Neurology Coding Cheat Sheet — HMS USA INC

Readable, printer-friendly reference — common CPTs, modifiers, documentation tips, and denial triggers

Office/Consult E/M

Common Procedure: New patient consult / Office visit

CPT Code(s): 99202–99205, 99241–99245 (consults vary by payer)

Common Modifiers: 25, 24

Notes / Tips: Verify payer acceptance of consult codes vs standard new patient E/M; document history, exam, and MDM clearly.

Documentation Tip: Include problem-focused history, detailed neurologic exam findings, and medical decision-making.

EEG / Ambulatory EEG

Common Procedure: Routine EEG, Ambulatory EEG

CPT Code(s): 95812, 95816–95819 (amb EEG variants)

Common Modifiers: 26 (professional), TC (technical)

Notes / Tips: Report professional and technical components separately when applicable; include indication and interpretation.

Documentation Tip: Attach impression and duration; note conditions during recording (sleep-deprived, medication status).

EMG / NCS

Common Procedure: Needle EMG and Nerve Conduction Studies (NCS)

CPT Code(s): 95860–95872 (EMG), 95900–95913 (NCS)

Common Modifiers: 59 or XE/XS/XP/XU (when distinct), RT/LT

Notes / Tips: Sequence codes by anatomical site; correlate billing with clinical documentation of specific muscles/nerves tested.

Documentation Tip: List muscles tested, findings (denervation/fibrillation), and clinical correlation.

Neurology Procedures

Common Procedure: Nerve block (diagnostic/therapeutic)

CPT Code(s): 64400–64530 (various nerve block sites)

Common Modifiers: 50 (bilateral if applicable), 59/X variants

Notes / Tips: Document laterality, indication, and whether diagnostic vs therapeutic.

Documentation Tip: Include procedural note with consent, ultrasound/fluoro guidance if used, and post-procedure assessment.

Neurosurgery - Craniotomy

Common Procedure: Craniotomy for tumor, excision, approach-specific

CPT Code(s): 61510–61512, 61518 etc.

Common Modifiers: RT/LT, 78 (return to OR), 79 (unrelated procedure)

Notes / Tips: Use approach/laterality-specific codes; bill revisional procedures separately with correct modifiers.

Documentation Tip: Detail operative findings, approach, and concurrent procedures; attach op report.

Spine - Laminectomy / Discectomy

Common Procedure: Lumbar laminectomy, discectomy, fusion

CPT Code(s): 63030, 63047, 22551–22554 (fusion ranges)

Common Modifiers: 59/X variants, 50 (bilateral where applicable), RT/LT

Notes / Tips: Specify levels operated and instrumentation; use add-on codes for additional levels.

Documentation Tip: Document level(s), approach, and use of grafts/instrumentation.

Spinal Cord Stimulator

Common Procedure: Trial and permanent implant

CPT Code(s): 63650 (trial), 63685 (implant)

Common Modifiers: 59 (if distinct procedure same day), 78/79 for returns or unrelated

Notes / Tips: Clearly separate trial from permanent implant episodes; document lead placement and trial outcome.

Documentation Tip: Include trial duration, lead configurations, and patient response.

Imaging/Guidance

Common Procedure: Image guidance for procedures

CPT Code(s): 61783 (stereotactic navigation), 77012/77022 for CT/fluoro guidance

Common Modifiers: 26/TC depending on component

Notes / Tips: Report guidance only when imaging guidance is separately documented and required.

Documentation Tip: Document imaging modality, findings, and how guidance impacted the procedure.

Pain Management Procedures

Common Procedure: Epidural steroid injection, facet joint procedures

CPT Code(s): 64483–64484, 64633–64636 (facet joint)

Common Modifiers: 59/X variants, RT/LT, 50 (if bilateral)

Notes / Tips: Differentiate diagnostic vs therapeutic injections; document approach and imaging guidance.

Documentation Tip: Include laterality, levels injected, medication used, and procedural outcomes.

Peripheral Nerve Procedures

Common Procedure: Carpal tunnel release, ulnar nerve decompression

CPT Code(s): 64721 (carpal tunnel), 64718 (ulnar nerve)

Common Modifiers: 50 (bilateral), RT/LT, 51 (multiple procedures) when required

Notes / Tips: Document operative details and laterality; note if done same session with other procedures.

Documentation Tip: Include operative report, anesthesia type, and postop condition.

Consult & Hospital Care

Common Procedure: Inpatient consults, subsequent hospital visits

CPT Code(s): 99221–99233 (hospital care), 99238–99239 (discharge)

Common Modifiers: 24 (unrelated E/M during global), 25 (significant, separately identifiable E/M)

Notes / Tips: Ensure consult documentation meets payer criteria; capture MDM and time if billing based on time.

Documentation Tip: Include reason for consult, findings, recommendations, and follow-up plan.

Telehealth / Remote Services

Common Procedure: Audio-only or video visits, e-visits

CPT Code(s): 99421–99423 (e-visits), 99201–99215 telehealth equivalents per payer

Common Modifiers: 95, GT (depending on payer), Place of Service codes

Notes / Tips: Check payer-specific telehealth policies and allowed modifier/POC combinations.

Documentation Tip: Document modality used, patient consent for telehealth, and tech issues if any.

Common Modifier Guidance

Common Procedure: Modifier usage overview

CPT Code(s): nan

Common Modifiers: 24, 25, 57, 59, XE/XS/XP/XU, RT/LT, 50, 26, TC, 78, 79

Notes / Tips: Use specific CMS X-modifiers when applicable; avoid overuse of 59; always document medical necessity.

Documentation Tip: For each modifier, maintain clear contemporaneous clinical notes explaining the rationale.

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Denial Triggers (Top Reasons)

Common Procedure: What causes denials

CPT Code(s): nan

Common Modifiers: nan

Notes / Tips: Insufficient documentation, bundling/NCCI edits, wrong CPT family, missing prior auth, incorrect modifiers.

Documentation Tip: Perform pre-bill scrubs and use payer-specific rules to prevent common denials.

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