

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT2026114 JULY 2, 2026

IHCP clarifies FQHC and RHC billing procedures for vision services

The Indiana Health Coverage Programs (IHCP) would like to provide guidance and clarity to federally qualified health centers (FQHCs) and rural health clinics (RHCs) regarding billing for vision services. Vision services fall under the scope of medical claims and should be submitted the same way the provider submits any other medical claim to the IHCP. This means that FQHCs and RHCs should bill all vision services that were provided during a valid face-to-face encounter with a qualifying practitioner on a professional claim that includes the following:



- Healthcare Common Procedure Coding System (HCPCS) procedure code T1015 – *Clinic visit/encounter, all-inclusive*
- A valid encounter code relevant to the visit
- Procedure codes for all other services and supplies provided during the visit

The claim will be eligible for reimbursement at the provider-specific prospective payment system (PPS) rate only if it includes the T1015 and at least one procedure code from the *FQHC-RHC Valid Encounter Code Listing* on the [Myers and Stauffer website](https://www.myersandstauffer.com) at [myersandstauffer.com](https://www.myersandstauffer.com).

Materials provided in conjunction with but *after* the FQHC or RHC encounter

If a member visits an FQHC or RHC for an eye exam and must return on a later date to pick up eyeglasses that were prescribed during that prior visit, the glasses (frames and lenses) are considered to be a part of the original encounter. The provider has two options for how to submit the claim:

Option 1: The provider can hold the claim until the member has been fitted and leaves the center with their completed glasses, so that all services and supplies can be included together on the same claim (along with the T1015 procedure code). *Note that providers using this option must be mindful of timely filing limits; if waiting until the materials have been provided to the member will cause the claim to exceed timely filing limits, option 2 should be used, instead.*

Option 2: The provider can submit a claim for only the eye exam, and then, later, submit another claim for only the materials. Both claims must include the T1015 procedure code.

With **option 1**, the claim for the eye exam and materials is eligible to receive the PPS rate. This claim must be submitted to the appropriate medical claim-processor – Gainwell Technologies for fee-for-service (FFS) members, or the member’s managed care organization (MCO) for managed care members.

With **option 2**, the claim for the eye exam is eligible to receive the PPS rate. The claim for materials-only is **not** eligible for payment because reimbursement for those items is already encompassed in the PPS rate for the other claim. The provider must submit these claims as follows:



- The claim for the eye exam (including the T1015 procedure code and a valid encounter code for the exam) must be submitted to the appropriate medical claim processor: Gainwell or the member’s MCO.
- Later, after the member has been fitted for and has received their glasses, the provider should submit the claim for materials (including the T1015 procedure code and applicable procedure codes for the eyewear) to the appropriate claim-processing entity. This claim must be denied for explanation of benefits (EOB) code 4124 – *The CPT/HCPCS code billed is not a valid encounter* (or equivalent EOB code).

Managed care claim processing and payment clarifications

For FQHC and RHC claims that are submitted to an MCO with both the T1015 procedure code and at least one valid encounter code, the MCO will pay **all** procedure codes on the claim that are covered codes on the [IHCP Professional Fee Schedule](#). The MCO will then pass the claim data to Gainwell Technologies for the wraparound payment (the difference between the provider’s PPS rate and the total amount paid by the MCO).

FQHC and RHC claims that are submitted to an MCO or VBM with the T1015 procedure code and **no** valid encounter code (such as a claim for materials only) will be denied. **FQHCs and RHCs should not use a different Provider ID/National Provider Identifier (NPI) when submitting claims for vision materials only to the VBM.** If the provider opts to bill a separate claim for only the vision materials, they must submit that claim under their FQHC or RHC NPI, and the VBM must deny the claim, because the materials are already included in the PPS rate.

Services provided outside a valid encounter

As a reminder to FQHCs and RHCs, services provided outside of a valid encounter are not eligible for **separate payment**. As explained in the [Federally Qualified Health Centers and Rural Health Clinics](#) provider reference module, some services – including **optician** services – **do not**, in and of themselves, constitute encounters. Providers can include these services in the encounter reimbursement when they are performed **in conjunction** with an office visit or other valid face-to-face encounter with a qualifying practitioner. However, the IHCP **does not** reimburse for these services through claim submission if performed **without** a face-to-face visit with a qualifying practitioner.

Vision materials

Materials for eyewear are limited to the basic frames and lenses for Medicaid reimbursement. Contact lenses are only covered by Medicaid when medically necessary. The member would be responsible for any costs associated with upgrading lenses and frames, adding a second pair of glasses, adding sunglasses or transitional lenses, and the ordering/fitting of contact lenses when not medically necessary. If a member chooses anything other than the standard Medicaid-covered eyewear, the provider can bill the IHCP for the basic V-code and bill the upgraded portion to the member **only** if they have given the member advance notification of noncoverage. See the following example.

Example: A Medicaid-enrolled member presents at an FQHC for a yearly eye exam. The member receives the exam and is told that they will need glasses. An FQHC staff member consults with the member and explains which eyewear products are fully covered by Medicaid and which are not. For products that are not fully covered, the staff member explains what portion of the cost will be paid by Medicaid (based on IHCP Professional Fee Schedule rates) and what portion will be the member's responsibility. If the member selects an item that is not fully covered by Medicaid, they must be informed that they are responsible for the noncovered balance of the claim. If they choose to continue with the purchase of the noncovered materials, the provider must have the member sign a waiver indicating that they are aware of their responsibility.

Note: If upgrades are medically necessary, the FQHC/RHC should refer to the [Vision Services](#) provider reference module and follow the instructions for billing the upgraded materials.

For more information

Questions about FFS billing and reimbursement should be directed to Gainwell Technologies Customer Assistance at 800-457-4584 or your [Provider Relations consultant](#).

Individual MCOs establish and publish billing and reimbursement criteria within the managed care delivery system. Questions about managed care billing and reimbursement should be directed to the MCO with which the member is enrolled.

QUESTIONS

If you have questions about this publication, please contact Customer Assistance at 800-457-4584.

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