Best Practices for ICD-10 Coding and Documenting MI and CVA

- **Active or History of Condition?**
  - **Active**: Medical conditions can occur suddenly and last a short period of time, such as a few days or weeks. An acute condition should be coded when present and actively being treated. Medical record documentation needs to support the active/acute condition.
  - **History of**: Medical conditions that no longer exists or have resolved should not be reported as active. History codes are used to explain a patient's past medical condition that they are no longer receiving active treatment. History of codes is acceptable on any medical record regardless of the reason for visit.

- **Myocardial Infarction (MI)**
  - **Acute Myocardial Infarction**: A new MI is considered acute from onset up to 4 weeks post MI. To report AMI, refer to the following code categories:

Code	Description
I21.0x - I21.2x	•STEMI of X specific site •5th digit identifies site
I21.3	•STEMI myocardial infarction of unspecified site
I21.4	•NSTEMI myocardial infarction •Nontransmural myocardial infarction

STEMI: ST-Elevation Myocardial Infarction

  - **Subsequent Myocardial Infarction**: Acute myocardial infarction occurring within four weeks (28 days) of a previous acute myocardial infarction, regardless of site.

Code	Description
I22.x	•Subsequent myocardial infarction •4th digit identifies location and type

  - **Old Myocardial Infarction**: Reported for any myocardial infarction described as older than four weeks (28 days). Also used for healed myocardial infarction that is observed via clinical testing such as ECG.

Code	Description
I25.2	•Old myocardial infarction

(Over)

- **Cerebral Infarction (CVA)**
  - **Cerebral Infarction, initial care**: An emergent event that requires treatment in an acute care setting.

I63.xx	•4th and 5th digit identify location and cause

  - **Cerebral Infarction, subsequent care**: After discharge from acute care setting, reports of any sequelae related to CVA.

I69.3xx	•5th and 6th digits indentify natue of late effects

  - **Cerebral Infarction and transient ischemic attack, history of**: Personal history of CVA/TIA with no residuals.

Z86.73	•Use in absence of sequelae

- **Medical Record Documentation**
  - Medical record documentation should be detailed and specific to show that the patient's medical conditions being reported are accurate.
  - The diagnosis codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.
  - CMS provides guidelines to help ensure every patient's health record contains quality documentation.

Note: The information provided are guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) that CMS and NCHS provide. Organizations that make up ICD-10-CM include AHA, AHIMA, CMS and NCHS.

If you have any questions regarding appropriate coding and documentation, or would like more education, please contact the Provider Services Helpline at 1-888-991-9023 (Monday to Friday, 9 a.m. to 5:30 p.m.).