



AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

Cerebral Palsy

Quick Reference Guide

2026

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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

HCC/RAF V28 Mapping

ICD-10 CODE(S) ^{2,3}	HCC CATEGORY (V28)	RAF (CNA)	DOCUMENTATION REQUIREMENT
G80.0 Spastic quadriplegic cerebral palsy	HCC 191 — Quadriplegic Cerebral Palsy^{4,10,11}	0.855³⁵	Document spastic quadriplegic CP, all four limbs affected or “quadriplegic,” GMFCS level, wheelchair/non-ambulatory status, transfer dependence, spasticity/contractures, DME/seating needs, and caregiver support ^{13,14}
G80.1-G80.9 Other specified or unspecified cerebral palsy	HCC 192 — Cerebral Palsy, Except Quadriplegic^{4,10,11}	0.314	Document the specific subtype when known: diplegic, hemiplegic, dyskinetic/athetoid, Ataxic, mixed, other CP , or unspecified only when the subtype is genuinely unknown. Include GMFCS level, movement pattern, functional status, mobility support, and active comorbidities ⁸
G40.- Epilepsy/seizure disorder	HCC 201 — Seizure Disorders and Convulsions^{4,10,11}	0.245³⁵	Code separately when addressed. Document seizure type, control status, antiseizure medication, adherence, breakthrough events , and relationship to CP when clinically supported ¹³

ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services; CNA = Community Non-Dual Eligible, Aged; HCC = Hierarchical Condition Category; RAF = Risk Adjustment Factor; V28 = CMS-HCC Model Version 28. *Annual value illustrative at AAVBC representative MA base rate ~\$10,402/year, applied at CMS-HCC 2026 model normalization factor 1.067 for PY2026; actual plan payment varies by county and contract

RAF values represent the Community Non-Dual Eligible Aged (CNA) coefficient from the 2026 CMS-HCC model; values vary across patient populations based on eligibility and care setting

Risk-Adjusted Care Resources per Patient/Year^{4,10,11}

RAF weight × \$10,402.34 MA base rate = estimated annual care coordination support per documented HCC.11

SPASTIC QUADRIPLEGIC CP
\$8.9K

HCC 191 · RAF 0.855

OTHER/UNSPECIFIED CP
~\$3.3K+

HCC 192 · RAF 0.314

RAF values represent the Community Non-Dual Eligible Aged (CNA) coefficient from the 2026 CMS-HCC model; values vary across patient populations based on eligibility and care setting



AAVBC PERSPECTIVE

*In adult value-based care, cerebral palsy should not be treated as a childhood diagnosis carried forward unchanged. The original brain injury is nonprogressive, but the **physical consequences can progress with age** — pain, fatigue, spasticity, mobility decline, dysphagia, osteoporosis, and caregiver dependence. The PCP's highest-value role is proactive surveillance: update function, swallowing, pain, falls, bone health, mood, DME needs, and caregiver support before decline becomes a hospitalization.^{1,4}*

2 RECOGNITION AND DIAGNOSIS

Medicare - Diagnostic and Surveillance Workup

SERVICE	COVERAGE	FREQUENCY	CPT/HCPCS	CLINICAL RELEVANCE
Annual Wellness Visit (AWV) ²¹	Medicare Part B; no copay	Once per year ²¹	G0438/ G0439	Use as the yearly CP surveillance checkpoint: update GMFCS/function , dysphagia screen, fall risk, PHQ-9, pain, DME/seating needs, DXA triggers, and caregiver support ²¹
Depression screening ³	Medicare Part B preventive	Annually, or sooner with symptoms ³	G0444	Depression is common in adult CP and may worsen pain, fatigue, adherence, and function. Use PHQ-9/GAD-7 when mood symptoms, caregiver concern, sleep change, or functional decline is present ^{3,6}
Bone density (DXA) ¹¹	Medicare Part B; medically necessary	Every 24 months (more often if indicated) ¹¹	77080	Trigger when non-ambulatory status, anticonvulsant exposure, low BMI/weight loss, prior fracture, recurrent falls, or prolonged immobility is present ^{5,11}

SERVICE	COVERAGE	FREQUENCY	CPT/HCPCS	CLINICAL RELEVANCE
Swallowing evaluation ¹⁰	Medicare Part B; medically necessary	As medically necessary; repeat with clinical change ¹⁰	92610	Use for coughing/choking with meals, prolonged feeding time, weight loss, recurrent pneumonia, or aspiration concern ^{9,10}
Videofluoroscopic swallow study ¹⁰	Medicare Part B; medically necessary	When aspiration risk suspected ¹⁰	92611	Objective assessment when aspiration risk, recurrent pneumonia, unexplained weight loss, or unsafe swallowing is suspected ¹⁰
PT/OT evaluation ¹⁵	Medicare Part B; covered benefit	Per functional need ¹⁵	97163/ 97167	Use for new mobility decline, transfer difficulty, falls, contracture risk, seating problems, caregiver transfer training, or loss of ADL function ¹⁵
Fall-risk assessment ⁹	Medicare Part B; often performed during AWW or chronic-care visit ²⁹	Annually and after any fall ⁹	GMFCS level, when documented, plus an individualized PT/OT functional mobility and transfer assessment	Adult CP increases risk through spasticity, weakness, balance impairment, contractures, sedating medications, and unsafe transfers. Document fall history and prevention plan ⁹
Wheelchair/ DME and seating evaluation ⁸	Medicare Part B; face-to-face documentation required	As medically necessary ⁸	97542/ 97755	Use when mobility, posture, pressure relief, transfers, or caregiver safety depends on wheelchair/seating/DME. Document medical necessity, repair/replacement needs, and functional benefit ^{1,8}
Advance Care Planning ¹⁶	Medicare Part B; no copay during AWW ¹⁶	Annually or when goals/ caregiver situation changes ¹⁶	99497/ 99498	Relevant in adults with severe CP, high caregiver dependence, dysphagia/ aspiration risk, recurrent hospitalization, or communication barriers. Engage the patient directly with supported communication ¹⁶

SERVICE	COVERAGE	FREQUENCY	CPT/HCPCS	CLINICAL RELEVANCE
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ABBREVIATIONS: ADL = activities of daily living; AWW = Annual Wellness Visit; CPT/HCPCS = Current Procedural Terminology/Healthcare Common Procedure Coding System; DME = durable medical equipment; DXA = dual-energy X-ray absorptiometry; GMFCS = Gross Motor Function Classification System; HR = hazard ratio; OT = occupational therapy; PHQ = Patient Health Questionnaire; PT = physical therapy

Subtle Early Signs in Older Adults (>65)

SIGN/SYMPTOM	CLINICAL SIGNIFICANCE
Gradual loss of walking distance or transfer ability¹	Up to 40% of adults with CP who walked earlier in life may lose ambulation over time. Treat this as a trigger for PT/PM&R reassessment, DME review, and fall-risk evaluation — not inevitable decline ¹
New or progressive swallowing difficulty, coughing with meals, weight loss¹⁰	Progressive dysphagia (prevalence up to 50.4% across the lifespan) precedes aspiration pneumonia, the leading cause of death in severe CP; screen actively rather than waiting for complaint ^{1,10}
Escalating chronic pain or new joint pain⁹	Pain is common but should not be normalized. It may reflect contracture, hip disease, scoliosis, fracture, pressure injury, constipation, reflux, or urinary retention^{7,9}
Recurrent falls or new instability²⁹	Spasticity, balance deficits, sarcopenia, sedating medications, and unsafe transfers raise fall risk. Document fall-risk assessment, PT/OT referral, DME needs, and home safety plan²⁹
Insidious weakness, numbness, or new hand clumsiness in dyskinetic CP²⁰	May suggest cervical myelopathy from accelerated cervical degeneration. New neurologic deficits warrant cervical spine imaging and specialist referral²⁰
Low mood, withdrawal, anhedonia⁶	Depression affects adults with CP at higher rates than the general population and may worsen pain, sleep, adherence, and function. Screen with PHQ-9/GAD-7 using communication accommodations when needed ^{3,6}
Progressive scoliosis or thoracic deformity⁹	Can compromise respiratory mechanics, seating tolerance, pain control, and skin integrity . Monitor curve progression, pulmonary symptoms, and equipment fit ⁹
Unexplained functional or cognitive change¹⁴	Distinguish new secondary conditions, delirium, depression, medication effects, infection, caregiver breakdown, or emerging dementia from baseline motor/communication impairment ¹⁴

ABBREVIATIONS: CP = cerebral palsy; DME = durable medical equipment; GMFCS = Gross Motor Function Classification System; PHQ-9 = Patient Health Questionnaire-9; PT = physical therapy

Geriatric Risk Factors

FACTOR	RISK SIGNAL	NOTES
GMFCS level IV-V (non-ambulatory) ⁷	Strongly associated with respiratory disease, GI disorders, pressure ulcers, pneumonia, falls, and care dependence ⁷	The most important functional stratifier; document GMFCS level at every AWW to guide surveillance intensity ^{7,27}
Premature sarcopenia ¹³	Sarcopenia prevalence reported around 47.9% in adults with CP, far exceeding age-matched norms ¹³	Higher GMFCS level and lower BMI are significant risk factors; reflects an accelerated-aging phenotype and is frequently uncoded (M62.84) ^{12,13}
Anticonvulsant use ¹¹	Independent risk factor for osteoporosis and fragility fracture ¹¹	Compounds immobilization-related bone loss; pair with DXA screening and bone-health management ¹¹
Non-ambulatory status + poor nutrition ¹¹	Major drivers of osteoporosis and fracture risk ^{5,11}	Osteoporosis prevalence ranges 5-43% across CP populations; fragility fractures may follow minimal trauma ¹¹
Vascular/cardiometabolic risk ⁸	Higher cardiovascular disease and heart failure risk compared with general population ^{4,8}	Driven by physical inactivity, premature sarcopenia, metabolic risk, hypertension, and care-access barriers; monitor BP, weight, A1c/lipids when indicated, and activity tolerance ^{3,8}
Respiratory compromise ⁴	Increased respiratory disease risk; aspiration pneumonia is a major preventable complication ^{3,4}	Screen for dysphagia, recurrent pneumonia, restricted chest mechanics, cough effectiveness, vaccination status, and caregiver feeding support ²²
Dyskinetic subtype ²⁰ [VER]	High risk for accelerated cervical disc degeneration and cervical myelopathy ²⁰	Monitor for new weakness, numbness, hand clumsiness, gait/transfer decline, or bowel/bladder change ; image promptly when new deficits appear ²⁰
Complex multimorbidity cluster ²⁵	Highest-risk adults often have cardiopulmonary, nutritional, mobility, medication, and caregiver needs together ²⁶	Identifies patients needing intensive care coordination, social work support, DME review, and specialist management ^{25,26}

ABBREVIATIONS: BMI = body mass index; CI = confidence interval; CP = cerebral palsy; DXA = dual-energy X-ray absorptiometry; GI = gastrointestinal; GMFCS = Gross Motor Function Classification System; HR = hazard ratio

Diagnostic Thresholds and Severity Classification

SYSTEM	CLASSIFICATION/CRITERION	NOTES
GMFCS/GMFCS-E&R ²⁷	Five-level gross motor function classification: Level I walks without limitation; Level V transported in wheelchair with limited head/trunk control ^{16,27}	Best functional anchor for adult CP. Document GMFCS level , ambulation status, transfers, seating/DME needs, and caregiver support ²⁷
GMFCS — limitation ²⁷	Classification tool, not a full outcome measure ²⁷	Walking ability can still decline in adulthood, especially in dyskinetic and bilateral spastic CP — re-document level rather than assuming stability ^{1,27}
MACS — Manual Ability Classification System ²⁷	Five-level classification of bimanual hand use in daily activities ²⁷	Supports OT referral, adaptive equipment needs, feeding/dressing support, communication-device access, and DME justification ²⁷
CFCS — Communication Function Classification System ²⁷	Five-level classification of everyday communication competence ²⁷	Documents communication barriers affecting care. Motor or speech impairment does not equal cognitive impairment ; assess cognition separately ²⁷
Modified Ashworth Scale (MAS) ¹⁹	Grades spasticity from 0 to 4 ¹⁹	Useful for tracking response to botulinum toxin, oral antispasticity agents, ITB pump therapy, stretching, and bracing ; document functional goal, not tone alone ¹⁹
No geriatric-specific staging ³⁰	No validated adult geriatric CP staging system exists ³⁰	Apply pediatric-derived classifications cautiously in older adults; pair them with functional trajectory, comorbidity burden, medication risk, and caregiver capacity ³⁰

ABBREVIATIONS: BoNT-A = botulinum toxin type A; CFCS = Communication Function Classification System; CP = cerebral palsy; DME = durable medical equipment; GMFCS-E&R = Gross Motor Function Classification System – Expanded & Revised; ITB = intrathecal baclofen; MACS = Manual Ability Classification System; MAS = Modified Ashworth Scale; OT = occupational therapy; κ = kappa



CLINICAL PEARL: SHIFT FROM “WAIT AND SEE” TO PREMATURE-AGING SURVEILLANCE

The key PCP behavior change in adult CP is to move from passive monitoring to **proactive premature-aging surveillance**. At every encounter, ask about **new or worsening pain, mobility change, swallowing difficulty, falls, weight loss, mood, and caregiver strain**. These changes are often actionable and may signal dysphagia, fracture risk, sarcopenia, medication adverse effects, depression, or equipment failure.^{6,18}

Clues to Dig Deeper

CLINICAL CLUE	WHY IT MATTERS	NEXT DIAGNOSTIC STEP
Any new symptom in an adult with CP¹	Evaluate new symptoms as potentially new disease — not automatically “just CP.” Diagnostic overshadowing is the most common adult-CP error¹	Take a focused history and exam; compare with baseline function; evaluate new symptoms before labeling them “CP-related.”
New or progressive dysphagia¹⁰	Swallow decline may precede aspiration pneumonia , weight loss, dehydration, and avoidable hospitalization ^{1,10}	Urgent swallow evaluation ; review diet texture, feeding time, weight trend, aspiration history, and caregiver feeding support ¹⁰
Loss of ambulation or transfer ability¹	May reflect cervical myelopathy, fracture, contracture progression, sarcopenia, medication effect, pain, or DME failure — not inevitable decline ^{1,20}	Neurologic/MSK exam; consider cervical spine MRI if myelopathy signs; PT/PM&R referral and DME reassessment^{1,20}
New weakness/numbness in dyskinetic CP²⁰	Cervical disc degeneration and myelopathy can be missed when symptoms are assumed to be baseline movement disorder ²⁰	Cervical spine MRI ; neurology/neurosurgery referral if cord compression signs are present ²⁰
Unintentional weight loss >5% over 3-6 months³	May signal progressive dysphagia, malnutrition, depression, occult disease, or caregiver/feeding difficult³	Nutrition assessment; weight/BMI trend; swallow evaluation; consider malnutrition coding when criteria are met ^{3,10}
New incontinence with neurological change⁹	May indicate UTI, constipation, medication effect, neurogenic bladder, or spinal cord compression when paired with weakness or sensory change ^{9,20}	UA/culture; bowel review; neurologic exam; urgent imaging if cord signs are present ⁹

CLINICAL CLUE	WHY IT MATTERS	NEXT DIAGNOSTIC STEP
Pain disproportionate to baseline⁹	Pain is common in CP but should not be dismissed. It may reflect fracture, hip disease, contracture, pressure injury, constipation, reflux, or urinary retention⁹	Localize pain; assess function/sleep impact; image focal or persistent pain; document treatment plan and follow-up ⁹

ABBREVIATIONS: BMI = body mass index; CP = cerebral palsy; DME = durable medical equipment; MRI = magnetic resonance imaging; PT = physical therapy



RED FLAG — DO NOT DISMISS NEW SYMPTOMS AS “JUST CP”

New or worsening symptoms in an adult with CP deserve evaluation, especially:

- **New dysphagia, coughing with meals, weight loss, or recurrent pneumonia**
- **Loss of ambulation or transfer ability**
- **New focal weakness, numbness, bowel/bladder change, or severe pain**
- **New depression, anxiety, withdrawal, or caregiver concern**
- **Falls, fracture concern, DME failure, or unsafe transfers**

The practical rule: **baseline CP is not a diagnosis for new decline**. Work up the change and look for treatable secondary conditions.

Common Oversights

OVERSIGHT	WHY IT MATTERS — WHAT TO DO INSTEAD
Attributing new symptoms to “just the CP”¹	Diagnostic overshadowing delays treatable conditions. Evaluate new mobility, pain, swallowing, respiratory, urinary, or behavioral changes as potentially new disease ¹
Treating CP as clinically static in older adults¹⁴	The brain lesion is nonprogressive, but adult consequences can progress. Reassess mobility, swallowing, pain, bone health, mood, equipment needs, and caregiver support annually ^{12,14}
Waiting for the patient to report dysphagia¹⁰	Swallowing decline may be silent until aspiration occurs. Ask directly about coughing/choking with meals, prolonged feeding time, weight loss, diet texture, and pneumonia history ^{1,10}

OVERSIGHT	WHY IT MATTERS — WHAT TO DO INSTEAD
Interpreting lost ambulation as inevitable decline¹	Loss of walking or transfer ability may be treatable. Evaluate for pain, contracture, myelopathy, sarcopenia, medication sedation, fracture, or equipment failure ; refer to PT/PM&R early ¹
Under-screening for osteoporosis¹¹	Non-ambulatory status, anticonvulsants, low BMI, falls, and prior fracture increase risk. Trigger DXA and bone-health management when risk factors are present ^{5,11}
Missing premature sarcopenia and functional mobility loss¹³	Weight loss and low muscle mass are not “expected disability.” Track weight trend, intake, swallowing, feeding support, and functional decline ; refer to nutrition when needed ¹³
Inferring cognitive impairment from motor or speech difficulty⁶	Dysarthria, abnormal movement, or use of communication devices does not equal impaired capacity. Assess directly using adapted communication and document decision-making capacity ⁶
Overlooking depression and anxiety⁶	Mood disorders are common and may worsen pain, sleep, adherence, and function. Screen with PHQ-9/GAD-7 using accommodations when needed; document severity and plan ^{3,6}
Not anticipating ITB pump or status-dystonic emergencies²⁰	Baclofen withdrawal and dystonic storm can be life-threatening. Document pump refill/safety plan and provide a clear emergency protocol ²⁰
ABBREVIATIONS: CP = cerebral palsy; DME = durable medical equipment; DXA = dual-energy X-ray absorptiometry; HR = hazard ratio; ITB = intrathecal baclofen	

Key Differentials in Elderly

PRESENTATION	DIFFERENTIAL	KEY TESTS
New progressive weakness or loss of ambulation²⁰	Could reflect cervical myelopathy , neuropathy, stroke, medication effect, deconditioning, pain/contracture, or true CP-related functional decline. Do not assume “baseline CP” ^{1,13,20}	Neurologic exam; cervical spine MRI if myelopathy signs; medication review; PT/PM&R assessment ²⁰
Acute respiratory deterioration²²	Consider aspiration pneumonia , viral/bacterial pneumonia, COPD/asthma, PE, medication sedation, or dysphagia-related aspiration ^{9,22}	Chest imaging; pulse oximetry; swallow assessment; medication review; consider vaccination status ^{10,22}

PRESENTATION	DIFFERENTIAL	KEY TESTS
Cognitive or behavioral change ¹⁴	May reflect delirium, depression/anxiety, medication effect, sleep disorder, pain, infection, or caregiver stress — not necessarily cognitive impairment from CP ^{6,14}	Cognitive screen; PHQ-9/GAD-7; CBC/CMP/TSH/B12/UA when indicated; medication review ^{6,14}
Worsening pain ⁹	Could be contracture, hip degeneration/dislocation, scoliosis, fracture, pressure injury, constipation, reflux, urinary retention, or spasticity-related pain ^{5,9}	Focused exam; pain location and functional impact; hip/spine imaging if focal or persistent; bowel/bladder review ^{5,9}
New incontinence urinary retention ⁹	Spinal cord compression; neurogenic bladder; UTI; medication can represent UTI, constipation, medication effect, neurogenic bladder, or spinal cord compression if paired with new weakness/sensory change ^{9,20}	UA/culture; post-void residual when indicated; constipation review; urgent imaging if neurologic deficits are present ⁹
Sustained severe dystonia with fever or autonomic instability ²⁰	Concern for status dystonicus , baclofen withdrawal, infection, dehydration, or medication-triggered crisis. This can become life-threatening ²⁰	ED evaluation; assess temperature, CK, renal function, hydration, infection source, medication changes, and ITB pump function if present ²⁰

ABBREVIATIONS: COPD = chronic obstructive pulmonary disease; CP = cerebral palsy; HR = hazard ratio; MRI = magnetic resonance imaging; PHQ-9 = Patient Health Questionnaire-9; UTI = urinary tract infection

Comorbidity Management

COMORBIDITY	APPROACH	CAUTION
Respiratory disease/aspiration risk ⁴	Screen for dysphagia annually; review coughing/choking with meals, feeding time, weight loss, pneumonia history, vaccination status, and SLP needs ^{3,4,22}	Aspiration pneumonia is a leading cause of death in severe CP; do not dismiss cough, weight loss, or recurrent infections as baseline ²²
Osteoporosis/fragility risk ¹¹	Trigger DXA when non-ambulatory status, anticonvulsant exposure, low BMI, recurrent falls, or prior fracture is present; review vitamin D/calcium and fracture prevention ^{5,11}	Anticonvulsants, immobility, low weight, and falls increase fracture risk; document bone-health plan before fracture occurs ¹¹

COMORBIDITY	APPROACH	CAUTION
Chronic pain ⁹	Screen pain location , severity, sleep impact, function, positioning, spasticity/contracture source, constipation, reflux, and pressure injury. ⁹	Avoid chronic NSAIDs and benzodiazepines in older adults when possible; evaluate focal pain for fracture, hip disease, or pressure injury ^{7,9}
Dysphagia and malnutrition ¹⁰	Dysphagia can drive aspiration, weight loss, dehydration, and avoidable hospitalization ^{3,10}	Annual swallow screen; weight trend; diet texture; caregiver feeding support ¹⁰
Hypertension/ cardiometabolic risk ⁶	Optimize antihypertensive regimen; document BP trend, adherence, lifestyle counseling, and follow-up ^{3,6}	Limited mobility and access barriers can worsen cardiometabolic risk; avoid assuming low activity is “just CP” ^{3,6}
Epilepsy ³	Coordinate antiseizure therapy with neurology; document seizure type, control status, medication adherence, adverse effects, and breakthrough events ^{3,7}	Balance seizure control against sedation, falls, cognition, osteoporosis risk, and drug interactions ^{3,11}

ABBREVIATIONS: CP = cerebral palsy; DXA = dual-energy X-ray absorptiometry; GAD-7 = Generalized Anxiety Disorder-7; GMFCS = Gross Motor Function Classification System; HR = hazard ratio; NSAID = non-steroidal anti-inflammatory drug; PHQ-9 = Patient Health Questionnaire-9



RED FLAG — URGENT (24-72 HOURS)

Arrange urgent evaluation when there is:

- **Rapidly worsening dysphagia**, coughing/choking with meals, new aspiration concern, or unexplained weight loss¹⁰
- **New loss of ambulation**, transfer ability, or major functional decline
- **New focal weakness, sensory change, or bowel/bladder change** suggesting possible spinal cord or neurologic process²⁰
- **New or worsening pressure injury**, severe pain, or suspected occult fracture²
- **New or worsening depression, suicidal ideation, or caregiver breakdown**⁵
- **Equipment failure** that makes transfers, seating, feeding, or mobility unsafe¹⁷

The practical rule: **Acute breathing, seizure, pump, or fracture crisis goes to the ED; rapid swallowing, mobility, skin, mood, or caregiver decline needs urgent outpatient action.**

**RED FLAG — EMERGENCY CRISIS RESPONSE**

Send for urgent emergency evaluation now for:

- **Acute aspiration with respiratory distress**, desaturation, stridor, or suspected pneumonia^{1,22}
- **New seizure lasting >5 minutes**, recurrent seizures without recovery, or status epilepticus³
- **Sustained severe dystonia with fever, autonomic instability, dehydration, rhabdomyolysis risk, or altered mental status**²⁰
- **Acute intrathecal baclofen pump failure or withdrawal concern**, especially with severe spasticity, fever, agitation, pruritus, hallucinations, or autonomic instability¹⁷
- **Acute hip or fracture concern** after fall/trauma, especially in non-ambulatory or osteoporotic patients⁵

3 MEAT DOCUMENTATION AND ESSENTIALS

Adult cerebral palsy documentation translates a lifelong neurologic condition into a record that supports **continuity, quality measurement, and care planning** — not code optimization. The most common gaps are defaulting to **G80.9 unspecified**,^{37,28} omitting **GMFCS level**,²⁸ treating CP as “stable” without documenting functional impact, and failing to capture active comorbidities such as **dysphagia, epilepsy, chronic pain, osteoporosis risk, malnutrition, depression, incontinence, and caregiver dependence**.^{3,33}

*A 71-year-old man with **spastic quadriplegic CP** presents for a chronic-care visit with his caregiver. He has had **two coughing episodes during meals, 6% unintentional weight loss, worsening hip/shoulder pain, low mood, and increased transfer difficulty**. He uses a **speech-generating device** and is fully oriented. Prior notes state only “cerebral palsy, stable.”*

MONITOR: GMFCS V reviewed — **all four limbs affected; wheelchair-dependent; dependent for transfers and most ADLs**. Caregiver reports **two coughing episodes with meals, 6% weight loss, increased transfer difficulty, and worsening hip/shoulder pain**. **Epilepsy controlled on levetiracetam**; no recent seizure reported. **Intrathecal baclofen pump** model, dose, refill date, response, and emergency plan reviewed. decline.

EVALUATE: **Oropharyngeal dysphagia suspected** based on coughing with meals and weight loss; **SLP/swallow evaluation ordered**. **Nutrition labs and weight trend reviewed**. Hip/shoulder pain assessed for **spasticity, contracture, positioning, or degenerative source**; imaging/PT/PM&R referral considered. **Fall risk, transfer safety, DME/seating fit, skin risk, PHQ-9, and DXA trigger reviewed**.

ASSESS: **Spastic quadriplegic cerebral palsy (G80.0), GMFCS V** with active functional and comorbidity burden. Active associated conditions include **oropharyngeal dysphagia/aspiration risk (R13.12), chronic musculoskeletal pain (G89.29), epilepsy (G40.-), osteoporosis risk due to non-ambulatory status/anticonvulsant exposure, weight loss/malnutrition risk, and depression symptoms** when PHQ-9 supports diagnosis.

TREAT: Continue **levetiracetam** and **intrathecal baclofen plan** with pump safety counseling. Initiate **swallow precautions, SLP referral, nutrition support, PT/OT/PM&R coordination, DME/seating reassessment, fall-prevention plan, pain management, and DXA/bone-health evaluation.** Engage patient directly using his communication device; document **caregiver role** in feeding, transfers, medication administration, transportation, and equipment coordination.

Clinical Documentation Elements

- **Document CP subtype explicitly:** spastic quadriplegic (**G80.0**), spastic diplegic/hemiplegic, dyskinetic/ataxic/mixed, or other documented subtype. Avoid **G80.9 unspecified** when subtype is known^{36,38}
- **Record GMFCS level:** document GMFCS at annual review and with functional change; it anchors mobility severity, transfer needs, DME/seating requirements, fall risk, and caregiver burden²⁷
- **Code active CP-related comorbidities separately:** epilepsy, dysphagia, chronic pain, osteoporosis, sarcopenia/malnutrition, urinary incontinence, depression/anxiety, constipation, and pressure-injury risk when addressed^{3,33}
- **Document dysphagia and aspiration risk:** coughing/choking with meals, prolonged feeding time, weight loss, aspiration history, diet texture, SLP referral, and caregiver feeding support¹
- **Document DME/seating dependence:** wheelchair, orthotics, seating system, gait aid, transfer equipment, pressure-relief needs, repair/replacement status, and how equipment supports mobility, posture, skin protection, and ADLs^{1,10}
- **Document ITB pump safety when present:** device, dose, refill date, last interrogation, response, adverse effects, and emergency plan for withdrawal or overdose symptoms¹⁷
- **Avoid “stable CP” rollover:** update subtype, GMFCS/function, active comorbidities, DME/seating needs, caregiver support, and current care plan at least annually^{6,16}

Reframing Common Documentation Shortcuts

INSTEAD OF...	DOCUMENT...
"Cerebral palsy, stable" ³⁸	"Spastic quadriplegic CP, GMFCS V (G80.0); all four limbs affected; ongoing surveillance for dysphagia, pain, and bone health" ^{27,36,38}
"CP with four-limb involvement" (no subtype word) ³⁸	"Spastic quadriplegic CP — all four limbs affected (G80.0)" so the record supports HCC 191 rather than defaulting to G80.9/HCC 192 ^{36,38}

INSTEAD OF...	DOCUMENT...
"Symptoms are due to their CP" ¹	"New coughing with meals and 6% weight loss — evaluating for progressive dysphagia and aspiration risk (R13.1-)" — a new condition, not baseline CP ^{1,10}
"Difficulty walking" (no detail) ¹	"Lost independent ambulation over 18 months; now transfers with assist — PT referral and seating/DME reassessment" with the functional change quantified ¹
"Patient nonverbal/limited" ⁶	"Communicates via speech-generating device; cognitively intact; decisions made directly with the patient" — motor/communication impairment is not cognitive impairment ⁶
Listing only G80.x ³	G80.x plus each addressed comorbidity coded independently (epilepsy, dysphagia, pain, depression, osteoporosis, malnutrition) ^{3,33}

ABBREVIATIONS: CP = cerebral palsy; DME = durable medical equipment; GMFCS = Gross Motor Function Classification System; HCC = Hierarchical Condition Category; PT = physical therapy



DOCUMENTATION REMINDER IS COMPREHENSIVE CODING

- **CP subtype and severity:** Clearly document the specific cerebral palsy subtype and **GMFCS level**. Avoid using **G80.9 (unspecified CP)** when a more precise diagnosis is known on²⁸
- **Functional status and trajectory:** Record **both** baseline **function** and **any changes** over time, including mobility, transfers, ADLs/IADLs, communication, falls, swallowing, pain, weight trends, and mobility decline^{1,2}
- **Active comorbidities:** List and address **each condition individually**, such as dysphagia, epilepsy, chronic pain, osteoporosis risk, malnutrition/sarcopenia, incontinence, depression/anxiety, and pressure-injury risk^{2,5,6}
- **DME and caregiver support:** Document needs for wheelchairs/seating, orthotics, transfer equipment, communication devices, as well as **repair/replacement needs, caregiver involvement, and social work support**²⁸
- **Medication and device safety:** Monitor and document **anticonvulsant use**, intrathecal baclofen pump dosing and refill dates, side effects, fall risk, sedation, constipation, and emergency plans for pump withdrawal^{23,24}
- **Annual surveillance:** During AWC or annual chronic-care visits, update GMFCS level and functional status, dysphagia screening, fall risk, PHQ-9, pain assessment, DXA screening needs, DME review, and caregiver support status

4 TREATMENT AND REFERRAL QUICK GUIDE

Treatment for cerebral palsy is **function-directed and specialist-supported**. The PCP role is to recognize **adult functional decline**, identify treatable comorbidities, coordinate PT and neurology referrals, monitor medication safety, review DME/seating needs, and prevent complications such as falls, aspiration, pain escalation, fractures, and caregiver breakdown.^{1,18} The goal of spasticity management shifts from developmental gain to **pain relief, contracture prevention, fall reduction, and preservation of remaining function**.¹

Therapy Escalation Criteria

TRIGGER	ACTION
Non-pharmacologic measures insufficient for generalized spasticity/pain ¹⁵	Add oral antispasticity therapy such as baclofen (GABA-B receptor agonist) first-line ; start low and titrate slowly, especially in older adults ^{15,17}
Focal/segmental disabling spasticity ¹⁸	Refer for botulinum toxin injection when focal tone limits hygiene, seating, bracing, transfers, or pain control ¹⁸
Generalized spasticity refractory to oral therapy ¹⁸	Refer to spasticity clinic for intrathecal baclofen pump evaluation when tone remains disabling despite oral therapy ¹⁸
Dysphagia, coughing with meals, weight loss, or recurrent pneumonia ¹⁰	Refer to swallow evaluation ; assess aspiration risk, diet texture, feeding support, and nutrition status ¹⁰
Lost ambulation/new mobility decline ¹	Refer to PT ; reassess seating, orthotics, DME, pain source, medication sedation, and caregiver transfer safety ^{1,20}
Osteoporosis risk: non-ambulatory status, anticonvulsants, falls, or fracture history ¹¹	Order DXA when indicated ; address calcium/vitamin D, fall prevention, and osteoporosis treatment when appropriate ^{11,29}
Fixed contracture, hip displacement, scoliosis, or progressive deformity ¹	Refer to orthopedics ; evaluate pain, seating tolerance, hygiene difficulty, skin risk, and surgical candidacy ¹
ABBREVIATIONS: BoNT-A = botulinum toxin type A; CP = cerebral palsy; DME = durable medical equipment; DXA = dual-energy X-ray absorptiometry; ITB = intrathecal baclofen; PT = physical therapy	



CLINICAL PEARL: ADULT CP TREATMENTS GOALS SHIFT WITH AGE

In pediatric CP, treatment often focuses on gaining function. In adult and geriatric CP, the goal shifts to **preserving function, controlling pain, preventing contractures, reducing falls, maintaining safe swallowing, and supporting DME/caregiver needs**. The PCP is the point of care for this lifelong condition, and should coordinate as needed to PM&R, PT/OT, SLP, neurology, orthopedics, nutrition, mental health, and equipment support as function changes.^{4,6}

Guideline-Aligned Spasticity and Motor Management by Step (FNAH/AAP/European Consensus)

STEP/CLASS	PREFERRED OPTION(S)*	KEY NOTES (GERIATRIC)
Step 1 — Non-pharmacologic first-line ¹⁵	PT/OT, stretching, strengthening, positioning, orthotics, gait training when appropriate, home exercise program ¹⁵	Foundation of adult CP care; document functional goals , fall risk, caregiver training, and DME needs ^{15,29}
Step 2 — Oral agents ¹⁷	Baclofen commonly first-line; tizanidine, diazepam, or gabapentin may be used for selected symptoms ¹⁷	Monitor sedation, weakness, dizziness, constipation, falls, cognition, and polypharmacy ; avoid dose escalation without functional benefit ¹⁷
Step 3 — Focal chemodenervation ¹⁸	Botulinum toxin for focal spasticity affecting hygiene, bracing, pain, transfers, or seating ¹⁸	Benefits are temporary; reassess tone, range of motion, therapy plan, and functional goal after injection ¹⁸
Step 4 — Intrathecal baclofen pump ¹⁸	ITB pump for severe generalized or multi-segmental spasticity when oral therapy is ineffective or poorly tolerated ^{18,19}	Requires pump clinic follow-up; document dose, refill date, response, adverse effects, and emergency plan for withdrawal/overdose ^{17,18}
Step 5 — Surgical/specialist ¹	Orthopedic evaluation for fixed contractures, hip displacement, scoliosis, pain, or progressive deformity ¹	Higher perioperative risk in adult CP; clarify functional goal, caregiver support, nutrition, bone health, and rehab plan before surgery ¹

ABBREVIATIONS: BoNT-A = botulinum toxin type A; CP = cerebral palsy; CPT = Current Procedural Terminology; ITB = intrathecal baclofen; qHS = at bedtime; TID = three times daily

***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

Non-Pharmacologic Care and Supportive Interventions

INTERVENTION	TARGET/RECOMMENDATION	NOTES
Physical therapy/gait training ¹⁵	Gain function, transfers, range of motion, and safe mobility ¹⁵	Strongly recommended for mobility maintenance; document functional baseline and change over time ¹⁵
Occupational therapy/adaptive equipment ¹⁵	Improve ADLs, transfers, seating, hand function, and home safety ¹⁵	Supports independence and caregiver safety; review DME, seating, bathing, toileting, and transfer equipment ^{1,15}
Stretching, bracing, serial casting ¹⁶	Reduce spasticity-related contracture risk	Most effective when paired with functional goals; document contracture risk, skin checks, and orthotic tolerance ¹⁶
Dysphagia management/SLP ¹⁰	Prevent aspiration; maintain safe nutrition ¹⁰	Refer when coughing/choking with meals, weight loss, prolonged feeding time, or recurrent pneumonia occurs ¹⁰
Bone-health program ¹¹	Non-ambulatory status, anticonvulsant exposure, low BMI, fracture history, or recurrent falls ¹¹	Address DXA, calcium/vitamin D, osteoporosis therapy, and fall-risk reduction when indicated ^{11,29}

ABBREVIATIONS: DME = durable medical equipment; DXA = dual-energy X-ray absorptiometry; OT = occupational therapy; SLP = speech-language pathology

Medication Safety and Key Interactions

DRUG/CLASS	INTERACTION/TOXICITY	CLINICAL ACTION
Baclofen oral ¹⁷	Sedation, weakness, dizziness, constipation, hypotonia, and increased fall/transfer risk ¹⁷	Start low and titrate slowly; monitor falls, cognition, constipation, transfer safety, and functional benefit . Avoid dose escalation without clear improvement ¹⁷

DRUG/CLASS	INTERACTION/TOXICITY	CLINICAL ACTION
Intrathecal baclofen (ITB) ¹⁷	Pump failure or abrupt interruption can cause life-threatening withdrawal , severe rebound spasticity, fever, autonomic instability, rhabdomyolysis, or altered mental status ¹⁷	Document dose, refill date, last interrogation, response, adverse effects, and emergency withdrawal/overdose plan . Confirm pump-clinic follow-up ¹⁷
Gabapentin ¹	Sedation, dizziness, edema, gait instability, and increased fall risk; renal dose adjustment may be needed ¹	Use cautiously in older adults; monitor sedation, balance, edema, renal function, and functional benefit . Reassess if no improvement in pain or sleep ¹
Tizanidine	Hypotension, sedation, dizziness, dry mouth, and liver enzyme elevation	Check BP and sedation risk; monitor LFTs when used chronically or at higher doses; avoid stacking with other sedatives when possible ¹
Dantrolene	Dose-related hepatotoxicity , weakness, and fatigue	Monitor LFTs ; avoid or use extreme caution in liver disease; reassess if weakness worsens transfers or function ¹
Benzodiazepines ¹⁶	Sedation, delirium, respiratory suppression, constipation, dependence, and high fall/fracture risk ¹⁶	Generally avoid chronic use in geriatric CP; if needed, use the lowest effective dose with a clear indication, stop plan, and fall-risk counseling ¹⁶
Anticholinergics/bladder medications	Dry mouth, constipation, urinary retention, confusion, and fall risk	Review bowel/bladder status and cognition; avoid worsening constipation or urinary retention; reassess need at each medication review
Botulinum toxin type A ¹⁸	Local weakness, dysphagia risk when injected near bulbar/neck muscles, and temporary functional change ¹⁸	Use for focal disabling spasticity ; document target muscle, functional goal, response, adverse effects, and therapy plan after injection ¹⁸

ABBREVIATIONS: AMS = altered mental status; CP = cerebral palsy; ITB = intrathecal baclofen; LFT = liver function test; qHS = at bedtime; TID = three times daily

When to Refer

CRITERION	SPECIALIST	URGENCY
Acute aspiration, respiratory distress, desaturation, or suspected aspiration pneumonia¹⁰	Emergency department/pulmonology as needed	Emergent¹⁰
New weakness, numbness, bowel/bladder change, or suspected cervical myelopathy²⁰	Neurology/neurosurgery	Urgent — same week²⁰
Disabling focal or generalized spasticity¹⁸	Physiatry/spasticity clinic	Routine-expedited¹⁸
Fragility fracture, hip dislocation, progressive scoliosis¹¹	Orthopedics	Emergent^{1,11}
Refractory osteoporosis or complex bone disease¹¹	Endocrinology/osteoporosis clinic	Routine-expedited¹¹
Moderate-severe depression, suicidality, or behavioral crisis⁶	Behavioral health/psychiatry	Urgency based on safety risk⁶
Suspected ITB pump withdrawal or overdose¹⁷	Emergency department + pump clinic/PM&R/neurosurgery	Emergent¹⁷

ABBREVIATIONS: BoNT-A = botulinum toxin type A; ITB = intrathecal baclofen; SLP = speech-language pathology

Follow-Up Timing

CATEGORY	FREQUENCY	MONITORING
Annual Wellness Visit/ chronic-care review²¹	Annually ²¹	Update GMFCS/function , dysphagia screen, falls, pain, PHQ-9/GAD-7, DME/seating, medications, caregiver support, and advance care planning ²¹
Bone density/DXA¹¹	Every 24 months when indicated; sooner if medically necessary ¹¹	DXA results, fracture history, anticonvulsant exposure, non-ambulatory status, vitamin D/calcium plan, fall risk, and osteoporosis therapy ¹¹

CATEGORY	FREQUENCY	MONITORING
Swallowing status ¹⁰	At least annually; sooner with symptoms ¹⁰	Coughing/choking with meals, prolonged feeding time, weight loss, recurrent pneumonia, diet texture, SLP recommendations, and caregiver feeding support ¹⁰
Baclofen toxin injections ¹⁷	Typically every 3 months as clinically needed ¹⁷	Sedation, weakness, constipation, cognition, falls, transfer safety, and functional benefit ¹⁷
Intrathecal baclofen pump ¹⁷	Per device schedule (refills) ¹⁷	Dose, refill date, last interrogation, catheter/pump concerns, adverse effects, and emergency withdrawal/overdose plan ¹⁷
Botulinum toxin injections ¹⁸	~Every 3 months as needed ¹⁸	Target muscle, dose, functional goal, adverse effects, response, and therapy follow-through ^{18,19}
Seizure management ³	Per neurology; review at AWW ³	Seizure frequency, breakthrough events, adherence, adverse effects, drug levels when indicated, and driving/safety counseling ^{3,11}
Mood/mental health ⁶	Annually and with clinical change ⁶	PHQ-9/GAD-7 , sleep, pain interaction, safety assessment, treatment response, and follow-up plan ⁶

ABBREVIATIONS: BMD = bone mineral density; BoNT-A = botulinum toxin type A; DME = durable medical equipment; DXA = dual-energy X-ray absorptiometry; GAD-7 = Generalized Anxiety Disorder-7; GMFCS = Gross Motor Function Classification System; ITB = intrathecal baclofen; MAS = Modified Ashworth Scale; PHQ-9 = Patient Health Questionnaire-9

***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

Comorbidity Management

COMORBIDITY	PRIMARY-CARE APPROACH	CAUTION
Respiratory/aspiration ²²	Screen for dysphagia annually; review coughing/choking with meals, feeding time, weight loss, pneumonia history, vaccination status, and SLP needs ²²	Aspiration pneumonia is a leading cause of death in severe CP ; do not dismiss cough, weight loss, or recurrent infections as baseline ^{1,22}
Osteoporosis/fragility risk ¹¹	DXA-guided therapy; vitamin D/ calcium; fall prevention ¹¹	Anticonvulsants and immobility compound risk ¹¹

COMORBIDITY	PRIMARY-CARE APPROACH	CAUTION
Chronic pain ⁹	Treat the source; positioning, PT, targeted analgesia ⁹	Avoid chronic NSAIDs and benzodiazepines in elderly ^{9,16}
Hypertension (prevalence 26%) ³	Standard antihypertensive management ³	Provide accessible BP monitoring for upper-limb impairment ³
Heart failure (HR 1.86) ⁸	Guideline-based HF management ⁸	Attention to fluid balance with swallowing difficulty ⁸
Depression/anxiety ⁶	PHQ-9/GAD-7; SSRI/SNRI; psychotherapy ⁶	Do not misattribute mood symptoms to disability ⁶
Epilepsy ³	Coordinate anticonvulsant therapy; monitor levels ³	Balance seizure control against fall and bone risk ^{3,11}

ABBREVIATIONS: BP = blood pressure; CP = cerebral palsy; GAD-7 = Generalized Anxiety Disorder-7; HF = heart failure; HR = hazard ratio; NSAID = non-steroidal anti-inflammatory drug; PHQ-9 = Patient Health Questionnaire-9; PT = physical therapy; SNRI = serotonin-norepinephrine reuptake inhibitor; SSRI = selective serotonin reuptake inhibitor

Cost-Smart Options

OPPORTUNITY/HIGH-COST RISK	APPROACH/ ALTERNATIVE	COST-SMART TIP
Preventable hospitalization from aspiration, falls, fracture, seizure, or caregiver crisis ¹	AWV-based surveillance and proactive care plan ²¹	Use AWV to capture GMFCS/function, dysphagia, falls, pain, mood, bone health, DME, medications, and caregiver support before crisis-driven ED use ^{21,23,24}
DME failure or unsafe seating/transfers ¹	Early wheelchair/ seating/ DME review; repair/ replacement planning before equipment failure	Document medical necessity, functional benefit, skin protection, transfer safety, and caregiver burden to avoid delayed approvals and prevent unsafe transfers
Brand or high-cost antispasticity/pain medications ¹⁷	Use generic baclofen, tizanidine, gabapentin/ pregabalin when clinically appropriate	reserve higher-cost agents or procedures for refractory symptoms with documented functional goals ¹

OPPORTUNITY/HIGH-COST RISK	APPROACH/ ALTERNATIVE	COST-SMART TIP
Delayed dysphagia recognition leading to aspiration admission¹	Early SLP/swallow evaluation, diet modification, caregiver feeding plan, and nutrition support ²⁸	New coughing with meals, prolonged feeding time, or weight loss should trigger swallow evaluation before pneumonia occurs ²⁸
Missed bone-health prevention before fracture	In-network MRI or negotiated MA plan imaging site ¹	Non-ambulatory status, anticonvulsants, low BMI, and falls should trigger bone-health review before a fragility fracture ¹
Uncoordinated care across PCP, PM&R, neurology, DME, and caregivers	Designated CP care coordinator or care-management workflow ^{15,17}	Coordinated care can reduce duplicate visits, delayed DME, medication confusion, missed referrals, and caregiver-driven crises ^{15,17}
Dual-eligible/high-need social support gaps	Connect to LTSS, SDOH supports, transportation, respite care, and MA supplemental benefits when available ^{28,31}	Food, transportation, home modifications, caregiver respite, and DME support can prevent avoidable decline when benefits are used early ^{28,31}
ABBREVIATIONS: ACP = advance care planning; AED = antiepileptic drug; ED = emergency department; MA = Medicare Advantage; MRI = magnetic resonance imaging; PCP = Pneumocystis pneumonia; TMZ = temozolomide *Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions		

Patient Education and Adherence

Patient and caregiver education should frame adult CP as a condition requiring **lifelong surveillance**, not a stable childhood diagnosis carried forward unchanged.

Education should reinforce that **new pain, dysphagia, falls, weight loss, mood change, or mobility decline** deserves evaluation rather than being dismissed as “just CP.” Review warning signs for aspiration, seizure change, ITB pump emergency symptoms, fall/fracture risk, DME failure, and when to call urgently. Engage the patient directly using their preferred communication method; motor or speech impairment does **not** imply cognitive impairment.^{1,21,611,17}



DOCUMENTATION REMINDER — PATIENT EDUCATION

Document the following education topics, the patient and caregiver(s) present, materials provided, communication method used, and patient/caregiver understanding:

- **Adult CP surveillance:** Explain that function, swallowing, pain, mood, falls, bone health, DME, and caregiver support should be reviewed annually
- **Dysphagia/aspiration warning signs:** Coughing or choking with meals, prolonged feeding time, weight loss, wet voice, fever, or recurrent pneumonia
- **Falls and bone health:** Fall prevention, transfer safety, DXA triggers, fracture risk, calcium/vitamin D plan, and osteoporosis therapy when indicated
- **ITB pump safety:** Refill schedule, pump-failure symptoms, withdrawal/overdose warning signs, and emergency plan
- **DME/seating needs:** Wheelchair, seating, orthotics, transfer equipment, repair/replacement needs, skin protection, and caregiver safety
- **Communication and capacity:** Document how the patient communicates and confirm they were included directly in decisions whenever possible^{6,17}

Quality Metrics Tie-In

MEASURE	STANDARD	NOTES
Care for Older Adults — Functional Status Assessment (HEDIS COA/ CMS Display DMC21)³⁷	Denominator: SNP/MA enrollees aged 66 and older Numerator: At least one complete functional status assessment completed annually	Directly relevant because adult CP affects mobility, transfers, ADLs/IADLs, communication, DME needs, and caregiver dependence . Document GMFCS/function, ambulation, transfers, assistive devices, and caregiver support ³⁷

MEASURE	STANDARD	NOTES
Care for Older Adults — Medication Review (HEDIS COA/CMS Star C06)²⁵	Denominator: SNP/MA enrollees aged 66 and older Numerator: At least one medication review conducted by a prescribing practitioner or clinical pharmacist, with a signed/dated medication list in the chart	Adult CP is a high-risk polypharmacy profile. Actively reconcile muscle relaxants (baclofen, tizanidine), anticonvulsants, anticholinergics (glycopyrrolate for sialorrhea), analgesics, and aggressive chronic bowel regimens. Screen for sedating drug-drug interactions and fall-risk profiles
Care for Older Adults — Pain Assessment (MIPS #131)²⁷	Denominator: All outpatient visits for patients aged 18 and older Numerator: Pain assessed using a standardized tool on the encounter date; if positive, a clinical follow-up plan must be documented ²⁷	Adult CP pain may reflect spasticity, contractures, hip disease, scoliosis, pressure injury, constipation, reflux, or fracture . Document pain location, severity, functional impact, source evaluation, and treatment plan ²⁷
Plan All-Cause Readmissions — HEDIS PCR/CMS Star³⁷	Denominator: Enrollees ≥ 18 with an acute inpatient discharge Numerator: Unplanned readmission within 30 days (lower rates are better) Excluding: Scheduled chemotherapy, transplant, psychiatric, or hospice ³⁷	CP readmissions often follow aspiration, falls/fractures, seizures, medication issues, DME failure, caregiver breakdown, or poor discharge planning . Document post-discharge follow-up, equipment needs, swallow plan, and caregiver support ^{22,37}

ABBREVIATIONS: BP = blood pressure; CMS = Centers for Medicare & Medicaid Services; CP = cerebral palsy; DXA = dual-energy X-ray absorptiometry; LOS = length of stay; PHQ = Patient Health Questionnaire. Note: no HEDIS or Star measure is CP-specific; the measures above are general measures applicable to this population³



QUALITY OUTCOME:

When primary care treats adult CP as an active surveillance condition, preventable complications are caught earlier: **dysphagia before aspiration pneumonia, fall risk before fracture, DME failure before unsafe transfers, mood symptoms before decline, and caregiver strain before crisis**. A structured AWV-based workflow — **GMFCS/ function, swallowing, falls, pain, mood, bone health, DME, blood pressure control, and caregiver support**.²¹

5 CODING REMINDERS AND CASE EXAMPLES

Coding Specificity

ELEMENT	DOCUMENTATION REQUIREMENT
Subtype specificity ³⁸	Code the documented CP subtype: G80.0-G80.8 . Reserve G80.9 unspecified only when subtype remains genuinely unknown after record review ³⁸
Spastic quadriplegic CP ³⁶	Document all four limbs affected , quadriplegic pattern, spasticity, contractures, wheelchair dependence, non-ambulatory status, and transfer assistance needs to support G80.0 spastic quadriplegic cerebral palsy ^{35,36}
GMFCS level ²⁷	Record GMFCS level to anchor functional severity, mobility support needs, fall risk, seating/DME requirements, caregiver burden, and care-planning intensity ²⁷
Comorbidity assessment ³³	Code each active CP-related condition separately when addressed: epilepsy (G40.-), dysphagia (R13.1-), chronic pain (G89.29/R52), osteoporosis (M81.-), sarcopenia/malnutrition (M62.84/E43-E44.-), incontinence (R32/N39.-), depression/anxiety (F32.-/F33.-/F41.-) ^{3,33}
Functional status and trajectory ³³	Document baseline and change over time: ambulation, transfers, falls, ADLs/IADLs, spasticity, contractures, pain, swallowing, nutrition/weight trend, communication method, and caregiver support ^{21,33}
DME/seating dependence ³⁸	Document wheelchair use, orthotics, seating system, transfer equipment, gait aid, pressure-injury risk, repair/replacement needs, and how equipment supports mobility, posture, skin protection, and ADLs ³⁸

ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services; CNA = Community Non-Dual Eligible, Aged; CP = cerebral palsy; GMFCS = Gross Motor Function Classification System; HCC = Hierarchical Condition Category; ICD-10-CM = International Classification of Diseases, 10th Revision, Clinical Modification; RAF = Risk Adjustment Factor



AAVBC PERSPECTIVE

For adults with cerebral palsy, the **Annual Wellness Visit** should be used to update **GMFCS/function**, screen for **dysphagia, falls, pain, depression, DXA triggers, DME/seating needs, and caregiver support** — not simply confirm “CP stable.” This structured check-in

helps identify preventable risks earlier and supports better care coordination. AAV completion is associated with **lower odds of preventable hospitalization**.²¹

Annual Clinical Review and Confirmation

- **Annual review:** Cerebral palsy subtype and functional impact should be reassessed at least once per calendar year with MEAT documentation, even when neurologic status is stable³³
- **Visit modality:** Face-to-face or synchronous audio-video telehealth qualifies when it supports meaningful functional assessment, caregiver input, medication review, DME review, and comorbidity documentation^{4,10,11}
- **Clinical context:** Adult CP is a lifelong neurologic condition with evolving risks, including **falls, pain, dysphagia, epilepsy, osteoporosis, depression/anxiety, malnutrition, caregiver burden, and mobility decline**³⁶
- **Avoid rollover:** Do not copy forward “cerebral palsy” without updating **subtype, GMFCS level, mobility status, assistive devices, comorbidities, caregiver support, and current care needs**^{1,14}

Good Documentation — EHR Tips

EHR TIP	WHAT TO INCLUDE
“Cerebral palsy”/“CP” ³⁸	Spastic quadriplegic cerebral palsy (G80.0), GMFCS V , wheelchair-dependent, dependent for transfers and most ADLs; caregiver assists with feeding, medications, transportation, and DME coordination” — not “cerebral palsy” alone ^{1,2,28}
“Stable CP” without functional review” ¹	Neurologic subtype stable, but adult CP functional status reviewed: mobility, transfers, falls, spasticity, pain, swallowing, nutrition, DME/seating, skin risk, caregiver support, and ADL/IADL needs ^{1,23}
Functional decline not trended ¹	Baseline wheelchair-dependent; now increased transfer difficulty, 2 falls this year, worsening hip pain, 6% weight loss, and new coughing with meals. PT/OT, swallow evaluation, nutrition review, and DME reassessment initiated ^{1,28}
Dysphagia not linked to aspiration risk ²⁸	Oropharyngeal dysphagia in adult with CP: coughing/choking with meals, prolonged feeding time, weight loss, aspiration risk, diet texture, swallow referral, and caregiver feeding support documented ^{1,28}

EHR TIP	WHAT TO INCLUDE
Falls documented without CP context¹	Falls related to CP-associated spasticity, contractures, impaired balance, transfer difficulty, and mobility limitations ; home safety review, PT/OT referral, orthotics/DME needs, and caregiver transfer training documented ¹
Pain documented without source or plan^{1,2}	Chronic musculoskeletal pain in adult with CP, likely related to spasticity, contractures, hip degeneration, positioning, or overuse ; pain score, functional impact, medication plan, PT/PM&R referral, and nonpharmacologic strategies reviewed ^{1,2}
ITB pump noted without safety plan¹⁷	Intrathecal baclofen pump: dose, refill date, last interrogation, response, adverse effects, and emergency plan for withdrawal/overdose symptoms documented; PM&R/pump clinic follow-up confirmed ¹
AWV missing CP surveillance items²¹	AWV used for CP surveillance: GMFCS/function, dysphagia screen, fall-risk assessment, PHQ-9, pain assessment, DXA trigger, DME/seating review, medication review, and caregiver support documented ^{23,24}
Communication impairment mistaken for incapacity^{18,27}	Patient communicates via speech-generating device/yes-no board/caregiver-supported communication; decision-making capacity assessed directly with accommodations. Motor or speech impairment does not equal cognitive impairment^{18,27}
Caregiver role not documented⁵	Primary caregiver present; assists with feeding, transfers, medication administration, appointments, transportation, DME coordination, skin checks, and symptom monitoring ; caregiver burden and social work needs assessed

ABBREVIATIONS: ACP = advance care planning; AED = antiepileptic drug; ASCO = American Society of Clinical Oncology; CBC = complete blood count; CYP3A4 = cytochrome P450 3A4; EGFR = epidermal growth factor receptor; IDH = isocitrate dehydrogenase; MGMT = O⁶-methylguanine DNA methyltransferase; MRI = magnetic resonance imaging; TERT = telomerase reverse transcriptase; TMZ = temozolomide



DOCUMENTATION REMINDER — MOTOR OR SPEECH IMPAIRMENT IS NOT COGNITIVE IMPAIRMENT

Document the patient's **preferred communication method**, accommodations used, decision-making participation, and capacity assessment when relevant. Do not infer cognitive impairment from **dysarthria, abnormal movement, wheelchair use, or communication-device use**. Engage the patient directly whenever possible; caregiver input supports care planning but should not replace the patient's voice when the patient can participate^{23,24,27}

Brief Case Examples

SUCCESS — Subtype Specified, Complications Caught Early, Care Coordinated

Patient: 71-year-old male with **spastic quadriplegic cerebral palsy, GMFCS V**, epilepsy on levetiracetam, and intrathecal baclofen pump. Communicates by speech-generating device and is fully oriented. Presents with coughing during meals, 6% weight loss, and hip/shoulder pain.

Documentation: “**Spastic quadriplegic cerebral palsy (G80.0), GMFCS V** — all four limbs affected, wheelchair-dependent, dependent for transfers and most ADLs; caregiver assists with feeding, medications, transportation, and DME coordination. New oropharyngeal dysphagia with aspiration risk (**R13.12**) → swallow evaluation ordered. Chronic hip/shoulder pain (**G89.29**) assessed; osteoporosis risk reviewed; DXA ordered. Epilepsy (**G40.-**) controlled on levetiracetam. PHQ-9 administered with caregiver support; depression treated. Intrathecal baclofen pump reviewed; dose/refill date confirmed and emergency withdrawal plan documented.”

Outcome: Documentation supports the correct CP subtype and functional severity, captures active comorbidities separately, and shows MEAT support for care coordination. Dysphagia is identified before aspiration pneumonia, bone-health risk is addressed before fracture, and medication/DME/caregiver needs are documented at the encounter.

PITFALL — Unspecified Coding and Omitted Complexity

Documentation as written: “71-year-old with cerebral palsy, stable. Continue current medications. Cerebral palsy, unspecified (**G80.9**).”

Consequence: CP subtype and GMFCS level are not documented. The note misses quadriplegic involvement, wheelchair dependence, transfer needs, dysphagia, weight loss, pain, epilepsy, baclofen pump safety, bone-health risk, depression screening, and caregiver support. “Stable CP” understates adult CP complexity and fails to show current MEAT support.

RAF Impact: If the patient has documented spastic quadriplegic CP, **G80.0** supports higher-severity CP classification than **G80.9 unspecified**. Missing active comorbidities such as epilepsy, dysphagia, malnutrition/weight loss, osteoporosis risk, depression, and chronic pain also understates clinical complexity and care needs.

Fix: “**Spastic quadriplegic cerebral palsy (G80.0), GMFCS V**, all four limbs affected; wheelchair-dependent and dependent for transfers/ADLs. New dysphagia with weight loss → swallow evaluation and nutrition plan. Chronic pain assessed; DXA ordered due to non-ambulatory status/anticonvulsant exposure. Epilepsy controlled on levetiracetam. Baclofen pump refill/safety plan reviewed. PHQ-9 completed; caregiver support and DME/seating needs documented.”

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