PA Data Dictionary/Glossary of Terms

Data/Function Term	Operational Definition
Reference ID	The unique value assigned to identify a provider as performing a service related to a prior authorization. This is not the provider Medicaid ID, but a number starting with REF that is used to distinguish two providers associated with one PA request. For some review types, a provider ID and provider REF number are required when entering cases via the web portal. On the *New Request for PA* page, the Reference ID is categorized according to the PA type requested. *Facility Reference ID* refers to the REF number for a hospital or ambulatory surgical center. *Medical Practitioner Reference ID* refers to the REF number for a physician or other medical practitioner such as a Podiatrist. *Physician Reference ID* refers to the REF number for a physician.
Provider ID	A provider's Medicaid identification number. On the web portal *New Request for PA* page, the provider ID is categorized as one of the following depending on the type of PA requested: *Facility Provider ID* (hospitals/ambulatory surgical centers); *Medical Practitioner Provider ID* (physicians; psychologists; oral max providers; other medical practitioners); *Dental Provider ID* (dentists); *Service Provider ID* (Ancillary service providers such as DME providers); *Transport Provider ID* (transport companies); *Therapist Provider ID* (CIS therapists); *Swingbed Provider ID* or *ICFMR Provider ID* (Swingbed or ICFMR facility).
Member ID	The Medicaid member identification number of the patient for whom you are requesting the prior approval.
Additional Information Questions	Online PA request forms may include an *Additional Information Questions* section. This section includes questions pulled into the online form based on all or some of the following determinants: type of review; place of service; diagnosis; and procedures. The questions are designed to capture key clinical information related to the service requested. Responses to the questions are important for the review process.
I Agree - Attestation	The following attestation statement has been added to each of the online request forms. The person entering the case must select *I Agree* in order to submit the PA. " To the best of my knowledge, the information I am submitting in this transaction is true, accurate, complete and is in compliance with applicable Department of Community Health polices and procedures. I am submitting this information to the Georgia Department of Community Health, Division of Medical Assistance, for the purpose of obtaining a prior authorization number. I understand that any material falsification, omission or misrepresentation of any information in this transaction will result in denial of payment and may subject the provider to criminal, civil or other administration penalties. To accept this information and proceed with your transaction, please click 'I agree'.
Review Criteria	The medical necessity review criteria approved by DCH that Alliant utilizes to make decisions regarding a prior approval request. Review criteria include InterQual and DCH policy/guidelines.

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Contact Information	Contact Information is a section of the online request form. Contact Name, phone and fax number are required in order to submit the request. In general, the person entering the case is considered the contact person. The PA system auto-populates the contact information if the data is in the provider file; but the provider may edit the information if not correct. Contact information is important in the event that there is a question about the request or additional information is required to process the request.
Release of Information Code	A HIPAA required field that addresses whether the patient has consented to having their medical information released to the reviewing organization in order to make a decision regarding medical necessity.
Taxonomy (Specialty)	The medical specialty or service specialty of the providers associated with a prior approval.
Category of Service	A Category of Service (COS) is a way of identifying a Provider according to the types of service(s) that a Provider is authorized to request and render under the Georgia Medicaid Program. Each category of service is identified by a number code. A provider may have more than one category of service. For example, a dentist may have 450 Child dental and 460 Adult dental categories of service.
PA types: ZD, LI, and ZT	New PA type codes have been assigned to three existing PA types. Medications PA Facility Setting is now PA type ZD. PASRR level I is now PA type LI; and Hospital Outpatient Therapy is now PA type ZT.
Patient Transfer Information	*Patient Transfer Information* is a section of hospital-based online request forms. This section is designed to capture the reasons why a patient is transferred to a facility or transferred from a facility. The reasons for transfer have been revised to better correspond with DCH policy. If the provider indicates that a transfer has occurred, the reasons for the transfer must be selected.
Create An Attachment	'Create an Attachment' is a new function available on the online request forms. This function allows providers to attach additional documentation to a PA when entering the request for authorization.
PA Number (PA ID) or Authorization ID	A unique reference number that is issued for each prior approval request and is transmitted to the Claims payment unit to ensure that appropriate prior approval was obtained for the services rendered to the Medicaid patient. When a PA is first entered, the case is assigned a 12 digit number which can be used to track the status of the case via the web portal. Once the case is reviewed and approved, the same number becomes the authorization number.
Review Decisions	Alliant will make the following review decisions for all prior approval types: • **Pended or suspended**- Upon initial submission of prior approval requests, the request will be pended until a decision is rendered. • **Approved** – Approvals may be rendered by nurse reviewers or peer consultant reviewers. • **Denied** - If the request fails to meet the review criteria for medical necessity, the prior approval request will be denied. Providers may submit a request for reconsideration of a denied case.

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Provider Workspace	A section of the web portal that provides all prior authorization functionality. On the *Provider Workspace*, the provider can find training information and policy information; and can request a PA, search for PA information, enter change requests and attach documents.
PA IVR - Interactive Voice Response	The caller accesses this interactive call system by dialing the main call system number. After entering identification information, the caller is able to select different options for obtaining PA information or to request a PA by phone (limited to Hospital Admissions).
NAP IVR- Interactive Voice Response	The NAP maintains an automated interactive call system designed to provide consumers, nurse aides and providers with accurate and timely information regarding the Nurse Aide Registry (NAR) and other aspects of the Nurse Aide Program (NAP). The system responds to queries regarding nurse aide certification and status, adverse findings, request for forms, out-of-state reciprocity, training programs, and information for reporting abuse. The functions that require intervention by a person are transferred to a NAP Customer Service Representative.