Documentation is key!

Documentation Tips
HCC Documentation Requirements

Documentation must be linked to at least one element of "MEAT"!
Diagnoses not clearly documented can cause interpretation errors to referring providers, affect RAF scores which results in fewer required pre-auth's, and lower co-pays.

M	**MONITOR-** Signs and symptoms, disease process (i.e. HgbA1c 5.5 or lipids within normal limits)
E	**EVALUATE-** test results, meds, patient response to treatment (i.e. amputation or ostomy site w/o infection, appears clean & dry)
A	**ASSESS/ADDRESS/REFER-** ordering tests, patient education, refer to another provider (i.e. DM stable and well controlled and/or refer to endocrinology)
T	**TREAT/PLAN-** meds, therapies, procedures, modality (i.e. Continue insulin; taking Fosamax for osteoporosis and/or plan bone density study)

Provider Notes

- MEAT can be abstracted from anywhere in the patient note when documented correctly.
- Largest problem areas: Coding from the "Problem List" or "Past Medical History" without sufficient MEAT
- Confirm & assign the diagnosis code as they exist at the time of the visit and/or how they affect patient care, treatment or management.
- MEAT cannot be abstracted from the patient voice alone i.e., "I have A-Fib." It must come from the provider's voice.
- This formula works for EVERY insurance plan as it is the CMS way.
  Diagnosis + Linked MEAT= Codable Diagnosis

Note: if further examples are desired, please see the MEAT power point