August 10, 2026

SUBMITTED ELECTRONICALLY ***via nchsicd10cm@cdc.gov***

National Center for Health Statistics
ICD-10-CM Coordination and Maintenance Committee
Centers for Disease Control and Prevention
nchsicd10cm@cdc.gov

RE: CPR Support for Proposed ICD-10-CM Diagnosis Code for Spasticity

Dear ICD-10-CM Coordination and Maintenance Committee Members:

On behalf of the undersigned organizational members of the Coalition to Preserve Rehabilitation ("CPR"), we write in strong support of the Academy of Physical Medicine & Rehabilitation's ("AAPM&R") proposal to establish a dedicated ICD-10-CM diagnosis code for spasticity. This proposal represents an important step toward improving the identification, evaluation, and management of one of the most common and disabling consequences of neurological injury and other conditions. As the number of Americans living with chronic neurological disabilities continues to grow, we believe accurately recognizing spasticity as a distinct clinical condition has become increasingly important to ensuring patients receive the comprehensive rehabilitation interventions necessary to maximize function, independence, health, and quality of life.

CPR is a coalition of more than 50 national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities, and chronic conditions may regain and/or maintain the maximum level of health and independent function. CPR is comprised of organizations that represent patients—as well as the providers who serve them—who are frequently inappropriately denied access to rehabilitative care in a variety of settings.

Spasticity is one of the most common and functionally significant secondary conditions experienced by individuals with neurological injury and disease. It affects individuals recovering from stroke, traumatic brain injury, spinal cord injury, multiple sclerosis, cerebral palsy, amyotrophic lateral sclerosis, and numerous other upper motor neuron disorders. Left untreated or inadequately managed, spasticity can substantially limit mobility, interfere with activities of daily living, increase caregiver burden, contribute to pain, contractures, skin breakdown, falls, and hospitalizations, and ultimately diminish an individual's ability to achieve or maintain functional independence.

For rehabilitation professionals, spasticity is not merely a symptom; it is frequently a primary target of interdisciplinary rehabilitation treatment. Physical medicine and rehabilitation physicians, physical therapists, occupational therapists, speech-language-pathologists, and other rehabilitation professionals routinely develop individualized treatment plans specifically designed to address the functional consequences of spasticity. Accurate identification of spasticity is therefore fundamental to the rehabilitation process and directly informs treatment planning, goal setting, resource utilization, and long-term care management.

Unfortunately, the current ICD-10-CM classification system does not adequately recognize spasticity as a distinct clinical indication. Clinicians are often forced to rely on diagnosis codes describing unrelated muscle spasms or broader neurological diagnoses that fail to capture the presence, severity, and functional significance of spasticity. These coding limitations obscure the true prevalence of the condition. ***CPR believes that a distinct diagnosis code will not only enhance clinical documentation, but also facilitate timely access to specialized rehabilitation services, improve care coordination across the continuum of care, strengthen outcomes measurement and research, and provide policymakers with more accurate data to inform future coverage and payment decisions.***

From a medical rehabilitation perspective, establishing a dedicated diagnosis code for spasticity would produce several important benefits. First, a distinct code would improve identification of patients who require specialized rehabilitation services. Spasticity frequently evolves over time following neurological injury, requiring ongoing reassessment and adjustment of treatment plans. Accurate coding would facilitate earlier recognition of clinically significant spasticity and help ensure that patients receive timely referrals to physiatrists and multidisciplinary rehabilitation teams before preventable secondary complications develop.

Second, improved coding would strengthen the collection of clinical data necessary to evaluate rehabilitation outcomes. Federal agencies, researchers, health systems, and payers increasingly rely upon administrative claims data to assess patterns of care, evaluate quality measures, monitor utilization, and identify opportunities for improving outcomes. Without a diagnosis code specifically identifying spasticity, these analyses remain incomplete and frequently underestimate the burden of this disabling condition. Third, we believe the creation of a dedicated code would improve care coordination across the continuum of rehabilitation. Individuals with spasticity often receive care from multiple providers over many years, including physicians, inpatient rehabilitation hospitals and units, outpatient rehabilitation therapy clinics, orthotic providers, home health agencies, and long-term care settings. Consistent documentation and coding would improve communication among treating professionals and support continuity of care throughout the rehabilitation process.

CPR strongly believes that a dedicated diagnosis code would also better support evidence-based patient management. Effective treatment of spasticity often requires a comprehensive combination of rehabilitation therapies, therapeutic exercise, stretching programs, orthotic management, oral medications, botulinum toxin injections, and other interventions tailored to an individual's functional goals. Because spasticity differs fundamentally from nonspecific muscle

spasms in its underlying treatment approach, it should be recognized through a distinct diagnostic classification that accurately reflects current clinical practice.

From a Medicare policy perspective, establishing a dedicated ICD-10-CM code for spasticity would also improve the ability of clinicians to document the medical necessity of rehabilitation services and other evidence-based interventions furnished to Medicare beneficiaries with neurological impairments. Many individuals with stroke, traumatic brain injury, spinal cord injury, multiple sclerosis, and other neurological conditions require ongoing management of spasticity to preserve function, prevent avoidable complications, and maintain independence in the least restrictive setting. More precise diagnostic coding would better reflect the clinical complexity of these beneficiaries and support documentation associated with rehabilitation therapies, orthotic management, and other medically necessary treatments directed specifically at spasticity.

CPR strongly impresses on this Committee that improved coding would likewise enhance the Center for Medicare and Medicaid Services' ("CMS") ability to evaluate health care utilization, patient outcomes, and the effectiveness of rehabilitation interventions across the Medicare program. As CMS increasingly relies on claims-based data to develop quality measures, evaluate payment policies, and assess value-based care initiatives, accurately distinguishing spasticity from nonspecific muscle spasms will generate more meaningful information regarding disease burden, treatment patterns, functional outcomes, and health care expenditures. Better data will support future coverage and payment decisions grounded in real-world evidence while helping identify opportunities for earlier intervention that may reduce preventable complications, hospitalizations, institutionalization, and overall Medicare spending associated with unmanaged spasticity.

For these reasons, CPR strongly supports AAPM&R's proposal to establish a dedicated ICD-10-CM diagnosis code for spasticity. Recognizing spasticity as a distinct clinical condition within the ICD-10-CM classification system will improve diagnostic accuracy, strengthen documentation of medical necessity, enhance rehabilitation outcomes management, facilitate research, improve care coordination, and provide CMS and other policymakers with more reliable data to inform future coverage, quality, and payment policies. Most importantly, it will help ensure that individuals living with neurological disabilities are identified earlier and have better access to timely, appropriate, and evidence-based rehabilitation services that maximize function, independence, and quality of life.

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Thank you for your consideration of these comments. Should you have any further questions regarding this information, please contact Peter Thomas or Michael Barnett, Co-coordinators of CPR, by e-mailing Peter.Thomas@PowersLaw.com or Michael.Barnett@PowersLaw.com, or by calling 202-466-6550.

Sincerely,

The Undersigned Members of the Coalition to Preserve Rehabilitation

ACCSES
ALS Association
American Association on Health and Disability
American Congress of Rehabilitation Medicine
American Medical Rehabilitation Providers Association
American Spinal Injury Association
American Therapeutic Recreation Association
Association of Academic Physiatrists
Association of Rehabilitation Nurses
Barin Injury Association of America*
Center for Medicare Advocacy*
Child Neurology Foundation
Christopher & Dana Reeve Foundation*
Clinician Task Force
Disability Rights Education and Defense Fund (DREDF)
Falling Forward Foundation*
Lakeshore Foundation
Muscular Dystrophy Association
National Association for the Advancement of Orthotics and Prosthetics (NAAOP)
National Association of Rehabilitation Providers and Agencies
National Association of Social Workers (NASW)
National Disability Rights Network (NDRN)
National Multiple Sclerosis Society*
RESNA
Spina Bifida Association
United Cerebral Palsy

****CPR Steering Committee Member***