



## Documenting M.E.A.T

### Monitoring, Evaluating, Assessing, Treating

To stay compliant, healthcare providers must make sure they present these four factors to present a diagnosis and ensure proper documentation in a medical record.



#### Monitoring:

- Signs
- Symptoms
- Disease Progression
- Disease Regression



#### Evaluating:

- Test Results
- Effectiveness of Medications
- Response to Treatment



#### Assessing:

- Ordering Tests
- Discussion
- Review of Records
- Counseling



#### Treating:

- Medications
- Therapies
- Other Modalities

#### Documenting M.E.A.T

According to CMS an acceptable problem list must show “evaluation and treatment” for **EACH** condition that relates to an ICD-10 CM code. Examples:

- CHF - Symptoms well controlled on Lasix and ACE inhibitor. Will continue to monitor.
- Hypertension - Stable on medications (medication list must be present).

#### Documenting “Pitfalls”

- Providers are not showing all documentation for work performed during the encounter.
- It is acceptable to include “history of” conditions if it directly affects the current treatment plan of the patient.
- Remember, stating “history of” means the patient no longer has that condition.

#### SUMMARY:

- Any and each condition that is addressed at the time of the encounter should be documented in the History and Physical.
- Each condition that relates to an ICD-10 code must show evaluation and/or treatment.
- A list of diagnoses is **NOT** acceptable as evidence that the diagnosis affected the patient management.
- Using M.E.A.T. ensures that documentation is sufficient for CMS’s requirements for validating coding.
- Following the MEAT principle will provide accurate documentation, patient of care quality, and improvement in data management for validating diagnosis codes.