home state health

Does your Documentation have MEAT?

The Medical Record

Due to its simplicity and popularity, many medical records take on the SOAP format: **S**ubject, **O**bjective, **A**ssessment and **P**lan. The SOAP format addresses patient's complaint in an organized and consistent manner. Over time, patient's chronic condition(s) may be overlooked, assumed or tacitly understood.

What does CMS say?

One of the documentation requirements, according to the May 9, 1992, HCFA, (now CMS) bulletin for Associate Regional Medicare Administrators, Issue 9, states that **progress notes should stand alone**. This means that Providers should code all documented ***conditions that co-exist*** at the time of the encounter ***and require or affect*** patient care, treatment, or management. This must be documented by the provider and cannot be inferred by coders.

One way to document ***chronic conditions*** is by utilizing the acronym MEAT:

Monitor ***E***valuate ***A***ssess/address ***T***reat

Examples of MEAT	
Monitor	• symptoms • disease progression/regression • ordering of tests • referencing labs/other tests
Evaluate	• test results • medication effectiveness • response to treatment • physical exam findings
Assess/Address	• discussion, review records • counseling • acknowledging • documenting status/level of condition
Treat	• prescribing/continuation of medications • surgical/other therapeutic interventions • referral to specialist for treatment/consultation • plan for management of condition

Documentation Tips

- A condition can be coded when documentation states that the condition affects the care, treatment, or management of the patient. This must be documented and cannot be assumed.
  → *Example: Sugar free cough syrup prescribed due to Type 2 DM*
- Medication/medication changes and the condition being treated need to be documented
  → *Example: Major Depression Disorder (MDD)-increase Paxil to 50 mg/day*
- Conditions can be coded when documentation states condition is being monitored and treated by a specialist.
  → *Example: patient on Coumadin for a-fib followed by Dr. X*

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Documentation Examples	
CHF	Stable. Will continue same dose of Lasix and ACE inhibitor.
AAA	Abdominal ultrasound ordered
Major Depression	Continued feelings of hopelessness despite increase in Zoloft. Will refer to psychiatrist for further management
Hypercholesterolemia *and* Chronic Hepatitis C	Prescribing Zetia for hypercholesterolemia as it won't adversely affect the liver as patient suffers from Chronic Hepatitis C
Type 2 DM	BS log and A1c results reviewed with patient
GERD	No complaints. Symptoms controlled on meds
Peripheral Neuropathy	Decreased sensation of BLE by monofilament test
Ulcerative Colitis	Currently managed by Dr. Smith
Morbid obesity	Advised patient to monitor calorie intake and increase activity level
Decubitus ulcer of heel	Wound measurements

Additional Tips

- Document each patient encounter as if it is the only encounter.
- Codes should be assigned for every condition documented in the chart note that has evidence of MEAT, not just the condition for which the patient came in.
- All chronic and complex conditions need to be ***coded annually.***
  - Review and document conditions managed by a specialist.
    - → This counts as MEAT and can be coded on the claim.
- When seeing a patient who comes in infrequently, ensure that chronic conditions are reviewed at the visit, even if they are only presenting for an acute issue.
- When refills are made outside of a visit, encourage patient to schedule a check-up so that the condition can be reviewed and managed at least once a year.
- Review and update the patient's active problem list at each visit. If a condition is no longer active, either remove it from the list or add "history of".
- Specify the basis for ordering additional testing/treatment.
- Show patient's progress or lack of progress.
- Avoid using the words "history of" for a condition that is chronic but currently stable, such as COPD, DM, or atrial fibrillation.
- Include all ICD-10 codes with the highest degree of specificity that correspond with the documentation on the encounter.

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➤ **Secure Portal Registration:** If you haven't already do so, please go to www.HomeStateHealth.com to register for our Secure Portal. Functions on the portal include: Verification of eligibility, submission of claims, entering authorizations, viewing patient care gaps, etc. Use of the portal is FREE for all services!

➤ **Electronic Funds Transfer / Electronic Remittance Advice**

- Home State Health Plan partners with PaySpan Health for EFT/ERA services.
- Please register with PaySpan Health at www.payspanhealth.com

Questions?
Contact Provider Relations at 1-855-694-4663.