PHYSICIAN AND PROVIDER RESOURCE

Medical Risk Adjustment
M-E-A-T

Bryan HEALTH CONNECT

A common acronym utilized by coders to identify documentation that supports coding accuracy is M-E-A-T. You can utilize this handy tool as you complete your documentation.

Including one or more of the M-E-A-T details at a face-to-face visit for each condition that requires or affects patient care treatment or management will put you on the path to success in capturing risk!

M monitor

signs, symptoms, ordering or reviewing and referencing of tests/labs, disease progression or disease regression.

E evaluate

test results, medication effectiveness, physical exam findings and response to treatment.

A assess or address

by discussion, acknowledging, reviewing records, documenting status/level conditions and counseling.

T treat

with prescribing/continuation of medications, referral to specialist for treatment/consultation, surgical/other therapeutic interventions and plan for management of condition(s).

Comprehensive Documentation Examples

CHF-STABLE. CONTINUE SAME DOSE OF BISOPROLOL, LISINOPRIL, AND LASIX.
MDD-CONTINUED FEELING OF HOPELESSNESS. WILL INCREASE PAXIL TO 50 MG/DAY.
A.FIB-PATIENT ON COUMADIN. INR MANAGED BY DR. JONES.
URI-LIKELY VIRAL. DISCUSSED SYMPTOMATIC TREATMENT OPTIONS. RECOMMENDED SUGAR FREE COUGH SYRUP DUE TO T2DM.

TIPS

- Document each patient encounter as if it is the only encounter.
- All chronic and complex conditions should be reviewed and documented annually.
- Review and document conditions managed by a specialist.
- Review and update the patient's active problem list at each visit.
- Avoid using the words "history of" in the progress note for a condition that is chronic but currently stable–such as COPD, DM or Atrial fibrillation.

  Example: "CHF, stable. Will continue same dose of Lasix and ACE inhibitor."