Documentation and Coding Tips

Acute Myocardial Infarction

Acute myocardial infarction (AMI), also known as a heart attack, is usually an emergent condition treated as an inpatient encounter, with follow-up and ongoing care provided in the physician office. Office chart audits often indicate the myocardial infarction is older than the four-week time frame or there is no documented date when the myocardial infarction occurred, which may lead to incorrect code assignment. Coding acute myocardial infarction is quite complex, please see specific chapter guidelines for appropriate sequencing and proper code selection.

Acute myocardial infarction:

Specified as acute or with a stated duration of 4 weeks (28 days) or less from onset.

Subsequent acute myocardial infarction:

 Patient has a new acute myocardial infarction occurring within 4 weeks (28 days) of a previous acute myocardial infarction.

Old Myocardial Infarction:

After the passage of 4 weeks (28 days) or a healed myocardial infarction, documentation should reflect there
is a past myocardial infarction diagnosed by ECG or other investigation but, currently presenting no
symptoms.

Document the following elements for accurate code assignment of Acute Myocardial Infarction:

- **Date of onset:** Always included the date and if more than one infarction occurs within a 4-week period, include both dates.
- **Type/Subtype:** ST elevation myocardial infarction (STEMI) or non-ST elevation myocardial infarction (NSTEMI), Type 1-5.
- Episode of care: Initial or subsequent.
- Artery/Vessel Location/Site: Left main, left anterior descending, right coronary artery, left circumflex, or anterior/interior wall.
- Underlying cause, if known: Atherosclerosis of the coronary arteries, blood clots, sudden severe stress.
- Workup/treatment plan: List any medications used specifically for AMI, oxygen therapy, referrals, surgical intervention.

Documentation and Coding Examples:

Acute myocardial infarction: Patient suffered a ST elevation acute myocardial infarction involving the right coronary artery 2 weeks ago and presents to the clinic for post-hospital follow-up. The patient reported no chest pain since discharge and was given refill prescriptions for beta-blocker and anti-platelet agent today.

Assign code: I21.11 ST elevation (STEMI) myocardial infarction involving right coronary artery

Rationale: Office visit is within the 4-week (28 days) or less time frame. Provider clearly documents timelines and site.

Old myocardial infarction: Patient presents for a routine check-up following acute myocardial infarction of the left main coronary artery 3 months ago. Patient is asymptomatic and requires no continued care.

Assign code: 125.2 Old myocardial infarction

Rationale: The acute myocardial infarction occurred more than 4-weeks and no longer receiving current care.