

Documentation and Coding

NOVEMBER 2025

Cerebral Palsy (CP)

At Healthfirst, we are committed to helping providers accurately document and code their patients' health records. This tip sheet is intended to assist providers and coding staff with the documentation and ICD-10-CM selection, along with the Centers for Medicare & Medicaid Services (CMS), on services submitted to Healthfirst - specifically for **Cerebral Palsy**. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for the services outlined. Coverage decisions are based on the terms of the applicable evidence of coverage and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.

Cerebral Palsy (CP) is a no progressive permanent disorder that affects normal movement in various areas of the body. CP can be caused by a number of things, including birth injury which affects healthy development of the brain.

ICD-10-CM Codes and Descriptions

ICD-10-CM	Description
G80.0	Spastic Quadriplegic Cerebral PalsyCongenital Spastic Paralysis (Cerebral)
G80.1	Spastic Diplegic Cerebral PalsySpastic Cerebral Palsy NOS
G80.2	Spastic Hemiplegic Cerebral Palsy
G80.3	 Athetoid Cerebral Palsy Double Athetosis Syndrome Dyskinetic Cerebral Palsy Dystonic Cerebral Palsy Vogt Disease
G80.4	Ataxic Cerebral Palsy
G80.8	Other Cerebral PalsyMixed Cerebral Palsy Syndromes

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ICD-10-CM	Description	
G80.9	Cerebral Palsy, UnspecifiedCerebral Palsy NOS	

Documentation Recommendations

Impairments	Other Conditions	Diagnostics	Treatment
 Motor Intellectual Movement Flexibility Dysphagia Other 	 Osteoarthritis Degenerative Arthritis Post-impairment syndrome Depression Seizures/Epilepsy ADHD Vision/hearing Heart & lung disease Other 	 Electroencephalogram (EEG) MRI/Cranial Ultrasound Labs Other 	 Physical/Occupational therapy Speech/Alternative/ Recreational therapy Medications Surgery/casting Mobility aids Assistive devices/referrals

Coding Tips

- Code the condition to the highest level of specificity.
- Cerebral Palsy is a chronic condition that should be captured & coded in every visit.
- Do not code **G80** Cerebral Palsy with **G11.4** Hereditary spastic paraplegia as they should never be coded at the same time.

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Coding Example

Case 1	A non-verbal 65-year-old male, who has cerebral palsy and an intellectual disability, presents to the emergency department with a traumatic head injury after falling and striking his head on the sidewalk. The patient was witnessed with loss of consciousness for approximately two minutes and on admission he appeared lethargic and drowsy. While completing the Glasgow coma scale, the provider evaluated eye opening and motor response; however, since the patient was non-verbal at baseline, the best verbal response could not be assessed. What is the appropriate code assignment for the Glasgow coma scale score? Is it appropriate to assign code R40.244-, Other coma, without documented Glasgow coma scale score, or with partial score reported, since the best verbal response could not be assessed?
AHA Coding Clinic, Volume 7, 3 rd Quarter, Number 3 2020, Page 46	Assign code R40.2442, Other coma, without documented Glasgow coma scale score, or with partial score reported, at arrival to emergency department, along with the appropriate codes from subcategories R40.21, Coma scale, eyes open; and R40.23 Coma scale, best motor response. Code R40.2441 indicates a partial score. Therefore, it would be appropriate to also assign codes from subcategories R40.21 and R40.23, with code R40.2441, to describe the other available scores (e.g., eye and motor response).

References

- Mayoclinic Cerebral-Palsy
- Cerebral-Palsy Guide
- ICD-10 CM Official Coding Guidelines

Questions?

Contact us at #Risk Adjustments and clinical Documentation@healthfirst.org.

For additional documentation and coding guidance, please visit the coding section on HFproviders.org

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