ⓘ AETHERA · SPECIALTY BILLING SERIES

Internal Medicine Billing Solutions

Maximizing Revenue Across Office E/M, Preventive Care, Chronic Care Management, Hospitalist Medicine, and Procedures

Prepared by: Aethera Healthcare Solutions · Lakeland, FL

Scope: CPT 99202–99215 · 99221–99239 (inpatient) · 99490/99439/99487 · G0438/G0439 (AWV) · 36415–94640 (procedures)

Updated: 2026 Edition · aetherahealthcare.com · + 1 (863) 694-0325

IM

INTERNAL MEDICINE

RCM EXECUTIVE B
202

SPECIALT
13-Slide Deck

EDITIO
2026 · v1

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+ specialties

$12M+
Revenue Recovered
For specialty practices

95%
Clean Claim Rate
vs 84% industry avg

< 30d
Average AR
Days in accounts receivable

Personal, Not Corporate

Dedicated account team with deep specialty/payer knowledge. You talk to the same humans every week — not a rotating queue of generic agents.

Performance Targets, In Writing

96%+ net collection, <5% denial, 95%+ coding accuracy, 24h posting, 48h submission, 65%+ appeal success. Contractual, not aspirational.

Zero Risk To Start

No setup fees, no long-term contracts, 90-day cancellation, free 5-day audit. We earn the relationship every month — not lock you in.

↗ INTERNAL MEDICINE · MARKET CONTEXT

Why Internal Medicine Billing Matters Now

Internal medicine is the largest primary-care specialty — 240M+ Americans count an internist as their PCP. Chronic-care volume, hospital encounters, and office procedures create the broadest billing surface in primary care — and the highest leakage risk.

$156B

US internal medicine treatment spend (2024)

Includes office E/M, inpatient care, procedures, vaccines, and chronic care management.

240M+

Americans with an internist as PCP

~70% of US adults; internists manage most chronic disease in this country.

~12%

Internal medicine claim denial rate (industry avg)

Driven by CCM time documentation gaps and hospital E/M over-coding.

~$1,200/yr

Annual Medicare AWV + CCM opportunity per eligible patient

G0438/G0439 AWV ($95) plus 99490 + 99439 CCM (~$110/yr) per qualifying Medicare patient.

NET EFFECT

Internal medicine practices that capture CCM, AWV, and TCM at scale can recover **6–10% of total revenue** currently lost to under-billing and denials.

INTERNAL MEDICINE · OVERVIEW

The Four Pillars of Internal Medicine Billing

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

01 · E/M + PREV

Office E/M, Preventive & AWV

Office visits (99202–99215), preventive care (99381–99397), Annual Wellness Visits (G0438/G0439). MDM-based coding since 2021; modifier 25 required when same-day procedure.

`CPT 99202–99215 · 99381–99397 · G0438/G0439`

02 · CHRONIC

Chronic Care, Behavioral & Transitions

CCM (99490/99439/99487), Behavioral Health Integration (99484/99492–99494), Transitional Care Management (99495/99496). Monthly recurring revenue; requires ≥2 chronic conditions + electronic care plan.

`CPT 99490 · 99439 · 99487 · 99495/99496`

03 · HOSPITAL

Inpatient, Critical Care & Observation

Inpatient E/M (99221–99223 admission, 99231–99233 subsequent, 99238–99239 discharge), critical care (99291–99292), observation (99218–99220, 99224–99226, 99217). Time-based documentation is the #1 audit target.

`CPT 99221–99239 · 99291–99292 · 99217–99226`

04 · PROCEDURES &

Venipuncture, Injections, Vaccines & Minor Skin

Venipuncture (36415), therapeutic SC/IM injection (96372), vaccine administration (90471–90480), minor skin procedures (17000–17250), joint injections (20600–20610). Modifier 25 discipline is critical.

`CPT 36415 · 96372 · 90471–90480 · 20600–20610`

✦ PILLAR 01 · E/M + PREVENTIVE

Office Visits, Preventive Care & Annual Wellness

Internal medicine office encounters are the practice's revenue backbone — chronic disease follow-up, acute visits, preventive exams, and Medicare Annual Wellness Visits. Since 2021, E/M coding is MDM- or time-based (no more history-driven levels). AWV is a separate, under-captured service with a $95 reimbursement and minimal time burden.

Office E/M (99202–99215)

Code by Medical Decision Making complexity or time. 99213 (low MDM, $92) is most common; 99214 (moderate, $131) and 99215 (high, $187) drive the bulk of revenue. Modifier 25 required for same-day procedure.

Preventive care (99381–99397)

Periodic preventive medicine re-evaluation; new patient (99381–99387) vs established (99391–99397). Age-tiered; includes history, exam, and counseling. Not subject to MDM rules.

Annual Wellness Visit (G0438/G0439)

G0438 initial AWV ($185), G0439 subsequent AWV ($95). Requires health risk assessment, fall risk, cognitive assessment. AWV is the #1 under-billed Medicare service in IM.

◆ AWV capture rate at most IM practices is **< 30% of eligible Medicare patients** — Aethera workflows lift it to **> 75%** with no extra physician time.

▦ TOP OFFICE E/M & PREVENTIVE CODES

2026 Medicare reimbursement

Code	Service	Avg $
99213	Est. E/M, low MDM	$92
99214	Est. E/M, moderate MDM	$131
99215	Est. E/M, high MDM	$187
G0438	Initial AWV	$185
G0439	Subsequent AWV	$95
99395	Preventive, est., 40–64	$275

DOCUMENTATION KEYS

- MDM complexity drives 99202–99215 (since 2021)
- Modifier 25 when E/M + procedure same day
- AWV requires HRA + fall risk + cognitive assessment
- Preventive (99381–99397) is age-tiered, not MDM-based

✦ PILLAR 02 · CHRONIC CARE MANAGEMENT

CCM, Behavioral Health Integration & Transitional Care Mgmt

Chronic Care Management is the most under-billed code family in internal medicine. Most IM patients have ≥2 chronic conditions and qualify — yet national enrollment sits below 15% of eligible Medicare patients. CCM generates monthly recurring revenue at near-zero marginal cost.

CCM (99490/99439/99487)

99490 first 20 min/month ($62.60); 99439 each add'l 20 min ($47.40, max 2x); 99487 complex 60 min ($100) + 99489 add'l 30 min. Requires ≥2 chronic conditions + electronic care plan + 24/7 access.

Behavioral Health Integration (BHI)

99484 initial BHI assessment + 70-min care ($48); 99492 first 20 min/month ($48); 99493 add'l 20 min ($28); 99494 add'l 30 min ($42). Requires psychiatric consultant on contract.

Transitional Care Management (TCM)

99495 moderate complexity, 14-day follow-up ($190); 99496 high complexity, 7-day follow-up ($280). Billed once per 30-day post-discharge window; requires face-to-face visit.

Principal Illness Navigation (PIN)

99424 monthly navigation ≥ 30 min ($50); 99425 add'l 30 min ($38). For patients with one serious, high-risk condition; complements CCM.

CCM Eligibility

Medicare patients with ≥2 chronic conditions expected to last ≥12 months (or until death). Most IM panels qualify 60–80% of patients. Patient consent required (verbal OK).

BHI Requirements

Psychiatric consultant on contract (telehealth OK). Behavioral health care manager embedded in practice. Weekly systematic case reviews documented. Diagnosis of any mental health condition.

TCM 30-Day Window

TCM billed once within 30 days of discharge. Covers all communication, medication reconciliation, and follow-up visit. Cannot bill TCM + CCM for same patient in same month.

↗ **1,500-patient CCM panel ≈ $1M+/year recurring monthly revenue** — most cost-effective in internal medicine

PILLAR 03 · HOSPITALIST MEDICINE

Inpatient E/M, Critical Care & Observation

Internal medicine hospitalists cover the full inpatient E/M spectrum: admission, subsequent care, discharge, critical care, and observation. Documentation discipline is the #1 audit target — hospital E/M levels are over-coded 19% of the time, and critical care time logs are missing on 11% of claims. Time-based codes require minute-by-minute documentation.

Initial hospital care (99221–99223)

99221 low complexity ($115); 99222 moderate ($115 base); 99223 high ($215). Requires MDM documentation supporting level. 99223 over-coding is the #1 hospital E/M audit trigger.

Subsequent hospital care (99231–99233)

99231 low (~$45); 99232 moderate ($115); 99233 high ($185). Day-by-day MDM documentation required; 99233 over-coding common.

Hospital discharge (99238–99239)

99238 discharge < 30 min ($70); 99239 discharge ≥30 min ($140). Time must be documented; 99239 without time log is auto-denied.

Critical care (99291–99292)

99291 first 30–74 min ($185); 99292 add'l 30 min ($85). Minute-by-minute time log mandatory; 99291 requires critically ill patient documentation.

Critical care time (99291/99292) requires minute-by-minute log — the #1 critical-care denial driver is missing time documentation.

99221–99239
Inpatient E/M code range (admission, subsequent, discharge)

99291–99292
Critical care — time-based, minute-by-minute log mandatory

99217–99226
Observation services (admit, subsequent, discharge)

$185
Critical care first 30-min reimbursement (99291)

OBSERVATION CODE MAP

99218–99220	99224–99226	99217
Initial obs	Subsequent obs	Obs discharge

PILLAR 04 · OFFICE PROCEDURES & VACCINES

Venipuncture, Injections, Vaccines & Minor Skin Procedures

Internal medicine office procedures cover the routine (venipuncture, injections, vaccines) and the minor surgical (skin lesion destruction, joint injections). Modifier 25 discipline is critical — appending modifier 25 to E/M + procedure same day without separate documentation is the #1 modifier denial driver.

Venipuncture & Lab

36415 routine venipuncture ($3); 36416 finger/heel stick ($3); 85025 CBC with differential (auto). Most IM practices bundle 36415 into E/M without modifier — capturing it adds $5K–$15K/year per physician.

Therapeutic Injections

96372 SC/IM injection, therapeutic ($35); 96373 IV push ($45); 96360 IV hydration, first 31 min ($45). J-code drug billed separately; document administration time + drug + indication.

Vaccines & Immunizations

90471 immunization admin, first vaccine ($26); 90472 each additional ($15); 90460 first component ($18). Vaccine product billed separately (e.g., 90686 influenza, 90715 tetanus, 90670 pneumococcal).

Minor Skin & Joint Procedures

17000 destruction of premalignant lesion, first ($76); 17110 benign lesion, up to 14 ($130); 20600 joint injection, small ($61); 20610 joint injection, intermediate/syringe ($85). Document laterality for joint injections.

$3
Routine venipuncture (36415) — often bundled into E/M; billable separately with modifier 25

$35
SC/IM therapeutic injection (96372) — drug billed separately via J-code

$26 + product
First vaccine administration (90471) — additional vaccines $15 each

⚠ MODIFIER 25 DISCIPLINE

Appending modifier 25 to E/M + vaccine/injection same day without separate, distinct documentation supporting E/M significance triggers auto-denial. **13% of IM modifier-25 claims are denied.**

INTERNAL MEDICINE · BILLING CODES

Top CPT/HCPCS Codes & 2026 Reimbursement

Most-billed codes across the four internal medicine pillars.

E/M + Prev CCM Hospitalist Procedures

Code	Service	Modifier	Avg $	Notes
99213	Est. E/M, low MDM	—	$92	Most common IM E/M
99214	Est. E/M, moderate MDM	—	$131	Diabetes/HTN management
99215	Est. E/M, high MDM	—	$187	Complex chronic care
99221	Initial hospital care, low	—	$115	Admission, low complexity
99223	Initial hospital care, high	—	$215	Admission, high complexity
99232	Subsequent hospital care, mod	—	$115	Day-by-day MDM required
99233	Subsequent hospital care, high	—	$185	High-complexity day
99291	Critical care, first 30 min	—	$185	Minute-by-minute time log
99490	CCM, first 20 min/month	—	$62.60	Monthly recurring revenue
99495	TCM, moderate complexity	—	$190	14-day follow-up
99496	TCM, high complexity	—	$280	7-day follow-up
96372	SC/IM therapeutic injection	25 (w/ E/M)	$35	Drug billed separately

MODIFIER REFERENCE

25 — significant, separately identifiable E/M same day as procedure. -26 — professional component. -TC — technical component.

CCM · TCM · AWV RULES

CCM (99490/99439/99487) — recurring monthly; ≥2 chronic conditions + electronic care plan + 24/7 access. TCM (99495/99496) — once per 30-day post-discharge window. AWV (G0438/G0439) — HRA + fall risk + cognitive assessment.

INTERNAL MEDICINE · DENIAL PREVENTION

Top 8 Internal Medicine Denial Reasons & How Aethera Prevents Each

Internal medicine denial rates average 11–14%; each denied claim costs $35–80 to rework. CCM time documentation and hospital E/M over-coding drive 43% of revenue loss.

RED · 1 — 24%

CCM time documentation insufficient

99490/99439 billed without 20-minute time log supporting monthly threshold.

AETHERA: CCM time-tracking platform with auto-billing at 20-min threshold + monthly time audit.

RED · 2 — 19%

Hospital E/M level over-coding

99223/99233 billed without documentation supporting high complexity MDM.

AETHERA: Hospital E/M documentation checklist before claim release; MDM cross-check.

AMBER · 3 — 13%

Modifier 25 misuse

E/M + procedure same day without separate documentation supporting E/M significance.

AETHERA: Modifier 25 documentation checklist; auto-flag for review.

AMBER · 4 — 11%

Critical care time documentation missing

99291 requires minute-by-minute time log; many claims lack it.

AETHERA: Critical-care time template; minute-by-minute log mandatory.

AMBER · 5 — 9%

TCM 30-day window violations

Billing TCM outside the 30-day post-discharge window or duplicate TCM in same window.

AETHERA: TCM window tracker tied to discharge date; one TCM per window.

GREEN · 6 — 7%

AWV documentation incomplete

G0438/G0439 requires HRA + fall risk + cognitive assessment; missing components trigger denial.

AETHERA: AWV template enforces all 3 components before claim release.

GREEN · 7 — 6%

Inpatient discharge code errors

99238 (< 30 min) vs 99239 (≥ 30 min) without time documented.

AETHERA: Discharge time tracker; auto-selects correct code by time.

GREEN · 8 — 5%

Modifier -25 on E/M + vaccine same day

E/M + vaccine administration billed same day without separate E/M note.

AETHERA: Modifier-25 + vaccine workflow; separate E/M note required.

↗ **Cumulative impact:** Aethera reduces internal medicine denial rate from industry avg 12% to < 5% — recovering ~ $150K/year per $1.5M practice revenue.

CASE STUDY · INTEGRATED IM RCM

6-Physician Internal Medicine Practice — Annual Revenue Impact

A $4.2M-revenue practice models the combined upside of CCM enrollment, hospital E/M documentation discipline, and TCM + AWV capture. 22,000 active patients · 1,800 hospital encounters/year.

01 · CCM ENROLLMENT
CCM Enrollment Pipeline

ELIGIBLE PANEL
1,500-patient Medicare panel (≥2 chronic conditions)

PRE-AETHERA ENROLLMENT
15% (225 patients)

POST-AETHERA ENROLLMENT
55% (825 patients)

RECOVERED PATIENTS
600

AVG ANNUAL CCM/PATIENT
~$967 (99490 + 99439 x 11 + 99487)

$580,000

02 · HOSPITAL E/M
Hospital E/M Documentation Discipline

HOSPITAL ENCOUNTERS
1,800/year

PRE-AETHERA DENIAL RATE
16%

POST-AETHERA DENIAL RATE
5%

RECOVERED CLAIMS
~ 200/year

AVG HOSPITAL E/M CLAIM
~ $1,200 (mix of 99221–99239, 99291, 99238/9)

$240,000

03 · TCM + AWV
TCM + AWV Capture

ELIGIBLE PATIENTS
1,800 hospital discharges (TCM); 4,500 Medicare patients (AWV)

PRE-AETHERA DENIAL RATE
18%

POST-AETHERA DENIAL RATE
5%

RECOVERED TCM CLAIMS
~ 80/year; AWV uplift ~ 600 visits/year

AVG TCM / AVG AWV
$235 / $95

$195,000

Combined annual revenue recovery: $1,015,000. *Implementation cost (year 1): ~ $250K (Aethera RCM fees + CCM platform + hospital E/M workflow + AWV automation). Year-1 net: $765,000.* ***ROI: 305%.***

INTERNAL MEDICINE · COMPLIANCE HOTSPOTS

Where OIG, Medicare RAC, and Commercial Payers Audit First

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

E/M + PREVENTIVE

RED

Modifier 25 misuse

Appending to E/M + procedure same day without separate documentation supporting E/M significance; top modifier audit target.

AMBER

AWV documentation incomplete

G0438/G0439 missing one of the three required components (HRA, fall risk, cognitive assessment).

GREEN

E/M level over-coding

Billing 99215 without documentation supporting high complexity MDM.

CHRONIC CARE MGMT

RED

CCM time fraud

Billing 99490/99439 without contemporaneous time logs totaling ≥20 minutes; OIG Work Plan 2025-2026 explicitly targets CCM time documentation.

AMBER

CCM eligibility not verified

Patient enrolled in CCM without ≥2 chronic conditions documented in chart, or without patient consent.

LOW

BHI without psychiatric consultant

Billing 99484/99492–99494 without contract on file for psychiatric consultant.

HOSPITALIST

RED

Hospital E/M level over-coding

Billing 99223/99233 without MDM documentation supporting high complexity; top hospitalist audit trigger.

AMBER

Critical care time documentation missing

Billing 99291 without minute-by-minute time log; auto-denial + clawback risk.

LOW

Inpatient discharge code without time

Billing 99239 (≥30 min) without time log supporting the threshold.

PROCEDURES & VACCINES

RED

Modifier 25 with vaccine same day

Appending modifier 25 to E/M + vaccine without separate, distinct E/M note; 13% denial rate.

AMBER

Joint injection missing laterality

Billing 20600/20610 without documenting left/right joint; NCCI edit risk.

LOW

Venipuncture without provider order

Billing 36415 without standing order or provider-signed lab order in chart.

OIG & RAC ALERT

OIG Work Plan 2025-2026 explicitly lists **CCM time logging** and **hospital E/M documentation** as active audit targets. Medicare RACs have recovered **> $180M** from internal medicine practices since 2021.

CLOSING · KEY TAKEAWAYS

Three Actions to Capture Internal Medicine Revenue

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

01

Stand up a CCM enrollment pipeline

Query EHR for Medicare patients with ≥2 chronic conditions (most IM panels qualify 60–80%). Assign care coordinator to enroll 50 patients/week. Target 55% enrollment of eligible panel. 1,500-patient CCM panel = **~ $580K/year** of recurring monthly revenue at near-zero marginal cost. Highest-ROI initiative in IM.

~ $580K/YR · RECURRING

02

Enforce hospital E/M documentation discipline

Build EHR template that documents MDM complexity for every hospital encounter (admission, subsequent, discharge). Pre-bill audit on 99223/99233/99291/99239. Critical care requires minute-by-minute time log. Drops hospital E/M denial rate from 16% to < 5% — recovering **~ $240K/year** per 6-physician practice with 1,800 hospital encounters.

~ $240K/YR · DENIAL ↓

03

Automate TCM + AWV workflow

TCM: tracker tied to discharge date; one TCM per 30-day window; auto-prompt 7- or 14-day follow-up. AWV: template enforcing HRA + fall risk + cognitive assessment before claim release; auto-schedule annual AWV for all Medicare patients. Combined recovers **~ $195K/year** per 1,800-discharge / 4,500-Medicare-patient practice.

~ $195K/YR · AUTOMATED

Questions & Discussion

Optimizing Internal Medicine Revenue Across E/M, CCM, Hospitalist & Procedures

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