AmeriHealth

Clinical documentation improvements and general coding tips: Myocardial infarction

Coding myocardial infarctions (MI) accurately requires the documentation to note the following:

- MI by Type or Unspecified.
- An Acute MI is equal to or less than four weeks old, including transfers to another acute setting or post-acute setting.
- For encounters after the fourth week, the following ICD code is assigned:
  - If care is related to the MI, the appropriate aftercare code (Z-code) is assigned — NOT the MI code.
  - If an old MI or healed MI with no continued symptoms or treatment, then ICD-10 I25.2 OLD MI may be assigned.
  - If a subsequent MI, which equals a new MI occurring within the four-week time frame of the initial MI:
    - Do not assign code I22 for subsequent myocardial infarctions other than type 1 or unspecified.
    - For subsequent type 2 AMI, assign only code I21.A1.
    - For subsequent type 4 or type 5 AMI, assign only code I21. A9.
- Document the date of onset and the location of the MI. Always document to the highest specificity and severity for accurate ICD code assignment.

Note: If a subsequent myocardial infarction of one type occurs within four weeks of a myocardial infarction of a different type, assign the appropriate codes from category I21 to identify each type. Do not assign a code from I22. Codes from category I22 should only be assigned if both the initial and subsequent myocardial infarctions are type 1 or unspecified.

For the accurate reporting of ICD-10-CM diagnosis codes, the documentation should describe the patient's condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter.

References

Red Flags for Myocardial Infarctions Coding and CDI

Mills, Lorie B. Susan Sweeney, Laura Little, Abhinav Goyal. "Red Flags for Myocardial Infarctions Coding and CDI." Journal of AHIMA, no. 7 (Jul-Aug): 54-55.

ICD-10-CM Reference Manual

AmeriHealth coding and documentation education materials are based on current guidelines, are to be used for reference only, and are not intended to replace the authoritative guidance of the ICD-10-CM Official Guidelines for Coding and Reporting as approved by the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), the Centers for Medicare & Medicaid Services (CMS), and the National Center for Health Statistics (NCHS). Clinical and coding decisions are to be made based on the following:

1. *The independent judgment of the treating physician or qualified health care practitioner.*
2. *The best interests of the patient.*
3. *The clinical documentation as contained in the medical record.*