

Medicine & Health

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Federal Budget

Congress Births FY 2010 Budget, Healthcare Reform Still on Horizon

► *Party lines split budget vote.*

Moving with more speed than usual, Congress passed President **Barack Obama's** \$3.4 trillion fiscal year 2010 budget resolution on April 29. The final budget resolution was approved in the House by a vote of 233 to 193 and in the Senate by a vote of 53 to 43.

The plan includes budget reconciliation as an option for passing health reform legislation, the *Wall Street Journal* reports.

The budget resolution is non-binding but sets the framework for Congress to make legislative decisions on taxes, appropriations, and entitlement programs later in the year. It includes reconciliation instructions that would allow Obama's proposed healthcare reform to move through Congress without the threat of filibusters and other obstacles that can be used to slow action on most other bills.

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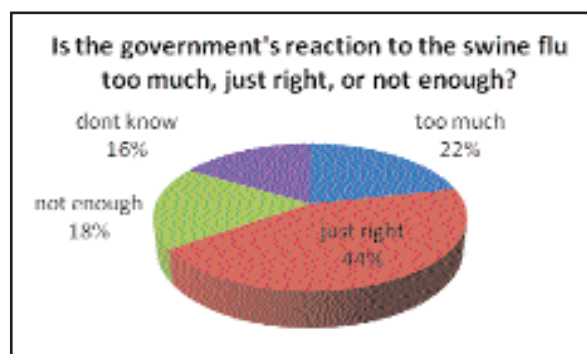
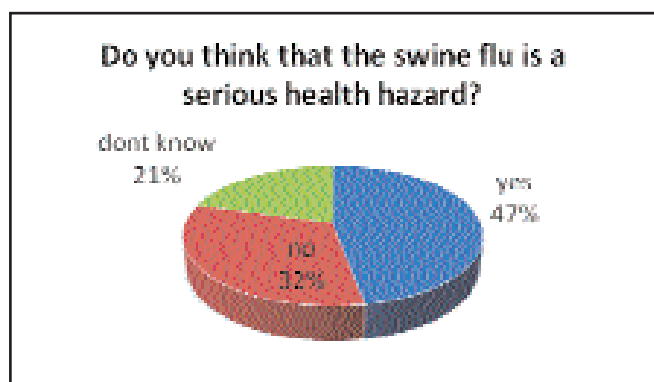
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Public Health

Public Weighs In on the Swine Flu

► *Less than half of those polled think it's a serious health hazard.*

For a view through U.S. citizens' eyes on how bad the swine flu is, check out the graphs below, provided by Silverlink Communications. The healthcare communication services company recently ran a poll querying people of the seriousness of the swine flu — and the quality of the government's reaction.



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Federal Budget, continued from cover

No Surprise: Budget Carries Controversy

Republicans were not happy with the budget, and none of them voted in favor of it. “The budget plan skirts difficult decisions on how to pay for Obama’s health care plan, which is expected to cost more than \$1 trillion over the next decade,” according to the *Washington Post*.

Even a few Democrats had concerns.

“While the budget resolution takes important steps in the near-term of cutting the deficit ... it is clear that more will be needed to address the long-term fiscal imbalance confronting the nation beyond the five-year budget window,” said Senate Budget Chairman **Kent Conrad** (D-N.D.). At the same time, “this budget is a major accomplishment,” Conrad acknowledged.

Conrad also said he opposed inclusion of the reconciliation instructions “at every step of the way, publicly and privately.” He said he will work to avoid using reconciliation and added that using reconciliation to advance healthcare reform legislation was unlikely.

Under the resolution, Congressional committees with jurisdiction over healthcare have until Oct. 15 to pass healthcare reform legislation. By setting the deadline at

this late date, Congress has given negotiators in the healthcare reform process an opportunity to develop a bipartisan bill that could be considered outside the reconciliation process, a legislative update on AHIP’s (America’s Health Insurance Plans) Web site states. If no measure is passed, healthcare overhaul legislation could be passed using reconciliation, says *CQ Today*.

Senate committees over healthcare — including Senate Finance Committee Chairman **Max Baucus** (D-Mont.) — intend to produce a stand-alone healthcare reform measure sooner than the October deadline, however. Their target date is June, in hopes that voting could occur before the August recess.

Healthcare Reform Sees Tight Parameters

Any healthcare reform legislation must be deficit-neutral in both the House and the Senate. The budget resolution does not specify the amount of funding that would be devoted to healthcare reform, although it allows for payment over 11 years, according to the *New York Times*. Keeping the proposed reserve funds deficit-neutral accommodates the President’s proposal to spend \$634 billion on healthcare reform legislation and offset the spending with changes in Medicare, Medicaid, and the tax code.

Questions remain on how the proposed initiatives will be shaped, particularly for healthcare.

“We are clearly as close as we’ve ever been, but it’s still a long journey,” Sen. **Charles E. Schumer** (D-N.Y.) told the *Washington Post*. Schumer is part of the Senate Finance Committee, which is taking the lead on health legislation. “This is one of the steepest ascents in politics. We have momentum. We have the right gear, shall we say. But reaching the peak is a hard thing to do.” □

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Jim McBee, Contributing Editor (jmcbee@eliresearch.com)

Leigh DeLozier, CPC, Contributing Editor (leighd@eliresearch.com)

Lindsey Rushmore, Executive Editor (lindseyr@eliresearch.com)

Mary Compton, PhD, CPC, Editorial Director (maryc@eliresearch.com)

Jeanne Caggiano, Group Publisher (888) 779-3718

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Public Health, continued from cover

The survey is based on interviews conducted April 30 through May 2 with 1,583 adults throughout the United States. The sample was drawn from a list of 50,000 U.S. citizens. The results are weighted to be representative of the U.S. adult population as described in the U.S. Census’ 2008 Current Population Survey. For more information, visit www.silverlink.com. □

*Vaccinations***Should HPV Vaccine Be Compulsory for U.S. Girls?**

► *Vaccine proves popular in California, but legislators are tougher to win over.*

Less than two years after the human papillomavirus vaccine was approved as a routine vaccination for girls, one-quarter of California adolescent girls have started the series of shots that protect against human papillomavirus, which is strongly linked to cervical cancer. Additionally, most teen girls, parents, and young women in California say they would like to have the vaccine, according to a UCLA Center for Health Policy Research policy brief.

Debate is heating up about whether or not to require girls to be vaccinated against HPV, which causes nearly all cases of cervical cancer and genital warts.

Federal Recommendation Got Ball Rolling

The legislative flurry of 2009 stems from the national Advisory Committee on Immunization Practices June 2006 recommendation that girls ages 11 and 12 get routine HPV vaccination. The Centers for Disease Control and Prevention further recommends that girls and women age 13 to 26 get the vaccine if they haven't already.

Proponents cite clinical trials that show Merck's HPV vaccine Gardasil and GlaxoSmithKline's HPV vaccine Cervarix are 100 percent effective in preventing infection with HPV strains 16 and 18, which cause about 70 percent of cervical cancer cases.

Human papillomavirus is transmitted through sexual contact and often acquired soon after onset of sexual activity, so females not yet sexually active and those with few sex partners are expected to benefit more from HPV vaccination, the UCLA Center for Health Policy Research said. Thus, the early teen years provide a timely opportunity for vaccine intervention and HPV-related disease prevention.

Critics attack HPV legislation as an intrusion on parental discretion and an invitation to teenage promiscuity, even though all proposals preserve a parental right to opt out.

"Access to these vaccines has already become more a political than a public health question," said **R. Alta Charo, JD**, in a 2007 article in *The New England Journal of Medicine*.

The Action Is in the Legislatures

Legislators in at least 41 states and the District of Columbia have introduced legislation to require, fund, or educate the public about the HPV vaccine, and at least 19 states have enacted such legislation, according to the National Conference of State Legislatures, including Colorado, Indiana, Iowa, Louisiana, Maine, Maryland, Michigan, Minnesota, Nevada, New Mexico, New York, North Carolina, North Dakota, Rhode Island, South Dakota, Texas, Utah, Virginia, and Washington.

In two states, Kentucky and New York, legislation now under consideration would require children to be immunized before being readmitted to school.

It's not smooth sailing for HPV vaccine legislation, though.

For instance, in 2007, Texas became the first state to enact a gubernatorial mandate that girls who enter the sixth grade receive the vaccine, with some exceptions. Legislators passed a bill to override the executive order, and the governor withheld his veto. And the Texas House recently voted 118-23 to pass a bill that would halt any mandatory HPV vaccination program for girls in school, the *Houston Chronicle* reported.

And in California, an assembly member withdrew consideration of a bill that would require all California girls entering the seventh grade to receive an HPV vaccine. □

*Substance Abuse***No. 1 Alcohol Problem? Cheap Booze, British Docs Say**

► *U.K. clinicians' concerns reflect those of American college parents.*

British doctors and nurses agree: If you want to address problems related to alcohol abuse, you've got to raise the price of cheap booze.

A snapshot survey of doctors and nurses who treat patients that have alcohol-related harm showed that many believe public health campaigns are not effective and that government should focus action on sales of low priced alcohol to combat alcohol problems.

The Royal College of Physicians and the Royal College of Nursing survey asked gastroenterologists,

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Substance Abuse, continued from page 3

hepatologists, acute physicians, and nurses for their opinions on government policy and strategies to tackle alcohol-related harm, the provision of service for people with alcohol-related health problems, and the scale of alcohol-related health harms.

Significant findings were:

- 84 percent of respondents thought that public health campaigns were not effective;
- 73 percent felt action on low-priced alcohol was needed to tackle alcohol-related problems;
- 90 percent believed that all alcohol products should be labeled with unit information and sensible drinking guidelines;
- 71 percent believed that greater investment in treatment services was needed; and,
- 81 percent thought that if alcohol were more expensive, consumption would decrease.

Americans Share Similar Sentiments

The results recall a 2004 AMA-sponsored national telephone survey that showed Americans support raising taxes on alcohol to fund abuse-prevention programs. The U.S. focus tends to be on underage and college binge drinking.

“Americans want policy makers to strengthen the enforcement of existing laws that restrict access of alcohol to underage drinkers, and create new common-sense laws that limit the availability and abundance of cheap alcohol to college students,” the report’s authors said.

Parents of college students worry about easy access to cheap alcohol and about the alcohol industry’s promotions, the study said.

When it comes to factors that contribute to excessive drinking, 93 percent of college parents and 96 percent of adults surveyed laid blame on lack of individual responsibility on the part of college students.

But most surveyed also pinned easy access to and availability of alcohol at the many bars and retail establishments surrounding campus: 93 percent and 85 percent respectively.

And 80 percent of parents, 77 percent of adults thought the cheap cost of beer and shots and promotions such as all you can drink specials, happy hours, and ladies’ nights contributed to collegiate alcohol abuse.

However, Americans in the 2004 survey were somewhat less enthused about restrictions on cheap alcohol than British medical professionals.

Only 44 percent said they “strongly support” limiting drink specials at bars, for instance, and 46 percent strongly supported banning happy hours at bars that offer two-for-one or all-you-can-drink specials. □

Alcohol Does Great Health, Social Damage

Here are the top problems associated with alcohol abuse, according to the National Institute on Alcohol Abuse and Alcoholism.

Injuries: Drinking too much increases chances of being injured or even killed. Alcohol is a factor in about 60 percent of fatal burn injuries, drownings, and homicides; 50 percent of severe trauma injuries and sexual assaults; and 40 percent of fatal motor vehicle crashes, suicides, and fatal falls.

Health problems: Heavy drinkers have a greater risk of liver disease, heart disease, sleep disorders, depression, stroke, bleeding from the stomach, sexually transmitted infections from unsafe sex, and several types of cancer. They may have problems managing diabetes, high blood pressure, and other conditions.

Birth defects: Drinking during pregnancy can cause brain damage and other serious problems in the baby. Because it is not yet known whether any amount of alcohol is safe for a developing baby, women who are pregnant or are trying to become pregnant should not drink.

Alcohol-use disorders: Generally known as alcoholism and alcohol abuse, alcohol use disorders are medical conditions that doctors can diagnose when a patient’s drinking causes distress or harm. In the United States, about 18 million people have an alcohol use disorder. □

*Grants***Project Looks to Expand Reach of Personal Health Records**

► *Could daily journaling of exercise, meals, pain, and sleep help doctors treat patients?*

The Robert Wood Johnson Foundation seeks projects “to assess and test the potential of ‘observations of daily living’ to help patients and physicians better manage chronic illnesses,” according to a press release.

The teams chosen to receive grants will demonstrate how observations on exercise, meals, pain, and sleep, for example, “can be collected, interpreted and integrated into the clinical care process.”

The project builds on a first round of funding that developed personal health records applications. One of the insights that came out of that work was “the importance of the subtle but systematic cues that people attend to as they monitor their health progress.” RWJF wants to see whether capturing that level of information can help clinicians treat patients.

PHRs can include information from a variety of sources, including a patient’s clinical record and one’s own observations about day-to-day experiences and feelings, the request for proposals said. The RFP cites PHR services such as Google Health, Microsoft HealthVault, and Dossia as examples of health-data storage that’s independent of where or how they are collected.

A total of \$2.4 million is available. RWJF expects grants of up to \$480,000 each will be awarded to five applicants for 24-month projects. The deadline for brief proposals is June 3 at 2 p.m. EDT. Get more information from **Gail Casper, RN, PhD**, deputy director, Project HealthDesign, at (877) 674-3170 or info@projecthealthdesign.org

For details, go to www.rwjf.org/applications/solicited/cfp.jsp?ID=20762. □

Fraud & Abuse

OIG Blasts Fraudulent S. Florida Inhalation Drug Claims

► Medicare paid five times more for two brand-name inhalation meds in Miami.

The HHS Office of Inspector General’s latest report slams fraudulent billing for inhalation medications used in conjunction with durable medical equipment, particularly budesonide and levalbuterol. “Although only 2 percent of Medicare beneficiaries live in South Florida, this area accounted for 17 percent of Medicare spending on inhalation drugs in 2007,” the OIG noted.

Medicare paid 20 times as much for inhalation drugs in Miami as in the Chicago area, even though Chicago has nearly twice as many beneficiaries, the OIG pointed out. “Among beneficiaries with paid inhalation drug claims, Medicare spent approximately \$4,400 per South Florida

beneficiary on inhalation drugs, compared to just \$815 per beneficiary on inhalation drugs in the rest of the country.”

It was spending on budesonide and levalbuterol that was markedly different in the area, the OIG found. “In 2007, 56 percent of South Florida beneficiaries who received inhalation drugs had claims paid for budesonide, compared to 14 percent of beneficiaries in the rest of the country,” the report said.

And 31 percent of South Florida benes had multiple suppliers for inhalation drugs versus 12 percent in the rest of the country.

A local coverage determination was in place for budesonide during the time the OIG studied, but Medicare’s claims system and contractors failed to enforce it, the OIG said. Consequently, 75 percent of South Florida benes who received the drug exceeded the LCD limit.

For 62 percent of inhalation drug claims, the patient didn’t have a visit with the prescribing doctor in the previous three years, the OIG added. “For 16 percent of suppliers, not a single South Florida beneficiary to whom they provided inhalation drugs had a billed claim with the physician.”

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- July 8, 1PM ET:** ON-DEMAND: *Electronic Discovery Meets Healthcare Information: How to Protect Your Best Interests*, with **Jim Sheldon Dean**

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Fraud & Abuse, continued from page 5

Some beneficiaries are finding out from Medicare Summary Notices that their information is being used to falsely bill for medication they were never prescribed and didn't receive, according to the *Miami Herald*.

CMS Will Have to Step Up Its Oversight

The OIG recommends that the Centers for Medicare & Medicaid Services enforce the LCD limits and review suspicious cases for action, the report concludes.

CMS says it has already put in place a medically unlikely edit (MUE) for budesonide, which took effect last September. That edit has cut both allowed and billed amounts for the drug in half in South Florida, the agency says in its official response to the OIG report.

CMS also touts its "DME Stop Gap Plan" — a crackdown on DME fraud in seven high-risk states. The anti-fraud campaign is already addressing many of the issues raised in this report, said CMS head **Charlene Frizzera** in the agency's comments.

Multiple inhalation drug suppliers, pharmacists, and physicians have faced charges under the crackdown, the *Herald* notes.

The report highlights CMS's lax oversight of the DME program, industry experts maintain. But it is legitimate suppliers who are likely to end up paying the price for that problem.

Sen. **Mel Martinez** (R-FL) has called a Senate Special Committee on Aging hearing about the report on May 6. "These findings are confirmation that not enough is being done to detect and prevent the waste of taxpayer dollars," Martinez says.

"It's clear that we must step up our efforts to not only detect fraud, but prevent this egregious waste," he added in a release.

Shining a spotlight on the abuses in the report could hurt legitimate suppliers' efforts to win help from Congress this year on pressing issues such as competitive bidding and the oxygen cap, industry veterans worry.

Both the OIG report and a recent congressional hearing "underscore the sorry state of Medicare fraud prevention in the United States," laments the American Association for Homecare. Medicare's laxity "has had a tragic, adverse impact on the vast majority of home medical equipment providers who fully comply with the law and that provide high quality services to seniors and people with disabilities who require medical equipment and care."

The OIG report is at www.oig.hhs.gov/oei/reports/oei-03-08-00290.pdf. □

Health Awareness

Key In to Arthritis Issues This Month

► *CMS reminds providers about Medicare coverage for this disease.*

The Arthritis Foundation is busy broadcasting that May is National Arthritis Awareness Month. In addition to touting the national Walk for Arthritis, the Foundation's Web site, www.arthritis.org, lists helpful information for providers and patients. For example, the Web site features a pamphlet on how diabetes and arthritis are connected, which includes self-management tips. Site visitors can also "read a health tip about rheumatoid arthritis" and how to manage it.

Meanwhile, the Centers for Medicare & Medicaid Services is promoting the awareness to healthcare providers and reminding them that Medicare provides coverage of a range of treatments for osteoarthritis.

Osteoarthritis is a painful, degenerative joint disease characterized by the breakdown of the joint's cartilage. It often involves the hips, knees, neck, lower back, or small joints of the hands. It is the most common form of arthritis, affecting approximately one third of Americans aged 65 and older. About 80 percent of patients with osteoarthritis have some degree of movement limitation, and 25 percent cannot perform major activities of daily living. Osteoarthritis of the knee is one of the leading causes of disability among non-institutionalized adults.

The good news is that, in many cases, treatment for osteoarthritis can control pain, minimize joint damage, improve physical functions, and enhance the quality of life. Exercise, physical therapy, weight loss, medications, and, for advanced cases, surgical intervention, can decrease pain and improve physical function. Early diagnosis can make it easier to successfully manage this disease.

In short, "National Arthritis Awareness Month provides an excellent opportunity for health care professionals to help increase awareness, knowledge, and understanding of strategies for managing arthritis," CMS said in an email to providers. The agency listed a number of ways providers can help patients with arthritis:

1) Stay informed of the latest clinical guidelines for prevention, diagnosis, and treatment;

2) Familiarize yourself with Medicare's coverage of the continuum of treatments for osteoarthritis, including the full range of treatment from physician office visits related to osteoarthritis care to total joint replacement surgery.

3) Talk with your patients about their risk factors for arthritis, prevention measures they can take to reduce their risk factors, and lifestyle changes they can make to improve their joint health.

4) Encourage eligible Medicare patients to take full advantage of Medicare's benefits that can help improve physical functions and decrease pain associated with arthritis. For example, certain prescription drugs for osteoarthritis are covered under the Medicare Part D drug program, and beneficiaries with osteoarthritis may be eligible for certain therapy services. Medicare also covers surgical procedures, including total joint replacement, for beneficiaries with advanced osteoarthritis, and most beneficiaries have supplemental coverage to help pay for out-of-pocket costs associated with these procedures.

Certain healthcare providers also have added incentive (aka a cash bonus from CMS via the Physician Quality Reporting Initiative) if they assess patients for function and pain, as well as their use of anti-inflammatory or analgesic over-the-counter medications.

See the links below for a variety of information on arthritis:

- For more information about arthritis, visit The National Institute of Arthritis and Musculoskeletal and Skin Diseases at www.niams.nih.gov.
- For additional information on total joint surgery, see www.aahks.org.
- For information for providers to share with Medicare patients, visit www.medicare.gov. □

In Brief

Another Medicare Fraud Contractor Makes Debut

► *Zone Program Integrity Contractors to take over Program Safeguard Contractors.*

Medicare is in the midst of naming its new fraud-fighting contractors. The agency recently announced its

third Zone Program Integrity Contractor, Rockville, Md.-based AdvanceMed Corp., which will cover Zone 5: West Virginia, Virginia, North Carolina, South Carolina, Georgia, Alabama, Mississippi, Tennessee, Arkansas, and Louisiana. AdvanceMed is currently a Program Safeguard Contractor for 15 states and is a wholly owned subsidiary of Computer Sciences Corp.

The Centers for Medicare & Medicaid Services is awarding ZPIC contracts in seven zones. ZPICs will take over PSCs' program integrity functions. CMS already announced the contracts for zones four (Health Integrity, covering Colorado, New Mexico, Oklahoma, and Texas) and seven (SafeGuard Services with subcontractor IntegriGuard, covering Florida, Puerto Rico, and the U.S. Virgin Islands). These contractors have already begun operating.

Last month, CMS issued a draft of its final solicitation for the remaining ZPICs in zones 3 (Minnesota, Wisconsin, Illinois, Michigan, Ohio, and Kentucky) and 6 (Pennsylvania, New York, Maryland, DC, Delaware, Maine, Massachusetts, New Jersey, Connecticut, Rhode Island, New Hampshire, and Vermont), according to the federal government's Federal Business Opportunities Web site, which lists vendor contract details.

In other news...

• **Ever since its 1997 report concluded that a North Carolina Marine base's drinking water** was safe, the Agency for Toxic Substances and Disease Registry has been under pressure from community activists who said the agency was sweeping a serious chemical-exposure problem under the rug.

The Camp Lejeune, N.C., system's water was contaminated for 346 months between November 1957 and February 1987 by an off-base dry-cleaning firm, according to ATSDR. The 1997 report concluded the water was safe to drink.

Twelve years later, ATSDR no longer stands behind its study, according to a House committee press release. When the House Committee on Science and Technology reviewed the Lejeune study, the agency had lost many of the scientific documents and data upon which the agency had based its assessment.

Camp Lejeune activists have claimed ATSDR's 1997 report used flawed data to support its conclusion that exposure to volatile organic compounds and other toxic chemicals, such as benzene, would not pose a health hazard for adults.

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“I hope that the agency’s decision to rescind the public health assessment on Camp Lejeune is a sign that the leadership of ATSDR is now willing to acknowledge the agency’s past mistakes and take measures to protect the public’s health in the future,” said Brad Miller (D-NC), Subcommittee on Investigations and Oversight chairman.

• **CMS dropped a major bomb for skilled nursing facilities** in the recently published proposed SNF PPS payment update for 2010. The rule unveils the new RUG-IV system, which determines how SNFs get paid for Medicare Part A stays. Changes include thirteen new RUGs, plus SNFs won’t be able to capture preadmission services. Some experts even think SNFs won’t be able to capture projected rehab therapy services. The RUG IVs are set to go into effect in October 2010.

Meanwhile, after some back and forth, the assessment form that rates SNF patients’ acuity, the MDS, is seeing more attention. MDS version 3.0 preparation will be heating up again in October — if the revised guidelines stay on track. CMS expects to publish the final MDS 3.0 data specifications, including RUGs, RAP triggers, and quality measures and indicators, in October 2009. It will also publish the MDS 3.0 data elements, which includes admission, quarterly, swing bed, and discharge MDSs. Providers should also look for publication of the MDS 3.0 RAI User’s Manual.

The timeline calls for MDS 3.0 implementation on Oct. 1, 2010. Providers may review the entire revised timeline for MDS 3.0 by clicking on the “Downloads” section on the “MDS 3.0 for Nursing Home” Web page at: www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp.

• **The HHS Office of Inspector General posted Recovery Act materials** to its Web site on April 29. This is the same information that’s on www.recovery.gov, but it’s in a slightly different form, the OIG said. To see the first OIG Monthly Recovery Update Report, visit www.oig.hhs.gov/recovery/monthly_report.asp. This report accounts for Recovery Act funding, and both completed and planned actions. The OIG will update this site on a regular basis.

Also posted in the Recovery Section of the OIG’s Web site is information on the special Whistleblower

Protections available under the Recovery Act: www.oig.hhs.gov/recovery/whistleblower.asp.

• **Watch out for alfalfa sprouts.** The Food and Drug Administration and the CDC warned consumers on April 26 not to eat raw alfalfa sprouts until further notice because the product has been linked to Salmonella serotype Saintpaul contamination. Michigan, Minnesota, Pennsylvania, South Dakota, Utah, and West Virginia have reported 31 cases of illness with the outbreak strain of Salmonella Saintpaul to the CDC.

The illnesses began in mid-March, and cases are still being reported. No one is aware of any deaths. The number of infected people may be higher than currently reported because some illnesses have not yet been confirmed with laboratory testing, the FDA warned.

For more information see www.cfsan.fda.gov/~lrd/tpsprout.html. □

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