AAVBC
AMERICAN ACADEMY OF VALUE BASED CARE

Cerebral Palsy

Quick Reference Guide

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1 CLINICAL SNAPSHOT

Definition: Cerebral palsy (CP) is a lifelong, heterogeneous group of permanent movement and posture disorders caused by a nonprogressive disturbance to the developing fetal or infant brain.[1] Although the underlying neurological lesion is static, the musculoskeletal and functional consequences are highly dynamic and deteriorate with age. This accelerated aging process manifests as progressive mobility decline, chronic neuropathic and nociceptive pain, recurrent falls, dysphagia, severe osteoporosis, fatigue, neurogenic bowel/bladder, and progressive caregiver dependence.[2-5] Because curative treatment is unavailable, primary care management must pivot from pediatric developmental milestones to adult risk mitigation. Care is framed by the patient's Gross Motor Function Classification System (GMFCS Level I–V) and focuses on optimizing remaining physical and communication function, managing complex non-motor comorbidities (including epilepsy, sensory deficits, and depression/anxiety), coordinating multidisciplinary subspecialty care, and meticulously documenting the patient's clinical complexity to support individualized, high-value preventive care.[6-8]

ICD-10 Codes:

CP is reported under **G80** and should be coded by documented subtype when known: **G80.0 spastic quadriplegic CP**, **G80.1 spastic diplegic CP**, **G80.2 spastic hemiplegic CP**, **G80.3 athetoid/dyskinetic CP**, **G80.4 ataxic CP**, **G80.8 other CP**, and **G80.9 unspecified CP**. Avoid defaulting to **G80.9** when prior neurology, rehabilitation, pediatric, or historical records support a more specific subtype. For **G80.0**, documentation should state **all four limbs affected** or "quadriplegic" and describe functional severity. CP-related conditions are **not mapped by the G80 code alone** and should be coded separately when addressed, including **epilepsy (G40.-), dysphagia (R13.1-), chronic pain (G89.29/R52), osteoporosis (M81.-), sarcopenia/malnutrition (M62.84/E43–E44.-), incontinence (R32/N39.-), and depression/anxiety (F32.-/F33.-/F41.-)**.[2]

Prevalence and Burden: CP is one of the most common motor disabilities beginning in childhood, and adults with CP are now living into older adulthood.[7] Adult CP care is often under-recognized because the condition is established early in life, but adult complications are common and clinically important. Adults with CP have higher rates of **hospitalization, pain, falls, osteoporosis, dysphagia/aspiration risk, mental health conditions, cardiometabolic disease, and functional decline** than adults without CP.[8,9] The primary care opportunity is to move documentation beyond "CP stable" and use annual visits to update **GMFCS/function, mobility, swallowing, pain, nutrition, DME/seating needs, caregiver support, and comorbidity burden**.[10]