PROVIDER ALERT

Revised Non-OMS Concurrent Review Parameters

October 24, 2011

The following applies to authorizations for consumers who receive traditional outpatient services outside of the OMS (an OMHC, FQHC, or Hospital-based clinic with an Outcomes Measurement System authorization) workflow. These outpatient authorizations are considered "Non-OMS" and include those to individual practitioners, group practices, and OMHCs.

Historically, the initial 12 services have been auto-authorized. This process will remain unchanged. Any additional outpatient services requested were pre-authorized by submitting concurrent review requests. These requests were reviewed by a care manager who confirmed that the requested services met the Medical Necessity Criteria and that the frequency of units being used matched the intensity of the consumer's presentation. **As of November 1, 2011, all requests for Non-OMS authorizations (both initial and concurrent review requests) will be auto-authorized; initial requests for 12 units and concurrent reviews for up to 24 units**.

Although the required fields will remain the same for both the Initial and Concurrent review requests, providers will begin to see a different screen which will explain the request for services was authorized and what the details of that authorization are.

ValueOptions® will continue to monitor a suite of reports designed to identify outliers in Non-OMS utilization compared to standards of clinical practice.