



ICD-10 Manifestation and Sequela Diagnosis

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NOTICE

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Blue KC reserves the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to: <https://providers.bluekc.com/ContactUs/PaymentPolicies>.

PROVIDER/ENTITY IMPACTED

<input checked="" type="checkbox"/> PROFESSIONAL	<input checked="" type="checkbox"/> FACILITY	<input type="checkbox"/> DME	<input type="checkbox"/> AMBULATORY SURGERY	<input checked="" type="checkbox"/> LAB	<input type="checkbox"/> OTHER
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LINES OF BUSINESS IMPACTED

<input checked="" type="checkbox"/> COMMERCIAL	<input checked="" type="checkbox"/> BLUE MEDICARE ADVANTAGE	<input checked="" type="checkbox"/> ACA QHP¹	<input checked="" type="checkbox"/> SMALL GROUP ACA	<input checked="" type="checkbox"/> JAA²	<input checked="" type="checkbox"/> FEP³	<input type="checkbox"/> DENTAL
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¹ ACA QHP: Affordable Care Act Qualified Health Plan for Individual/Family ² JAA: Joint Administrative Account ³ FEP: Federal Employee Program

Disclaimer

Blue KC has developed Provider Payment Policies to provide guidance on payment methodologies as they pertain to submitted claims. These policies are written following industry standard recommendations from sources such as:

- Current Procedural Terminology
- Centers for Medicare and Medicaid
- American Medical Association
- National Correct Coding Initiative
- Other professional organizations and societies

Coverage of any service is determined by date of service, a member's eligibility and benefit limits for the service or services rendered, all terms of the Provider Service Agreement, and other standards of coding rules and guidelines.

Final payment is subject to the application of claims adjudication and edits common to the industry.

For confirmation of which services may be eligible for coverage and description of when medical services are considered medically necessary, not medically necessary, or investigational, please contact:

- Blue KC Provider Hotline for Commercial lines of Business 816-395-3929
- Affordable Care Act Provider Hotline 866-859-3822
- Blue Medicare Advantage Provider Hotline 866-508-7140

In the event of a conflict between any policies, the Member's coverage document will govern.

Description/Application

Manifestation ICD-10 codes describe the manifestation of an underlying disease, not the disease itself. Sequela diagnosis has an S as the seventh character and is for complications or conditions that arise as a direct result of

an injury, such as scar formation after a burn. The scars are sequelae of the burn.” In other words, sequela are the late effects of an injury.

Policy

Manifestation

Manifestation codes have a coding convention that requires the underlying condition be sequenced first, if applicable, followed by the manifestation. Wherever such a combination exists, there is a “use additional code” note at the etiology code, and a “code first” note at the manifestation code.

Use the following ICD-10-CM Manual instructions for manifestation codes:

- Do not report a manifestation code as the only diagnosis.
- Do not report a manifestation code as a first listed or principal diagnosis.
- Code the underlying disease first.

Example:

D46.2 - Secondary sideroblastic anemia due to drugs and toxins

(Code first poisoning due to drug or toxin, (T36-T65 with fifth or sixth character 1-4) (T36-T65.94XS)

Sequela

ICD-10-CM says the seventh character S is “for use for complications or conditions that arise as a direct result of an injury, such as scar formation after a burn. The scars are sequelae of the burn.” In other words, sequela are the late effects of an injury.

A late effect can occur only after the acute phase of the injury or illness has passed; therefore, you cannot report a code for the acute illness and a code for the late effect at the same encounter, for the same patient. The only exception occurs if both conditions exist (for example, the patient has a current cerebrovascular condition and deficits from an old cerebrovascular condition).

When reporting sequela(e), you usually will need to report two codes. The first describes the condition or nature of the sequela(e) and second the second describes the sequela(e) or “late effect.” For example, you may report M81.8 Other osteoporosis without current pathological fracture with E64.8 Sequelae of other nutritional deficiencies (calcium deficiency).

According to the ICD-10-CM Manual guidelines, a sequela (7th character “S”) code cannot be listed as the primary, first listed, or principal diagnosis on a claim, nor can it be the only diagnosis on a claim.

Claim lines submitted with a manifestation or sequela ICD-10 CM code submitted as the primary/only diagnosis will be denied.

Coding

N/A

References and Resources

Blue KC Provide Reference Guide

American Medical Association

Centers for Medicare and Medicaid Services

Related Documents

N/A

Revision History

Version	Date	Summary of Revisions
001	3/1/2022	Initial Version
002	4/12/2023	Annual review, there were no changes or updates made to the policy.
003	3/1/2025	Annual review, there were no changes or updates made to the policy.
004	3/1/2026	Annual review, there were no changes or updates made to the policy.