**Type 2 Myocardial Infarction**

Detection of a rise and/or fall of cTn values with at least one value above the 99th percentile URL, and evidence of an imbalance between myocardial oxygen supply and demand unrelated to coronary thrombosis, requiring at least one of the following:

* Symptoms of acute myocardial ischemia;
* New ischemic ECG changes;
* Development of pathological Q waves;
* Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality in a pattern consistent with an ischemic etiology.A pathological fracture is a break in a diseased bone due to weakening of the structure by pathologic processes, such as osteoporosis or bone tumors, without any identifiable trauma or following only minor trauma. Only the provider can make the determination that the fracture is out of proportion to the degree of trauma. A pathological fracture is a break in a diseased bone due to weakening of the structure by pathologic processes, such as osteoporosis or bone tumors, without any identifiable trauma or following only minor trauma. Only the provider can make the determination that the fracture is out of proportion to the degree of trauma.

\*\*\*Be sure to include clinical findings and/or opinion in your documentation to support your diagnosis of Type 2 MI in effort to prevent payer denial. Example: “Type II MI as evidenced by elevated troponin and chest pain in the setting of severe anemia.”

**Acute Kidney Failure**

In 2012 the Kidney Disease Improving Global Outcomes (KDIGO) released their clinical practice guidelines for acute kidney injury (AKI), which build off of the RIFLE criteria and the AKIN criteria.

KDIGO defines AKI as any of the following:

* Increase in serum creatinine by 0.3mg/dL or more within 48 hours (prospective measurement) **OR**
* Increase in serum creatinine to 1.5 times baseline or more within the last 7 days **OR**
* Urine output less than 0.5 mL/kg/h for 6 hours

\*\*The serum creatinine increase by greater than 0.3 mg/dL can only be used when measured prospectively, when the baseline has been measured during the preceding 48 hours, or if the patient’s baseline is known from previous records and renal function was considered stable prior to admission.

\*\* If the Cr is elevated on admission, the measurement occurs retrospectively. The diagnosis cannot be made until the downward trend reaches the higher threshold of a difference of greater than or equal to 1.5 times the baseline value.

* Documentation of a recent or baseline Cr can be documented to support the diagnosis of acute renal failure

CDMP

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Please contact Clinical Documentation Specialists for any questions

NAME AND EXTENSION/CELL NUMBER HERE