Documenting M.E.A.T.

Monitoring, Evaluating, Assessing, Treating

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To remain compliant, healthcare providers must ensure that the following four factors are presented in their diagnoses along with proper documentation in their medical records.

M	**Monitoring** • Signs • Symptoms • Disease Progression • Disease Regression
E	**Evaluating** • Test Results • Effectiveness of Medications • Response to Treatment
A	**Assessing** • Ordering Tests • Discussion • Review of Records • Counseling
T	**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.
- Medication list should be updated and reconciled at each encounter. All medications should be addressed with a corresponding diagnosis.
- Using M.E.A.T. ensures that documentation is sufficient for CMS's requirements for validating coding.
- Following the M.E.A.T. principle will provide accurate documentation, patient of care quality, and improvement in data management for validating diagnosis codes.