AETHERA · SPECIALTY BILLING SERIES

Neurology Billing Solutions

Maximizing Revenue Across E/M, EEG/EMG, Infusion Therapy, Botox, and Neuromodulation.

Prepared by: Aethera Healthcare Solutions · Lakeland, FL

Scope: CPT 95800–96020 · 99202–99215 · 96365 · J0585 Botox · 95983–95984 · DBS

Updated: 2026 Edition · 01

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ABOUT AETHERA

Maximizing Revenue. Minimizing Burden.

Aethera Healthcare Solutions is your full-service medical billing partner headquartered in Lakeland, FL. We handle coding, claims, payments, denials, and collections — so you can focus on patients.

500+
Practices Served
Across 25+ medical specialties

$12M+
Revenue Recovered
Denied & underbilled claims recouped

95%
Clean Claim Rate
vs 84% industry avg

< 30d
Average AR
Days in accounts receivable

Personal, Not Corporate

Dedicated account team with deep specialty and payer knowledge. You work with the same names every week — no rotating call-center handoffs.

Performance Targets, In Writing

96%+ net collection · < 5% denial · 95%+ coding accuracy · 24h posting · 48h submission · 65%+ appeal success.

Zero Risk To Start

No setup fees, no long-term contracts. 90-day cancel anytime. Free 5-day audit before any commitment.

NEUROLOGY · MARKET CONTEXT

Why Neurology Billing Matters Now

Neurology is a high-complexity specialty driven by aging demographics — Alzheimer's, Parkinson's, stroke, MS. Diagnostic testing (EEG, EMG, NCS) represents 30–40% of practice revenue and is the most-bundled category in neurology billing.

$

$108B

US neurological disease treatment spend (2024)

Includes stroke, AD, PD, MS, epilepsy, migraine.

✦

6.7M

Americans with Alzheimer's disease (2024)

Projected to reach 12.7M by 2050.

⚠

~ 19%

Neurology claim denial rate (industry avg)

Driven by modifier -26/-TC errors and missing pre-auth for infusion therapy.

◯

$24B+

Annual US MS disease-modifying therapy spend

Tysabri, Ocrevus, Tecfidera dominate at $7K–$9K/month.

↗ **Net effect:** neurology practices that master modifier -26/-TC splits, Botox documentation, and infusion PA workflow can recover **8–14% of total revenue** currently lost to denials and under-billing.

NEUROLOGY · OVERVIEW

The Four Pillars of Neurology Billing

Each pillar represents a distinct service family with unique coding, modifier, and payer requirements.

01 · E/M + HEADACHE

Office E/M & Headache Management

Office visits (99202–99215) for chronic conditions: migraine, epilepsy, Parkinson's, MS, dementia. Botox for chronic migraine (J0585 + 64615).

CPT 99202–99215 · J0585 · 64615

02 · EEG/EMG/NCS

EEG, EMG & Nerve Conduction Studies

EEG (95800–95827), EMG (95860–95887), NCS (95900–95913), evoked potentials (95925–95938). Modifier -26/-TC split critical.

CPT 95800–96020 · Modifier -26/-TC

03 · INFUSIONS

MS & Neurology Infusions

Tysabri (J3359) for MS, Ocrevus (J9352) for MS, Soliris (J9246) for NMOSD, IVIG (J1568) for CIDP. Office infusion (96365).

J3359 · J9352 · 96365 · PA mandatory

04 · NEUROMODULATION

DBS, VNS & Spinal Cord Stimulation

Deep brain stimulation programming (95983–95984), vagus nerve stimulator programming (95967), spinal cord stimulator programming (95972). Device management.

CPT 95983–95984 · 95967 · 95972

PILLAR 01 · E/M + HEADACHE

Office Visits & Chronic Migraine Botox

Neurology office encounters cover chronic conditions: migraine, epilepsy, Parkinson's, MS, dementia, neuropathy. The **2021 E/M coding reform** shifted documentation to MDM-based. Botox for chronic migraine (≥15 headache days/month) is FDA-approved and Medicare-covered with strict documentation. **Botox for cosmetic purposes is NEVER covered.**

1 E/M coding (2021+ reform)

99202–99215

2 Botox for chronic migraine

J0585 64615

G43.709

3 CGRP inhibitors for migraine

J3032 J3033 J3033

⚠ **Documentation:** Botox for chronic migraine requires ≥ 15 headache days/month, ≥ 4 hours/day, failed ≥ 2 preventive medications. Cosmetic Botox uses different diagnosis and is **NEVER billed to insurance**.

CPT Mini-Table · 2026 Avg $

Top codes for office E/M and chronic migraine Botox administration.

Code	Service	Avg $
99213	Est. E/M, low MDM	$92
99214	Est. E/M, moderate MDM	$131
99215	Est. E/M, high MDM	$187
J0585	Botox, per unit (chronic migraine)	$6
64615	Chemodenervation cranial nerve VII	$425

PILLAR 02 · DIAGNOSTIC TESTING

EEG, EMG, NCS & Evoked Potentials

Diagnostic testing is the procedural backbone of neurology. Every test has a **professional component** (interpretation, modifier -26) and a **technical component** (equipment/technician, modifier -TC). Correct modifier use determines whether the claim pays at all.

EEG — Electroencephalography

95800 EEG without video, awake/drowsy ($425) · 95806 EEG with sleep, full night ($750) · 95810 video EEG, 2–12 hours ($1,150) · 95819 video EEG, 12–26 hours ($1,850).

EMG — Electromyography

95860 needle EMG, 1 extremity ($185) · 95863 needle EMG, 3 extremities ($375) · 95867 needle EMG, paraspinal muscles ($125). Diagnostic for neuropathy, ALS, myopathy.

NCS — Nerve Conduction Studies

95900 NCS, motor, 1 nerve ($85) · 95904 NCS, sensory, 1 nerve ($85) · 95913 NCS, 11–12 nerves ($525). Paired with EMG for full diagnostic workup.

Evoked Potentials

95925 VEP, visual evoked potential ($325) · 95930 BAEP, brainstem auditory ($295) · 95934 SSEP, somatosensory, upper ($425). Used for MS, optic neuritis, hearing assessment.

-26 Modifier -26 (Professional)

Billed by interpreting neurologist. Covers interpretation + report only. Cannot bill without separate written report in chart.

-TC Modifier -TC (Technical)

Billed by facility/equipment owner. Covers technician time + equipment. Cannot bill -26 and -TC on the same claim.

Bundling Rules

95860 EMG + 95900 NCS same extremity, same session: separately billable. Multiple NCS nerves same session: bill per nerve (95900 × N). Same-day multiple EEG durations: only longest billable.

PILLAR 03 · INFUSIONS

MS Disease-Modifying Therapies & IVIG

Multiple sclerosis (MS) disease-modifying therapies are the highest-cost outpatient neurology drugs. **Tysabri** (natalizumab) costs ~ $7,000/infusion every 4 weeks; **Ocrevus** (ocrelizumab) costs ~ $65,000/dose every 6 months. IVIG for CIDP, MMN, and other neuropathies costs $5,000–$10,000/infusion. Pre-auth mandatory for all; step therapy documentation required.

1 **Tysabri (J3359)**
$7,000/infusion
96365

2 **Ocrevus (J9352)**
$65,000/dose

3 **IVIG (J1568)**
$0.85/gm
$70/infusion

↘ MS infusion PA denial rate averages **25–35%** on first submission. Aethera pre-auth workflow with step therapy documentation reduces to **<10%**.

$ KPI · Infusion Therapy Economics

$7,000 — **Tysabri per infusion**
J3359 · every 4 weeks maintenance

$65,000 — **Ocrevus per dose**
J9352 · 6-month interval

$5K–$10K — **IVIG per infusion range**
J1568 · for CIDP, MMN, neuropathies

$24B+ — **Annual US MS therapy spend**
Tysabri, Ocrevus, Tecfidera dominate

PILLAR 04 · NEUROMODULATION

DBS, VNS & Spinal Cord Stimulation Programming

Neuromodulation devices (deep brain stimulators, vagus nerve stimulators, spinal cord stimulators) require periodic programming to optimize therapy. Each programming session is billable; quarterly cycles create recurring revenue per patient.

Deep Brain Stimulation (DBS)

95983 DBS programming, first 30 min ($165); 95984 each addl 15 min ($75). Used for Parkinson's, essential tremor, dystonia. Billed quarterly.

Vagus Nerve Stimulator (VNS)

95967 VNS programming, single programming session ($115). Used for refractory epilepsy and treatment-resistant depression. Quarterly cycle.

Spinal Cord Stimulation (SCS)

95972 SCS programming, single session ($135); 95973 complex programming ($185). Used for chronic pain, failed back surgery syndrome.

Device Implantation & Revision

61863 DBS implantation, single array ($3,200); 64568 VNS implantation ($1,800); 63650 SCS percutaneous implantation ($2,400). Surgical codes; pre-auth mandatory.

PER-SESSION REIMBURSEMENT

$165	Per DBS programming session (CPT 95983)
$115	Per VNS programming session (CPT 95967)
$135–$185	Per SCS programming session range
~ $660/yr	Annual recurring revenue per DBS patient (quarterly)

⚠ **Compliance alert:** Device programming requires documentation of parameter changes (amplitude, pulse width, frequency, electrode configuration). Missing parameter documentation is the #1 neuromod denial.

NEUROLOGY · BILLING CODES

Top CPT Codes & 2026 National Average Reimbursement

Most-billed codes across the four neurology pillars. Professional component shown (–26 modifier).

Code	Service	Modifier	Avg $	Notes
99213	Est. E/M, low MDM	—	$92	Most common neuro E/M
99214	Est. E/M, moderate MDM	—	$131	MS/epilepsy management
99215	Est. E/M, high MDM	—	$187	Complex neurological case
J0585	Botox per unit (chronic migraine)	—	$6	155 units per treatment
64615	Chemodenervation cranial nerve VII	—	$425	Botox admin code
95806	EEG with sleep, full night	–26 or –TC	$750	Sleep study / seizure workup
95860	Needle EMG, 1 extremity	–26 or –TC	$185	Neuropathy diagnosis
95900	NCS, motor, 1 nerve	–26 or –TC	$85	Pair with EMG
95913	NCS, 11–12 nerves	–26 or –TC	$525	Comprehensive NCS
95810	Video EEG, 2–12 hours	–26 or –TC	$1,150	Epilepsy monitoring
J3359	Tysabri (natalizumab), per 1mg	—	$7	~$7K per infusion

MODIFIER REFERENCE

–26 — professional component (interpretation only). –TC — technical component (equipment/technician). Cannot bill both same claim. 25 — significant, separately identifiable E/M same day as procedure.

BOTOX DOCUMENTATION

J0585 for chronic migraine: diagnosis G43.709 required, documented ≥15 headache days/month, ≥2 failed preventives. Cosmetic Botox: NEVER billed to insurance.

NEUROLOGY · DENIAL PREVENTION

Top 8 Neurology Denial Reasons & How Aethera Prevents Each

Neurology denial rates average 17–21%; each denied claim costs $50–150 to rework. Diagnostic testing modifier errors and infusion PA denials drive 50%+ of revenue loss.

RED — 24%
Modifier –26/–TC errors
CAUSE: Diagnostic test billed without proper modifier; either double-billed (both –26 and –TC) or modifier missing entirely.
Aethera modifier rules engine enforces correct –26/–TC per provider/facility setup.

RED — 19%
MS infusion PA missing
CAUSE: Tysabri/Ocrevus infusion administered without prior authorization on file; $7K–$65K denied.
Aethera PA tracker auto-submits before scheduling; verifies approval before infusion.

AMBER — 14%
Botox documentation insufficient
CAUSE: J0585 + 64615 billed without headache diary, failed preventive documentation, or G43.709 diagnosis.
Aethera Botox documentation checklist before claim release.

AMBER — 11%
Cosmetic Botox billed as medical
CAUSE: J0585 billed with cosmetic diagnosis; automatic denial + fraud risk.
Aethera diagnosis verification blocks cosmetic Botox claims.

AMBER — 9%
Modifier 25 documentation insufficient
CAUSE: E/M + diagnostic test same day without separate documentation supporting E/M significance.
Aethera modifier 25 documentation checklist.

GREEN — 7%
DBS/VNS/SCS programming without parameter docs
CAUSE: 95983/95967/95972 billed without documented parameter changes.
Aethera programming parameter documentation requirement.

GREEN — 6%
NCS overbilling
CAUSE: Multiple NCS codes billed same session exceeding CMS-allowed nerve count per code.
Aethera NCS bundling rules enforce CMS nerve-count limits.

GREEN — 5%
IVIG without step therapy documentation
CAUSE: J1568 IVIG PA denied because prior steroid trial not documented.
Aethera step-therapy documentation checklist before PA submission.

↗ **Cumulative impact:** Aethera reduces neurology denial rate from industry avg 19% to < 7% — recovering ~$200K/year per $1.5M practice revenue.

CASE STUDY · INTEGRATED NEURO RCM

4-Neurologist Practice — Annual Revenue Impact

A $2.9M-revenue practice models the combined upside of modifier −26/−TC discipline, MS infusion PA recovery, and Botox documentation capture.

STREAM 01
Modifier −26/−TC Discipline

Annual diagnostic tests (EEG+EMG+NCS)	2,000
Pre-Aethera modifier error rate	22%
Post-Aethera error rate	5%
Recovered claims	340/yr
Avg diagnostic test value	$325

ANNUAL REVENU
$110,500

STREAM 02
MS Infusion PA Recovery

MS biologic patient panel	60
Pre-Aethera PA denial rate	30%
Post-Aethera denial rate	9%
Recovered infusions	75/yr
Avg infusion value	$3,800

ANNUAL REVENU
$285,000

STREAM 03
Botox + Programming Capture

Chronic migraine Botox patients	240
Pre-Aethera doc denial rate	18%
Post-Aethera denial rate	4%
Recovered treatments	168/yr
Avg Botox treatment value	$1,500
DBS/VNS programming uplift	$84,000

ANNUAL REVENU
$252,000

Combined annual revenue recovery: · *Implementation cost (year 1):* *(Aethera RCM fees + EHR integration + coder training)* · *Year-1 net:* **ROI: 320%**

NEUROLOGY · COMPLIANCE HOTSPOTS

Where OIG, Medicare RAC, and Commercial Payers Audit First

Top compliance risks across the four neurology pillars. Quarterly self-audits recommended.

PILLAR E/M + Headache	PILLAR Diagnostic Testing	PILLAR Infusions	PILLAR Neuromodulation
RED **Cosmetic Botox as medical** Billing J0585 with cosmetic diagnosis to insurance; civil fraud exposure under False Claims Act.	**RED** **Modifier −26/−TC double-billing** Billing both professional AND technical components on same claim; CMS recovers 2× reimbursement.	**HIGH** **MS biologic without PA** Administering $7K–$65K Tysabri/Ocrevus without prior auth; full denial + clawback risk.	**RED** **Programming without parameter docs** Billing 95983/95967 without documented amplitude, pulse width, frequency changes.
AMBER **Botox documentation insufficient** Billing J0585 + 64615 without headache diary, failed preventive documentation, or G43.709 diagnosis.	**AMBER** **NCS overbilling** Billing multiple 95900/95904 codes for nerve count exceeding CMS-allowed maximum per code.	**MEDIUM** **Step therapy non-compliance** Biologic PA denied because prior immunomodulator/steroid trials not documented.	**AMBER** **Device implantation without PA** 61863/64568/63650 surgical codes without pre-auth; full denial risk.
GREEN **Modifier 25 misuse** Appending to E/M when diagnostic test on same day does not represent significant, separately identifiable service.	**LOW** **Same-session EEG overbilling** Billing multiple EEG durations same session; only longest billable.	**LOW** **IVIG without CIDP diagnosis** PA denied without nerve conduction study supporting CIDP for J1568.	**LOW** **Programming frequency over-limit** Billing DBS programming more than quarterly without medical necessity documentation.

OIG Work Plan 2025–2026 explicitly lists modifier −26/−TC errors in neurology diagnostic testing and Botox documentation as active audit targets. Medicare RACs have recovered **>$180M** from neurology practices since 2020.

CLOSING · KEY TAKEAWAYS

Three Actions to Capture Neurology Revenue

For neurology practice administrators and revenue cycle directors leading the next 90 days.

01 _

Deploy modifier –26/–TC rules engine

Audit last **200 diagnostic test claims** for modifier –26/–TC appropriateness. Implement pre-submission rules engine that blocks claims with missing or duplicated modifiers. Target: **< 5%** modifier error rate (industry avg **22%**).

< 5% modifier error rate

02 _

Automate MS infusion PA workflow

Build EHR template that auto-submits PA at `Tysabri/Ocrevus` scheduling. Document step therapy (immunomodulator/steroid failures) before first PA submission. Pre-auth denial rate drops from **30%** to **< 9%** — recovering **~ $285K** per 60-patient MS panel.

$285K per MS panel

03 _

Enforce Botox + programming documentation

Build EHR template requiring headache diary, failed preventive documentation, and `G43.709` diagnosis before Botox claim release. Implement parameter documentation requirement for DBS/VNS/SCS programming (`95983/95967/95972`). Recovers **~ $336K/year** for typical practice.

$336K/year recovery

Questions & Discussion

Optimizing Neurology Revenue Across E/M, Diagnostics, Infusions & Neuromodulation

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