Rather than falling back on an unspecified code for a myocardial infarction (MI) diagnosis when you don't have enough information, remind your provider to note when the MI happened and where the damage occurred.

When the physician documents these two aspects of the MI, you can easily choose the correct diagnosis code, including the required characters to make the code specific to the patient’s case.

Start With ‘NSTEMI’

Often called a heart attack, myocardial infarction (MI) refers to when the heart's blood supply is cut off, leading to a lack of oxygen that causes muscle death. "ST" refers to a specific portion of an electrocardiogram (ECG). ST elevated away from the baseline suggests a heart attack is occurring (STEMI). But this elevation won't appear on ECGs for more than half of patients experiencing an MI, so the physician will classify them as NSTEMI.

- I21.4, Non-ST elevation (NSTEMI) myocardial infarction
  - Acute subendocardial myocardial infarction
  - Non-Q wave myocardial infarction NOS
  - Nontransmural myocardial infarction NOS

Be sure to note that ICD-10 official guidelines state, "For encounters after the 4 week time frame and the patient is still receiving care related to the myocardial infarction, the appropriate aftercare code should be assigned, rather than a code from category I21."

Documentation: Clear documentation that the patient suffered a non-ST elevation MI (as opposed to STEMI) is crucial for proper coding. Documentation should indicate whether the MI is initial and acute. You’ll code subsequent MIs within 28 days of the original using I22.- (Subsequent ST elevation [STEMI] and non-ST elevation [NSTEMI] myocardial infarction). For old MIs, you’ll use I25.2 (Old myocardial infarction) for healed MIs that no longer require care.

Also take time to read through the official guidelines, and pay close attention to guidelines for diagnoses you code most often. For example, guidelines state, “If NSTEMI evolves to STEMI, assign the STEMI code. If STEMI converts to NSTEMI due to thrombolytic therapy, it is still coded as STEMI.”

Watch Wall and Vessel for STEMI

- I21.0-, ST elevation (STEMI) myocardial infarction of anterior wall
  - I21.01, ST elevation (STEMI) myocardial infarction involving left main coronary artery
  - I21.02, ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery
  - I21.09, ST elevation (STEMI) myocardial infarction involving other coronary artery of anterior wall
- I21.1-, ST elevation (STEMI) myocardial infarction of inferior wall
  - I21.11, ST elevation (STEMI) myocardial infarction involving right coronary artery
  - I21.19, ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall
- I21.2-, ST elevation (STEMI) myocardial infarction of other sites
  - I21.21, ST elevation (STEMI) myocardial infarction involving left circumflex coronary artery
I21.29, ST elevation (STEMI) myocardial infarction involving other sites.
I21.3, ST elevation (STEMI) myocardial infarction of unspecified site.

Get Specific When Coding Sequelae

For myocardial infarction (MI) sequelae, report codes for specific complications and keep in mind the time frames each code set applies to acute myocardial infarctions.

ICD-10-CM Codes

- I23.0, Hemopericardium as current complication following acute myocardial infarction
- I23.3, Rupture of cardiac wall without hemopericardium as current complication following acute myocardial infarction
- I23.6, Thrombosis of atrium, auricular appendage, and ventricle as current complications following acute myocardial infarction
- I23.7, Postinfarction angina
- I23.8, Other current complications following acute myocardial infarction

Sequelae of myocardial infarctions are complications resulting from the myocardial infarction.

ICD-10 offers unique codes for hemopericardium (blood in the pericardial sac), cardiac wall rupture without hemopericardium, cardiac thrombosis, and postinfarction angina.

Documentation: Note that I23.- (Certain current complications following ST elevation [STEMI] and non-ST elevation [NSTEMI] myocardial infarction [within the 28 day period]) applies to current complications within 28 days of the AMI. Providers should be sure to document the date of the AMI.

Coder tips: Both I23.0 and I23.6 have Excludes1 notes pointing you elsewhere for conditions if “not specified as current complication following acute myocardial infarction.” Instead of I23.0, you would use I31.2 (Hemopericardium, not elsewhere classified), and instead of I23.6, you would use I51.3 (Intracardiac thrombosis, not elsewhere classified).

Know Codes for Emergent NSTEMI Intervention

Question: The emergency department sent an AMI patient (NSTEMI) through to the cath lab within minutes of arrival. The cardiologist used right femoral access. He performed selective angiography of the left coronary system and determined intervention was required for severe LAD lesions causing the NSTEMI. There was a 99 percent stenosis after the fourth diagonal. He positioned a balloon in the distal portion of the mid LAD stenosis, inflating and deflating. Angiography showed improvement in the stenosis and allowed sizing for the stent. He repeated balloon inflations and angiography. After several attempts to place the stent, the cardiologist decided to abandon the stenting procedure because of the patient’s advanced age and the state of her vessels. How should I code this case?

Answer: Because the procedure occurred during the acute myocardial infarction, you should report 92941 (Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel).

Append modifier LD (Left anterior descending coronary artery) to 92941 to indicate the vessel involved.

You also may report the diagnostic angiography separately using 93454 (Catheter placement in coronary artery[s] for coronary angiography, including intraprocedural injection[s] for coronary angiography, imaging supervision and interpretation). Append modifier 59 (Distinct procedural service) to 93454 to override the edit with 92941. For those
payers who accept or require it, you may use modifier XU (Unusual non-overlapping service) instead of 59.

**Support for override:** In a case like this where there is no indication of a prior study, CPT® guidelines allow you to report diagnostic angiography at the time of intervention when the physician performs a full diagnostic study and makes the decision to perform the intervention based on the angiography.

The code includes any combination of stenting, atherectomy, and angioplasty, so it’s the only code you need, regardless of whether the cardiologist was able to place the stent.

**ICD-10:** To report the myocardial infarction diagnosis, use I21.4 (Non-ST elevation [NSTEMI] myocardial infarction).

For the stenosis, report a secondary code of I25.10 (Atherosclerotic heart disease of native coronary artery without angina pectoris), assuming there is no specific mention of angina pectoris in the documentation.

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