Myocardial Infarction
A Quick Reference Guide for Providers

Myocardial infarction (MI), known as "heart attack," is caused by decreased cessation of blood flow to a portion of the myocardium. Myocardial infarction may be "silent" and go undetected, or it could be a catastrophic event leading to hemodynamic deterioration and sudden death. The following may be used as a reference guide for myocardial infarction documentation and coding.

Acute Conditions

Many acute conditions can be life-threatening and require hospital treatment. Carefully review documentation to determine if the patient has already moved from the acute phase of the condition into a chronic phase, or if the condition is no longer active. If it is no longer in the acute phase, assign the appropriate history code (e.g., "chronic," "history of," "late effect," or "residual.")

History Of:

- Diagnoses that have resolved and are no longer being actively treated should be documented as "personal history of" using the appropriate history code
- Documentation and coding guidelines for MI:
  - Document the date of the MI or episode of care (admission and discharge dates)

Coding Tip

Angina and myocardial infarction: If a patient has symptomatic angina and is subsequently diagnosed with an acute MI (AMI), the angina is assumed to be included in the AMI. Therefore, only the AMI is coded.

Documentation Classification

MI is documented and coded based on:

- Site
- Type: 1 (STEMI, NSTEMI), 2 (due to embolisms), 3 (causes death), 4A (due to angioplasty), 4 (due to stent thrombosis), 5 (due to bypass graft)
- Chronology of an AMI

Myocardial Infarction Classification		
Acute MI	(I21.0-) to (I21.3) STEMI of [site] (I21.4) NSTEMI (I21.9) – unspecified site	Initial onset through four weeks (28 days) after the event
Subsequent MI	(I22.-) Subsequent STEMI or NSTEMI. Also document the appropriate (I21.-) Code for the initial MI	Occurring ≤ four weeks (28 days) from initial MI
Old MI	(I25.2) Old MI	> four weeks and no longer needing treatment

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