PROFESSIONAL RESOURCE

MRA Documentation & Coding Best Practices

QUICK REFERENCE GUIDE

NEBRASKA HEALTH NETWORK | METHODIST | Nebraska Medicine

Documentation Tips & Hints:

1. **ALL chronic conditions need to be documented at least once annually.** The patient's slate is wiped clean on Jan. 1, annually.

2. **Document each patient visit as if it is the only visit the patient will have this year.**

3. **Document medication/medication changes and the condition being treated.**
   Example: Major depressive disorder-increase Paxil to 50 mg/day.

4. **Review and document conditions managed by a specialist.**

5. **Review and update the patient's active problem list at each visit. If a condition is no longer active, either remove or add "history of".**
   Example: Patient has history of CKD Stage 3 and based on trending GFRs is now diagnosed with CKD Stage 4-referring to nephrologist today.

6. **Be specific with documentation.**
   Example: Instead of documenting- ESRD, HTN, GFR 10.
   Document instead: End stage renal disease and hypertension. Patient's GFR is stable at 10. Continues dialysis three times per week. Patient's hypertension is well controlled with anti-hypertensives noted on med list.

7. **For BMI documentation: Code first the underlying condition such as overweight, obese, morbidly obese, protein calorie malnutrition and then the corresponding status Z code.**
   Example: Patient is morbidly obese (E66.01) with BMI of 42.5 (Z68.41) and here to discuss weight loss referral.

8. **When medication refills are made outside of a visit, encourage the patient to schedule a check-up to ensure that their condition(s) can be reviewed and managed at least once a year.**

9. **Specify the basis for ordering additional testing/treatment.**
   Example: Patient having difficulty breathing-chest x-ray ordered.

10. **Tell your patient's story: The only visibility insurers have to the care you provide and the conditions you manage is through your documentation and coding.**

Medical Risk Adjustment M-E-A-T

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.

ex: ***CHF:*** *Stable. Will continue same does of Lasix and ACE inhibitor.*

E evaluate

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

ex: ***GERD:*** *No complaints. Symptoms controlled by meds.*

A assess or address

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

ex: ***AAA:*** *Abdominal ultrasound ordered.*

T treat

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

ex: ***Major depression:*** *continued feelings of hopelessness. Will refer to psychiatrist.*

Make sure your face-to-face visit documentation is comprehensive enough to withstand an audit. Including one or more of the **M-E-A-T** details for each condition you are coding will put you on the path to success!