



Evaluation of SF XXXX – Coverage for Bowel and Bladder Management for Spinal Cord Injuries

Report to the Minnesota Legislature Pursuant to Minn. Stat. § 62J.26

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Report Prepared By

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Defrayal analysis completed by the Minnesota Department of Commerce is independent of AIR's evaluation.

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Executive Summary

This proposed mandate would require a health issuer to provide coverage for bowel and bladder management for spinal cord injuries without quantity limits.

Spinal cord injuries can occur at different levels of the spinal cord, resulting in impaired signaling to various areas of the body that can impact an individual's voluntary control of bowel and bladder function. These injuries may result in neurogenic bowel, neurogenic bladder, or urinary tract infections. For individuals with spinal cord injury, bowel and bladder management must be tailored to the specific symptoms experienced. Management often includes daily maintenance supplies such as diapers, wipes and pads, more intensive procedures such as rectal tubes or catheters, or longer-term treatments such as sacral nerve stimulation or biofeedback therapy.

There are no state or federal laws specific to the full spectrum of the proposed coverage for bowel and bladder management for spinal cord injury. However, some of the treatments that are considered to be within the standard of care for this condition are covered by existing state health benefit mandates and current requirements of Minnesota's Essential Health Benefit benchmark plan.

Public Comment respondents provided perspectives that many treatments for bowel and bladder management are already required under current Minnesota policy. Some public comment respondents noted that several plans already cover many treatments for these conditions, but may impose quantity limit requirements. Other respondents shared concern that some of the covered treatments, such as surgery or stimuli implants, are costly and may lead to an increase in premiums for all members.

The literature on treatment for bowel and bladder management for spinal cord injury emphasizes the varying ways that this condition could present depending on the level and severity of spinal cord damage leading to neurogenic bowel, neurogenic bladder or both. Many individuals require daily maintenance treatments such as diapers and catheters, but some may require medications, manual assistance, or more intensive procedures such as sacral nerve stimulation. Neurogenic bowel and/or bladder can significantly impact quality of life for those affected, and appropriate treatment may increase their societal participation, health outcomes, and mental wellbeing.

This mandate is projected to result in a potential net increase of between \$0.01 and \$0.03 per member per month (PMPM) for the total non-public insured population in the first year and a net increase of between \$0.02 and \$0.05 PMPM in Year 10. Due to the broad nature of the mandate, the scope of the actuarial analysis was reduced. As a result, actual costs could be higher.

The potential state fiscal impact of this mandate is as follows:

- Minnesota Management and Budget does not estimate any state fiscal impact to the state plan, as the State Employee Group Insurance Program currently provides coverage in its medical benefit package for various treatments, services, supplies, and equipment for bowel and bladder management under the medical and prescription drug benefit.
- It is unclear if the proposed mandate would be subject to partial defrayal.

- This proposed mandate would apply to Minnesota Health Care Programs (e.g., Medical Assistance and MinnesotaCare), which covers treatments and supplies for bowel and bladder management with quantity restrictions, and may have a potential cost.

Introduction

In accordance with Minn. Stat. § 62J.26, the Minnesota Department of Commerce (Commerce), in consultation with the Minnesota Department of Health (MDH) and Minnesota Management and Budget (MMB), performs an evaluation of benefit mandate proposals. For evaluation criteria and required evaluation components, please review the Evaluation Report Methodology, available at <https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/>.

Bill Requirements

Senate File (SF) XXXX is sponsored by Senator Kari Dziedzic.^a At the time Commerce received the request for evaluation, the bill had not yet been introduced.

If enacted, this bill would require a health issuer to provide coverage for bowel and bladder management for spinal cord injuries, without imposing quantity limits. Additionally, a health issuer would not be able to apply cost-sharing (e.g., deductible, co-insurance, or co-payment) or referral limitations (e.g., utilization review, referral requirement, or delay period) to be more than what is applicable for other coverage items in the plan.

For the purposes of this mandate, “bowel and bladder management for spinal cord injuries” means any treatment, service, supply, or equipment for bowel or bladder management, prescribed for the enrollee by a provider licensed in this state, as the result of a spinal cord injury, including but not limited to over-the-counter medications and supplies prescribed by the provider.

This proposed mandate would apply to fully insured small and large group commercial health plans, individual market plans, the State Employee Group Insurance Program (SEGIP), and Minnesota Health Care Programs (e.g., Medical Assistance and MinnesotaCare). This would not apply to self-insured employer plans, grandfathered plans, and Medicare supplemental policies.

This bill creates Minn. Stat. § 62Q.6661 and amends Minn. Stat. § 256B.0625, by adding a subdivision.

^a Senator Kari Dziedzic passed away on December 27, 2024.

Related Health Conditions

A spinal cord injury is defined as “damage to the bundle of nerves and nerve fibers that send and receive signals from the brain”.¹ The spinal cord originates in the brain and travels down through the lower back, where remaining nerve roots form the cauda equina. Spinal cord injuries are most likely to occur in a motor vehicle accident or a serious fall but may also occur from other factors related to the nervous system (e.g., infection or tumors).¹ Spinal cord injuries can occur at different levels of the spinal cord, resulting in impaired signaling to various areas of the body that can impact an individual’s voluntary control of bowel and bladder function. Individuals with higher-level injuries (e.g., cervical and upper thoracic injuries) typically experience more severe bowel and bladder dysfunction due to greater impairment of the autonomic nervous system, which regulates unconscious bodily functions.² Health conditions associated with bowel and bladder management for spinal cord injury include,^{3,4} but are not limited to:

- Neurogenic bowel, resulting in fecal incontinence and/or constipation;
- Neurogenic bladder, resulting in urinary incontinence, inability to empty the bladder, and/or urinary frequency; and
- Urinary tract infections, which may occur secondary to bowel and bladder dysregulation.

Neurogenic bowel and bladder are often chronic conditions requiring life-long management.²

Associated Services/Treatments

Bowel and bladder management includes services and treatments to help control when an individual urinates or has a bowel movement.⁵ These services and treatments may potentially include medications for bladder spasm, stool softeners or suppository, as well as catheters and rectal tubes. Sacral nerve stimulation, enteric nervous system retraining, and surgery are also potential treatments to manage bowel and bladder function for individuals living with a spinal cord injury.

Related State and Federal Laws

This section provides an overview of state and federal laws related to the proposed mandate and any external factors that provide context on current policy trends related to this topic.

Relevant Federal Laws

There are no federal laws that specifically relate to coverage for bowel and bladder management for individuals with a spinal cord injury. However, Medicare covers some supplies and treatments for bowel and bladder management. Under section 11.08 of the Social Security Act, Medicare provides health insurance and disability benefits for qualified enrollees with spinal cord disorders.⁶ Medicare covers prosthetic devices and durable medical equipment (DME) under section 1861(s)(8) and 1861(s)(6) of the Social Security Act, specifically including bowel and bladder management supplies and equipment.⁷ This can include urological supplies such as intermittent catheters, rectal tubes and inserts, electrical continence aids, ostomy bags, and bed pans.^{8,9}

Covered DME does not include reusable supplies.⁸ Additionally, under section 1834(10)(C) of the Social Security Act, Medicare covers transcutaneous electrical nerve stimulators which provide pelvic floor electrical stimulation for urinary incontinence.^{10,11} This may be a treatment for an individual with a spinal cord injury.

Relevant Minnesota Laws

Medical Assistance and MinnesotaCare currently provide coverage for incontinence products and bowel and urological supplies, which can be used for bowel and bladder management for spinal cord injury.^{12,13} According to Minn. Rule 4685.0700, subsection 3B, all health maintenance organizations must cover DME, prosthetic and orthotic supplies, and nondurable medical equipment that may be used for bowel and bladder management.¹⁴ This coverage allows for quantity restrictions.

During the 2023-24 legislative session, a health benefit mandate was passed requiring commercial health plans to cover up to 180 intermittent catheters per month along with insertion supplies for enrollees if recommended by a health care provider.¹⁵ This mandate was not specific to coverage for individuals with a spinal cord injury.

Minnesota's Essential Health Benefit (EHB) benchmark plan includes coverage for medications that can be used for bowel and bladder management, such as anticoagulants (quantity cap of 7 units) and antispasmodics (quantity cap of 8 units).¹⁶ If enacted, this proposed mandate would remove the current quantity caps and expand coverage to include other over-the-counter and prescription drugs for bowel and bladder management.

State Comparison

No other state legislation was found that specifically addresses coverage for bowel and bladder management for spinal cord injury. However, most state Medicaid programs cover supplies utilized for bowel and bladder management.¹⁷ This coverage is not specific to individuals with a spinal cord injury.

While Medicaid programs cover incontinence supplies (both over-the-counter and prescription) when deemed medically necessary,¹⁷ coverage requirements for incontinence supplies vary by state.¹⁸ While most states provide coverage for enrollees over the age of 21, some states (e.g., Alabama, Georgia, and Louisiana) do not.^{19–21} Incontinence supplies covered by Medicaid programs may include, but are not limited to, over-the-counter products and prescriptions, such as barrier creams, bladder control pads and guards, booster pads, diapers, disposable or protective underwear, disposable wipes, and underpads. Quantity limits vary by state, but in many states qualified enrollees provide an estimated number of supplies needed per day. Medicaid also covers intermittent catheters in at least 17 states, including Minnesota, Colorado, Connecticut, Florida, Georgia, Idaho, Illinois, Massachusetts, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Texas and Washington.^{22–25} Across all of these states, coverage requirements range from 30 to 250 intermittent catheters per month per enrollee.

Public Comments Summary

Commerce solicited public input on the potential health benefit mandate through a request for information (RFI) posted to Commerce’s website and the Minnesota State Register. The summary below represents only the opinions and input of the individuals and/or organizations who responded to the RFI.

Key Stakeholder Comment Themes

For this proposed mandate, Commerce received RFI responses from four commercial health issuers, one health care organization, and three advocacy organizations.

Current Coverage and Quantity Limits. Three respondents noted that some commercial health insurance plans in Minnesota already provide coverage for many types of treatments, services, supplies, and equipment for bowel and bladder management for spinal cord injury, though some plans may apply quantity limits and/or cost-sharing requirements. Some respondents expressed concerns about the lack of quantity limits in the proposed mandate and expressed that the proposed coverage may increase the opportunity for fraud, waste, and abuse. Additionally, some respondents highlighted that any cost increases from the proposed mandate, such as those resulting from coverage for additional supplies and the increased utilization in the absence of quantity limits, may lead to higher premiums for enrollees.

Clarity of Bill Language. Two respondents noted that if the definition of “services” includes surgery or bladder stimuli implants, this mandate has the potential to become very costly and may result in allocating resources to solutions that may prove ineffective.

Overlap with Current Legislation. Another respondent noted that coverage for catheters was mandated in last year’s health benefit mandates, and this proposed mandate may be duplicative with some of the coverage for bowel and bladder management supplies.

General Comments. One respondent highlighted Minnesota’s implementation of [Minn. Stat. § 62M.07](#), effective January 1, 2026, which prohibits prior authorization for certain medical conditions, including outpatient mental health or substance use disorder treatment, antineoplastic cancer treatment per National Comprehensive Cancer Network® guidelines (excluding medications), preventive services, pediatric hospice care, neonatal abstinence program treatment by pediatric pain or palliative care specialists, and ongoing chronic condition treatment. The respondent suggested that many of this year’s proposed benefit mandates fall under this new statute and expressed concerns that removing prior authorization could increase health care costs and negatively affect health outcomes for Minnesotans.

Another respondent noted that all of the proposed health benefit mandates have the potential to broadly improve health outcomes for Minnesotans by enhancing their quality of life, supporting individuals, families, and caregivers, and increasing workforce participation, while also benefiting the broader health care system.

Cost Estimates Provided in Stakeholder Comments

Stakeholders and MMB provided the following cost estimates related to the proposed health benefit mandate:

- MMB does not estimate any state fiscal impact to the state plan, as SEGIP currently provides coverage for various treatments, services, supplies, and equipment for bowel and bladder management under the medical and prescription drug benefit (see State Fiscal Impact section).
- Respondents indicated that some commercial health insurance plans in Minnesota currently provide coverage for many bowel and bladder management services at various quantity limits and with cost-sharing. If enacted, respondents indicated that this expanded coverage may result in an estimated cost increase of up to \$0.10 per member per month (PMPM).

Cost estimates shared in RFI responses may reflect different methodologies, data sources, and assumptions than those used in the actuarial analysis for this evaluation. Stakeholders' results may or may not reflect generalizable estimates for the mandate.

Evaluation of Proposed Health Benefit Mandate

Methodology

The following section includes an overview of the literature review and actuarial analysis performed to examine the potential public health and economic impact of the mandate. The literature review includes moderate- to high-quality relevant peer-reviewed literature and/or independently conducted research with domestic data that was published within the last 10 years and is related to the public health, economic, or legal impact of the proposed health benefit mandate. For further information on the literature review methodology, please reference <https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/>.

Public Health Impact

Literature Review

Spinal cord injuries are a multi-dimensional disorder stemming from direct or indirect spinal cord damage, often caused by acute trauma such as motor vehicle crashes.¹ It is estimated that spinal cord injuries affect approximately 18,000 new individuals each year in the United States²⁶ and that nearly 11,000 Minnesotans are living with some level of paralysis from a spinal cord injury, as of 2018.²⁷ Spinal cord injuries can occur at different levels of the spinal cord, resulting in impaired neural signaling throughout the body. Spinal cord injuries often cause disruption in bowel and bladder function. The two most common bowel and bladder related outcomes are neurogenic bowel and neurogenic bladder, which impact control of bowel function and urination, respectively. Often these two conditions co-occur, causing simultaneous issues with both bowel and bladder function.²⁸

Neurogenic Bowel. Neurogenic bowel dysfunction is caused by an injury to the nervous system that results in a loss of normal bowel function.^{2,29} There are two common presentations of neurogenic bowel depending on where on the spinal cord the injury takes place. Spastic bowel occurs when an individual cannot voluntarily relax the sphincter, meaning that an individual cannot control when a bowel movement occurs. This can result in

unplanned bowel movements. Flaccid bowel is the second most common form of neurogenic bowel, which results in reduced movement in the colon leading to increased constipation and stool leakage.

Standards of Care for Neurogenic Bowel. Based on the current standards of care, there are a range of interventions that may be used to manage neurogenic bowel. Treatment often consists of daily disposable supplies, which may include diapers, wipes, pads, liners and protective underwear, all of which can be used to manage involuntary bowel movements.¹² If an individual suffers from constipation, manual bowel evacuation techniques may be needed.³⁰ Oral medications, such as laxatives can be used to assist in manual bowel evacuation and to maintain stool consistency to prevent constipation.²⁶ Other treatments may be used less frequently to aid in the management of bowel dysfunction, such as rectal tubes and irrigation supplies.¹²

Alternative treatments such as sacral nerve stimulation and biofeedback offer alternative methods to restoring some control over bowel and bladder function, especially when conventional methods are insufficient.^{11,28} Sacral nerve stimulation treatment requires a neurostimulator to be implanted near the sacral nerves in the lower back. The implanted device helps override incorrect neural signals being received by the bowel which helps improve both bladder emptying and bowel function.^{11,31} Biofeedback therapy has been shown to help some patients regain partial control over their bowel movements by allowing the patient to learn how to target activating specific pelvic floor muscles so that they function more effectively.²⁸ Additionally, modifying dietary habits to ensure the correct intake of fiber and liquids has been shown to improve incontinence in patients with a spinal cord injury.² Physical activity has been shown to offer many benefits to those with a spinal cord injury including improving regular bowel movements for those with constipation.³² Recommended care plans include, but are not limited to, scheduled daily bowel care, oral medications to improve the consistency of stool, fluid and fiber intake recommendations, as well as physical activity when tolerated.²⁶

Neurogenic Bladder. Neurogenic bladder is caused by nerve damage, which affects the normal function of the bladder. Similar to neurogenic bowel, this condition presents in two ways: bladder overactivity (spastic) or inability to empty completely (flaccid).³³ According to one study, approximately 77% of patients with a spinal cord injury cannot urinate voluntarily and may require assistance via treatment.³⁴

Standards of Care for Neurogenic Bladder. The most common treatment for neurogenic bladder is through the use of catheters to aid in bladder evacuation, which can include intermittent catheterization, indwelling, or external catheters.³⁴ Intermittent catheterization is most frequently used to address bladder management among patients with a spinal cord injury.³⁴ Intermittent catheters are used for a wide variety of conditions associated with urinary retention, where obstruction of structures for urination or interference with the nerves and muscles used for urination may occur.⁷ Complications due to unmanaged urinary retention include urinary tract infections (UTIs) as well as damage to the bladder and kidneys. Kidney damage associated with urinary retention can lead to chronic kidney disease and failure.⁷

While intermittent catheters can mitigate the negative effects of urinary retention, their use is not without risk. Intermittent catheters can introduce bacteria into the urinary tract and cause infection, and the insertion of the catheter itself can damage the urinary tract.⁷ The most common reasons for emergency department visits and hospitalizations related to intermittent catheters are UTI, blood in urine (hematuria), and sepsis/bacteremia.⁸ UTI is the most common complication due to intermittent catheter use.⁹ The risks associated with UTI, however,

are multifactorial and vary by condition.¹⁰ The CDC recommends frequent changing of intermittent catheters to avoid complications, such as UTIs or overdistention of the bladder.⁷ Frequent changing and certain catheter features, such as hydrophilic coating, are recommended for reducing the risk of UTI.⁹ Individuals with a spinal cord injury are likely to use sterile kit catheters due to the potential for a backflow of urine and resulting complications.⁷ Comfort and ease of use are considered critical factors for compliance with intermittent catheterization.^{7,11} The frequency of intermittent catheter use varies by condition, though those with a spinal cord injury likely require lifelong use. Studies have found that between 16% and 56% of individuals living with a spinal cord injury use intermittent catheters, depending on age and severity.⁹

Aside from catheters, there are other treatments available for neurogenic bladder. These treatments include oral medications to manage bladder pressure by blocking chemicals received by the brain that trigger bladder contractions.³⁴ Addressing incontinence and bladder emptying may also include catheter drainage bags as well as disposable items including diapers, pads, liners, and wipes.⁹ In 90% of patients with neurogenic bladder, the combination of oral medication and intermittent catheter use is sufficient to preserve bladder function.³⁴ As with neurogenic bowel, sacral nerve stimulation and biofeedback may offer alternative treatment options in restoring some control over bladder function.^{11,28}

Common Spinal Cord Injury Comorbidities. Individuals with a spinal cord injury often experience comorbidities such as chronic pain, cardiovascular problems, and depression, which further complicate the management of bowel and bladder dysfunction by requiring additional chronic disease maintenance.³⁵ These individuals may also face significant mental health challenges due to the stigma of incontinence and the ongoing burden of care.³⁶ Maintenance or treatment of bowel and bladder dysfunction may allow individuals to focus on improving other areas of their physical and mental health through exercise, social activities, and diet.

Health Equity. Certain populations face inequities related to bowel and bladder dysfunction secondary to spinal cord injury. For example, Minnesotans with disabilities are more than two times as likely to live in poverty as those without a disability, and 2.6 times more likely to be unemployed.³⁷ Additionally, Black non-Hispanic men have higher rates of spinal cord injury compared to other populations, and may face disparities in care, such as less frequent receipt of evidence-based acute care (e.g., decompressive surgery).³⁸ Patients in rural or underserved urban areas often face difficulties in obtaining timely care or the resources necessary for managing neurogenic bowel and bladder dysfunction, which may compound the impact of limited coverage for required interventions for management.³⁹ A study by the Mayo Clinic found that adults with a spinal cord injury who are insured through Medicare have “significantly higher prevalence of and risk for developing common psychological, cardio metabolic, and musculoskeletal morbidities, compared with privately insured adults”.³⁶ The proposed mandate may address inequities faced by unserved populations for spinal cord injury-associated bowel and bladder dysfunction.

Economic Impact

Actuarial Analysis^b

Objective

This actuarial analysis includes an assessment of the current prevalence of diagnoses, current levels of utilization, and potential effects of increased utilization with expanded coverage on cost-sharing, premiums, and overall expenditures. Due to the broad nature of the mandate, the scope of the actuarial analysis was reduced to focus on treatment and supplies most commonly referenced in the literature for treatment of bowel and bladder dysfunction. As a result, actual costs could be higher.

Assumptions and Approach

MDH provided the Actuarial Research Corporation with tabulations from the Minnesota All Payer Claims Database (MN APCD) from 2018-2022 that included the following: all spinal cord injury diagnoses, co-occurring bowel and bladder dysfunction diagnoses and claims for associated bowel and bladder management supplies, procedures and medications (see [Appendix C](#)), expenditures, and enrollee cost-sharing for bowel and bladder management and treatment for Minnesota commercial health plan enrollees.⁴⁰ Bowel and bladder dysfunction diagnoses and claims for associated bowel and bladder management treatment and supplies codes provided a snapshot of current prevalence, medication, and procedure utilization.

The following criteria were used by MDH to identify commercial enrollees with a spinal cord injury diagnosis, a co-occurring bowel and bladder management diagnosis and claims for associated drugs and/or procedures:

- Enrollees were identified as having a spinal cord injury diagnosis if they had one of the spinal cord injury International Classification of Diseases, Tenth Revision (ICD-10) diagnosis codes in [Appendix C](#).
- Enrollees were identified as having a co-occurring bowel and bladder management diagnosis if they had one of the bowel and bladder management ICD-10 diagnosis codes in [Appendix C](#).
- The Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) procedure codes in [Appendix C](#) were used to identify procedures associated with bowel and bladder management and treatment.

Not all commercial insurance plans are required to provide data to the MN APCD,⁴¹ and this proposed mandate would only apply to certain plans. As such, the insurance plans impacted by the proposed mandate may not perfectly align with those represented in the MN APCD. However, claims that are not captured in the MN APCD largely represent health plans that are not subject to the requirements of the state health benefit mandate and

^b Michael Sandler and Anthony Simms are actuaries for Actuarial Research Corporation (ARC). They are members of the American Academy of Actuaries and meet the qualification standards of the American Academy of Actuaries to render the actuarial opinions contained herein.

are not in the scope of the evaluation. All available non-public claims data from the MN APCD were used to improve the robustness and accuracy of PMPM estimates.

Developing the methodology and related assumptions for the data collection and analysis for this proposed mandate was complex, given the current gaps in coverage for certain bowel and bladder management supplies and low levels of co-occurring diagnoses and utilization under current law. There was a limited population sample available in the MN APCD for commercial claims, as many individuals with a spinal cord injury are covered by Medicare and Minnesota Health Care Programs.⁴² With limited data, this actuarial estimate relied on the most robust and accessible metrics available at the time of analysis.

In addition to the tabulations indicated above, MDH tabulated the utilization and expenditures for bowel and bladder management and the equipment/supplies and medications for all commercially insured Minnesotans included in the MN APCD. For the historical period 2018–2022, as tabulated by MDH, the proportion of enrollees with a spinal cord injury diagnosis was fairly stable, in the range of 0.032% to 0.039%. The proportion of these enrollees with a co-occurring bowel and bladder dysfunction diagnosis ranged from 19% to 26% among the full commercial population in the MN APCD (which, per MDH, includes approximately 40% of the total commercial market in Minnesota).⁴³ Additionally, among those with a spinal cord injury and a co-occurring bowel and bladder dysfunction diagnosis, the proportion of enrollees identified by MDH as utilizing bowel and bladder management treatment and services ranged from 15% to 18%. These latter two figures, the proportion of enrollees with a co-occurring bowel and bladder dysfunction diagnosis and proportion of those enrollees' utilization of bowel and bladder management treatment and services, are lower than the proportion of all enrollees with a spinal cord injury who also receive bowel and bladder dysfunction-related treatment in the literature. A recent study referenced a wide range of reported prevalence of bowel and bladder dysfunction for individuals with a spinal cord injury varying from 13% to 90%, with the published values for bladder incontinence ranging from 33% to 74%.⁴⁴ While no data is available to identify and track existing coverage levels for bowel and bladder management treatment, it is possible that the level of coverage could be a catalyst for formal diagnosis. Expanded coverage for the management and treatment of bowel and bladder dysfunction may lead to an increase in bowel and bladder dysfunction diagnosis among individuals with a spinal cord injury given the gaps in current coverage.

For the purposes of this analysis, spinal cord injury prevalence, co-occurring bowel and bladder dysfunction prevalence and total expenditures for bowel and bladder management treatment were projected based on current law and for three scenarios based on different assumptions. The per-user expenditure rates for each of the three categories were trended forward to the projection period of 2026–2035 using category-specific projection factors derived from the National Health Expenditure data compiled by the Centers for Medicare & Medicaid Services (CMS)⁶ as well as the 2024 Medicare Trustees Report.⁴⁵ The specific assumptions used for each scenario are as follows:

- The current law scenario assumes a constant 0.035% spinal cord injury prevalence, a 25% co-occurring bowel and bladder dysfunction prevalence in the base year with a 4% annual increase and, among enrollees with a co-occurring bowel and bladder dysfunction diagnosis, a constant 17% utilization rate for bowel and bladder management and treatment.

- The low-impact scenario, like the current law scenario, assumes a constant 0.035% spinal cord injury prevalence; it also assumes a 30% co-occurring bowel and bladder dysfunction prevalence in the base year with a 2% annual increase and, among enrollees with a co-occurring bowel and bladder dysfunction diagnosis, a 60% utilization rate for bowel and bladder management and treatment in the base year, with a 1% annual increase.
- The moderate-impact scenario, like the current law scenario, assumes a constant 0.035% spinal cord injury prevalence; it also assumes a 55% co-occurring bowel and bladder dysfunction prevalence in the base year with a 2% annual increase and, among enrollees with a co-occurring bowel and bladder dysfunction diagnosis, a 70% utilization rate for bowel and bladder management and treatment in the base year, with a 1% annual increase.
- The high-impact scenario, like the current law scenario, assumes a constant 0.035% spinal cord injury prevalence; it also assumes an 80% co-occurring bowel and bladder dysfunction prevalence in the base year with a 2% annual increase and, among enrollees with a co-occurring bowel and bladder dysfunction diagnosis, an 80% utilization rate for bowel and bladder management and treatment in the base year, with a 1% annual increase.

The actual population impacted by the proposed mandate is unknown. While certain plans may not be impacted directly by the proposed mandate, individuals within those plans may be impacted by broader changes to insurance design in response to the mandate. Therefore, results for prevalence, utilization, and expenditures were scaled to the entire non-publicly insured market in Minnesota for illustrative purposes. This does not affect PMPM estimates, which are based on prevalence and per-user expenditure rates. The overall Minnesota population projections for 2026 (the base year) through 2035 are based on the figures published by the Minnesota State Demographic Center.⁴⁶ Given the historic non-public health insurance coverage levels from Minnesota Public Health Data Access, 65% of the total state population under the age of 65 was assumed to be included in the non-public insured population.⁴⁷

Results

This analysis projects spinal cord injury and co-occurring bowel and bladder dysfunction diagnoses prevalence in Minnesota for the total non-public insured population in addition to current law utilization and expenditures for the management and treatment of bowel and bladder dysfunction. The analysis then projects potential utilization and total expenditures under the mandate's expanded coverage.

Table 1 shows the total projected spinal cord injury and co-occurring bowel and bladder dysfunction prevalence, alongside projected current law utilization and expenditures based on historic claims.

Table 2 shows the total projected spinal cord injury and co-occurring bowel and bladder dysfunction prevalence, projected utilization and expenditures, and net projected effect on the total non-public insured population PMPM under the low-impact scenario assumption set.

Table 3 shows the total projected spinal cord injury and co-occurring bowel and bladder dysfunction prevalence, projected utilization and expenditures, and net projected effect on the total non-public insured population PMPM under the moderate-impact scenario assumption set.

Table 4 shows the total projected spinal cord injury and co-occurring bowel and bladder dysfunction prevalence, projected utilization and expenditures, and net projected effect on the total non-public insured population PMPM under the high-impact scenario assumption set.

Table 1. Total Projected Current Law Spinal Cord Injury and Co-Occurring Bowel and Bladder Dysfunction Prevalence and Expenditures^c

Year	Population		Spinal cord injury and co-occurring bowel/bladder dysfunction prevalence		Enrollees with a spinal cord injury utilizing...	Current law expenditures	
	Total Minnesota population	Non-public insured population	Enrollees with a spinal cord injury diagnosis	Enrollees with co-occurring bowel/bladder dysfunction diagnosis	Bowel and bladder management and treatment	Plan paid	Cost-sharing
2026	5,830,008	3,067,013	1,073	302	51	\$43,974	\$7,456
2027	5,854,785	3,064,627	1,073	314	53	\$48,714	\$8,260
2028	5,878,663	3,070,240	1,075	327	56	\$52,937	\$8,976
2029	5,901,603	3,075,295	1,076	340	58	\$59,282	\$10,051
2030	5,923,535	3,079,734	1,078	355	60	\$65,446	\$11,097
2031	5,944,374	3,083,514	1,079	369	63	\$72,373	\$12,271
2032	5,964,016	3,086,623	1,080	384	65	\$80,392	\$13,631
2033	5,982,648	3,095,934	1,084	401	68	\$90,401	\$15,328
2034	6,000,234	3,104,721	1,087	418	71	\$101,638	\$17,233
2035	6,016,749	3,112,910	1,090	436	74	\$114,248	\$19,371

^c The state health benefit mandates generally only apply to fully insured individual and small group health plans regulated in Minnesota, except where explicitly indicated. Prevalence, utilization, and expenditures were scaled to the entire non-publicly insured market in Minnesota for illustrative purposes. This does not impact PMPM estimates. For more details, see the *Assumptions and Approach* section.

Table 2. Total Projected Spinal Cord Injury and Co-Occurring Bowel and Bladder Dysfunction Prevalence and Expenditures and Total Non-Public Insured PMPM, Low Impact^d

Year	Population		Spinal cord injury and co-occurring bowel/bladder dysfunction prevalence		Enrollees with a spinal cord injury utilizing...	Projected expenditures		Total non-public insured PMPM change
	Total Minnesota population	Non-public insured population	Enrollees with a spinal cord injury diagnosis	Enrollees with co-occurring bowel/bladder dysfunction diagnosis	Bowel and bladder management and treatment	Plan paid	Cost-sharing	
2026	5,830,008	3,067,013	1,073	366	224	\$324,256	\$62,866	\$0.01
2027	5,854,785	3,064,627	1,073	380	234	\$361,003	\$69,991	\$0.01
2028	5,878,663	3,070,240	1,075	395	245	\$393,402	\$76,272	\$0.01
2029	5,901,603	3,075,295	1,076	409	255	\$440,891	\$85,479	\$0.01
2030	5,923,535	3,079,734	1,078	423	265	\$486,216	\$94,267	\$0.01
2031	5,944,374	3,083,514	1,079	437	275	\$536,180	\$103,953	\$0.01
2032	5,964,016	3,086,623	1,080	450	285	\$592,994	\$114,968	\$0.01
2033	5,982,648	3,095,934	1,084	464	296	\$662,946	\$128,531	\$0.02
2034	6,000,234	3,104,721	1,087	478	307	\$740,008	\$143,471	\$0.02
2035	6,016,749	3,112,910	1,090	491	317	\$824,811	\$159,912	\$0.02

^d The state health benefit mandates generally only apply to fully insured individual and small group health plans regulated in Minnesota, except where explicitly indicated. Prevalence, utilization, and expenditures were scaled to the entire non-publicly insured market in Minnesota for illustrative purposes. This does not impact PMPM estimates. For more details, see the *Assumptions and Approach* section.

Table 3. Total Projected Spinal Cord Injury and Co-Occurring Bowel and Bladder Dysfunction Prevalence and Expenditures and Total Non-Public Insured PMPM, Moderate Impact^e

Year	Population		Spinal cord injury and co-occurring bowel/bladder dysfunction prevalence		Enrollees with a spinal cord injury utilizing...	Projected expenditures		Total non-public insured PMPM change
	Total Minnesota population	Non-public insured population	Enrollees with a spinal cord injury diagnosis	Enrollees with co-occurring bowel/bladder dysfunction diagnosis	Bowel and bladder management and treatment	Plan paid	Cost-sharing	
2026	5,830,008	3,067,013	1,073	619	439	\$634,774	\$123,069	\$0.02
2027	5,854,785	3,064,627	1,073	627	447	\$688,896	\$133,562	\$0.02
2028	5,878,663	3,070,240	1,075	637	456	\$733,006	\$142,114	\$0.02
2029	5,901,603	3,075,295	1,076	647	464	\$803,296	\$155,741	\$0.02
2030	5,923,535	3,079,734	1,078	657	473	\$867,429	\$168,175	\$0.02
2031	5,944,374	3,083,514	1,079	666	482	\$937,793	\$181,817	\$0.02
2032	5,964,016	3,086,623	1,080	675	490	\$1,017,942	\$197,356	\$0.03
2033	5,982,648	3,095,934	1,084	685	499	\$1,118,075	\$216,770	\$0.03
2034	6,000,234	3,104,721	1,087	695	508	\$1,227,316	\$237,949	\$0.03
2035	6,016,749	3,112,910	1,090	705	517	\$1,346,407	\$261,039	\$0.03

^e The state health benefit mandates generally only apply to fully insured individual and small group health plans regulated in Minnesota, except where explicitly indicated. Prevalence, utilization, and expenditures were scaled to the entire non-publicly insured market in Minnesota for illustrative purposes. This does not impact PMPM estimates. For more details, see the *Assumptions and Approach* section.

Table 4. Total Projected Spinal Cord Injury and Co-Occurring Bowel and Bladder Dysfunction Prevalence and Expenditures and Total Non-Public Insured PMPM, High Impact^f

Year	Population		Spinal cord injury and co-occurring bowel/bladder dysfunction prevalence		Enrollees with a spinal cord injury utilizing...	Projected expenditures		Total non-public insured PMPM change
	Total Minnesota population	Non-public insured population	Enrollees with a spinal cord injury diagnosis	Enrollees with co-occurring bowel/bladder dysfunction diagnosis	Bowel and bladder management and treatment	Plan paid	Cost-sharing	
2026	5,830,008	3,067,013	1,073	871	702	\$1,016,220	\$197,022	\$0.03
2027	5,854,785	3,064,627	1,073	875	707	\$1,090,086	\$211,343	\$0.03
2028	5,878,663	3,070,240	1,075	880	713	\$1,146,916	\$222,362	\$0.03
2029	5,901,603	3,075,295	1,076	886	719	\$1,243,329	\$241,054	\$0.03
2030	5,923,535	3,079,734	1,078	891	725	\$1,328,590	\$257,584	\$0.03
2031	5,944,374	3,083,514	1,079	896	730	\$1,421,881	\$275,671	\$0.02
2032	5,964,016	3,086,623	1,080	900	736	\$1,528,355	\$296,314	\$0.04
2033	5,982,648	3,095,934	1,084	907	743	\$1,662,860	\$322,392	\$0.04
2034	6,000,234	3,104,721	1,087	913	749	\$1,808,659	\$350,659	\$0.05
2035	6,016,749	3,112,910	1,090	919	756	\$1,966,613	\$381,283	\$0.05

^f The state health benefit mandates generally only apply to fully insured individual and small group health plans regulated in Minnesota, except where explicitly indicated. Prevalence, utilization, and expenditures were scaled to the entire non-publicly insured market in Minnesota for illustrative purposes. This does not impact PMPM estimates. For more details, see the *Assumptions and Approach* section.

The total statewide non-public insured population potential plan paid expenditures for the management and treatment of spinal cord injury-associated bowel and bladder dysfunction are projected to be between \$324,000 (low-impact scenario) and \$1.0 million (high-impact scenario) in Year 1 and to increase to between \$825,000 (low-impact scenario) and \$2.0 million (high-impact scenario) in the 10th and final year of the projection period. These expenditures are projected to result in a net increase of between \$0.01 PMPM under the low-impact assumption set and \$0.03 PMPM under the high-impact assumption set for the total non-public insured population in the first year and to result in a net increase of between \$0.02 PMPM and \$0.05 PMPM in Year 10.

Data Sources

- Minnesota state population projections are from the “Long-Term Population Projections for Minnesota” published by the Minnesota State Demographic Center.⁴⁶
- Minnesota non-public health insurance coverage levels are from Minnesota Public Health Data Access.⁴⁸
- Trends and projection factors are derived from the National Health Expenditure data compiled by CMS as well as the 2024 Medicare Trustees Report.⁴⁵
- MDH tabulations of the MN APCD from 2018 to 2022 were used to estimate the prevalence of spinal cord injury diagnosis and co-occurring bladder and bowel dysfunction and historical utilization, expenditures, and enrollee cost-sharing for procedures related to bowel and bladder management and treatment.⁴⁹

Literature Review

A more comprehensive actuarial analysis and modeling of all services related to and associated with bowel and bladder dysfunction for individuals with a spinal cord injury, including downstream effects, and a full picture of what current coverage and expenditures are for Minnesota were not possible with the available data. A literature review was conducted to assess the broader environment of coverage, utilization, and expenditures and to assess potential long-term savings and improved health outcomes.

Cost and Utilization of Bowel and Bladder Management. The costs of managing bowel and bladder dysfunction for individuals with spinal cord injury include medical supplies (e.g., catheters and absorbent products), medications, and ongoing health care visits.³⁹ Some treatments, like intermittent catheterization, disposable supplies and medications, incur recurring annual costs, while surgical treatments may involve a significant one-time expense but reduce the need for ongoing management.³¹ A review article found that routine maintenance costs varied depending on the services required, but annual costs ranged from approximately \$2,000 to \$12,000, with lifetime costs averaging over \$100,000.⁵⁰ More invasive treatment options, such as sacral nerve stimulation, can cost over \$20,000.⁵¹ Though this cost is significantly higher than the average cost of a hospital stay for a UTI, more invasive treatments can be long lasting and provide quality of life benefits.⁵² The trend in utilization of more invasive treatments, with or without coverage, cannot be assessed from the current body of literature.

Secondary Cost Implications for Proposed Coverage. The proposed coverage may reduce expenditures on secondary health effects related to management of bowel and bladder dysfunction and associated

comorbidities. It is estimated that the lifetime cost of treating spinal cord injuries, including costs related to bowel and bladder dysfunction, is between \$1.2M and \$5.1M.³⁹ This estimate excludes indirect costs associated with lost wages, benefits and productivity. Compared with average adults, individuals with a spinal cord injury experience twice as many hospitalizations, which are typically due to secondary health concerns.³⁹

Approximately 30% of patients with a spinal cord injury are readmitted to the hospital every year.⁵³ The most common reason for readmission is genitourinary infection (23.5% to 29.8%), which is also the fifth-most common cause of death among these patients. Bowel dysfunction has the highest reported incidence, between 20% and 60%, and is the ninth most common reason for readmission. Within the first year of having a spinal cord injury, UTIs are the primary reasons for rehospitalization.³⁹ While appropriate management of bowel and bladder dysfunction may reduce the incidence of UTI, the degree to which access and degree of coverage impacts these health outcomes is unclear.

A study of the health care burden associated with UTI among individuals with a spinal cord injury found that, among other factors, having noncommercial insurance increased the odds of getting a UTI within 2 years.⁵⁴ The study also cited a cross-sectional survey of patients with neurogenic bladder due to a spinal cord injury. The survey found comparable symptoms by insurance type, but its authors noted that noncommercial insurance was associated with a higher incidence of “frequent” (four or more) UTIs per year than commercial insurance: 30.4% versus 24.5%. It is unclear from these findings whether other health and/or socioeconomic barriers, quality of care received, or population differences may account for the higher rates of UTI in the noncommercially insured population.

Limitations

There is a lack of comprehensive data in the current literature on the long-term impact of managing bowel and bladder dysfunction for individuals with a spinal cord injury, meaning that the benefits from coverage provided by the proposed mandate will likely vary by individual. While various treatment options, including medications, intermittent catheterization, and surgical interventions are available, the effectiveness and long-term benefits of these treatments can depend on their injury and bowel and bladder dysfunction severity. The complex and multifactorial nature of bowel and bladder dysfunction in spinal cord injury, involving factors such as diet, fluid intake, routine bowel evacuation, and comorbidities further complicates the development of standardized care plans and assessment for the specific impacts of the proposed coverage.

The correlation between the severity of neurogenic bladder and neurogenic bowel suggests that patients with more severe bladder dysfunction may experience worse bowel dysfunction, yet the degree to which this affects potential utilization of services is difficult to assess from the existing literature. While studies indicate that medical costs associated with spinal cord injuries are high, particularly in relation to hospitalizations due to secondary health issues like UTIs, there is insufficient data on the cost-effectiveness of various treatment strategies for bowel and bladder dysfunction. Overall, the scientific literature reviewed in this report indicates that the added coverage will, on average, improve quality of life for those with a spinal cord injury, though the magnitude of the public health and economic impact is difficult to estimate from the information currently available.

State Fiscal Impact

The potential state fiscal impact of this proposed mandate includes the estimated cost to SEGIP as assessed by MMB in consultation with health plan administrators, the cost of defrayal of benefit mandates as understood under the Patient Protection and Affordable Care Act (ACA), and the potential impact to Minnesota Health Care Programs.

- This proposed mandate is estimated to have no fiscal impact on SEGIP.
- It is unclear if the proposed mandate would be subject to partial defrayal.
- This proposed mandate would apply to Minnesota Health Care Programs (e.g., Medical Assistance and MinnesotaCare) and may have a cost.

Fiscal Impact Estimate for SEGIP

MMB does not estimate any state fiscal impact to the state plan, as SEGIP currently provides coverage in its medical benefit package for various treatments, services, supplies, and equipment for bowel and bladder management under the medical and prescription drug benefit. MMB assumes the proposed mandate would require removing all quantity limits for bowel and bladder management under the Advantage Plan. While a quantity limit exists for one prescription drug class, it is rarely reached, and MMB expects removing it would have no fiscal impact on the plan.

Patient Protection and Affordable Care Act Mandate Impact and Analysis

States may require qualified health plan issuers to cover benefits in addition to the 10 EHBs defined by the ACA but must defray the costs, either through payments to individual enrollees or directly to issuers, and can partially defray the costs of proposed mandates if some of the care, treatment, or services are already covered in the state's benchmark plan or mandated by federal law, pursuant to section 1311(d)(3)(b) of the ACA. For further defrayal requirements and methodology, please visit <https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/>.

If enacted, it is unclear if SF XXXX would constitute an additional benefit mandate requiring partial defrayal, relating to any new requirements for specific care, treatment, or services that are not already covered by Minnesota's EHB benchmark plan. Given the broad range of applicable services and conditions potentially covered by the proposed mandate, and overlap with existing coverage requirements in the Minnesota EHB benchmark plan,¹⁶ it cannot be determined if any of the services required by the proposed mandate would require defrayal.

Fiscal Impact of State Public Programs

This proposed mandate would apply to Minnesota Health Care Programs (e.g., Medical Assistance and MinnesotaCare) and may have a cost. Supplies for bowel and bladder management are generally covered by Minnesota Health Care Programs.¹² Medical Assistance does not have any cost-sharing and MinnesotaCare has \$0 copays for DME. There is a possibility that the proposed health benefit mandate may increase costs due to

prohibition on quantity limits or the possibility of coverage for new treatments. However, a fiscal estimate has not yet been completed.

Appendix A. Bill Text

Section 1. [62Q.6661] COVERAGE OF BOWEL AND BLADDER MANAGEMENT FOR SPINAL CORD INJURIES.

Subdivision 1. **Definition.** For the purposes of this section, "bowel and bladder management for spinal cord injuries" means any treatment, service, supply, or equipment for bowel or bladder management, prescribed for the insured by a provider licensed in this state, as the result of a spinal cord injury, including but not limited to over-the-counter medications and supplies prescribed by the provider.

Subd. 2. **Required coverage.** All health plans must cover bowel and bladder management for spinal cord injuries.

Subd. 3. **Cost-sharing requirements.** A health plan must not impose on the coverage under this section any cost-sharing requirement that is not generally applicable to other coverages under the plan, including but not limited to the following requirements:

- (1) deductible;
- (2) co-payment; or
- (3) coinsurance.

Subd. 4. **Review and referral limitations.** A health plan must not impose on the coverage under this section any review or referral limitation that is not generally applicable to other coverages under the plan, including but not limited to the following limitations:

- (1) utilization review, as defined in section 62M.02;
- (2) referral requirement; or
- (3) delay period.

Subd. 5. **Quantity limitations.** A health plan must not impose on the coverage under this section any quantity limitation.

Subd. 6. **Reimbursement.**

(a) The commissioner of commerce must reimburse health plan companies for coverage under this section, as required by Code of Federal Regulations, title 45, section 155.170. Reimbursement is available only for coverage that would not have been provided by the health plan without the requirements of this section. Treatments, services, supplies, and equipment covered by the health plan as of January 1, 2025, are ineligible for payments under this subdivision by the commissioner of commerce.

(b) Health plan companies must report to the commissioner of commerce quantified costs attributable to the additional benefit under this section in a format developed by the commissioner. A health plan's coverage as of January 1, 2025, must be used by the health plan company as the basis for determining whether coverage would not have been provided by the health plan for purposes of this subdivision.

(c) The commissioner of commerce must evaluate submissions and make payments to health plan companies as provided in Code of Federal Regulations, title 45, section 155.170.

Subd. 7. **Appropriation.** Each fiscal year, an amount necessary to make payments to health plan companies to defray the cost of providing coverage under this section is appropriated to the commissioner of commerce.

EFFECTIVE DATE. This section is effective January 1, 2026, and applies to all health plans offered, issued, or sold on or after that date.

Sec. 2. Minnesota Statutes 2024, section 256B.0625, is amended by adding a subdivision to read:

Subd. 77. Bowel and bladder management for spinal cord injuries.

(a) Medical assistance covers bowel and bladder management for spinal cord injuries, as defined in section 62Q.6661.

(b) Medical assistance must meet the requirements that would otherwise apply to a health plan under section 62Q.6661, except that medical assistance is not required to comply with any provision of section 62Q.6661 if compliance with the provision would prevent the state from receiving federal financial participation for the coverage under this subdivision.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 3. **DEFRAYAL OF COSTS FOR MANDATED COVERAGE OF BOWEL AND BLADDER MANAGEMENT FOR SPINAL CORD INJURIES.**

(a) \$..... in fiscal year 2027 and \$..... in fiscal year 2028 are appropriated from the general fund to the commissioner of commerce for the estimated amount of defrayal costs for mandated coverage of bowel and bladder management for spinal cord injuries.

(b) \$..... in fiscal year 2027 and \$..... in fiscal year 2028 are appropriated from the general fund to the commissioner of commerce for administrative costs to implement mandated coverage of bowel and bladder management for spinal cord injuries.

Appendix B. Key Search Terms for Literature Scan

Alpha blockers	Neurogenic bladder
Biofeedback	Neurogenic bowel
Bladder	Oxybutynin
Bladder spasm	Quality of life
Bowel	Rectal tube
Cauda equina	Sacral nerve stimulation
Cystectomy	Sphincterotomy
Enema	Spinal cord injury
Enteric system	Stool softeners
Enterocystoplasty	Suppository
Fecal incontinence	Urinary catheter
Home care	Urinary incontinence
Indwelling catheter	Urinary tract infection

Appendix C. Associated Codes

Spinal Cord Injury Diagnosis Codes

Name	Code
OTH INCPL LESION AT C3 LEVEL CERV SPINAL CORD	S14.153
BROWN-SEQUARD SYND T1 LEVL THOR SPINAL CORD SEQ	S24.141S
OTH INCPL LESION AT C7 LEVEL CERV SPINAL CORD	S14.157
UNS INJURY AT C1 LEVEL CERV SPINAL CORD SEQUELA	S14.101S
UNS INJURY L5 LEVL LUMB SP CORD SUBSEQUENT ENC	S34.105D
COMPLETE LESION L1 LEVEL LUMBAR SPINAL CORD SEQ	S34.111S
COMPLETE LESION SACRAL SPINAL CORD INITIAL ENC	S34.131A
CNTRL CORD SYND AT C3 LEVL CERV SP CORD INIT ENC	S14.123A
COMPLETE LESION AT C4 LEVEL CERVICAL SPINAL CORD	S14.114
BROWN-SEQUARD SYND AT C2 LEVEL CERV SPINAL CORD	S14.142
OTH INCPL LES AT C3 LEVL CERV SP CORD INIT ENC	S14.153A
OTH INCPL LESION AT C4 LEVEL CERV SPINAL CORD	S14.154
ANT CORD SYND T11-T12 LEVEL THOR SPINAL CORD SEQ	S24.134S
UNS INJURY AT C1 LEVEL CERV SPINAL CORD INIT ENC	S14.101A
UNS INJURY L4 LEVEL LUMBAR SPINAL CORD	S34.104
UNS INJURY L2 LEVEL LUMBAR SPINAL CORD SEQUELA	S34.102S
COMPLETE LESION AT C5 LEVEL CERV SPINAL CORD SEQ	S14.115S
OTH INCPL LES AT UNS LEVEL CERV SPINAL CORD SEQ	S14.159S
COMPLETE LESION AT C6 LEVEL CERVICAL SPINAL CORD	S14.116
CMPL LESION L3 LEVEL LUMBAR SPINAL CORD INIT ENC	S34.113A
ANT CORD SYND AT UNS LEVEL CERV SPINAL CORD SEQ	S14.139S
BRWN-SEQUARD SYND UNS LVL THOR SPINAL CORD INIT	S24.149A
CNTRL CORD SYNDROME AT C5 LEVEL CERV SPINAL CORD	S14.125
CNTRL CORD SYND AT C1 LEVEL CERV SPINAL CORD SEQ	S14.121S
UNS INJURY AT T2-T6 LEVL THOR SPINAL CORD INIT	S24.102A
OTH INCPL LES AT C1 LEVL CERV SP CORD SUBSQT ENC	S14.151D
ANT CORD SYND AT T1 LEVL THOR SPINAL CORD SUB	S24.131D
UNS INJURY L2 LEVEL LUMBAR SPINAL CORD	S34.102
INCOMPLETE LESION OF SACRAL SPINAL CORD	S34.132
CNTRL CORD SYND AT C5 LEVL CERV SP CORD INIT ENC	S14.125A
UNS INJURY L4 LEVEL LUMBAR SPINAL CORD INIT ENC	S34.104A
OTHER & UNS INJURY LUMBAR & SACRAL SPINAL CORD	S34.1
BROWN-SEQUARD SYND AT T2-T6 LVL THOR SPINAL CORD	S24.142
ANT CORD SYND AT C2 LEVEL CERV SPINAL CORD SEQ	S14.132S
BROWN-SEQUARD SYND AT C5 LEVEL CERV SPINAL CORD	S14.145
BROWN-SEQUARD SYND AT C7 LVL CERV SP CRD SUB ENC	S14.147D

INCMPL LES L2 LEVEL LUMBAR SPINAL CORD INIT ENC	S34.122A
COMPLETE LESION AT C6 LEVEL CERV SPINAL CORD SEQ	S14.116S
CMPL LESION AT C1 LEVL CERV SPINAL CORD INIT ENC	S14.111A
UNS INJURY AT T11-T12 LEVL THOR SPINAL CORD INIT	S24.104A
BROWN-SEQUARD SYND AT C8 LVL CERV SP CRD SUB ENC	S14.148D
UNS INJURY AT T1 LEVEL THOR SPINAL CORD SEQUELA	S24.101S
COMPLETE LESION UNS LEVEL LUMBAR SPINAL CORD SEQ	S34.119S
UNS INJURY AT C2 LEVL CERV SPINAL CORD SUB ENC	S14.102D
COMPLETE LESION L2 LEVEL OF LUMBAR SPINAL CORD	S34.112
BROWN-SEQUARD SYND AT C5 LVL CERV SP CRD SUB ENC	S14.145D
OTH INCPL LES AT T11-T12 LVL THOR SPINL CRD SUB	S24.154D
BRWN-SEQUARD SYND UNS LVL THOR SPINAL CORD SUB	S24.149D
BRWN-SEQUARD SYND AT C6 LVL CERV SP CRD INIT ENC	S14.146A
OTH INCPL LESION AT C7 LEVL CERV SPINAL CORD SEQ	S14.157S
ANT CORD SYNDROME AT C7 LEVEL CERV SPINAL CORD	S14.137
INCOMPLETE LESION OF SACRAL SPINAL CORD SEQUELA	S34.132S
BRWN-SEQUARD SYND T2-6 LVL THOR SPINAL CORD SUB	S24.142D
OTH INCPL LESION AT C1 LEVEL CERV SPINAL CORD SEQ	S14.151S
ANT CORD SYND AT C1 LEVL CERV SP CORD SUBSQT ENC	S14.131D
ANT CORD SYND AT C7 LEVL CERV SP CORD SUBSQT ENC	S14.137D
UNS INJURY AT C4 LEVEL CERVICAL SPINAL CORD	S14.104
CMPL LES L5 LEVL LUMB SPINAL CORD SUBSEQUENT ENC	S34.115D
ANT CORD SYND AT C7 LEVEL CERV SP CORD INIT ENC	S14.137A
COMPLETE LESION L4 LEVEL OF LUMBAR SPINAL CORD	S34.114
ANT CORD SYND AT C4 LEVL CERV SP CORD INIT ENC	S14.134A
OTH INCPL LESION AT UNS LEVEL THOR SPINAL CORD	S24.159
COMPLETE LESION T2-T6 LEVEL THOR SPINAL CORD SEQ	S24.112S
INCOMPLETE LESION L5 LEVEL OF LUMBAR SPINAL CORD	S34.125
COMPLETE LESION AT C8 LEVEL CERVICAL SPINAL CORD	S14.118
BROWN-SEQUARD SYND AT C3 LVL CERV SP CRD SUB ENC	S14.143D
INCOMPLETE LESION L3 LEVEL OF LUMBAR SPINAL CORD	S34.123
BROWN-SEQUARD SYND AT C8 LEVEL CERV SPINAL CORD	S14.148
ANT CORD SYND AT C5 LEVEL CERV SP CORD INIT ENC	S14.135A
UNS INJURY AT C4 LEVL CERV SPINAL CORD SUB ENC	S14.104D
CONCUSSION & EDEMA OF LUMBAR SPINAL CORD	S34.01
COMPLETE LESION SAC SPINAL CORD SUBSEQUENT ENC	S34.131D
OTH INCPL LESION AT C8 LEVL CERV SPINAL CORD SEQ	S14.158S
ANT CORD SYND AT C8 LEVEL CERV SPINAL CORD SEQ	S14.138S
OTH INCPL LES AT C2 LEVL CERV SP CORD SUBSQT ENC	S14.152D
BRWN-SEQUARD SYND AT C3 LVL CERV SP CRD INIT ENC	S14.143A
INCMPL LES L2 LEVEL LUMB SP CORD SUBSEQUENT ENC	S34.122D
OTHER INCOMPLETE LESIONS OF CERVICAL SPINAL CORD	S14.15
INJURY OF CAUDA EQUINA INITIAL ENCOUNTER	S34.3XXA

BRWN-SEQUARD SYND AT C8 LVL CERV SP CRD INIT ENC	S14.148A
INCMPL LESION L3 LEVEL LUMBAR SPINAL CORD SEQUA	S34.123S
UNSPECIFIED INJURY TO SACRAL SPINAL CORD	S34.139
OTH INCPL LESION AT C8 LEVEL CERV SPINAL CORD	S14.158
CONCUSSION & EDEMA THORACIC SPINAL CORD SEQUELA	S24.0XXS
BROWN-SEQUARD SYND AT UNS LEVEL THOR SPINAL CORD	S24.149
ANT CORD SYND AT C2 LEVEL CERV SP CORD INIT ENC	S14.132A
CNTRL CORD SYND AT C1 LEVEL CERV SP CORD INIT ENC	S14.121A
BRWN-SEQUARD SYND T7-10 LVL THOR SPINAL CORD SUB	S24.143D
INCOMPLETE LESION UNS LEVEL LUMBAR SPINAL CORD	S34.129
CNTRL CORD SYND AT C6 LEVEL CERV SP CORD SUB ENC	S14.126D
UNS INJURY L1 LEVEL LUMBAR SPINAL CORD SEQUELA	S34.101S
UNS INJURY AT C3 LEVEL CERV SPINAL CORD INIT ENC	S14.103A
OTH INCPL LES AT C7 LEVEL CERV SP CORD SUBSQT ENC	S14.157D
COMPLETE LESION AT C3 LEVEL CERVICAL SPINAL CORD	S14.113
ANT CORD SYND AT C6 LEVEL CERV SP CORD SUBSQT ENC	S14.136D
INCMPL LESION L4 LEVEL LUMBAR SPINAL CORD SEQUA	S34.124S
CMPL LESION L2 LEVEL LUMBAR SPINAL CORD INIT ENC	S34.112A
UNS INJURY AT C7 LEVEL CERVICAL SPINAL CORD	S14.107
UNS INJURY L1 LEVEL LUMB SP CORD SUBSEQUENT ENC	S34.101D
UNS INJURY UNS LEVEL LUMBAR SPINAL CORD SEQUELA	S34.109S
CNTRL CORD SYND AT C2 LEVEL CERV SP CORD INIT ENC	S14.122A
OTH INCOMPL LESION T1 LEVEL THOR SPINAL CORD INIT	S24.151A
INCMPL LES UNS LEVEL LUMBAR SPINAL CORD INIT ENC	S34.129A
CONCUSSION & EDEMA LUMBAR & SACRAL SPINAL CORD	S34.0
UNS INJURY SACRAL SPINAL CORD INITIAL ENCOUNTER	S34.139A
CNTRL CORD SYNDROME AT C2 LEVEL CERV SPINAL CORD	S14.122
CNTRL CORD SYND AT C6 LEVEL CERV SPINAL CORD SEQ	S14.126S
UNS INJURY AT UNS LEVEL CERV SPINAL CORD INIT ENC	S14.109A
OTH INCPL LESION AT C3 LEVEL CERV SPINAL CORD SEQ	S14.153S
INCMPL LES L3 LEVEL LUMBAR SPINAL CORD INIT ENC	S34.123A
OTH INCPL LES AT T11-T12 LVL THOR SPINAL CRD INIT	S24.154A
ANT CORD SYND AT T1 LEVEL THOR SPINAL CORD SEQ	S24.131S
UNS INJURY AT C8 LEVEL CERVICAL SPINAL CORD	S14.108
COMPLETE LESION AT T7-T10 LEVEL THOR SPINAL CORD	S24.113
BROWN-SEQUARD SYNDROME OF THORACIC SPINAL CORD	S24.14
ANT CORD SYND AT C3 LEVEL CERV SPINAL CORD SEQ	S14.133S
INCMPL LESION SACRAL SPINAL CORD SUBSEQUENT ENC	S34.132D
CNTRL CORD SYND AT C7 LEVEL CERV SP CORD INIT ENC	S14.127A
CMPL LES L3 LEVEL LUMB SPINAL CORD SUBSEQUENT ENC	S34.113D
CNTRL CORD SYND AT C8 LEVEL CERV SP CORD INIT ENC	S14.128A
BRWN-SEQUARD SYND AT UNS LVL CERV SP CRD INIT ENC	S14.149A
BRWN-SEQUARD SYND AT C5 LVL CERV SP CRD INIT ENC	S14.145A

UNS INJURY L3 LEVEL LUMBAR SPINAL CORD INIT ENC	S34.103A
INCMPL LESION L1 LEVEL LUMBAR SPINAL CORD SEQUA	S34.121S
OTHER INCOMPLETE LESIONS OF THORACIC SPINAL CORD	S24.15
UNS INJURY L3 LEVL LUMB SP CORD SUBSEQUENT ENC	S34.103D
CNTRL CORD SYND AT C4 LEVEL CERV SP CORD SUB ENC	S14.124D
ANT CORD SYND AT C8 LEVL CERV SP CORD SUBSQT ENC	S14.138D
CMPL LESION UNS LEVEL CERV SPINAL CORD INIT ENC	S14.119A
OTH INCPL LES UNS LEVL THOR SPINAL CORD SEQ	S24.159S
CONCUSS & EDEMA CERVICAL SPINAL CORD SEQUELA	S14.0XXS
UNS INJURY AT C5 LEVEL CERV SPINAL CORD SEQUELA	S14.105S
CNTRL CORD SYND AT UNS LEVEL CERV SP CORD SUB ENC	S14.129D
INCOMPLETE LESION L4 LEVEL OF LUMBAR SPINAL CORD	S34.124
COMPLETE LESION OF SACRAL SPINAL CORD	S34.131
ANT CORD SYNDROME AT C5 LEVEL CERV SPINAL CORD	S14.135
CONCUSS & EDEMA OF SACRAL SPINAL CORD SEQUELA	S34.02XS
CNTRL CORD SYNDROME AT C3 LEVEL CERV SPINAL CORD	S14.123
UNS INJURY AT T7-T10 LEVEL THOR SPINAL CORD SEQ	S24.103S
COMPLETE LESION L3 LEVEL OF LUMBAR SPINAL CORD	S34.113
CNTRL CORD SYND AT C8 LEVEL CERV SPINAL CORD SEQ	S14.128S
OTH INCPL LES AT C4 LEVL CERV SP CORD SUBSQT ENC	S14.154D
ANT CORD SYNDROME AT C8 LEVEL CERV SPINAL CORD	S14.138
CMPL LESION AT C5 LEVL CERV SPINAL CORD INIT ENC	S14.115A
BROWN-SEQUARD SYND AT UNS LEVEL CERV SP CORD SEQ	S14.149S
COMPLETE LESION AT T1 LEVEL THORACIC SPINAL CORD	S24.111
CNTRL CORD SYND AT C2 LEVEL CERV SPINAL CORD SEQ	S14.122S
OTH INCPL LES AT T7-10 LEVL THOR SPINAL CORD SEQ	S24.153S
ANT CORD SYND AT C5 LEVL CERV SP CORD SUBSQT ENC	S14.135D
ANT CORD SYND AT C4 LEVEL CERV SPINAL CORD SEQ	S14.134S
ANT CORD SYND AT C5 LEVEL CERV SPINAL CORD SEQ	S14.135S
CMPL LESION AT C2 LEVL CERV SPINAL CORD SUB ENC	S14.112D
CNTRL CORD SYND AT UNS LEVEL CERV SPINAL CORD	S14.129
UNS INJURY AT C8 LEVEL CERV SPINAL CORD INIT ENC	S14.108A
COMPLETE LESION UNS LEVEL THOR SPINAL CORD INIT	S24.119A
UNS INJURY UNS LEVL LUMB SP CORD SUBSEQUENT ENC	S34.109D
COMPLETE LESION T2-T6 LEVL THOR SPINAL CORD INIT	S24.112A
ANT CORD SYND AT C3 LEVL CERV SP CORD SUBSQT ENC	S14.133D
COMPLETE LESION AT C1 LEVEL CERVICAL SPINAL CORD	S14.111
INCMPL LES L3 LEVL LUMB SP CORD SUBSEQUENT ENC	S34.123D
BROWN-SEQUARD SYND AT C1 LVL CERV SP CRD SUB ENC	S14.141D
OTH INCOMPL LESION T7-T10 LEVL THOR SPINAL CORD	S24.153
CNTRL CORD SYNDROME AT C4 LEVEL CERV SPINAL CORD	S14.124
OTH INCPL LES AT T7-10 LEVL THOR SPINL CORD INIT	S24.153A
BRWN-SEQUARD SYND T2-6 LVL THOR SPINAL CORD INT	S24.142A

INCMPL LES L4 LEVEL LUMBAR SPINAL CORD INIT ENC	S34.124A
UNS INJURY AT C4 LEVEL CERV SPINAL CORD INIT ENC	S14.104A
COMPLETE LESION L1 LEVEL OF LUMBAR SPINAL CORD	S34.111
COMPLETE LESION AT C7 LEVEL CERVICAL SPINAL CORD	S14.117
UNS INJURY AT T11-T12 LEVL THOR SPINAL CORD SUB	S24.104D
ANT CRD SYND AT T7-T10 LVL THOR SPINAL CORD INIT	S24.133A
INJURY OF CAUDA EQUINA SUBSEQUENT ENCOUNTER	S34.3XXD
ANTERIOR CORD SYNDROME OF CERVICAL SPINAL CORD	S14.13
CNTRL CORD SYND C5 LEVEL CERV SPINAL CORD SEQ	S14.125S
COMPLETE LESION L3 LEVEL LUMBAR SPINAL CORD SEQ	S34.113S
OTH INCPL LESION AT C5 LEVEL CERV SPINAL CORD	S14.155
CNTRL CORD SYND AT C7 LEVEL CERV SP CORD SUB ENC	S14.127D
INCMPL LES L1 LEVEL LUMBAR SPINAL CORD INIT ENC	S34.121A
CONCUSSION AND EDEMA OF THORACIC SPINAL CORD	S24.0
OTH INCPL LES AT C5 LEVL CERV SP CORD INIT ENC	S14.155A
OTH INCPL LESION AT C5 LEVL CERV SPINAL CORD SEQ	S14.155S
UNS INJURY SACRAL SPINAL CORD SUBSEQUENT ENCNTNTR	S34.139D
OTH INCPL LES AT C8 LEVL CERV SP CORD INIT ENC	S14.158A
OTH INCOMPL LESION T2-T6 LEVEL THOR SPINAL CORD	S24.152
UNS INJURY AT T11-T12 LEVEL THOR SPINAL CORD SEQ	S24.104S
ANT CORD SYND AT UNS LEVEL THOR SPINAL CORD SEQ	S24.139S
ANT CORD SYND AT C6 LEVEL CERV SPINAL CORD SEQ	S14.136S
BROWN-SEQUARD SYND AT C4 LEVEL CERV SP CORD SEQ	S14.144S
CMPL LESION AT C1 LEVL CERV SPINAL CORD SUB ENC	S14.111D
CONCUSSION AND EDEMA OF CERVICAL SPINAL CORD	S14.0
ANT CRD SYND T11-T12 LVL THOR SPINAL CORD INIT	S24.134A
OTH INCPL LESION T2-T6 LEVL THOR SPINAL CORD SEQ	S24.152S
UNSPECIFIED INJURY TO SACRAL SPINAL CORD SEQUELA	S34.139S
CNTRL CORD SYNDROME AT C7 LEVEL CERV SPINAL CORD	S14.127
CMPL LES L1 LEVL LUMB SPINAL CORD SUBSEQUENT ENC	S34.111D
CNTRL CORD SYND AT C1 LEVEL CERV SP CORD SUB ENC	S14.121D
BROWN-SEQUARD SYND AT C1 LEVEL CERV SPINAL CORD	S14.141
ANT CORD SYNDROME AT UNS LEVEL CERV SPINAL CORD	S14.139
ANT CORD SYND AT C2 LEVL CERV SP CORD SUBSQT ENC	S14.132D
COMPLETE LESION AT UNS LEVL THOR SPINAL CORD SEQ	S24.119S
ANT CORD SYND A UNS LEVEL CERV SP CORD SUBSQT ENC	S14.139D
COMPLETE LESION T11-T12 LVL THOR SPINAL CORD SEQ	S24.114S
COMPLETE LESION UNS LEVEL THORACIC SPINAL CORD	S24.119
INCMPL LESION UNS LEVEL LUMBAR SPINAL CORD SEQ	S34.129S
OTH INCPL LES AT T11-T12 LEVEL THOR SPINAL CORD	S24.154
COMPLETE LESION T11-T12 LEVEL THOR SP CORD INIT	S24.114A
ANTERIOR CORD SYNDROME OF THORACIC SPINAL CORD	S24.13
UNS INJURY AT C6 LEVL CERV SPINAL CORD SUB ENC	S14.106D

CNTRL CORD SYND AT C2 LEVEL CERV SP CORD SUB ENC	S14.122D
UNS INJURY AT UNS LEVL THOR SPINAL CORD SUB ENC	S24.109D
COMPLETE LESION OF CERVICAL SPINAL CORD	S14.11
CNTRL CORD SYND AT C5 LEVEL CERV SP CORD SUB ENC	S14.125D
ANT CORD SYND AT C7 LEVEL CERV SPINAL CORD SEQ	S14.137S
CONCUSS & EDEMA CERVICAL SPINAL CORD SUBSQT ENC	S14.0XXD
ANT CRD SYND AT T11-T12 LVL THOR SPINAL CORD SUB	S24.134D
CMPL LESION AT UNS LEVL CERV SPINAL CORD SUB ENC	S14.119D
UNSPECIFIED INJURY L1 LEVEL LUMBAR SPINAL CORD	S34.101
CNTRL CORD SYNDROME AT C8 LEVEL CERV SPINAL CORD	S14.128
INCMPL LESION L2 LEVEL LUMBAR SPINAL CORD SEQUA	S34.122S
UNS INJURY UNSPECIFIED LEVEL LUMBAR SPINAL CORD	S34.109
BROWN-SEQUARD SYND AT T1 LEVEL THOR SPINAL CORD	S24.141
CNTRL CORD SYND AT C8 LEVEL CERV SP CORD SUB ENC	S14.128D
UNS INJURY AT C1 LEVEL CERVICAL SPINAL CORD	S14.101
UNS INJURY AT T1 LEVEL THOR SPINAL CORD INIT ENC	S24.101A
ANT CORD SYND AT T7-T10 LEVEL THOR SPINAL CORD	S24.133
UNS INJURY AT C2 LEVEL CERVICAL SPINAL CORD	S14.102
UNS INJURY L3 LEVEL LUMBAR SPINAL CORD SEQUELA	S34.103S
CONCUSS & EDEMA OF SACRAL SPINAL CORD	S34.02
OTH INCPL LES AT UNS LEVL CERV SP CORD SUB ENC	S14.159D
COMPLETE LESION L4 OF LUMBAR SPINAL CORD SEQUELA	S34.114S
COMPLETE LESION AT C3 LEVEL CERV SPINAL CORD SEQ	S14.113S
UNS INJURY AT UNS LEVEL CERVICAL SPINAL CORD	S14.109
CNTRL CORD SYND AT UNS LEVL CERV SPINAL CORD SEQ	S14.129S
OTH INCPL LES AT C3 LEVL CERV SP CORD SUBSQT ENC	S14.153D
CMPL LESION A C2 LEVEL CERV SPINAL CORD INIT ENC	S14.112A
UNSPECIFIED INJURY TO LUMBAR SPINAL CORD	S34.10
CONCUSSION & EDEMA THORACIC SPINAL CORD SUBSQT	S24.0XXD
UNS INJURY L5 LEVEL LUMBAR SPINAL CORD	S34.105
ANT CORD SYND AT UNS LEVEL THOR SPINAL CORD SUB	S24.139D
ANT CORD SYND AT T2-T6 LEVL THOR SPINAL CORD SEQ	S24.132S
UNS INJURY AT C1 LEVL CERV SPINAL CORD SUB ENC	S14.101D
UNS INJURY AT C2 LEVEL CERV SPINAL CORD INIT ENC	S14.102A
CNTRL CORD SYND AT C4 LEVL CERV SP CORD INIT ENC	S14.124A
OTH INCPL LES AT C7 LEVL CERV SP CORD INIT ENC	S14.157A
BRWN-SEQRD SYND T7-10 LVL THOR SPINAL CORD INT	S24.143A
UNS INJURY AT C7 LEVEL CERV SPINAL CORD SEQUELA	S14.107S
BROWN-SEQUARD SYND AT C6 LEVEL CERV SP CORD SEQ	S14.146S
BROWN-SEQUARD SYND AT C5 LEVEL CERV SP CORD SEQ	S14.145S
BROWN-SEQUARD SYND T7-T10 LEVEL THOR SPINAL CORD	S24.143
UNS INJURY AT UNS LEVEL THORACIC SPINAL CORD	S24.109
UNS INJURY AT T2-T6 LEVEL THORACIC SPINAL CORD	S24.102

UNS INJURY AT T2-T6 LEVEL THOR SPINAL CORD SEQ	S24.102S
BROWN-SEQUARD SYND T11-T12 LEVL THOR SPINAL CORD	S24.144
BROWN-SEQUARD SYND AT C3 LEVEL CERV SPINAL CORD	S14.143
OTH INCPL LES AT T7-10 LEVL THOR SPINAL CORD SUB	S24.153D
UNS INJURY AT UNS LEVL THOR SPINAL CORD INIT ENC	S24.109A
UNS INJURY L4 LEVEL LUMBAR SPINAL CORD SEQUELA	S34.104S
BROWN-SEQUARD SYND AT C3 LEVEL CERV SP CORD SEQ	S14.143S
INCOMPLETE LESION L1 LEVEL OF LUMBAR SPINAL CORD	S34.121
COMPLETE LESION T2-T6 LEVEL THOR SPINAL CORD SUB	S24.112D
COMPLETE LESION L5 LEVEL OF LUMBAR SPINAL CORD	S34.115
OTH INCPL LES AT UNS LEVL CERV SP CORD INIT ENC	S14.159A
UNS INJURY AT UNS LEVEL THOR SPINAL CORD SEQUELA	S24.109S
ANT CORD SYNDROME AT C6 LEVEL CERV SPINAL CORD	S14.136
UNS INJURY AT C7 LEVL CERV SPINAL CORD SUB ENC	S14.107D
UNS INJURY AT T7-T10 LEVEL THORACIC SPINAL CORD	S24.103
COMPLETE LESION T1 LEVL THOR SPINAL CORD SUBSQT	S24.111D
COMPLETE LESION AT C4 LEVEL CERV SPINAL CORD SEQ	S14.114S
COMPLETE LESION AT C8 LEVEL CERV SPINAL CORD SEQ	S14.118S
ANT CORD SYNDROME AT C4 LEVEL CERV SPINAL CORD	S14.134
CMPL LESION AT C3 LEVL CERV SPINAL CORD SUB ENC	S14.113D
INCOMPLETE LESION SACRAL SPINAL CORD INITIAL ENC	S34.132A
OTH INCPL LES AT C8 LEVL CERV SP CORD SUBSQT ENC	S14.158D
COMPLETE LESION AT C2 LEVEL CERV SPINAL CORD SEQ	S14.112S
COMPLETE LESION AT T1 LEVEL THOR SPINAL CORD SEQ	S24.111S
UNS INJURY AT C8 LEVEL CERV SPINAL CORD SEQUELA	S14.108S
INCOMPLETE LESION OF LUMBAR SPINAL CORD	S34.12
UNS INJURY L1 LEVEL LUMBAR SPINAL CORD INIT ENC	S34.101A
CONCUSS & EDEMA CERVICAL SPINAL CORD INITIAL ENC	S14.0XXA
CMPL LES L4 LEVL LUMB SPINAL CORD SUBSEQUENT ENC	S34.114D
ANT CORD SYND AT T2-T6 LEVL THOR SPINAL CORD SUB	S24.132D
CNTRL CORD SYND AT C3 LEVEL CERV SPINAL CORD SEQ	S14.123S
BROWN-SEQUARD SYND T2-T6 LVL THOR SPINL CORD SEQ	S24.142S
BROWN-SEQUARD SYND AT C4 LVL CERV SP CRD SUB ENC	S14.144D
BROWN-SEQUARD SYND AT UNS LEVEL CERV SPINAL CORD	S14.149
CMPL LESION L1 LEVEL LUMBAR SPINAL CORD INIT ENC	S34.111A
CMPL LES L2 LEVL LUMB SPINAL CORD SUBSEQUENT ENC	S34.112D
UNS INJURY AT C5 LEVEL CERV SPINAL CORD INIT ENC	S14.105A
UNS INJURY AT T7-T10 LEVL THOR SPINAL CORD INIT	S24.103A
OTH INCPL LESION AT UNS LEVEL CERV SPINAL CORD	S14.159
BROWN-SEQUARD SYND UNS LEVL THOR SPINAL CORD SEQ	S24.149S
CMPL LES UNS LEVEL LUMBAR SPINAL CORD INIT ENC	S34.119A
ANT CORD SYND AT C8 LEVEL CERV SP CORD INIT ENC	S14.138A
CNTRL CORD SYND AT UNS LVL CERV SP CORD INIT ENC	S14.129A

COMPLETE LESION T7-T10 LVL THOR SPINAL CORD INIT	S24.113A
CONCUSS & EDMA LUMBAR SPINAL CORD INITIAL ENCNTR	S34.01XA
OTH INCPL LESION AT C6 LEVL CERV SPINAL CORD SEQ	S14.156S
BRWN-SEQURD SYND T11-12 LVL THOR SPINAL CORD SUB	S24.144D
COMPLETE LESION AT T2-T6 LEVEL THOR SPINAL CORD	S24.112
BROWN-SEQUARD SYND AT C7 LEVEL CERV SP CORD SEQ	S14.147S
OTH INCPL LESION AT C2 LEVL CERV SPINAL CORD SEQ	S14.152S
BRWN-SEQUARD SYND AT C7 LVL CERV SP CRD INIT ENC	S14.147A
CMPL LESION AT UNS LEVEL CERV SPINAL CORD SEQ	S14.119S
UNS INJURY L4 LEVEL LUMB SP CORD SUBSEQUENT ENC	S34.104D
CONCUSS & EDMA SACRAL SPINAL CORD INITIAL ENCNTR	S34.02XA
ANT CORD SYND AT C6 LEVEL CERV SP CORD INIT ENC	S14.136A
BROWN-SEQUARD SYND AT C8 LEVEL CERV SP CORD SEQ	S14.148S
CONCUSS & EDMA LUMBAR SPINAL CORD SUBSEQUENT ENC	S34.01XD
OTH INCPL LES AT C2 LEVEL CERV SP CORD INIT ENC	S14.152A
COMPLETE LESION T7-T10 LVL THOR SPINAL CORD SUB	S24.113D
OTH INCPL LES AT C6 LEVL CERV SP CORD INIT ENC	S14.156A
UNS INJURY L5 LEVEL LUMBAR SPINAL CORD SEQUELA	S34.105S
UNS INJURY AT T1 LEVL THOR SPINAL CORD SUBSQT	S24.101D
ANT CORD SYND AT T1 LEVL THOR SPINAL CORD INIT	S24.131A
BROWN-SEQUARD SYND AT C2 LEVEL CERV SP CORD SEQ	S14.142S
CMPL LESION AT C6 LEVEL CERV SPINAL CORD SUB ENC	S14.116D
BRWN-SEQUARD SYND AT UNS LVL CERV SP CRD SUB ENC	S14.149D
BRWN-SEQUARD SYND AT C4 LVL CERV SP CRD INIT ENC	S14.144A
OTH INCPL LESION AT C6 LEVEL CERV SPINAL CORD	S14.156
ANT CORD SYND AT UNS LEVEL THOR SPINAL CORD INIT	S24.139A
COMPLETE LESION OF SACRAL SPINAL CORD SEQUELA	S34.131S
INCMPL LES UNS LEVL LUMB SP CORD SUBSEQUENT ENC	S34.129D
UNS INJURY AT UNS LEVL CERV SPINAL CORD SUB ENC	S14.109D
INJURY OF CAUDA EQUINA SEQUELA	S34.3XXS
BROWN-SEQUARD SYND AT C2 LVL CERV SP CRD SUB ENC	S14.142D
OTHER & UNSPECIFIED INJURY TO SACRAL SPINAL CORD	S34.13
COMPLETE LESION T7-T10 LVL THOR SPINAL CORD SEQ	S24.113S
INCMPL LES L5 LEVEL LUMBAR SPINAL CORD INIT ENC	S34.125A
BROWN-SEQUARD SYND AT C6 LEVEL CERV SPINAL CORD	S14.146
OTH INCPL LESION T2-T6 LVL THOR SPINAL CORD INIT	S24.152A
UNS INJURY AT C3 LEVL CERV SPINAL CORD SUB ENC	S14.103D
UNS INJURY L3 LEVEL LUMBAR SPINAL CORD	S34.103
UNS INJURY AT T7-T10 LEVL THOR SPINAL CORD SUB	S24.103D
UNS INJURY AT C8 LEVL CERV SPINAL CORD SUB ENC	S14.108D
ANT CORD SYND AT T7-T10 LVL THOR SPINAL CORD SEQ	S24.133S
OTHER & UNS INJURIES CERVICAL SPINAL CORD	S14.1
BROWN-SEQUARD SYND T7-T10 LVL THOR SP CORD SEQ	S24.143S

BROWN-SEQUARD SYND AT C7 LEVEL CERV SPINAL CORD	S14.147
UNS INJURY AT C6 LEVEL CERVICAL SPINAL CORD	S14.106
OTH INCPL LES AT T11-T12 LVL THOR SPINL CRD SEQ	S24.154S
OTH INCPL LES AT C4 LEVL CERV SP CORD INIT ENC	S14.154A
UNS INJURY AT UNS LEVEL CERV SPINAL CORD SEQUELA	S14.109S
OTH INCPL LES AT C5 LEVL CERV SP CORD SUBSQT ENC	S14.155D
ANT CORD SYND AT C4 LEVL CERV SP CORD SUBSQT ENC	S14.134D
UNS INJURY AT C7 LEVEL CERV SPINAL CORD INIT ENC	S14.107A
ANT CORD SYND AT UNS LEVEL THORACIC SPINAL CORD	S24.139
OTH INCOMPL LESION T1 LEVL THOR SPINAL CORD SUBS	S24.151D
UNS INJURY AT C5 LEVL CERV SPINAL CORD SUB ENC	S14.105D
INCMPL LES L4 LEVL LUMB SP CORD SUBSEQUENT ENC	S34.124D
ANT CORD SYND AT C3 LEVEL CERV SP CORD INIT ENC	S14.133A
CNTRL CORD SYND AT C3 LEVEL CERV SP CORD SUB ENC	S14.123D
ANT CRD SYND T2-T6 LVL THOR SC INIT	S24.132A
COMPLETE LESION OF LUMBAR SPINAL CORD	S34.11
COMPLETE LESION AT T1 LEVL THOR SPINAL CORD INIT	S24.111A
CMPL LES UNS LEVL LUMB SP CORD SUBSEQUENT ENC	S34.119D
BROWN-SEQUARD SYND AT C1 LEVL CERV SP CORD SEQ	S14.141S
CONCUSS & EDMA SACRAL SPINAL CORD SUBSEQUENT ENC	S34.02XD
ANT CORD SYND AT C1 LEVEL CERV SP CORD INIT ENC	S14.131A
COMPLETE LESION T11-T12 LVL THOR SPINAL CORD SUB	S24.114D
UNS INJURY AT C2 LEVEL CERV SPINAL CORD SEQUELA	S14.102S
CMPL LESION AT C7 LEVL CERV SPINAL CORD INIT ENC	S14.117A
OTH INCPL LESION AT C1 LEVEL CERV SPINAL CORD	S14.151
CONCUSSION & EDEMA THORACIC SPINAL CORD INITIAL	S24.0XXA
OTHER & UNS INJURIES THORACIC SPINAL CORD	S24.1
UNS INJURY AT C4 LEVEL CERV SPINAL CORD SEQUELA	S14.104S
CNTRL CORD SYND AT C7 LEVEL CERV SPINAL CORD SEQ	S14.127S
ANT CORD SYNDROME AT C1 LEVEL CERV SPINAL CORD	S14.131
BRWN-SEQUARD SYND T1 LVL THOR SPINAL CORD INIT	S24.141A
UNS INJURY AT C6 LEVEL CERV SPINAL CORD SEQUELA	S14.106S
COMPLETE LESION AT UNS LEVL CERVICAL SPINAL CORD	S14.119
BROWN-SEQUARD SYNDROME OF CERVICAL SPINAL CORD	S14.14
BRWN-SEQUARD SYND AT C1 LVL CERV SP CRD INIT ENC	S14.141A
CMPL LESION AT C4 LEVL CERV SPINAL CORD SUB ENC	S14.114D
CONCUSS & EDEMA OF LUMBAR SPINAL CORD SEQUELA	S34.01XS
UNS INJURY L5 LEVEL LUMBAR SPINAL CORD INIT ENC	S34.105A
ANT CORD SYNDROME AT C3 LEVEL CERV SPINAL CORD	S14.133
ANT CORD SYND AT T11-T12 LEVEL THOR SPINAL CORD	S24.134
ANT CORD SYND AT T7-T10 LVL THOR SPINAL CORD SUB	S24.133D
UNS INJURY L2 LEVEL LUMBAR SPINAL CORD INIT ENC	S34.102A
UNSPECIFIED INJURY OF CERVICAL SPINAL CORD	S14.10

OTH INCOMPLETE LESION T1 LEVEL THOR SPINAL CORD	S24.151
BRWN-SEQUARD SYND AT C2 LVL CERV SP CRD INIT ENC	S14.142A
CMPL LESION L5 LEVEL LUMBAR SPINAL CORD INIT ENC	S34.115A
UNS INJURY AT T1 LEVEL THORACIC SPINAL CORD	S24.101
UNS INJURY AT T11-T12 LEVEL THORACIC SPINAL CORD	S24.104
COMPLETE LESION L2 LEVEL LUMBAR SPINAL CORD SEQ	S34.112S
COMPLETE LESION AT C1 LEVEL CERV SPINAL CORD SEQ	S14.111S
CMPL LESION AT C8 LEVL CERV SPINAL CORD INIT ENC	S14.118A
UNS INJURY AT C3 LEVEL CERVICAL SPINAL CORD	S14.103
INCMPL LESION L5 LEVEL LUMBAR SPINAL CORD SEQUA	S34.125S
INJURY OF CAUDA EQUINA	S34.3
CMPL LESION A C3 LEVEL CERV SPINAL CORD INIT ENC	S14.113A
OTH INCPL LES UNS LEVL THOR SPINAL CORD INIT ENC	S24.159A
UNS INJURY AT C3 LEVEL CERV SPINAL CORD SEQUELA	S14.103S
OTH INCPL LES UNS LEVL THOR SPINAL CORD SUB ENC	S24.159D
CMPL LESION AT C4 LEVL CERV SPINAL CORD INIT ENC	S14.114A
INCOMPLETE LESION L2 LEVEL OF LUMBAR SPINAL CORD	S34.122
ANT CORD SYND AT T1 LEVEL THORACIC SPINAL CORD	S24.131
COMPLETE LESION OF THORACIC SPINAL CORD	S24.11
UNS INJURY L2 LEVL LUMB SP CORD SUBSEQUENT ENC	S34.102D
COMPLETE LESION UNS LEVEL LUMBAR SPINAL CORD	S34.119
CMPL LESION AT C8 LEVEL CERV SPINAL CORD SUB ENC	S14.118D
BROWN-SEQUARD SYND AT C4 LEVEL CERV SPINAL CORD	S14.144
OTH INCPL LES AT C6 LEVL CERV SP CORD SUBSQT ENC	S14.156D
UNS INJURY AT T2-T6 LEVL THOR SPINAL CORD SUBSQT	S24.102D
CMPL LESION AT C6 LEVL CERV SPINAL CORD INIT ENC	S14.116A
ANT CORD SYND AT UNS LEVEL CERV SP CORD INIT ENC	S14.139A
COMPLETE LESION AT C2 LEVEL CERVICAL SPINAL CORD	S14.112
CMPL LESION AT C7 LEVEL CERV SPINAL CORD SUB ENC	S14.117D
BROWN-SEQUARD SYND AT C6 LVL CERV SP CRD SUB ENC	S14.146D
UNS INJURY AT C6 LEVEL CERV SPINAL CORD INIT ENC	S14.106A
BRWN-SEQURD SYND T11-12 LVL THOR SPINAL CORD INT	S24.144A
OTH INCPL LES AT C1 LEVEL CERV SP CORD INIT ENC	S14.151A
CNTRL CORD SYND AT C6 LEVL CERV SP CORD INIT ENC	S14.126A
CNTRL CORD SYNDROME AT C6 LEVEL CERV SPINAL CORD	S14.126
OTH INCPL LESION AT C2 LEVEL CERV SPINAL CORD	S14.152
INCMPL LES L1 LEVL LUMB SP CORD SUBSEQUENT ENC	S34.121D
UNS INJURY AT C5 LEVEL CERVICAL SPINAL CORD	S14.105
CMPL LESION AT C5 LEVL CERV SPINAL CORD SUB ENC	S14.115D
ANT CORD SYNDROME AT C2 LEVEL CERV SPINAL CORD	S14.132
UNS INJURY UNS LEVEL LUMBAR SPINAL CORD INIT ENC	S34.109A
CMPL LESION L4 LEVEL LUMBAR SPINAL CORD INIT ENC	S34.114A
COMPLETE LESION L5 LEVEL LUMBAR SPINAL CORD SEQ	S34.115S

OTH INCPL LESION AT C4 LEVEL CERV SPINAL CORD SEQ	S14.154S
ANT CORD SYND AT C1 LEVEL CERV SPINAL CORD SEQ	S14.131S
BROWN-SEQUARD SYND T1 LVL THOR SPINAL CORD SUB	S24.141D
CNTRL CORD SYND AT C4 LEVEL CERV SPINAL CORD SEQ	S14.124S
ANT CORD SYND AT T2-T6 LEVL THORACIC SPINAL CORD	S24.132
CENTRAL CORD SYNDROME OF CERVICAL SPINAL CORD	S14.12
COMPLETE LESION AT C5 LEVEL CERVICAL SPINAL CORD	S14.115
COMPLETE LESION AT C7 LEVEL CERV SPINAL CORD SEQ	S14.117S
OTH INCOMPL LESION T1 LEVL THOR SPINAL CORD SEQ	S24.151S
INCMPL LES L5 LEVEL LUMB SP CORD SUBSEQUENT ENC	S34.125D
COMPLETE LESION UNS LEVL THOR SPINAL CORD SUBSQT	S24.119D
CNTRL CORD SYNDROME AT C1 LEVEL CERV SPINAL CORD	S14.121
UNSPECIFIED INJURY OF THORACIC SPINAL CORD	S24.10
COMPLETE LESION AT T11-T12 LEVL THOR SPINAL CORD	S24.114
BROWN-SEQUARD SYND T11-T12 LVL THOR SP CORD SEQ	S24.144S
OTH INCPL LESION T2-T6 LEVL THOR SPINAL CORD SUB	S24.152D
OTHER AND UNSPECIFIED CORD COMPRESSION	G952

Bowel and Bladder Dysfunction Diagnosis Codes

Name	Code
OTHER SPECIFIED DISORDERS OF URINARY SYSTEM	N39.8
FECAL IMPACTION	K56.41
INCOMPLETE DEFECATION	R15.0
OTHER SPECIFIED URINARY INCONTINENCE	N39.4
FULL INCONTINENCE OF FECES	R15.9
DISORDER OF URINARY SYSTEM UNSPECIFIED	N39.9
FECAL URGENCY	R15.2
OTHER DISORDERS OF URINARY SYSTEM	N39.0
REFLEX NEUROPATHIC BLADDER NEC	N31.1
UNINHIBITED NEUROPATHIC BLADDER NEC	N31.0
FLACCID NEUROPATHIC BLADDER NEC	N31.2
OVERFLOW INCONTINENCE	N39.490
IRR CNTCT DRMTS D/T FECAL URINARY DUAL INCONT	L24.A2
RETENTION OF URINE	R33.0
UNSPECIFIED URINARY INCONTINENCE	R32.0
FUNCTIONAL URINARY INCONTINENCE	R39.81
URGE INCONTINENCE	N39.41
NEUROMUSCULAR DYSFUNCTION OF BLADDER UNSPECIFIED	N31.9
OTHER DIFFICULTIES WITH MICTURITION	R39.1
INCONTINENCE WITHOUT SENSORY AWARENESS	N39.42
OTHER NEUROMUSCULAR DYSFUNCTION OF BLADDER	N31.8

Bowel and Bladder Dysfunction CPT Codes

Name	Code
COLONIC LAVAGE 35+L WATER W/INDUCED DEFECATION	0736T
SPHINCTEROTOMY ANAL DIVISION SPHINCTER SPX	46080
CSTC COMPL W/CONTINENT DVRJ OPN NEOBLDR	51596
INSJ NON-NDWELLG BLADDER CATHETER	51701
INSJ TEMP NDWELLG BLADDER CATHETER SIMPLE	51702
INSJ TEMP NDWELLG BLADDER CATHETER COMPLICATED	51703
ENTEROCYSTOPLASTY W/INTESTINAL ANASTOMOSIS	51960
PRQ IMPLTJ NEUROSTIM ELTRD SACRAL NRVE W/IMAGING	64561
INC IMPLTJ NEUROSTIMULATOR ELTRD SACRAL NERVE	64581
REVJ/RMVL PERIPHERAL NEUROSTIMULATOR ELECTRODE	64585
INSERTION/RPLCMT PERIPHERAL/GASTRIC NPGR	64590
REVISION/RMVL PERIPHERAL/GASTRIC NPGR	64595
BIOFEEDBACK TRAINING ANY MODALITY	90901
BFB TRAIING W/EMG &/MANOMETRY 1ST 15 MIN CNTCT	90912
BFB TRAIING W/EMG&/MANOMETRY EA ADDL 15 MIN CNTCT	90913
SACRAL NERVE STIMULATION TEST LEAD EACH	A4290
LUBRICANT INDIVIDUAL STERILE PACKET EACH	A4332
INCONTINENCE SUPPLY; MISCELLANEOUS	A4335
INTERMIT URIN CATH; STRAIGHT TIP W/WO COAT EA	A4351
INTERMITTENT URINARY CATHETER; COUDE TIP EACH	A4352
INTERMIT URINARY CATHETER W/INSERTION SUPPLIES	A4353
SLINGS	A4565
SURGICAL SUPPLY; MISCELLANEOUS	A4649
GENERATOR NEUROSTIMULATOR NONRECHARGEABLE	C1767
LEAD NEUROSTIMULATOR	C1778
GEN NEUROSTIM W/RECHRG BATTERY & CHARGING SYSTEM	C1820
ADAPTOR/EXT PACING LEAD/NEUROSTIMULATOR LEAD	C1883
LEAD NEUROSTIMULATOR TEST KIT	C1897
IMPLANTABLE NEUROSTIMULATOR ELECTRODE EACH	L8680
ADLT SIZED DISPBL INCONT PROD BRF/DIAPER SM EA	T4521
ADLT SIZED DISPBL INCONT PROD BRF/DIAPER MED EA	T4522
ADLT SIZED DISPBL INCONT PROD BRF/DIAPER LG EA	T4523
ADLT SZD DISPBL INCONT PROD BRF/DIAPER X-LG EA	T4524
ADLT SZD DISPBL INCONT PROD UNDWEAR/PULLON SM EA	T4525
ADLT SZD DISPBL INCONT PROD UNDWEAR MED EA	T4526
ADLT SZD DISPBL INCONT PROD UNDWEAR/PULLON LG EA	T4527
ADLT SZD DISPBL INCONT PROD UNDWEAR XTRA LG EA	T4528
PED SZD DISPBL INCONT PROD BRF/DIAPER SM/MED EA	T4529
PED SZD DISPBL INCONT PROD BRF/DIAPER LG SZ EA	T4530

PED SZD DISPBL INCONT PROD UNDWEAR SM/MED EA	T4531
PED SZD DISPBL INCONT PROD UNDWEAR/PULLON LG EA	T4532
YOUTH SIZED DISPBL INCONT PRODUCT BRF/DIAPER EA	T4533
YOUTH SZD DISPBL INCONT PROD UNDWEAR/PULLON EA	T4534
DISPBL LINER/SHIELD/GUARD/PAD/UNDGRMNT INCONT EA	T4535
INCONT PROD PROTVE UNDWEAR/PULLON REUSBL SIZE EA	T4536
INCONT PROD PROTVE UNDPAD REUSABLE BED SIZE EA	T4537
DIAPER SERVICE REUSABLE DIAPER EACH DIAPER	T4538
INCONTINENCE PRODUCT DIAPER/BRF REUSABLE SIZE EA	T4539
INCONT PROD PROTVE UNDPAD REUSABLE CHAIR SIZE EA	T4540
INCONTINENCE PRODUCT DISPOSABLE UNDPAD LARGE EA	T4541
INCONTINENCE PRODUCT DISPBL UNDPAD SMALL SIZE EA	T4542
ADULT SIZE DISP INCONTINENCE PROD ABOVE XL EA	T4543
ADULT SIZE DISPBL INCONT PULLUP ABVE EXTRA LG EA	T4544
INCONTINENCE PRODUCT DISPOSABLE PENILE WRAP EACH	T4545

Bowel and Bladder Dysfunction ICD-10 Codes

Name	Code
COLONIC LAVAGE 35+L WATER W/INDUCED DEFECATION	0736T
SPHINCTEROTOMY ANAL DIVISION SPHINCTER SPX	46080
CSTC COMPL W/CONTINENT DVRJ OPN NEOBLDR	51596

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