

## MYOCARDIAL INFARCTION

*From KFMC's Medical Director: Brian Hunt, M.D.*

Recently we have come across cases where the attending physician has described a myocardial infarction based on a classification system that is becoming much more common. Because of the increase use of this nomenclature I would like to take a few minutes outlining this system.

This system is based on the 2007 joint task force of the European Society of Cardiology, American College of Cardiology, the American Heart Association and the World Health Federation.

This task force outlined a more specific definition of an acute myocardial infarction and went on to develop a classification system outlining the types of myocardial infarctions that can occur.

### **Definition of acute myocardial infarction:**

Clinical event consequent to the death of cardiac myocytes caused by ischemia, resulting from an imbalance between supply and demand

### **Clinical Classification:**

- Type 1  
MI consequent to a pathologic process in the wall of the coronary artery  
(plaque erosion/rupture, fissuring or dissection)
- Type 2  
MI consequent to increased oxygen demand or decreased supply  
(coronary artery spasm, coronary artery embolus, anemia, arrhythmias, hypertension or hypotension)
- Type 3  
Sudden unexpected cardiac death before blood samples for biomarkers could be drawn or before their appearance in the blood
- Type 4a  
MI associated with PCI
- Type 4b  
MI associated with stent thrombosis
- Type 5  
MI associated with coronary artery bypass graft surgery

From a coding perspective there is no real advantage between a type 1 or a type 5 MI. Both result in similar DRG coding. The purpose for this article is to outline some not so new terminology that is becoming more main stream.

## ***Hello to our KFMC Physician Reviewers:***

We would like to provide you with an update of some changes that will be occurring as a result of the Medicare 10<sup>th</sup> Scope of Work (10SOW) contract that began on August 1, 2011.

CMS has determined that, based on contracts the QIO may have with other entities, QIOs may have a potential conflict of interest for a limited number of Medicare review cases. Therefore, KFMC has subcontracted with three other QIOs to process KFMC's conflicted Medicare cases. The subcontractors include Metastar of Wisconsin, CIMRO of Nebraska and Stratis of Minnesota.

KFMC's conflicted Medicare beneficiary complaints, higher weighted DRGs, quality of care reviews, expedited appeals and EMTALA cases will be processed by one of the subcontracted QIOs. You may receive emails, phone calls, and packages of medical records from the staff at the subcontracted QIOs. The 10SOW Physician Review Assessment Form (PRAF) has also been revised however the changes are minimal. The subcontracted QIOs will be creating the determination letter, so please provide rationale that supports your decision for each question asked, to assist them (samples below specific to expedited appeals). KFMC will continue to process your PR timesheets for completed reviews.

The Medicare 10SOW changes also include the formation of a National Coordinating Center (NCC) for Beneficiary and Family Centered Care. The Florida Medical Quality Association, Inc. (FMQAI), the Florida QIO, has been awarded this contract. The NCC will initiate all Medicare review cases, and will also process Medicare re-reviews. Therefore, you may be contacted by the NCC to serve as a PR on KFMC's Medicare re-review cases. This process is under development.

There are many changes with the Medicare 10SOW contract. If you encounter any issues as you are working with the subcontracted QIO's or the NCC, please let us know so we can assist you. If you have any general questions regarding these new processes, please feel free to contact us. We would be happy to provide further explanation.

### **PHYSICIAN REVIEWER Expedited Appeals RATIONALE SAMPLES (specific only to expedited appeals):**

1. The medical record documentation indicated that you were admitted to the skilled nursing facility on August 4, 2011, for rehabilitation following a hospitalization for a small bowel obstruction which required surgery. You have been receiving skilled therapy, and therapy notes indicate that your progress in therapy has plateaued. You have not been participating in all therapy sessions or following recommendations. It appears that at this time skilled nursing services are no longer needed.
2. The medical record documentation indicated that Ms. X was admitted to the hospital following a fall at home resulting in a hematoma on her head and a cervical (neck) fracture. According to physician documentation, her pain has been controlled with oral medications and a soft collar is being worn for the cervical fracture. Nursing staff have indicated that she is tolerating her diet and that her breathing, heart rate, temperature and blood pressure are all within normal expected parameters. The hematoma on her head is still swollen but does not require any further interventions. It appears that at this time acute hospital inpatient care is no longer needed and she could be cared for in a less restrictive environment.
3. The medical record documentation indicated that Ms. X was admitted for rehabilitation following a hospitalization for a fractured hip. She has been receiving therapy services since her arrival to the skilled nursing facility. Therapy notes indicated she walked with a walker 200 feet with standby assistance. She requires assistance with bathing, dressing, and toileting. She has poor recall of safety factors related to her hip precautions. Therapy notes indicated she has reached a plateau as a result of her cognitive issues. It appears that at this time skilled nursing services are no longer needed.

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