Chapter 4. Prior Authorization

The Nevada Medicaid and Nevada Check Up Provider Web Portal allows providers, or their delegates, the ability to create/submit, update, and view prior authorizations online using the Provider Web Portal.

4.1. Acronyms

- ABA – Applied Behavior Analysis
- ADHC – Adult Day Health Center
- BH – Behavioral Health
- DME – Durable Medical Equipment
- Inpt – Inpatient
- IOP – Intensive Outpatient Program
- M/S – Medical/Surgical
- Outpt – Outpatient
- PA – Prior Authorization
- PCS – Personal Care Services
- PHP – Partial Hospitalization Program
- RTC – Residential Treatment Center
- SDS – Self-Directed Skills

4.2. Creating a Prior Authorization

To create a prior authorization on the Provider Web Portal:

1. Log into the Provider Web Portal.
2. On the “My Home” page, under Care Management tab click the “Create Authorization” link:
Or

On the “My Home” page, click on the Care Management tab and click the “Create Authorization” link:

3. The Create Authorization page displays and defaults to Medical. All of the fields marked with a red asterisk (*) are required fields.
4. Select the Dental radio button to create a Dental PA. All of the fields marked with a red asterisk (*) are required fields.
When the Create Authorization is first displayed, all of the panels are expanded.

**Collapse:**

Click on the (–) button on the right hand side of the panel to collapse that panel.

Click the “Collapse All” link on the top right hand corner of the page to collapse all of the panels.
Expand:
Click on the (+) button on the right hand side of the panel to expand that panel.

Click the “Expand All” link on the top right hand corner of the page to expand all of the panels.
4.3. Process Types

Create Authorization is a one-page process for all prior authorization requests.

1. Select Medical or Dental to indicate the type of authorization that is being created.

2. The Process Type drop-down lists will display all of the available process types based on the type of authorization that was selected. The required information in the Service Details section is dependent on the process type selected.

Medical – Select one of the following process types from the drop-down list:

- ABA
- ADHC
- Audiology
- BH Inpt
- BH Outpt
- BH PHP/IOP
- BH Rehab
- BH RTC
- DME
- Home Health
- Hospice
- Inpt M/S
- Ocular
- Outpt M/S
- PCS Annual Update
- PCS One-Time
- PCS SDS
- PCS Significant Change
- PCS Temporary Auth
- PCS Transfer
- Retro ABA
- Retro Audiology
- Retro BH Inpt
- Retro BH Outpt
- Retro BH PHP/IOP
- Retro BH Rehab
- Retro BH RTC
- Retro DME
- Retro Home Health
- Retro Inpt M/S
- Retro Ocular
- Retro Outpt M/S

Dental – Select one of the following process types from the drop-down list:

- Dental
- Dental Orthodontia
- Retro Dental
- Retro Dental Orthodontia
4.4. Provider Information

The Requesting Provider Information is automatically populated with the Provider ID and Name of the provider that the signed-in user is associated with.

Medical Process Types:

- **Referring Provider Information**
  - If there is a referring provider, complete one of the following options:
    1. Check the box to indicate - Referring Provider same as Requesting Provider OR
    2. Use the “Select from Favorites” drop-down list to select a provider from your favorites list OR
    3. Enter Provider ID and ID Type

- **Service Provider Information**
  - Complete one of the following options:
    1. Check the box to indicate – Service Provider same as Requesting Provider OR
    2. Use the “Select from Favorites” drop-down list to select a provider from your favorites list OR
    3. Enter Provider ID and ID Type

- Check the Add to Favorites checkbox to add the entered provider to the favorite providers list

- Select service location from the “Location” drop-down list (Optional)

Required fields are marked with a red asterisk (*)
Dental Process Types:

- Rendering Provider Information
  
  o If there is a rendering provider, complete one of the following options:
    1. Check the box to indicate - Rendering Provider same as Requesting Provider
    OR
    2. Use the “Select from Favorites” drop-down list to select a provider from your favorites list
    OR
    3. Enter Provider ID and ID Type
  
  o Check the Add to Favorites checkbox to add the entered provider to the favorite providers list.
  
  o Select place of service from the “Place of Service” drop-down list (Required)

Required fields are marked with a red asterisk (*)
4.5. Recipient Information

The Last Name, First Name, and Birth Date will be automatically populated based on the Recipient ID that is entered.

**Medical**

![Recipient Information](image)

Required fields are marked with a red asterisk (*)

**Dental**

The recipient information panel for dental PAs also includes a field to enter the initial X-Ray/Photo Date, and a tooth chart to indicate which of the patient’s teeth are missing (if applicable).

![Recipient Information](image)

Required fields are marked with a red asterisk (*)
4.6. Service Information

The Process Type selected determines the fields presented in Service Details panel.

- All authorizations require:
  - At least one diagnosis code (enter without decimals)
  - Service details (up to 27 service lines)
  - At least one electronic attachment
- Attachments can be submitted:
  - Electronically
  - By mail only if dental x-rays or dental molds that do not allow for electronic submission.

**Diagnosis Information**

The first diagnosis entered is considered to be the principal or primary diagnosis code.

- Portal allows for up to 9 diagnosis codes.
- Diagnosis codes are searchable.
  - Enter the first three letters or the first three numbers of the code to use the predictive search.
- Click “Add” button to add each diagnosis code.

Required fields are marked with a red asterisk (*)
Service Details for Inpatient Process Types

Inpatient M/S, BH Inpatient, BH RTC, Hospice, Retro BH Inpatient, Retro BH RTC, Retro Hospice and Retro Inpatient M/S

- Inpatient Process Type authorizations can have up to 27 service lines.
- For hospital inpatient concurrent reviews that are greater than 27 lines, beginning at what would be line 28, please start a new PA with the next day’s date following the “through” date from line 27.
  
  For example:
  - Line 27: 1/1 to 1/4
  - Line 28 of new PA: 1/5

  This is only for concurrent review PAs with more than 27 lines.

  **Note:** Please remember that only one (1) PA is allowed per claim. If you have more than one PA, please split bill the claim if it is for one continuous stay.

- Revenue codes are searchable.
  - Enter the first three numbers, or description of the code to use the predictive search.

- Enter the requested From Date. The Through date will automatically be calculated when the service line is added to the PA by clicking the “Add Service” button.
  - The Through date will be based on the # of Days requested without the addition of a day for the Date of Discharge
  - Service lines with overlapping dates are not allowed.

- The Medical Justification field allows up to 6000 characters. Acceptable characters include [a-z], [A-Z], [0-9], spaces and characters ',.?!+-;_%/\=',&*$^@.

- If your National Provider Identifier (NPI) is tied to multiple provider types, i.e., 10, 11 and 12, 20, please enter the provider type associated with the authorization request in the medical justification field.

- Click “Add Service” button to add the service line to the PA

- Use the Copy link to copy the service line information to the next line.

- Use the Remove link to remove any service lines added in error.

Required fields are marked with a red asterisk (*)
Service Details for Medical Non Inpatient Process Types

ABA, ADHC, Audiology, BH Outpatient, BH PHP/IOP, BH Rehab, DME, Home Health, Hospice, Ocular, Outpatient M/S, PCS Annual Update, PCS Informational Cancel, PCS Initial, PCS One-Time, PCS Significant Change, PCS SDS, PCS Temporary Auth, PCS Transfer, Retro ABA, Retro Audiology, Retro BH Outpatient, Retro BH PHP/IOP, Retro BH Rehab, Retro DME, Retro Hospice, Retro Home Health, Retro Ocular, and Retro Outpatient M/S

- Non Inpatient Process Type authorizations can have up to 27 service lines.
- CPT/HCPCS codes are searchable.
  - Enter the first three numbers or description of the code to use the predictive search.
- Enter the requested “From Date.” The “To Date” is optional but can be used to request a date range.
- Modifiers – If applicable, up to four modifiers can be entered.
- Enter the number of units for the service being requested.
- (Optional) Frequency – drop-down list that only appears for ADHC and PCS Process Types. If applicable, select the frequency of the service being requested.
- The Medical Justification field allows up to 6000 characters. Acceptable characters include [a-z], [A-Z], [0-9], spaces and characters '.,?!,()+_-%$^@.
- If your National Provider Identifier (NPI) is tied to multiple provider types, i.e., 10, 11 and 12, 20, please enter the provider type associated with the authorization request in the medical justification field.
- Click “Add Service” button to add the service line to the PA.
- Use the Copy link to copy the service line information to the next line.
- Use the Remove link to remove any service lines added in error.

Required fields are marked with a red asterisk (*)
**Service Details for Dental Process Types**

*Dental, Dental Orthodontia, Retro Dental, and Retro Dental Orthodontia*

- Dental Process Type authorizations can have up to 27 service lines.
- CPT/HCPCS and CDT codes are searchable.
  - Enter the first three numbers or description of the code to use the predictive search.
- Enter the requested “From Date.” The “To Date” is optional, but can be used to request a date range.
  - If a “To Date” is entered, it can’t exceed more than 365 days from the “From Date.”
- Modifiers – If applicable, up to four modifiers can be entered.
- Enter the number of units for the service being requested.
- Tooth Number – drop-down list to select the tooth number of the service being requested.
- Tooth Surface – drop-down list to select the tooth surface of the service being requested.
- Oral Cavity Area – drop-down list to select the oral cavity area of the service being requested.
- Requested Dollars – If applicable, enter a requested dollar amount.
- The Medical Justification field allows up to 6000 characters. Acceptable characters include [a-z], [A-Z], [0-9], spaces and characters ' .?!(),;:_%/\&=#$^@.
- Click “Add Service” button to add the service line to the PA
- Use the Copy link to copy the service line information to the next line.
- Use the Remove link to remove any service lines added in error.

Required fields are marked with a red asterisk (*)
Attachments
Attachments are required for all prior authorization requests. Requests are not considered submitted unless there is an attachment. If an attachment is added at a later time, the request will be considered submitted at the time the attachment is added.

To include attachments electronically with a prior authorization request:

- Transmission Method – Electronic Only is selected by default
- Upload File – click “Browse” button and locate file to be attached and click to attach
- Attachment type – select from the drop-down box the type of attachment being sent
- Select the “ADD” button to attach your file
- Repeat for additional attachments if needed (Note: the combined size of all attachments cannot exceed 4 MB)
- To remove any attachments that were attached incorrectly, use the Remove link

Note: Attachment section is required to be completed and at least one attachment is required.

Required fields are marked with a red asterisk (*)

To submit dental prior authorization x-rays or molds that do not allow for electronic submission by mail:

Mail attachments to:
Nevada Medicaid
Attention: “Dental PA”
PO BOX 30042
Reno, NV 89520-3042
**Unsaved Data Warning**
For a new or resubmitted prior authorization request, when at least one service line has been entered and there is another service line added but not saved by clicking the “Add Service” button before clicking the “Submit” button, then the following error message will be displayed:

![Unsaved Data Warning](image)

**Finalizing a Prior Authorization**
Once all of the required information, service details lines, and attachment information has been added, click the “Submit” button to go to the Confirm Authorization page. This page contains all of the authorization details. Review the information for accuracy. Use the “Back” button to return to the Create Authorization page if errors are present. After all of the information has been reviewed, select the “Confirm” button to send your authorization for processing.
Authorization Receipt Page

The Authorization Receipt page will display the Authorization Tracking number; this number is used to track your authorization in the portal.

Print Preview
- Opens new window with all of the authorization information viewable
- Printable page with date and time stamp

Copy
- Copy recipient data or authorization data to a new authorization

New
- Create a new authorization for a different recipient

Copying an Authorization

The ability to copy an authorization, by recipient or service, is available on the authorization receipt page, after successfully submitting an authorization.

Copy authorizations by Member Data
- You can copy an authorization for an existing recipient when requesting a new service.
- Only the recipient data is copied for the copy request.

Create Authorization:
- Review pre-populated recipient data
• Select process type
• Enter provider information
• Enter all required data
• Add attachments
• Click Submit
• Review all information
• Select Confirm
• Authorization Receipt page

Copy authorizations by Authorization Data
• You can copy an authorization by service, so a specialist can submit authorizations for similar services but for a different recipient.
• All of the authorization data is copied with the exception of the recipient data and the attachments section.

Create Authorization:
• Enter recipient data
• Review all pre-populated data
• Add attachments
• Select submit
• Review all information
• Select Confirm
• Authorization Receipt page

4.7. Submitting Additional Information
If you have submitted a PA request via the Provider Web Portal, but need to submit additional information such as:
• Requests for additional services
• Attachments that were not submitted with original PA submission
• FA-29 Prior Authorization Data Correction Form
• FA-29A Request for Termination of Service

Resubmission process:
1. Search for the PA using the View Authorization Search page
2. Click on the Authorization Tracking Number in the Search Results grid
3. Click on the “Edit” button on the View Authorization Response page.
4. The PA is re-opened, new diagnosis codes, service details, and/or attachment can be added.
   - Changes cannot be made to previously submitted information. If you need to update previously submitted information, attach the FA-29 Prior Authorization Data Correction Form to the PA that needs to be updated.

5. Once the new information has been added to the PA, click on the “Resubmit” button to review the PA information
6. Click the “Confirm” button to resubmit the PA.
7. The Authorization Tracking Number will remain the same.

4.8. Checking prior authorization status

Logged-in users are able to inquire on the status of any Prior Authorization (PA) request.

To check status of a PA:
1. After logging in, click the Care Management tab at the top of the page.

You will be directed to the Authorizations page.

2. Click View Status of Authorizations.

You will be directed to the View Authorization Status page. Two tabs will be displayed.

3. The Prospective Authorizations tab displays a list of authorizations with dates of service starting with the current date going forward, by either the requesting or servicing provider. If there are no authorizations to view, you will see the following page.
If there are authorizations to view, they will be listed under Prospective Authorizations. You can click on the column heading to sort the view of the last 20 authorizations by Authorization Tracking Number, Service Date, Recipient Name, Recipient ID, Authorization Type, Requesting Provider, or Servicing Provider.

To view authorizations:

4. Click the Authorization Tracking Number to get the PA for the member listed.

5. Click “Expand All” or the “+” icons to view the full PA details.
By expanding the page, you can view:

1. Requesting Provider Information
2. Recipient Information
3. Diagnosis Information
4. Service Provider/Service Details Information
5. To view full page in printable format, click the “Print Preview” box that will appear at the bottom of the page.
6. An additional small page will display giving you a printable view. Click “Print” for printing option.

7. You can also print using View Provider Request displayed on the View Authorization Response page. The View Provider Request page will display all of the dates of service and units requested by the provider.

8. To check status of another PA, click on “Back to View Authorization Status.”
Medical Citation

If there is medical citation or notes to the provider, a View link will be displayed in the Medical Citation Column.

To view the medical citation and notes to provider, click on the View link.
Search Options Tab:

You also have the ability to search for specific authorizations by clicking on the Search Options tab instead of the Prospective Authorizations tab.

To search for authorizations under the View Authorization Status, enter at least one of the following:

1. **Authorization Information**
   - Authorization Tracking Number
   - Day Range or Service Date

2. **Status Information**
   - Select a status from the Status drop-down list
   - When searching using status you will have to also enter at least one of the following:
     - Authorization Tracking Number
     - Day Range or Service Date
     - Recipient Information
     - Provider Information
   - Please allow up to one hour after the time of your PA submission before trying to search using “Status Information.”

3. Enter at least one of the following: **Recipient Information**
   - Recipient ID
   - Birth Date
   - Last Name
   - First Name
   - If birth date or first name is entered, then member ID and/or last name must also be entered.

4. Enter the following: **Provider Information**
   - Provider ID
   - ID Type
   - Servicing/Referring Provider selection
   To search by Provider Information, you can search for servicing/rendering provider by clicking on the magnifying glass icon “🔍”. Clicking on the magnifying glass will take you to the Provider Search page.

5. After the search criteria has been entered, click the “Search” button.
The Search Results grid will display the PAs that match the search criteria or display a message that there are no results. Click on the “Authorization Tracking Number” to view the statuses of the individual detail lines. Prior authorization searches done without selecting a status will not display status information in the search results. The service dates displayed in the search results are the overall service dates of the PA.

Prior Authorization searches done using status will display service lines of all PAs with the specified status. The service dates displayed in the Search Results grid are the service dates on the service line and not the overall service dates of the PA. The results will also display the service line details including the Procedure or Revenue Code.
6. For additional searches, click the “Reset” button on the View Authorization Status page and enter in required information. Click “Search” button again.

4.9. Checking PA status through member focused viewing

The Member Focused Viewing link allows you to view a summary of all recipients’ information on one page, based on the last 10 recipients previously viewed in the Electronic Verification System (EVS). When you search for other recipients in EVS, the Member Focused Viewing page remains available, so you do not have to repeat searches.

To check on PA status:

1. Click Member Focused Viewing from the My Home page.

The Member Focus Search page displays two tabs. If you have previously viewed recipients, the Last Member Viewed tab displays up to the last 10 searches. If no recipients have been previously viewed, then only the Search tab displays. Selection of an individual recipient from either tab
displays the Member In Focus bar at the top of the page, and summary information below, including their recent activity.

2. Click the name that is listed on the Member Focus Search page.

-OR-

3. Click the Search tab and enter in required information.

        The Search tab allows you to search for recipients and select a recipient to view. When searching for recipients, you must enter complete information. Partial information will not generate a search.

        To avoid generating a large number of search results, you should enter as much information as possible to limit your searches.

4. After search criteria has been entered, click the “Search” button.

Search results display on the Search Results page.

5. Click recipient’s name in the search results for Member in Focus details.
The recipient details show the recipient’s demographics, benefit plans (if applicable), pending claims, authorizations, or no results. At the top of the page, the recipient will remain in focus even if the user checks details on another recipient.

6. Click the authorization listed under the Your Member Authorizations heading. You will be directed to the View Authorization Response page.

7. Click **Expand All** or the “+” icons to view the PA details.
By expanding the page, you can view:

8. Requesting Provider information
9. Recipient information
10. Diagnosis information
11. Service Provider/Service Details

**Note:** The recipient is still in focus at the top of the page.
To print the Authorization Request:

1. To view full page in printable format, click Print Preview. An additional small page displays giving you a printable view.

2. Click “Print” button for printing option.
3. You can also print by clicking View Provider Request displayed on the View Authorization Response page. This will show the units and “From” and “To/Through” dates requested by the provider.

1. To check the status of another PA or for another recipient, click Back to View Authorization Status.
2. To view the original requested dates of service and units on the PA, click View Provider Request.
3. To change the recipient in focus, click Change next to the name in the Member in Focus bar. This will take you back to the Member in Focus page. You can select from the other recipients on the list.
4. To remove the member in focus while checking PA status on another recipient, click Close Member Focus or click on the “X” icon. The View Authorization Response page will then be in view and the user will no longer be in Member Focused Viewing.
4.10. Maintain Favorite Providers

Providers and delegates can add and remove providers from their favorites list using the Maintain Favorite Providers page, located under the Care Management tab. The list of favorite providers will be available for selection as the servicing provider, referring provider and rendering provider when creating a prior authorization. Up to 20 providers can be added to the favorites list.

Add a Favorite Provider:

1. Enter the Facility or Provider ID and ID Type, then click Add.

2. If you do not know the ID and type, click the magnifying glass for a provider look up.

The Provider Search page allows you to Search By ID or search by name when clicking on the Search By Name tab, and search by organization when clicking on the Search By Organization tab.
Delete a Favorite Provider:

1. To delete a provider, select the Remove link on the right side of the row.

4.11. Logging out of PA status

After verifying PA status, it is strongly recommended that you log off after each session. This will ensure PHI is secure and makes the login readily available for the next user.

1. To log out, click Logout located at the top right-hand corner of the page.
   
   This hyperlink is located in the same area on all pages within EVS.

   ![Logout](image)

After clicking Logout, the Logout Confirmation page displays.

2. Click OK or click Cancel to go back to previous page.

![Logout Confirmation](image)

After clicking OK, you will be taken back to the Provider Login Home page.

The Authorization Criteria page allows providers and their delegates the ability to search criteria for PA requirements for a procedure or revenue code based on provider type and specialty using Provider Web Portal. The online authorization criteria search can be accessed through the unsecured and secured areas of the Provider Web Portal.

Gaining access to Authorization Criteria

To access the Authorization Criteria page using the unsecured area of the Provider Web Portal:

1. Open a web browser such as Internet Explorer or Firefox.
2. Enter www.medicaid.nv.gov in the address bar.
3. The Provider Web Portal Home page opens as shown below. Then click EVS. The submenu displays User Manual or Provider Login (EVS).
4. Click Provider Login (EVS). The EVS Home page opens.
5. Click Authorization Criteria.

To access the Authorization Criteria page using the secured area of the Provider Web Portal:

1. Open a web browser such as Internet Explorer or Firefox.
2. Enter www.medicaid.nv.gov in the address bar.
3. The Provider Web Portal homepage opens as shown below. Then click EVS. The submenu displays User Manual or Provider Login (EVS).

4. Click Provider Login (EVS). The EVS Home page opens.

5. Log in to the Provider Web Portal.
6. On the “My Home” page, under Care Management click the “Authorization Criteria” link to open the Authorization Criteria page:
When the Authorization Criteria link is clicked on either the unsecured or secured areas of the Provider Web Portal, the Authorization Criteria provider portal page is displayed.

The following fields are displayed on the Authorization Criteria page:

1. Code Type (Dental, Medical (CPT/HCPCS) and Revenue Code)
2. Procedure Code or Description
3. Provider Type
4. Provider Specialty (optional)

The fields marked with a red * are required fields.

**Note:** The provider type will default to the logged in provider’s type when the Authorization Criteria page is accessed from the secure portal. The defaulted provider type can be overridden.

1. **Code Type** select one of the following options:

   ![Code Type Selection]

2. **Procedure Code or Description.**
   Enter Procedure Code:

   ![Procedure Code Selection]

   OR

   Enter Description of the code:
3. **Provider Type.**
Enter Number: (If not using the default)

```
*Code Type
Medical

*Procedure Code or Description
33222-RELOCATION POCKET PACEMAKER

*Provider Type
02
020-PHYSICIAN,M.D.,OSTEOPATH
021-PODIATRIST
022-DENTIST

OR

Enter Description:
```

```
*Code Type
Medical

*Procedure Code or Description
33222-RELOCATION POCKET PACEMAKER

*Provider Type
phy
020-PHYSICIAN,M.D.,OSTEOPATH
058-PHYSICALLY DISABLED WAIVER

OR

Enter Description:
```

4. **Provider Specialty.**
Enter Specialty Code:

```
Provider Specialty
06
060-INTERNAL MEDICINE
061-NEUROLOGICAL SURGERY
062-OBSTETRICS AND GYNECOLOGY
063-OPHTHALMOLOGY

OR

Enter Description:
```

**Please note:** In most instances the Provider Specialty is not necessary and may not be required. If you enter a specialty and the result you receive is “There are no records found based on the search criteria entered,” please re-check with the Provider Specialty field blank.
After all of the search criteria has been entered, click the “Search” button to display the search results:

**Authorization Criteria**

- Code Type: Medical
- Procedure Code or Description: 33222-RELOCATION POCKET PACemaker
- Provider Type: 020-PHYSICIAN,M.D.,OSTEOPATH
- Provider Specialty:

**Search Results**

- To show/hide Service Limits click on Required if exceeding service limitations hyperlink.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Provider Type</th>
<th>Provider Specialty</th>
<th>Claim Type</th>
<th>PA Required</th>
<th>Age Restrictions</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>33222-RELOCATION</td>
<td>020-PHYSICIAN,M.D.,OSTEOPATH</td>
<td>DENTAL SPECIALTY</td>
<td>PRACTITIONER</td>
<td>Always</td>
<td>0-999</td>
<td>01/01/1993</td>
</tr>
<tr>
<td>PACmaker</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12/31/1999</td>
</tr>
</tbody>
</table>

If multiple rows are returned, the search results can be sorted by:

- Provider Specialty
- Claim Type
- PA Required
- Age Restrictions
- Effective date

The example below is sorted by Provider Specialty:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Provider Type</th>
<th>Provider Specialty</th>
<th>Claim Type</th>
<th>PA Required</th>
<th>Age Restrictions</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4777-DRAINABLE PLASTIC PCH W/O PF</td>
<td>017-SPECIAL CLINICS</td>
<td>155-FAMILY PLANNING</td>
<td>PRACTITIONER</td>
<td>Secured if exceeding service limitations</td>
<td>0-999</td>
<td>06/01/2006</td>
</tr>
<tr>
<td>A4777-DRAINABLE PLASTIC PCH W/O PF</td>
<td>017-SPECIAL CLINICS</td>
<td>174-PUBLIC HEALTH</td>
<td>PRACTITIONER</td>
<td>Secured if exceeding service limitations</td>
<td>0-999</td>
<td>06/01/2006</td>
</tr>
<tr>
<td>A4777-DRAINABLE PLASTIC PCH W/O PF</td>
<td>017-SPECIAL CLINICS</td>
<td>183-COMPREHENSIVE COUTPATIENT REHAB FACILITIES (CO)</td>
<td>PRACTITIONER</td>
<td>Secured if exceeding service limitations</td>
<td>0-999</td>
<td>06/01/2006</td>
</tr>
<tr>
<td>A4777-DRAINABLE PLASTIC PCH W/O PF</td>
<td>017-SPECIAL CLINICS</td>
<td>193-COMMUNITY HEALTH CLINICS - STATE HEALTH DIVIS</td>
<td>PRACTITIONER</td>
<td>Secured if exceeding service limitations</td>
<td>0-999</td>
<td>06/01/2006</td>
</tr>
<tr>
<td>A4777-DRAINABLE PLASTIC PCH W/O PF</td>
<td>017-SPECIAL CLINICS</td>
<td>196-SPECIAL CHILDREN’S CLINICS</td>
<td>PRACTITIONER</td>
<td>Secured if exceeding service limitations</td>
<td>0-999</td>
<td>06/01/2006</td>
</tr>
</tbody>
</table>

EVS User Manual, Chapter 4
Updated 12/28/2018 (pv04/17/2018) MODERNIZATION