Opinion

Coyote vs. Acme: Must We Always Chase the Road Runner?

I was leafing through the Feb. 26, 1990, issue of *The New Yorker* in my waiting room, killing time until my last patient of the day returned from the bathroom. In its pages, I discovered the opening statement of the attorney for Wile E. Coyote in his lawsuit against Acme Co., which read in part: "Mr. Coyote states that on eighty-five separate occasions he has purchased of the Acme Company (hereinafter, 'Defendant'), through that company's mail-order department, certain products which did cause him bodily injury due to defects in manufacture or improper cautionary labeling … Mr. Coyote states that on December 13th he received of Defendant via parcel post one Acme Rocket Sled." It continued, "The Rocket Sled soon brought Mr. Coyote abreast of his prey. At that moment the animal he was pursuing veered sharply to the right. Mr. Coyote vigorously attempted to follow this maneuver but was unable to, due to poorly designed steering on the Rocket Sled and a faulty or nonexistent braking system. Shortly thereafter, the unchecked progress of the Rocket Sled brought it and Mr. Coyote into collision with the side of a mesa."[1] Inexplicably, I began thinking about coding and chasing abruptly changing government requirements—and what we are going to do about them.

In this issue's Savvy Coder on p. 65, the new glaucoma severity codes (effective Oct. 1) are explained. "Why on earth would we want more complexity in coding?" you might ask. Well, there are two really big reasons.

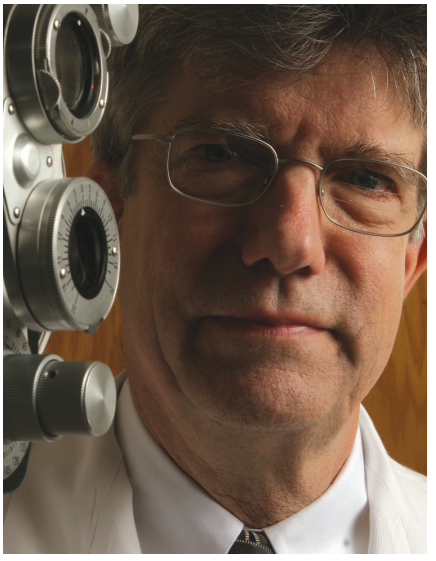
The first is that we ophthalmologists are being profiled for our costs of care. Until Oct. 1, each type of open-angle glaucoma has a single code (365.10 for open-angle, unspecified; 365.11 for primary open-angle, etc.), no matter how severe the disease. Let's consider what Medicare or the private insurance company sees when you take care of glaucoma patients with more severe disease than, say, your neighborhood optometrist or your ophthalmologist colleague who got rid of all of his difficult cases by referring them out. Pretty simple: The optometrist or colleague has much lower costs of care on average than you do.[2] And since the insurers plan to make that information public in the not-too-distant future, there will be no place to hide.

The other reason to move away from the one-glaucoma-code-fits-all paradigm is that payment for care of a chronic disease like glaucoma is likely to move by 2015 to an annual allowance per patient. If you take care of easy patients, you can do nicely with an average allowance. But if you take care of difficult glaucoma (as your friendly old editor does), you can't make ends meet with the average payment. So a severity code will help steer more payment to difficult glaucoma cases.

Will we see gaming of the system or lying about severity? Undoubtedly. That's why the severity classification has to be simple and auditable, because "providers" billing the more severe codes will be audited more frequently.

So maybe the best policy is simply to refuse to chase the Road Runner by omitting the severity codes in billing. But then I imagine Wile E. Coyote setting up the lounge chair and beach umbrella on the newly asphalted parking lot, lying back to soak up the sun's rays—and promptly being steamrolled flat by the Road Runner.

1 Frazier, I. *The New Yorker* Feb. 26, 1990: 42–43.
2 Lee, P. P. et al. *J Glaucoma* 2007;16(5):471–478.



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