Documentation & Coding Best Practices:
Does your documentation have M.E.A.T.?

One of the most critical and basic requirements for coding is proper documentation of the diagnosis. Documentation of chronic conditions can be straightforward by following the acronym M.E.A.T. Using any one of the M.E.A.T criteria will justify the coding of that condition.

Monitor – signs and symptoms, disease progression, regression, remission status

Evaluate – test results or findings, medication effectiveness or reactions, response to treatments, physical exam findings

Assess/Address – discussion or review of records, counseling, ordering tests

Treat – prescribing, continuing, or adjusting medications, surgical or other therapeutic interventions, referral to specialist for treatment or consultation

Examples of Documentation using M.E.A.T.	
CHF	Stable. Will continue same dose Lasix and ACE inhibitor.
Major Depression	Continued feelings of hopelessness despite increase in Zoloft. Will refer to psychiatrist for further management.
Type 2 DM	Blood sugar log and A1c results reviewed with patient.
GERD	No complaints. Symptoms controlled on meds.
AAA	Abdominal ultrasound ordered.
Morbid Obesity	Advised patient to monitor calorie intake and increase activity level.

Some additional documentation reminders:

- Document each patient encounter as if it is the only patient encounter. Each note should stand alone and provide full picture of patient's medical state.
- Codes should be assigned for EVERY condition documented in the note that has evidence of M.E.A.T., not just the condition for which the patient came in
- All chronic and complex conditions need to be coded annually
- Review and document conditions that are managed by a specialist
- Review and update the patient's active problem list at each visit
- Avoid using the words "history of" for a condition that is chronic but currently stable, such as COPD, DM, or atrial fibrillation

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