Codify
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Internal Medicine Coding Alert

ICD-9: Make Valve Coding an Open-and-Shut Case

Coders often have trouble finding the correct diagnosis code for a patient with a heart murmur, but you can quickly pump out the right ICD-9 code if you know three key facts: the origin of the valve disorder, the nature of the problem, and whether more than one valve is involved.

Common valve disorders, often called heart murmurs because of the distinctive sound the patient's heart makes, include stenosis (a narrowing of the valve that interferes with the valve opening) and insufficiency or regurgitation (a problem that results when the valve doesn't close completely).

When coding valve disorders, you should be sure to first check the index of your ICD-9 manual and then read the code descriptions for guidance, including references to other codes, 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.

"The subtext under the headings is very important in coding valve disease," Rappoport says. "It will tell you what is included in and excluded from the code."

Find the Correct Series

The first step in coding a valve disorder is to determine the problem's origin, because that determines which ICD-9 series you use.

"Coders often forget that there are three different code series," Rappoport says.

Use the 393-398 series (Chronic rheumatic heart disease) if the defect resulted from rheumatic fever, an inflammatory disease that begins with a strep throat infection and can cause heart complications. When using these codes, "make certain that the word 'rheumatic' is stated in the documentation," says **Marti Geron, CPC, CMA, CM,** reimbursement manager at the University of Texas Southwestern Medical Center at Dallas.

That said, this rule has an important and confusing variant. Although the ICD-9 manual describes the 393-398 series as being for "chronic rheumatic heart disease," it specifies that you should use 396.x (Diseases of mitral and aortic valves) when the patient has problems with both the mitral and aortic valves "whether specified as rheumatic or not." This may be because physicians once believed that multiple valve problems were predominantly rheumatic in nature, Rappoport says. But today, doctors do see multiple valve problems from other causes. (See more detail on coding multiple valve problems below.)

The other two code series used most often for valve disorders are more straightforward. Use the 746.x series (Other congenital anomalies of heart) if the valve problem is congenital, or dates from birth. Use the 424.x series (Other diseases of endocardium) for heart valve disorders resulting from other causes, such as infection.

Specify the Valve and the Problem

After you select the code series, you should next determine which valve is diseased and what the specific defect is. Remember, as stated above, that if more than one valve is involved, you will not code each valve disorder separately, Rappoport says.

If you can't find information in the patient's chart concerning which valve is involved or on the particular problem with

the valve, you must ask the physician for more information before you can code the encounter. "A lot of times, physicians won't be clear enough," Geron says. "There should be a physician's note specifying the valve and noting if there is stenosis or insufficiency or stenosis with insufficiency."

Here are basic principles for coding disorders of valves:

Mitral valve.

For cases originating from rheumatic disease, choose the 394.x series (Diseases of mitral valve) when the patient's problem involves the mitral valve only. Use 394.0 (Mitral stenosis) when the doctor notes stenosis or an obstruction of the mitral valve, typically a result of childhood rheumatic fever. Use 394.1 (Rheumatic mitral insufficiency) when the doctor notes incompetence or regurgitation of the mitral valve. Sometimes patients have both defects. In that case, use 394.2 (Mitral stenosis with insufficiency). Code 394.9 for other and unspecified mitral defects related to rheumatic disease.

Use 746.5 (Congenital mitral stenosis) and 746.6 (Congenital mitral insufficiency) for defects that date to the patient's birth.

Use 424.0 (Mitral valve disorders) for mitral insufficiency, regurgitation or incompetence not caused by rheumatic fever and not present at birth.

Aortic valve.

When a rheumatic patient has aortic valve defects, use 395.0 (Rheumatic aortic stenosis) for a narrowing or obstruction, 395.1 (Rheumatic aortic insufficiency) for regurgitation or incompetence, and 395.2 (Rheumatic aortic stenosis with insufficiency) when both defects are present. Use 395.9 for other and unspecified aortic defects related to rheumatic disease.

Use 746.3 (Congenital stenosis of aortic valve) and 746.4 (Congenital insufficiency of aortic valve) when the defects date to birth.

Use 424.1 (Aortic valve disorders) for aortic stenosis, insufficiency, regurgitation or incompetence not caused by rheumatic heart disease and not present at birth.

Other valve disorders.

Code tricuspid and pulmonary valve disorders that are rheumatic in origin using the 397 series. Use the 746 series if these valve disorders are congenital, and use the 424 series if they were not present from birth.

Use One Code for Multiple Valve Defects

Sometimes a patient will have stenosis or insufficiency in both the aortic and the mitral valves or stenosis in one and insufficiency in the other. Instead of coding the mitral and aortic valve disorders separately, use the 396 series (Diseases of mitral and aortic valves) and choose the correct fourth digit to describe the particular problem the patient has,

Rappoport says.

For example, a patient presents with chest pain and syncope. The internist does an examination, listens to the heart, performs an echocardiogram and determines that the patient has aortic stenosis with mitral regurgitation. If you simply look in the numerical section of the ICD-9 manual, you'll find aortic stenosis listed at 424.1. If you read the exclusions there or look up the diagnosis in the index, the manual will direct you to 396 for this disorder when combined with a mitral defect. So 396.2 (Mitral valve insufficiency and aortic valve stenosis) is the correct code.

A common mistake in the scenario above is to code only one of the valve problems, but you should always code to the highest specificity, which means coding both, Rappoport says.

Coders sometimes also use two separate codes for the disorder, overlooking 396 because it is under the "chronic rheumatic heart disease" heading. Remember that both the index and the subtext under the headings will direct you to the right code, Rappoport notes.

One other code sometimes used with valve disease is V43.3 (Organ or tissue replaced by other means; heart valve). You will most often use this as a secondary code when a patient who has had a valve replacement comes in for a follow-up visit, Rappoport says.