Primary Care Network

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1 SERVICES

The Primary Care Network (PCN) was implemented under a waiver of federal Medicaid requirements that allows the State to use Medicaid funding to cover a population in addition to Traditional and Non-Traditional members. The Scope of Service is limited to basic medical services of a general nature to provide preventive and palliative care in an outpatient, office setting. Services in the office should comport with the definition of Primary Care found in the Utah Administrative Code R414-100-2(3) and in this PCN Manual. For purposes of this PCN Manual, when "Medicaid" is used it is also applicable to the PCN program or PCN member.

Verification

The Division mails a wallet-sized plastic Medicaid Member Card and a Benefit Letter to members who are eligible for the PCN program.

For information regarding the Medicaid Member Card refer to the Medicaid Provider Manual, Section I: General Information, Overview of the Medicaid Program at: https://medicaid.utah.gov.

1 - 1 Authority

The Primary Care Network is authorized by a waiver of federal Medicaid requirements approved by the Centers for Medicare and Medicaid Services (CMS) and allowed under Section 1115(a) of the Social Security Act.

1 - 2 Definitions

Clinical Laboratory Improvement Amendments (CLIA) means the federal CMS program which limits reimbursement for laboratory services based on the equipment and capability of the physician or laboratory to provide an appropriate, competent level of laboratory services.

CMS means the Centers for Medicare and Medicaid Services.

Division means the Division of Medicaid and Health Financing within the Department of Health.

Emergency means the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

a) placing the client's health in serious jeopardy;
b) serious impairment to bodily functions;
c) serious dysfunction of any bodily organ or part; or
d) death.

Emergency Services means

a) attention provided within 24 hours of the onset of symptoms or within 24 hours of diagnosis;
b) for a condition that requires acute care, and is not chronic;
c) reimbursed only until the condition is stabilized sufficient that the patient can leave the hospital emergency department; and
d) is not related to an organ transplant procedure.

Member means a person the Division or its duly constituted agent has determined to be eligible for assistance under the PCN program. "Member" is often interchangeable with "client," recipient," "patient" or "enrollee." Individuals eligible for the PCN program are ages 19 to 64 with incomes under 95% of the federal poverty level who are not otherwise eligible for Medicaid.

Outpatient means a member who is not admitted to a facility, but receives services from a licensed outpatient care facility.

Outpatient Setting means the physician's office.

Primary Care means services to diagnose and treat illness and injury as well as preventive health care services. Primary care promotes early identification and treatment of health problems, which can help to reduce unnecessary complications of illness or injury and maintain or improve overall health status.

Provider means any person, individual, corporation, institution or organization, qualified to perform services available under the Medicaid program and who has entered into a written contract with the Medicaid program.

1 - 3 Billing Members

Co-Payment Requirement

Co-payments apply to PCN members. For PCN co-payments, refer to the Utah Medical Benefits website at: https://health.utah.gov/umb under Benefits.

Providers who serve PCN members may bill patients for non-covered services as set forth in the Primary Care Network Provider Manual, Primary Care Network Information Bulletins, and letters to providers. A written agreement upon time of service is recommended, but not required.

2 SCOPE OF SERVICE

Services covered under the PCN program are limited. Please refer to the Division's Coverage and Reimbursement Code Lookup Tool for the Current Procedural Terminology (CPT) code coverage under the PCN program.

The tool can be found at:
https://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

For a summary of covered services please refer to the PCN Member Guide at:
https://www.health.utah.gov/pcn/pdf/PCNMemberGuideEng.pdf.

2 - 1 Physician Services

Physician services provide for the basic medical needs of eligible individuals and must be provided within the parameters of accepted medical practice. Physician services may be provided directly by the physician or by other professionals (i.e., licensed nurse practitioners and physician assistants) authorized to serve the health care needs of the practice population through an approved scope of service and, in the case of physician assistants, under the physician's supervision.

The following types of providers may provide Primary Care services to PCN members:

Family Practitioner,
General Practitioner,
Internist,
Nurse Practitioner,
Obstetrician/Gynecologist,
Osteopath,
Pediatrician, and
Physician Assistant

In addition, providers of physician services in Federally Qualified Health Centers, Rural Health Clinics, Local Health Department clinics, and Health Clinics of Utah can provide services based on the Scope of Service and procedure codes covered under the PCN program.

Physician services include those that can be performed in an Outpatient Setting.

1. The CPT Manual is the standard for defining and coding physician services. Under the provisions of the PCN program, not all procedures are acceptable, e.g., experimental, cosmetic, or those not reasonable, medically necessary or cost effective. Nonspecific or unlisted codes require physician review because of the potential for use to cover otherwise non-covered services.

2. The Evaluation and Management (E&M) CPT codes (99201 - 99215) for either new or established patients are appropriate for billing office visits.

3. In general, both office visits and procedure codes will not pay for the same dates of service.

   a) Modifier 25: (Significant and separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) Medicaid will ***not*** recognize modifier 25. The system will pay according to policy, the editing program, and correct coding

initiative edits. Manual review has found an overwhelming number of claims submitted with modifier 25 when the E&M code is the only service, with a minor procedure such as drawing blood, or the services are those included within the procedure. Extensive review of provider documentation on manual review found claims warranting modifier 25 a rare occurrence. Claims submitted with modifier 25 will be denied. Denied claims with unpaid modifier(s) 24 and/or 25 continue to have hearing rights.

b) Therapeutic procedures: An E&M code and a diagnostic procedure or therapeutic procedure code will generally not be covered separately on the same date of service. This includes services in the Emergency Room and outpatient services.

c) Incidental procedures: Incidental edits occur when a procedure is considered an integral component of another procedure.

4. Services covered by the PCN program that can be provided and billed by a licensed nurse practitioner are indicated on the Division's Coverage and Reimbursement Code Lookup Tool at: https://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

   When a procedure is provided by a nurse practitioner then billed through the collaborating physician, the bill is not considered appropriate. When Medicaid identifies procedures billed through the physician, a refund will be required. Nurse practitioners who have been approved by the Division to perform a specific procedure, based on their training and certifications, are the only individuals who will receive reimbursement for these services.

5. Physician assistants work under the supervision of a physician to provide services to patients within the practice population. The physician bills for the service.

   An individual who has met the requirements of federal regulation and state law is authorized to participate in the Medicaid program serving patients in cooperation with a supervising provider. The working relationship between physician and physician assistant allows the physician and physician assistant to determine the appropriate amount of supervision and how that supervision will be documented. Under the practice rules, the following applies:

   a) The supervising physician shall provide supervision to the physician assistant to adequately serve the health care needs of patients and ensure that the patient's health, safety and welfare will not be adversely compromised.

   b) A Delegation of Services Agreement, maintained at the site of practice, shall outline specific parameters for review that are appropriate for the working relationship.

   c) There shall be a method of immediate consultation by electronic means whenever the supervising physician is not present and immediately available.

d) The supervising physician shall review and co-sign sufficient numbers of patient charts and medical records to ensure that the patient's health, safety, and welfare are not adversely compromised.

A physician assistant can provide services consistent with the practice of the physician with whom he works. If the physician is a primary care provider, then by definition the physician assistant working with that physician would be providing primary care services. Often, the physician assistant is the first person to evaluate a patient presenting for service at the physician's office. Under the statute, the physician assistant works under the supervision of a physician, is not an independent practitioner, and cannot bill independently.

Physician assistant services will be subject to applicable limitations and exclusions set forth in Medicaid policy. The physician assistant must have a committed and documented practice relationship under the supervision of a physician. Physician assistants working as employed staff in clinics or other facilities do not qualify to have their services separately billed. For limitations on applicable physician assistant services, refer to the Utah Medicaid Provider Manual for Physician Services, Chapter 1 - 7, Physician Assistant Services: Limitations.

6. Physicians providing services in the Emergency Department must use CPT Codes 99281 - 99285 to bill for services.

7. For services related to removal of benign or premalignant skin lesions, refer to the Utah Medicaid Provider Manual for Physician Services, Section 2, Limitations.

2 - 2 Limitations for Physician Services

Services covered under the PCN program are limited. The limitations in this section are general guidelines. Please refer to the Division's Coverage and Reimbursement Code Lookup Tool for coverage under the PCN program. The tool can be found at: http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

1. The CPT Manual is the standard for defining and coding physician services. However, not all procedures are covered under the PCN program, e.g., experimental, ineffective, cosmetic, or those not cost effective, reasonable or medically necessary.

2. Use of nonspecific or unlisted codes to cover procedures not otherwise listed in the CPT Manual require Medicaid physician consultant review and approval because of the potential for use to cover otherwise non-covered services.

3. Office visit codes (E&M) and service codes (10060 - 69990) will not be paid on the same date of service.

4. Services identified by the 90000 series of codes are specialty medical services and will be limited only to those that can be safely provided in the physician's office.

5. After-hours office visit codes cannot be used in a hospital setting, including the Emergency Department, by a private or staff physician under any circumstances. They cannot be used for standby for surgery or waiting time for surgery, delivery, or other similar circumstances. Billing for after-hours service requires the service be provided outside of scheduled staffed hours. For more details see Section 2 of the Utah Medicaid Provider Manual for Physician Services.

6. Cognitive services are limited to one service per day by the same provider.

7. Modifier 25 will not be recognized as a stand-alone entity to override the one service per day limitation.

8. Laboratory services provided by a physician in his office are limited to the waived tests or those laboratory tests identified by CMS for which each individual physician is CLIA certified to provide, bill and receive Medicaid payment. Refer to the Division's lookup tool for laboratory services covered under the PCN program.

   When the Affirm Test for DNA probes, CPT codes 87660, 87510, or 87480 are billed, only one of the three codes will be paid to the physician. DNA probe testing by the amplified method is not covered for these organisms.

   Unspecified laboratory codes are not accepted when there is a specific test available. The specific test must be ordered to receive reimbursement. Examples of this policy include:

   - The code 87797 (Infectious agent detection; not otherwise specified, direct probe technique) or 87798 (Infectious agent detection; not otherwise specified, amplified probe technique) will not be accepted when the test completed is code 87669 (Trichomonas vaginalis, direct probe).
   - The code 87800 (Infectious agent detection, direct probe technique) will not be accepted when the test is code 87490 (Chlamydia trachomatis, direct probe).

   Medicaid follows the recommendations of the editing program which includes payment recommendations from the American Society of Microbiology.

   Clinical diagnostic laboratory tests that are sent to an outside independent laboratory to be completed must be billed by the laboratory completing the service. The physician cannot bill for these services and seek payment from Medicaid.

   - Urinalysis using a code like 81002 is incidental to an office visit and use of an appropriate E&M code.
   - Blood gas determination (82800) is considered clinically integral to the primary procedure, anesthesia, or critical care. No additional payment will be made for this procedure.
   - Pulse oximetry (94760, 94761) is a non-invasive measurement of oxygen saturation which requires a minimal amount of time and is considered incidental to an E&M code or anesthesia administration. No additional payment will be made for this procedure.

Drug screening tests should be ordered to reflect only those drugs likely to be present based on the patient's medical history, or current clinical presentation. Urine and serum tests which are for the same class are considered duplicative, and therefore, are not covered. Medicaid considers drug screening for medico-legal purposes or employment purposes as not medically necessary. The medical necessity of completing additional tests beyond those of abuse must be well documented by the diagnoses submitted. All tests for drug screening should be reported with HCPCS G-codes.

9. A specimen collection fee is limited only to venipuncture specimens drawn under the supervision of a physician to be sent outside of the office for processing and only to specimens collected by the following method: Drawing a blood sample through venipuncture, i.e., inserting a needle attached to a syringe into a vein and withdrawing a sample of blood. (Code 36415 is used to bill this fee.) Venipuncture is not a covered service when finger or heel sticks are done for a reagent strip test with codes like the following:

   82947, glucose blood home monitoring device
   82948, blood glucose by reagent strip
   83036 with QW modifier, glycated hemoglobin
   85013, spun microhematocrit
   85014 with QW modifier, hematocrit
   85610 with QW modifier, prothrombin time
   86318, immunoassay for infectious agent by reagent strip

   None of these are venipuncture procedures. Therefore, code 36415 for venipuncture will be considered mutually exclusive to any of the CPT codes used for reagent strip testing. However, if other blood specimens are ordered which require venipuncture, 36415, payment will be allowed.

10. Genetic counseling and genetic testing: Genetic testing is not a covered service. Molecular diagnostic testing is covered only for infectious disease evaluation and management. Testing beyond 2 units of a molecular diagnostic code requires review and prior authorization through the PCN program.

11. Over-the-counter drugs and medications are limited to those on the list of covered OTC drugs established for the PCN program. Refer to the Over-the-Counter Drug List attached to this PCN Manual.

12. Drugs and biologicals are limited to those approved by the Food and Drug Administration or the local Drug Utilization Review Board which has the authority to approve off label use of drugs. For updates on adult vaccination, visit the Centers for Disease Control and Prevention website at: http://cdc.gov/vaccines/schedules/hcp/adult.html.

    Coverage of drugs and biologicals is based on individual need and orders written by a physician when the drug is given in accordance with accepted standards of medical practice and within the

protocol of accepted use for the drug. Coverage requirements are described in the Utah Medicaid Provider Manual for Pharmacy Services.

a. Medicaid covers most medications prescribed by qualified practitioners as a Medicaid benefit, in compliance with Federal law (42 CFR 440.120).

b. Medicaid has additional requirements for drugs identified on the Drug Criteria and Limits List attached to this manual, including limits or requirements for prior authorization.

c. Nonprescription, over-the-counter items are limited to those OTC drugs on the Over the Counter Drug List attached to this manual.

13. Additional payment for services is limited to those cases where the circumstances are so unusual and severe that excess time is required to safely monitor and treat the patient. Documentation in the medical record must clearly show the extenuating circumstances and the unusual time commitment to warrant medical review and consideration for additional reimbursement.

14. Medical services provided by ophthalmologists or optometrists are limited to the following codes:

    92002, 92004, 92012, 92014, 92020, 92083, 92133, 92134, 99201- 99205, 99211- 99215, S0620, and S0621.

15. In order to comply with provisions of the Deficit Reduction Act of 2006, section 6002, billings for medications administered in the physician's office must include the national drug code (NDC) from the container from which the medication is obtained, and the number of units administered, in addition to the J-Code normally used. Billings for all drugs administered in the physician's office without the NDC information will be denied for payment.

2 - 3 Hospital Services

The PCN program does ***not cover*** inpatient hospital services.

Emergency services in a designated acute care general hospital emergency department are covered. The list of Authorized Diagnoses for Emergency Department Reimbursement can be found on the second page of the Division's Coverage and Reimbursement Code Lookup Tool at: https://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

Emergency room services (including laboratory and radiology) that are billed with any diagnosis code other than one of those listed is a non-covered service resulting in no payment being made.
Revenue codes appropriate to be ***covered*** for emergency services are:

Emergency Room	450, 459
Laboratory	300, 302, 305, 306, 309, 925, 929
Radiology	320, 324, 329

EKG/ECG	730, 739
Respiratory Therapy Services	410
Inhalation Therapy	412, 419
Cast Room	700,709
Pharmacy (medications used in ED)	250, 260, 269
IV Solutions	258
Med-Surg Supplies (use in ED only)	270

All other revenue codes are non-covered.

Laboratory and radiology services are covered as long as the services performed are indicated as covered for the PCN program on the Division's "Coverage and Reimbursement Code Lookup" tool.

Physicians providing services in the emergency department must use CPT codes 99281-99285 to bill for services.

2 - 4 Minor Surgery and Anesthesia in an Outpatient Setting

For the purposes of this program, Outpatient Setting means only in the physician's office. Only those procedures that can be safely provided in the physician's office can be covered.

2 - 5 Laboratory and Radiology Services

Professional and technical laboratory and radiology services are furnished by certified providers with use of the 70000 and 80000 series of codes.

1. For the PCN program, laboratory and radiology procedures will be limited to those which are indicated as covered for the PCN program on the Division's Coverage and Reimbursement Code Lookup Tool at: https://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

2. Laboratory services are limited under federal CLIA regulations. All laboratory testing sites providing services must have either a CLIA certificate of waiver or a certificate of registration along with a CLIA identification number. Only laboratories CLIA certified can complete certain tests and receive payment. (CLIA Certification for Laboratory Services is attached to this manual.)

3. Some laboratory and radiology procedures are non-covered because they relate to otherwise non-covered services.

4. CPT code 80074, acute hepatitis panel, includes four other codes: 86705, 86709, 86803, and 87340. When three of the four codes are billed, they will be rebundled into the acute hepatitis panel code 80074 for payment.

5. Digital mammography add-on code 77051 and code 77052 are covered strictly for coding purposes. The CPT manual instructs the provider to submit the add-on code 77051 or 77052 with the code for

standard mammography, and codes 77055, 77056, or 77057 to indicate digital mammography was completed. The provider may complete standard or digital mammography. However, the PCN program will continue to pay the reimbursement rate for standard mammography.

6. CPT codes 87624 (HPV high risk types) and 87625 (HPV types 16 and 18 only) are limited to one payment per service. This edit follows the American Society of Microbiology guidelines.

7. Laboratory and radiology services done in the emergency room that are billed with any diagnosis code other than one of those listed on the current Authorized Diagnoses for Emergency Department Reimbursement list are non-covered services which will result in no payment being made. (The list can be found on the second page of the Division's Coverage and Reimbursement Code Lookup Tool at: https://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php).

2 - 6 Pharmacy Services

The Medicaid Pharmacy policy as set forth in the Utah Provider Manual for Pharmacy Services is hereby adopted for the PCN program with the changes noted below.

Pharmacy services include prescribed drugs and preparations provided by a licensed pharmacy. The fact that a provider may prescribe, order, or approve a prescription drug, service, or supply does not make it an eligible benefit, even though it is not specifically listed as an exclusion. The following pharmacy benefits and restrictions are incorporated into the PCN program.

1. Drug Limitations and Benefits

   a. This program is limited to four prescriptions per month, per member with no overrides or exceptions in the number of prescriptions.
   b. OTC prescriptions count against the four Rx/month limit.
   c. Diabetic supplies OTC prescriptions (syringes, strips, and lancets) do not count against the four Rx/month limit. The co-pay for diabetic supplies is limited to $3.00 for the first supply per month and no co-pay for additional supplies in the same month.
   d. A patient paid prescription is not counted as one of the four prescriptions per month.
   e. The co-pay is $3.00 per prescription. Effective January 1, 2014, there is a monthly maximum limit of $15.00.
   f. When a generic product is available and the name brand is requested, the total payment must be made by the member. No physician DAW or Prior Authorization is available.
   g. Prior approval and the criteria governing such are the same as the regular Medicaid program.
   h. Generic drugs with an A B rating are mandated for dispensing.
   i. Over-the-counter products: The extent of these products is more limited than regular Medicaid.
      - Products covered are: Insulin 10cc vials; Insulin syringes; glucose blood test strips; lancets; contraceptive creams, foams, tablets, sponges, and condoms. Insulin pens are not a covered benefit.

j. OTC products that are covered require a written prescription just like legend drugs in order for the pharmacy to fill them.
k. PCN members may receive brand name Tegretol and Dilantin, without a brand name prior authorization, due to the narrow therapeutic index of these drugs.

2. Exclusions and Restrictions

a. No duplicate prescription will be paid by Medicaid for lost, stolen, spilled or otherwise non usable medications.
b. No injectable products are available for payment by Medicaid, except for 10 ml vials of insulin and medroxyprogesterone acetate 150mg (Depo-Provera) when used for family planning.
c. Compounded prescriptions are not covered.
d. Drugs are covered for labeled indications only.
e. Rapidly dissolving tablets, lozenges, suckers, pellets, or other unique formulations or delivery methodologies are NOT covered, except where the specific medication is unavailable in any other form. Lower-cost generic alternatives may be reviewed for exception to this policy. Patches are NOT reimbursable (this includes Fentanyl).
f. Cosmetics, weight gain or loss products are not covered.
g. No vitamins or minerals are covered, except for prenatal vitamins for pregnant women.
h. Drugs for Erectile Dysfunction are not covered.

3. Cumulative Monthly Amounts

Cumulative monthly amounts for certain drugs are outlined in the *Drug Criteria and Limits* list attached to this manual.

There are no "grace" periods to obtain these drugs early. They are available only at 30-day intervals. For long-acting narcotic analgesics and for short-acting single agent narcotic analgesics with a cancer diagnosis, the correct diagnosis code waives the limits.

4. Drugs Requiring Prior Approval: Drugs on the current *Drug Criteria and Limits* list require prior approval. (The list is attached to this manual.)

2 - 7 Durable Medical Equipment and Supplies

Equipment and appliances are necessary to assist the patient's medical recovery, including both durable and nondurable medical supplies and equipment. However, the Primary Care Network waiver notes that "The fact that a provider may prescribe, order, recommend, or approve a service or supply does not, of itself, make it an eligible benefit, even though it is not specifically listed as an exclusion."

The following codes are the only medical equipment and supplies covered under the PCN program:

A4259, A4565, A4490 - A4510, A4253, E0114, E0135 LL, A4570, A4614, E1390 RR, K0001 LL, L0120, and S8490.

2 - 8 Preventive Services and Health Education

Preventive Screening Services: The PCN program includes preventive screening services, including routine physical examinations and immunizations, and educational methods and materials for promoting wellness, disease prevention and management.

One comprehensive preventive health examination is covered per calendar year. The initial code 99385 or 99386 may be billed once for an annual examination, in subsequent years code 99395 or 99396 should be billed.

Evaluation and Management care for preventive services includes counseling, anticipatory guidance, and/or risk factor reduction interventions. Except for immunization codes, no special programs or codes are covered.

Diabetes Self-Management Training: Code S9455 (Diabetic management program, group session) is available for use by authorized diabetes self-management providers.

A newly diagnosed patient with Type I, Type II, or gestational diabetes or a patient previously diagnosed with Type I or Type II diabetes, is eligible to receive diabetes self-management training through the PCN program when a physician provides a referral for the patient to an approved diabetes self-management education program.

Diabetes self-management training services must be provided through one of the following:

- Nationally recognized American Diabetes Association (ADA) certified diabetes education [refer to http://www.diabetes.org]
- American Association of Diabetes Educators (AADE) [refer to http://www.diabeteseducator.org]

Nutritional Counseling: Members may receive one hour of initial (97802) and one hour of subsequent (97803) nutritional counseling for a BMI > 30 with supportive documentation. Nutritional counseling and an E&M code are not covered for the same provider on the same date of service. Medicaid does not pay two E&M codes on the same date of service.

Tobacco Cessation Training: Providers with personnel trained to provide in-office tobacco cessation counseling may bill code S9453, smoking cessation classes per session, as “incident to” in addition to the E&M code. This code is used on the date the patient initially decides to quit smoking and on follow-up counseling visits.

For the E&M and S9453 to pay, medical record documentation must include all of the following:

The provider/trained personnel will:

- Advise tobacco users to quit and inform users of the health benefits of tobacco cessation.
- Provide positive, practical behavioral coaching as part of a quit plan:
    - The STAR acronym may be used as a guide:
        - **S**et a quite date
        - **T**ell family, friends, and co-workers (importance of support systems)
        - **A**nticipate challenges (withdrawals and triggers)
        - **R**emove tobacco products from environment

      Also, advise the user to consider oral alternatives for the habit of smoking and suggest keeping a log of progress.
- Discuss options for tailored pharmacotherapy treatments.
    - FDA-approved tobacco cessation medications that are covered under the PCN program.
- Inform the patient of additional resources available between office visits:
    - Utah Tobacco Quit Line (1-800-QUIT-NOW) provides free and confidential phone-based counseling to Utah callers. Eligible callers may receive nicotine replacement therapy (patch or gum) at no cost.
    - Way to quit website (www.waytoquit.org) provides information about free quitting resources including a text-to-quit program and online coaching.
- Arrange for a follow-up visit starting the first week after the patient's quit date. Follow-up counseling visit may be paid under S9453, but an E&M service will not be paid in addition. Follow-up visits must be documented and address the progress and counseling that was completed at that session. There is a limit of four counseling visits per year with manual review.

Health care providers can receive free training and materials from local health departments. For more information, call 1-877-220-3466 or email waytoquit@utah.gov.

2 - 9 Immunizations

Immunizations are available to PCN members in a medical office, but not at the pharmacy point-of-sale. For further information, see the Utah Provider Manuals for Pharmacy and Physician available at: https://medicaid.utah.gov.

2 - 10 Family Planning Services

This service includes disseminating information, treatment, medications, supplies, devices, and related counseling in family planning methods to prevent or delay pregnancy. Family Planning services not covered under the PCN program are birth control patches, surgical and non-surgical sterilizations. All services must be provided or authorized by a physician or nurse practitioner and must be provided in concert with Utah law.

2 - 11 Vision Care

Services provided by licensed ophthalmologists or licensed optometrists, within their scope of practice. Covered services are limited to:

1. Examinations and refractions. Glasses are not covered.
2. One exam every 12 months.

The following codes are covered: 92002, 92004, 92012, 92014, S0620, and S0621. The examination fee includes the refraction (glasses prescription).

2 - 12 Dental Services

The following preventive and restorative dental services are covered under the PCN program:

D0120, D0150, D0210, D0270, D0272, D0274, D1110, D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, and D4355.

In addition, the following emergency dental services are covered:

D0140, D0220, D0230, D7140, D7210, and D7510.

2 - 13 Transportation Services

Ambulance (ground and air) services are covered for medical emergencies only.
The following codes are covered:

A0422, A0425, A0429, A0430, A0431, A0435, and A0436.

2 - 14 Interpretive Services

Services provided by entities contracted with Medicaid to provide medical translation services for people with limited English proficiency and interpretive services for the deaf are covered.

No specific codes are identified. When providers use the Medicaid authorized interpretive services, payment is made to the entity under terms of the signed contract. Medical providers may use their own interpreters. However, independent interpreters cannot bill nor be paid by Medicaid. If independent interpreters are used, payment remains the responsibility of the provider who secured their services.

Medicaid administrative funding for translation or interpretation services is available only when associated with a Medicaid State Plan covered service. Translation or interpretation services are available to eligible individuals for whom English is not their primary language. This includes individuals whose primary language is American Sign Language or Braille, since these languages are considered distinct and separate languages from English.

Medicaid providers are required to provide foreign language interpreters for Medicaid members who have limited English proficiency (LEP).

Members are entitled to an interpreter to assist in making appointments for qualified procedures and during visits. Providers must notify members that interpretive services are available at no cost. Payment for interpretative services will only be made if there is a paid corresponding claim from a Medicaid provider for a Medicaid covered service(s).

LEP members may prefer or request to use family and/or friends as interpreters. The use of family and/or friends as interpreters should occur only after the LEP member is informed of the right to receive free interpreter services, and the offer for assistance has been declined and documented in the patient's record. Family and/or friends are not reimbursed for interpretive services. Minor children and other members and/or patients will not be used to interpret, in order to ensure confidentiality of personal health information (PHI).

2 - 15 Audiology Services

Audiology services are limited to one annual hearing test for hearing loss. The procedure code is V5010, assessment for hearing aid.

3 NON-COVERED SERVICES UNDER THE PRIMARY CARE NETWORK

1. Inpatient or outpatient hospital diagnostic, therapeutic, or surgical services, except for those in the emergency department or those very minor procedures which can be provided in the physician's office. Note: Observation codes 99217-99236 are not covered.
2. Procedures that are cosmetic, experimental, investigational, ineffective or not within the limits of accepted medical practice
3. Health screenings or services to rule out familial diseases or conditions without manifest symptoms
4. Routine drug screening
5. Medical or psychological evaluations or testing for legal purposes such as paternity suits, custodial rights, or for insurance or employment examinations
6. Non-emergency ambulance services through common or private aviation services
7. Transportation services for the convenience of the patient or family
8. The following types of family planning services:
    - Infertility studies and reversal of sterilization
    - Assisted Reproductive Technologies (ART's) (in-Vitro)
    - Genetic Counseling
    - Cytogenetic studies
9. Abortion
10. Sterilization
11. Weight loss programs

12. Office visit for allergy injections or other repetitive injections - Non-covered:
    - CPT procedure codes 95115 through 95134
    - CPT procedure codes 95144 through 95199
13. Vitamins - prescription or injection
14. Physical therapy
15. Occupational therapy
16. Massage therapy
17. Podiatric (podiatry) services - routine foot care
18. End Stage Renal Disease (Dialysis)
19. Medical and surgical services of a dentist
20. Organ transplant services
21. Charges incurred as an organ or tissue donor
22. Home health and hospice services. This exclusion applies regardless of whether services are recommended by a provider and includes the following:
    Skilled nursing service
    Supportive maintenance
    Private duty nursing
    Home health aide
    Custodial care
    Respite care
    Travel or transportation expenses, escort services, or food services
23. Mental health
24. Substance abuse and dependency services
25. Hypnotherapy or biofeedback
26. Long term care
27. HIV prevention
28. Home and Community-Based Waiver services
29. Targeted case management
30. Other outside medical services in free standing centers – Emergency centers (Insta-Care type), surgical centers, or birthing centers
32. Chiropractic services
33. Speech services
34. Pregnancy-related services