Godreau raises the point that methods of electrocardiogram (ECG) interpretation are inconstant. While truly normal ECGs are in the minority among emergency department patients with chest pain, this concern reflects inadequate understanding of the HDPI. Whether an ECG is interpreted as "normal" or has "nonspecific" changes is not relevant; the instrument specifies clear criteria on which to score ECGs.

Dr Godreau states that he selects patients for his preferred approach based on their cardiac risk factors. However, the traditional cardiac risk factors such as smoking, family history, obesity, and cholesterol levels are epidemiological risks. They are useful in estimating a person's lifetime risk of developing coronary artery disease but are of little or no predictive power for the patient presenting with chest pain.²

Dr Godreau indicates that he favors use of echocardiography as a means of evaluating patients presenting to his office with chest pain. Echocardiography may eventually prove to be useful for real-time evaluation of patients in the emergency department with suspected acute ischemia. At this point, however, data are very sparse. To our knowledge, three applicable studies have been reported,³⁻⁵ all of them small (two with fewer than 50 patients, fewer than half of whom actually had pain when studied) and with serious methodological shortcomings. None of the studies followed full episodes of care, nor obtained complete ascertainment. One study selected only patients with normal or nonspecific ECGs, another mixed patients who were and were not having pain at the time of echocardiography, and the third demonstrated only a small added predictive value over history taking and ECG for echographic demonstration of left ventricular dysfunction. Echocardiography has some intriguing theoretical advantages, but at this point evaluating acute ischemia in the emergency department by echocardiography clearly must still be regarded as experimental.

There is an enormous difference between the emergency department and the family physician's office. A preliminary analysis of data from 400 completed episodes of chest pain followed by the physicians of the Michigan Research Network indicates that the prevalence of

actual acute ischemia seen in the family physician's office is less than one tenth of that found in the emergency department (Klinkman MS, personal communication). Dr Godreau claims an excellent negative predictive value in precisely the setting where negative predictive value is easiest to obtain: a low-prevalence population. Most CCU admissions are drawn from the high-prevalence emergency department population.

The assertion of having evaluated hundreds of patients with chest pain, referred fewer than 20 for catheterization, and placed no one in the CCU, without anyone dying of an undetected MI, suggests that Dr Godreau has thus far been protected by the low prevalence of disease in the office practice. Low prevalence, however, is not zero prevalence. Frankly, we regard Dr. Godreau's zero admission rate as evidence not of a better approach but of tempting fate.

Most important, neither physiological plausibility nor subjective clinical experience is an adequate substitute for scientific data. Nor does "marketing" a method of risk stratification in a newsletter substitute for critical evaluation in a peer-reviewed journal. Although Dr Godreau's approach has interesting theoretical potential, it must be regarded as only that until real data are presented. We cannot recommend taking such an approach (outside of an approved experimental protocol) when others based on sound, diverse, peer-reviewed research are available. Doing so represents unscientific practice and significant liability risk.

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DYSLIPIDEMIA

To the Editor:

Dr Stelmach and his colleagues are to be congratulated for tackling a difficult but common problem in family practice (Stelmach WJ, Rush DR, Brucker PC, Schaefer EJ, Holverson HA, Kane WJ, Huffiman BL. Diet and exercise and gemfibrozil therapy for the management of dyslipidemia: a CEN study. *J Fam Pract* 1993; 36:401-8). To attempt to do so in such a coordinated and cooperative manner is even more laudable.

As in many studies, more questions were stimulated as a result of the findings in their study. For example, would not one expect the lipid-lowering effect of the Step Two American Heart Association (AHA) diet to be greater than that observed in this study? Recommending the AHA diet to all enrolled patients (instead of leaving the type of diet chosen to the physician) may have clarified the role that short-term diet changes have on lipid levels in a family practice setting. Certainly more patients would be required to enroll in the study to maintain adequate size of the gemfibrozil group. However, a 40% response rate to a simple dietary intervention is important and prompts the question: What would be the lipid-lowering response rate to a more aggressive and restrictive dietary intervention?

Second, the percentage of patients given gemfibrozil who achieved the desired overall lipid changes is unclear. It appears that, even with gemfibrozil treatment, total cholesterol, and possibly LDL levels were not reduced to desired levels in many patients.

Certainly, we cannot ignore the importance of hyperlipidemia and its adverse impact on health. However, the conclusion I draw from this study is that the proposed combined lipid target levels for patients at risk are unrealistic. Alternatively, simple dietary and exercise prescriptions plus gemfibrozil treatment are

futile in meeting these goals for the majority of our hyperlipidemic patients.

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The preceding letter was referred to Dr Stelmach, who responds as follows:

Our research protocol was designed for use under actual clinical conditions. Individualized treatment was a more important factor in our protocol than a rigid stipulation that *all* patients adhere to the Step Two diet. Before participation in the study, some patients may not have had any dietary restrictions, whereas others may have already attempted the Step One diet. At the start of the study, patients were individually advised by their physicians to begin the Step One or Step Two diet. This approach was in keeping with the National Cholesterol Education Program (NCEP) guidelines.

We acknowledge in our article's introduction that diets that are "rigidly controlled to decrease the intake of saturated fat and cholesterol" can reduce total cholesterol levels by an average of 10% to 20%. Although we agree this could possibly have been achieved by means of a more restrictive protocol, our report of an average decrease in total cholesterol of 4.1% is a measure of what typically occurs in a broad sampling of family practices.

Dr McNabb concludes from our study that lipid target levels for at-risk groups are unrealistic. Our target levels, however, were those proposed in the NCEP guidelines. Diet and exercise alone did not achieve these "desirable" levels in a majority of patients when total cholesterol (TC), triglycerides, HDL cholesterol, LDL cholesterol, and TC:HDL ratio were all considered. The addition of gemfibrozil to the diet and exercise regimen resulted in further beneficial changes in lipid levels. Although desired levels for all of these lipids combined were still not attained in the majority of patients, the introduction of gemfibrozil brought our study patients closer to NCEP goals and affirmed the clinical benefit of using this drug.

No diet and exercise regimen alone or in combination with any currently available pharmacologic treatment can achieve all of the goals for the majority of dyslipidemic patients. Nevertheless, it is not futile, as Dr McNabb suggests, to continue our efforts to reach these goals. We feel that the true benefits of pharmacologic and nonpharmacologic interventions must continue to be clarified in terms of patient outcomes, cost, and quality-of-life issues in order to truly understand the full value of lipid-level alterations.

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SOFTWARE UPDATE

To the Editor:

Thank you for the review of *The Food Processor II* software.

We wanted to let you know that the 1990 version you reviewed has long been updated. The 1993 version is now called *The Food Processor*, and does a lot more things. It tracks fitness and exercises with over 200 activities, as well as evaluating unlimited menus, diets, and daily intakes. The Basic program has 3000 foods and 36 nutrients, and the Plus version has 5000 foods and 92 nutrients including all the amino acids and fatty acids.

We also wanted to correct two items. We have *always* offered a free demo disk and a money-back guarantee. The review inadvertently said we had *neither*. In fact, for the Plus version, we send out a *free* 30-day preview of the entire program.

It is exciting to see the increase in understanding of good nutrition and good health. Computer programs make all this information available in a few keystrokes, and allow physicians to include or eliminate nutrition issues from a patient's health status relatively quickly. This is not possible without the power of computers.

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