

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT202636 MARCH 17, 2026

IHCP corrects claim processing for office visit procedure codes with family planning modifier FP

The Indiana Health Coverage Programs (IHCP) discovered a system error that may have caused claims for certain evaluation and management (E/M) services to deny incorrectly when billed with modifier FP – *Family planning*.

As part of the rollback of temporary coverage expansion related to the COVID-19 public health emergency, *IHCP Bulletin BT202570* announced that, for dates of service (DOS) on or after **Oct. 1, 2024**, the procedure codes in Table 1 would no longer be reimbursable for Family Planning Eligibility Program or Presumptive Eligibility – Family Planning members when billed without modifier FP – *Family planning*. However, these codes should have continued to be reimbursable for these members when billed *with* modifier FP, to indicate the service was specific to family planning.

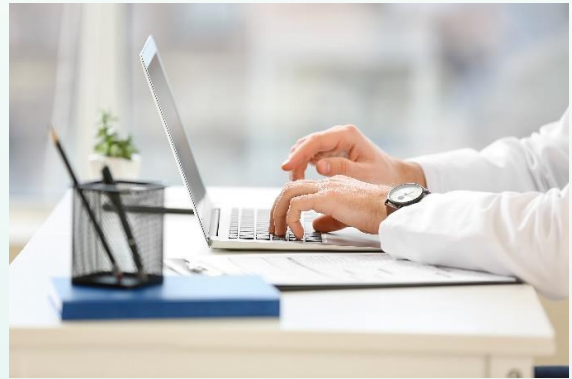


Table 1 – Procedure codes that may have denied in error when billed with modifier FP for DOS on or after Oct. 1, 2024

Procedure code/modifier	Code description
99202 FP	New patient office or other outpatient visit with straightforward medical decision making, if using time, 15 minutes or more
99203 FP	New patient office or other outpatient visit with low level of medical decision making, if using time, 30 minutes or more
99204 FP	New patient office or other outpatient visit with moderate level of medical decision making, if using time, 45 minutes or more
99205 FP	New patient office or other outpatient visit with a high level of medical decision making, if using time, 60 minutes or more
99211 FP	Office or other outpatient visit for the evaluation and management of established patient that may not require presence of healthcare professional
99212 FP	Established patient office or other outpatient visit with straightforward medical decision making, if using time, 10 minutes or more
99213 FP	Established patient office or other outpatient visit with low level of decision making, if using time, 20 minutes or more
99214 FP	Established patient office or other outpatient visit with moderate level of decision making, if using time, 30 minutes or more
99215 FP	Established patient office or other outpatient visit with high level of medical decision making, if using time, 40 minutes or more

The claim-processing system has been corrected. Claims for the procedure codes listed in Table 1, submitted with modifier FP, for DOS on or after Oct. 1, 2024, that denied in error will be reprocessed. Providers should see adjusted or reprocessed claims on remittance advices (RAs) beginning April 15, 2026, with internal control numbers (ICNs)/Claim IDs that begin with 52 (mass replacements non-check related) or 80 (reprocessed denied claims).

Alternatively, providers can submit or resubmit fee-for-service (FFS) claims for these procedure-code-and-modifier combinations for DOS within the indicated time frame. Claims resubmitted beyond the original filing limit must include a copy of this bulletin (first-page only) as an attachment and must be submitted within 180 days of the bulletin's publication date.

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