

Briefings on APCs

Coding Q&A: October 2025

Fontan-associated liver disease

Q: CMS has added an ICD-10-CM code for Fontan-associated liver disease (I27.840). Can you explain when reporting this code is appropriate?

A: The Fontan procedure is used in children who have univentricular hearts. For example, we'll see this in patients who may have hypoplastic left heart syndrome. It is definitely a very complex procedure. But, based off its extensiveness, it can also cause patients to have liver disease, as well as lymphatic dysfunctions, I27.841 (Fontan-associated lymphatic dysfunction).

The Fontan procedure involves diverting the venous blood from the inferior vena cava and the superior vena cava to the pulmonary arteries. It is a very complex procedure that is performed with children with severe congenital anomalies where essentially they kind of have to restructure the heart so that it can act in a different way.

The procedure's ultimate goal is to route oxygen-depleted blood directly to the lungs to receive oxygenation so that it can enter the heart and be pumped out through the body. Typically, that is performed by the right ventricle. Unfortunately, when there are cardiac anomalies, we'll see that that can't happen. In those types of situations, they have to rewire the heart from a vascular standpoint so that they can still get blood to the lungs.

Most patients who have these procedures can live another thirty years or more after surgery.

Editor's note: This information was provided by **Shannon McCall, RHIA, CCS, CCS-P, CPC, CEMC, CRC, CCDS, CCDS-O**, during the webinar, "JustCoding's 2026 ICD-10-CM Updates: What's New to the Mix?"

De Quervain's disease

Q: How is treatment for De Quervain's disease reported?

A: De Quervain's disease, also known as radial styloid tenosynovitis (M65.4), is a painful swelling of the extensor pollicis brevis (EPB) and the abductor pollicis longus (APL) tendons that connect to the thumb.

A common cause of this repetitive use-injury is texting on cell phones. Symptoms include pain and swelling near the base of the thumb and difficulty moving the thumb and wrist to grasp or pinch.

The EPB and APL tendons pass through the first dorsal compartment of the wrist. Many times, the surgeon documents: "release of the first dorsal compartment," or "tenolysis/synovectomy of the APL tendon."

Surgery to treat the condition is a tendon release, reported with CPT code 25000 (Incision, extensor tendon sheath, wrist).

Intersection syndrome (M70.03-), also known as tenosynovitis of the radial wrist extensors, is a chronic overuse disorder that is sometimes confused with De Quervain's, but the anatomy is different.

Intersection syndrome affects the wrist extensor tendons, usually in the first two of the six extensor compartments. The tenosynovial lining around the tendons can become inflamed, causing the tendons to thicken and pain to occur on the back (radial) side of the wrist. Weightlifting, and other athletic activities may trigger the condition.

Surgery in most cases is reported with the "single compartment" CPT code, so it is important to know the extensor tendons being treated and in which compartment they are located, to correctly report the appropriate code. Typically, you will code intersection syndrome with 25118 (Synovectomy, extensor tendon sheath, wrist, single compartment) or, for more extreme cases, radical excision codes 25115 (Radical excision of bursa, synovia of wrist, or forearm tendon sheaths; flexors) or 25116 (Radical excision of bursa, synovia of wrist, or forearm tendon sheaths; extensors, with or without transposition of dorsal retinaculum) may be used.

Editor's note: This question and answer comes from the [2025 Orthopedic Coding & Documentation Trainer](#).

Prolonged services

Q: What prolonged service CPT codes would be used to report this scenario: A new patient was seen in a physician's office for the evaluation and management. The medical decision-making was high. The time spent in the encounter was 106 minutes.

A: You're going to use a different code depending on who's providing it.

If this was provided by a physician, use code 99205 for sixty minutes and +99417 times three for three units of fifteen minutes. That equals 105 minutes. That's as high as you're going to get to the 106 minutes.

On the other hand, if the provider was clinical staff supervised by a qualified healthcare professional, use codes 99203 for 34 minutes and +99415 for the additional 72 minutes. This equals 106 minutes. For the clinical staff, add on code +99415 is used for services lasting 71-115 minutes. You can't report +99416 because that only starts at 116 minutes.

Here's another example: A new patient was seen in the physician's office. The medical decision-making was documented as high. The time spent in the encounter was sixty minutes.

If the provider was a physician, use code 99205 only. This scenario meets the code's requirements of 60 minutes and high medical decision-making for this visit, so no add-on code is needed.

On the other hand, if the provider was clinical staff, use 99202, which is 29 minutes, and +99415 (total time 31 minutes). This equals sixty minutes. Add-on code +99415 is used for 59 to 103 minutes and this time with 60 minutes, so you can use it. You can't use +99416 because that only kicks in after 121 minutes of service.

Editor's note: This information was provided by **Terry Tropin, MSHAI, RHIA, CCS-P**, during HCPro's webinar, "CPT Coding for Outpatient Services: Office Visits, Emergency Department Visits, and Consultations."

These answers were provided based on limited information. Be sure to review all documentation specific to your own individual scenario before determining appropriate code assignment.

"Except where specifically encouraged, no part of this publication may be reproduced, in any form or by any means, without prior written consent of HCPro, or the Copyright Clearance Center at 978-750-8400. Opinions expressed are not necessarily those of RCA. Mention of products and services does not constitute endorsement. Advice given is general, and readers should consult professional counsel for specific legal, ethical, or clinical questions."