Codify
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Internal Medicine Coding Alert

Get on the Right Beat in MI Coding

Coding a myocardial infarction (MI) can test your endurance because you often have to go the extra mile to get details needed to select a code and choosing the wrong code can lead to a denial.

The key to success is to make sure your physicians know they must include two W's in the documentation: **When** (the MI occurred) and **Where** (the damage occurred). With that information, you can cross the finish line with the correct diagnosis code, including required fourth and fifth digits.

Typically, you will choose from diagnosis codes 410-414 when reporting an MI-related encounter, with the correct choice hinging on when the MI occurred.

Choose 410 Series for Acute MI

Let's say a patient suffers an MI (commonly known as a heart attack), and your doctor sees the patient in the hospital, the office or another setting during the eight weeks immediately following the MI.

Code the diagnosis using the 410 series (Acute myocardial infarction), with required fourth and fifth digits.

"The doctor will often just write 'MI,'" says **Michele Zimmerman, CPC,** coder at the four-physician Florida Heart and Vascular Associates in Tampa, Fla. "You need to ask the doctor what wall the MI is in."

That information will enable you to pick the correct fourth digit, ranging from 0 (Of anterolateral wall) to 9 (Unspecified site).

Except in unusual circumstances, "an MI should not be coded as 'unspecified,'" says **Carol Sissom, CPC**, formerly a primary-care coding consultant and now business manager of Physiotherapy Associates, a national physical therapy firm, in Indianapolis.

In most cases, you should be able to find the location of the MI in the patient's chart, she says. Look for the results of an electrocardiogram (EKG), a cardiac catheterization or a coronary angioplasty, says **Bruce Rappoport, MD, CPC**, a board-certified internist who works with physicians on compliance, documentation, coding and quality issues for RCH Healthcare Advisors LLC, a Fort Lauderdale, Fla.-based healthcare consulting company.

If you find the location of the MI in the chart, "be sure to confirm that location with the physician to be certain that this applies to the current episode of care," Rappoport says.

You must also use a fifth digit with 410 and this can be confusing. Choose 1 (Initial episode of care) for the period of care immediately following an MI until the patient is discharged from medical care, no matter where the care is provided. For example, if the patient is admitted to a hospital with an MI, then moved to another location for treatment, you should still use 1 as the fifth digit.

"It doesn't matter if the patient is transferred to a different hospital for ongoing care it's still the same episode of care," Rappoport says.

Use 2 (Subsequent episode of care) when the patient is "admitted for further observation, evaluation or treatment for a myocardial infarction that has received initial treatment but is still less than eight weeks old," ICD-9 says.

For example, a patient who went home after having an MI six weeks ago comes back to the hospital for a cardiac

catheterization. The eight-week window is still open, but the initial episode of care ended with the patient's discharge. So you should use 2 as the fifth digit, Rappoport says.

Use 0 (Episode of care unspecified) when you do not have enough information to assign 1 or 2. You should use this digit rarely, because it's important to code to the greatest specificity possible, and you should be able to locate information on when the MI occurred in most cases. Putting all five digits together, you would use 410.31 (Acute myocardial infarction of inferoposterior wall; initial episode of care) for an encounter with a patient who had an MI of the inferoposterior wall three weeks ago and has not been discharged from care. But if the same patient is discharged and then returns for observation or a procedure, you would code the visit as 410.32

Tap 414.8 for Symptoms Post-Eight Weeks

Let's say the patient in the example above comes in for a visit three months after her MI and shows symptoms of continuing coronary artery disease.

You're past the eight-week mark and the patient has not had a second MI, so you can't use the 410 series.

The correct diagnosis is 414.8 (Other specified forms of chronic ischemic heart disease), which ICD-9 describes as including "any condition classifiable to 410 specified as chronic or presenting with symptoms after 8 weeks from date of infarction," Rappoport says

Use 412 for Healed MI

Now, let's say that the same patient has no cardiac symptoms three months after her MI and is returning for a checkup.

"The doctor may put down MI as the diagnosis," Zimmerman says, and that may lead the coder to use the 410 series. "But the patient did not have an MI in the office. This was a follow-up for a previous MI."

Code 412 (Old myocardial infarction) is the correct code for a healed MI or past MI diagnosed using an EKG or other means but presenting no current symptoms, Zimmerman says.

Sometimes the physician will write "history of MI" without noting when the MI occurred, Zimmerman says. When this occurs, be sure to ask the doctor or check the chart for documentation of when the MI occurred because the MI could be just seven weeks old (meaning you would use the 410 series) or could be a much older healed MI fitting the criteria for 412.

You may also use 412 as a secondary diagnosis when the internist sees a patient who had an MI in the past whether it was three months or three years ago for another problem, such as diabetes, where a previous MI may be a factor in treatment.

Differentiate Angina Types

Coders are sometimes confused about what diagnosis to use when a patient comes to the office with severe angina or chest pain but has not had an MI.

Use 413.9 (Angina pectoris) when the patient presents with angina that is stable and responds to treatment. ICD-9 defines angina pectoris as a "severe constricting pain in the chest, often radiating from the precordium to the left shoulder and down the arm, due to ischemia of the heart muscle, usually caused by coronary disease; pain is often precipitated by effort or excitement." Internists often see this form of severe pain in patients but rarely see two others in the same series: angina decubitus (413.0), angina pain that develops when the patient is lying down, or Prinzmetal angina (413.1), a variant associated with unusual EKG manifestations.

When the physician states that the patient presented with "unstable angina," you will not use one of the angina codes in the 413 series but instead will use 411.1 (Intermediate coronary syndrome). The CPT manual describes this as "an intermediate stage between angina of effort and acute myocardial infarction." Sometimes a doctor will write "chest pain"

instead of "unstable angina" in the chart, leading the coder to use 786.50 (Chest pain, unspecified) as the diagnosis, Zimmerman says.

This diagnosis can be problematic if the physician orders cardiac catheterization to diagnose the cause of the unstable angina. Although most payers will cover an EKG with a 786.50 diagnosis, many will not reimburse a cardiac catheterization with this diagnosis, Zimmerman says. If 786.50 is the proper diagnosis for the patient's symptoms, however, the physician should not change the diagnosis for reimbursement reasons, Rappoport says. Instead, the physician should substantiate in the medical record why the cardiac catheterization was necessary.