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Myocardial Infarction (MI)

The level of coding detail required for MI has increased in the ICD-10-CM coding guidelines. It is critical to document the status of the MI as old versus new. Below are details to include in your documentation:

- Identify the number of weeks since the MI occurred.
- Indicate subsequent MI appropriately.
- When a Non-ST segment elevation myocardial infarction (NSTEMI) evolves into a STEMI and when a STEMI converts into an NSTEMI as a result of thrombolytic therapy.
- If a member is:
  - Still receiving MI care, use "aftercare."
  - No longer receiving MI care, use "history of/old."
- An exact site (left main coronary, anterolateral wall or true posterior wall).

To fully understand when to use "history of/old" myocardial infarction codes, take a careful look at the number of weeks listed in the definitions of acute diagnoses to assign the appropriate ICD-10-Code. For example:

- It's important to document the MI as either "history of/old" or "current."
- For an "history of /old" MI, 125.2 should be reported. This code would apply to any MI that occurred more than four weeks before admission.
- If documentation didn’t specify when the MI occurred, a code from the I22 and I21 category would be assigned, indicating the condition as a current.

Acceptable documentation for old MI
60-year-old male following up with a cardiologist. Inferior wall MI one year ago, received thrombolytic therapy. Last EF, last month was 50%.

- **Code: I25.2** – Old myocardial infarction.