

Clinical documentation improvements and general coding tips: Myocardial infarction

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

- 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.
- Subsequent equals a new MI occurs within the four-week time frame of the initial MI (I22.X).
- Document the date of onset and the location of the MI. Always document to highest specificity and severity for accurate ICD code assignment.

For 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.

Independence Blue Cross 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.*