IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT2026155 SEPTEMBER 24, 2026

IHCP updates billing requirements for specific waiver services and specific vision services

Effective for dates of service (DOS) on or after Oct. 28, 2026, the Indiana Health Coverage Programs (IHCP) will implement new claim-processing restrictions affecting billing requirements for specific home- and community-based waiver services as well as specific vision services.

Providers should review the following billing requirements and update their claim-submission practices as necessary.

Waiver services billed with modifier HQ

The IHCP uses modifier **HQ** to identify applicable services performed in a 24-hour congregate, or group, setting. The modifier indicates that electronic visit verification (EVV) is not required for the service.

Effective for DOS on or after Oct. 28, 2026, the IHCP will deny a claim detail when one of the Healthcare Common Procedure Coding System (HCPCS) procedure codes listed in Table 1 is billed with both modifier HQ and place of service (POS) code 12 – *Home*.

Table 1 – Services to be denied if billed with modifier HQ and POS code 12, effective for DOS on or after Oct. 28, 2026

Procedure code	Code description
T2033	Residential care, not otherwise specified, waiver; per diem. For the affected Indiana waiver billing identified in the project materials, this code is used for Participant Assistance and Care.
S5151	Unskilled respite care, not hospice; per diem.
T2016	Habilitation, residential, waiver; per diem. For the affected Indiana waiver billing identified in the project materials, this code is used for Residential Habilitation services.

A claim detail containing this combination will deny with explanation of benefits (EOB) code 4406 – *HCPCS code T2033, S5151, or T2016 billed with modifier HQ and Place of Service 12 (Home) is not payable. Modifier HQ indicates services performed in a 24-hour congregate setting and is not valid when billed with Place of Service 12 (Home)*.

Providers should verify the modifier and place of service accurately reflect where and how the service was delivered. Modifier HQ should not be used with POS code 12 for the affected services.

The *Division of Disability and Rehabilitative Services Home- and Community-Based Services Waivers* provider reference module will be updated to reflect this claim-processing requirement.

Billing restriction for polycarbonate lenses and ultraviolet lens treatment

Effective for DOS on or after Oct. 28, 2026, the IHCP will implement claim editing involving certain vision procedure codes to align claim adjudication with the medically necessary provisions of the IHCP.

When procedure codes V2784 – *Lens, polycarbonate or equal* and V2755 – *Ultraviolet lens treatment*, *faceted, per lens* are billed for the same member and date of service, the claim detail for V2755 will be paid at zero *unless V2755 is associated with at least one diagnosis code outside the Refractive Error Diagnoses group* (see Table 2). The V2784 detail will continue to process subject to all other applicable IHCP coverage and billing requirements.

The V2755 detail will be paid at zero with EOB code 6338 – *V2755 (Ultraviolet lens treatment, faceted, per lens) is not reimbursable when billed with V2784 (Lens, polycarbonate or equal) for the same member and date of service unless V2755 is associated with at least one diagnosis code outside the Refractive Error Diagnoses group*.

Providers should review claims before submission to ensure that V2755 is not billed with V2784 for the same member and date of service *unless V2755 is associated with at least one diagnosis code outside the Refractive Error Diagnoses group* (see Table 2).

Diagnosis-based processing for V2755

The IHCP will also implement diagnosis-based claim processing for V2755 – *Ultraviolet lens treatment, faceted, per lens*.

When V2755 is associated **only** with diagnosis codes included in the Refractive Error Diagnoses group (see Table 2), the V2755 detail will process with a payment of $0 rather than denying.

Reimbursement for V2755 may be allowed when at least one diagnosis code associated with the V2755 claim detail is not included in the Refractive Error Diagnoses group, subject to all other applicable IHCP coverage and billing requirements.

Table 2 – Refractive Error Diagnoses group

ICD-10-CM diagnosis code	Code description
H52.01	Hypermetropia, right eye
H52.02	Hypermetropia, left eye
H52.03	Hypermetropia, bilateral
H52.11	Myopia, right eye
H52.12	Myopia, left eye
H52.13	Myopia, bilateral
H52.209	Unspecified astigmatism, unspecified eye
H52.221	Regular astigmatism, right eye
H52.222	Regular astigmatism, left eye
H52.223	Regular astigmatism, bilateral
H52.229	Regular astigmatism, unspecified eye
H52.4	Presbyopia

Example 1: V2755 processes at $0

A provider bills V2755 with the following associated diagnosis codes:

- H52.01, Hypermetropia, right eye
- H52.221, Regular astigmatism, right eye
- H52.4, Presbyopia

Claim-processing result: The V2755 detail will be processed with a payment of $0 because all associated diagnoses are included in the Refractive Error Diagnoses group.

Example 2: V2755 may be reimbursed

A provider bills V2755 with the following associated diagnosis codes:

- H52.223, Regular astigmatism, bilateral
- H25.013, Age-related nuclear cataract, bilateral

Claim-processing result: Reimbursement for V2755 may be allowed because H25.013 is associated with the V2755 detail and is not included in the Refractive Error Diagnoses group. All other applicable IHCP coverage and billing requirements must also be met.

The *Vision Services* provider reference module will be updated to reflect this claim-processing requirement.

QUESTIONS

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