MCAIP: Suspect medical conditions documentation guide

Refer to this guide for documentation guidelines and submission requirements following an assessment.

We appreciate the time and effort you spend assessing suspect medical conditions in your patients who are UnitedHealthcare members. When you do, you help us gain an accurate overall picture of our plan member's health — and it can help you reach your Medical Condition Assessment Incentive Program (MCAIP) goals for this year. This guide offers best practices for completing documentation when a suspect medical condition is assessed and tips for submitting the information properly.

Documentation guidelines or "M.E.A.T."

If you've assessed a patient and determined they have a suspect medical condition, it's important to include as many details as possible with your diagnosis. The level of information needed is often referred to as M.E.A.T., which stands for Monitor, Evaluate, Assess/Address and Treat. It's essential there is M.E.A.T. to support the diagnosis selected. When documenting, include all M.E.A.T. details for an accurate representation of the work to diagnose and treat your patient. At least 1 of the 4 components should be documented.

1 Monitor

Document how you're following the condition, such as:

- Disease progression or regression
- Diagnostic tests ordered or performed to monitor a condition — labs, radiology, etc.
- Signs or symptoms related to the condition

Example: A1C ordered for monitoring the status of diabetes.

2 Evaluate

Document the significance of findings from tests and/or the physical exam used to evaluate the condition and/or response to treatment. Be sure to include your diagnostic conclusion(s).

Example: A1C is 9.5 and diabetes is poorly controlled.

3 Assess/Address

Document any of the following:

- Your assessment of the condition
- Statement of the definitive diagnosis
- Intervention taken
- Key findings from the consultant's report discussed with the patient
- Education provided to patient.

Example: Referred to dietitian for nutrition education related to diabetes.

4 Treat

Document your treatment plan for the patient's condition, such as:

- Therapies
- Prodedures needed
- Intervention taken

Example: Increase dose of metformin from 500 mg to 1,000 mg twice a day for diabetes.

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When documenting M.E.A.T. details, please keep these key points in mind:

- M.E.A.T. must be specific — an outside reviewer should be able to clearly understand your statements
- Provide a direct link between the condition and M.E.A.T. — for example, “CXR ordered to monitor pneumonia”
- M.E.A.T. can be a negative finding — for example, “No rales on lung exam and CHF is stable”
- Your findings must be from the same date of service
- M.E.A.T. can be added almost anywhere in the progress note — the only exception is when it’s documented as “history of.” Simply listing the condition in “Past Medical History” or on the “Problem List” isn’t enough
- M.E.A.T. must be documented to support the listed condition, indicating how the condition was monitored or evaluated or assessed/addressed or treated
- M.E.A.T. must be based on a face-to-face visit with the patient and performed by a physician or appropriate non-physician professional, such as a nurse practitioner or physician assistant. For example, a registered nurse can conduct the questionnaire portion of the Annual Wellness Visit, but the MD, DO, NP or PA must see the patient, document the chronic conditions, including M.E.A.T., and authenticate the note.

Basic documentation requirements

Please also follow these general guidelines when completing a patient’s progress note:

- Use the recommended Subjective, Objective, Assessment, Plan (SOAP) note format. Some electronic health records (EHRs) use the History, Exam and Medical Decision Making (MDM) format. Whether you code your office visit based on Time or MDM, document a clinically relevant history and exam, and clearly delineate your medical decision making.
- Include the patient’s name, another unique identifier, such as date of birth and date of service on every page
- Include a provider’s signature dated 180 days or less from the date of service
  - If note is handwritten or dictated/typed — Add a handwritten signature with the provider’s name and credentials. A signature stamp isn’t acceptable.
  - If note is electronic — Authenticate by acceptable electronic signature, such as “completed by/signed by”, and include the provider’s name with credentials and a date/time stamp
- Place the signature at the end of every document — even in an EHR
- Make sure the diagnosis included on your claim is supported by the documentation in the current note — it can’t refer to a previous date of service for clarification

After the visit

When you submit your claim, you must include the most specific ICD-10-CM code(s) for the diagnosis. Multiple diagnosis codes may be required for a single encounter and must be coded to the highest level of specificity. Documentation in the medical record should reflect the same specificity as the ICD-10-CM code on the claim form.

If you’ve assessed a patient for a suspect medical condition and determined the condition is more specific, never existed, no longer exists or doesn’t exist, then a staff member designated on your team can go into Practice Assist and check the box for “Assessed but Unable to Diagnose at this Time.” Include the DOS when that determination was made.

If there’s a question if the more specific diagnosis coded on the claim falls into the same Suspect Category as the suspect medical condition, check the MCAIP Medical Condition Category - ICD-10-CM Crosswalk. Your UnitedHealthcare representative can provide a copy of the Crosswalk and the instructional documents. If the more specific diagnosis falls into the same Suspect Category, you do NOT check the box in Practice Assist.

This guide contains documentation best practices for providers and isn’t intended as coding guidance.

Contact us to learn more. For more information about how our programs can help support your patients who are UnitedHealthcare plan members, please contact your UnitedHealthcare representative. Thank you.

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