Provider Frequently Asked Questions (FAQ)

Covered Services	
1. What behavioral health services does Magellan of Virginia manage for Virginia Medicaid?	Magellan is responsible for management of the behavioral health services for the fee-for-service Medicaid population, as well as traditional and non-traditional behavioral health services for the FAMIS, FAMIS plus, Governor's Access Plan for the seriously mentally ill (GAP), and Incarcerated membership. If a member is enrolled in Commonwealth Coordinated Care (CCC), please refer to Question #5 below. If a member is enrolled in Commonwealth Coordinated Care Plus (CCC Plus), please refer to Question # 6 below.
2. Does Magellan of Virginia cover services for children in foster care?	Magellan does manage Treatment Foster Care Case Management services (TFC-CM). Magellan does not manage Treatment Foster Care services, however. If the child is covered within the Medicaid fee-for-service program, Magellan would also manage their array of behavioral health benefits.
3. Is teletherapy allowed as a covered service?	Telemedicine services are reimbursable under limited circumstances. Please refer to Virginia Medicaid Psychiatric Services Manual Chapter IV page 30. Telemedicine codes are billed to Magellan with a GT modifier. For telemedicine billing codes, refer to the VA DMAS Medicaid Rates posted on www.MagellanofVirginia.com under the "For Providers" section. See also the provider communication dated October 5, 2015, *Telemedicine Assessment Codes Billing Changes* under "2015 Communications".
4. Is Magellan responsible for step-down services? Who do I contact?	For the fee-for-service Medicaid population, Magellan is responsible for all behavioral health services. For members enrolled in managed care organizations (MCOs), Magellan is responsible for step-down to non-traditional services, but not for traditional outpatient services. Magellan also conducts care coordination with the MCOs.

5. We have members who are enrolling into the Commonwealth Coordinated Care (CCC). How does this affect service authorization requests?	If a member is enrolled in the CCC, Magellan only covers mental health case management (H0023) during the member's enrollment. If a member is not enrolled in CCC at the time of a service request start date, Magellan will review the entire span of the request, regardless of the service type. If the member is enrolled in CCC at the time of the requested start date and the service is not MHCM, providers should submit their requests directly to CCC. Providers can contact CCC at: 1-800-552-8627. If the member dis-enrolls from CCC in the middle of the authorization, please call Magellan at 1-800-424-4046 within 30 days of the end of their enrollment in CCC. Upon verification of the CCC authorization, Magellan will authorize up to 60 days without receiving additional clinical information.
6. We have members receiving a CMHRS services who are enrolling into the Commonwealth Coordinated Care Plus (CCC Plus). I normally submit my authorization and billing to Magellan of Virginia. How does the change effective January 1, 2018 impact service authorization requests and billing?	For Medicaid individuals who are enrolled in the Commonwealth Coordinated Care Plus (CCC Plus) Program, DMAS is preparing to transition the Community Mental Health Rehabilitation Services (CMHRS) into the CCC Plus managed care organization (MCO) contract effective January 1, 2018. On this date, Magellan of Virginia, DMAS's Behavioral Health Services Administrator (BHSA), will no longer administer CMHRS for CCC Plus-enrolled members. If the member is receiving a CMHRS service and has a CCC Plus plan, authorization requests, registration, and billing should be submitted to the member's plan. A list of CCC Plus plans can be located on the DMAS website, www.dmas.virginia.gov.
Authorization/Eligibility	
1. What is the turnaround time for a service authorization?	Magellan's goal is to make an authorization decision as soon as possible. Established maximum limits are as follows: • 3 hours if someone is at an ER and requesting inpatient admission; • 1 business day if already admitted to inpatient; and

	• 3 business days for all other services.
2. What happens if Medicaid eligibility gets established retroactively, after December 1, 2013, but the dates of service are before December 1, 2013?	Any service authorized after December 1, 2013 (including retroactively), is directly handled by Magellan. For dates of service prior to December 1, 2013, providers are to submit through Magellan and Magellan submits to DMAS/Behavioral Health Unit for review and rendering decision.
3. What is the primary method for notifying providers of authorizations?	For inpatient requests submitted on the secured provider website, www.magellanhealth.com/provider, feedback will be given immediately. These requests are submitted online using the "VA DMAS Registration/Auth" link on the left hand side of the home page under "My Practice." If a provider talks with a care manager to receive the inpatient authorization, the provider will receive verbal confirmation of authorization. For all service requests, the authorization is also available for viewing on the secure section of the provider website. Providers can view and download approved authorization letters or run an Excel/PDF report to capture all authorizations as well.
4. If an authorization is pended, what is the turnaround time for notification? How will providers be notified?	If a service authorization request is incomplete, Magellan will notify the provider by telephone using the phone number provided on the service request application (SRA). If we are unable to reach a live person, we will leave a confidential message as long as provider indicates their voicemail messages are secure. The provider has three business days to respond to the request for additional information. Magellan then has three business days to review and process the response to the request. If the provider does not respond to the request for additional information within three business days, Magellan may not be able to authorize the request. If the SRA is missing necessary information, Magellan will non-authorize the request. If the SRA is complete but does not

	appear to meet Medical Necessity Criteria, the SRA will be reviewed by Magellan's medical director to make a determination. If Magellan non-authorizes the request and the provider disagrees with Magellan's decision, the provider will need to submit a request for reconsideration. The process for submitting a request for reconsideration is outlined in the member's and provider's non-authorization letter.
5. How are authorizations handled for TDO (Temporary Detention Order)? Are they authorized and paid as inpatient?	TDO is a legal status. Yes, Magellan will authorize and pay inpatient services that are ordered through the TDO process for Medicaid members. If the TDO is *not* for a Medicaid member, the TDO claims will be paid from a special State Fund exclusive to TDOs. Follow the billing guidelines in the State Medicaid Hospital Manual for billing to DMAS for non-Medicaid members.
6. Regarding physician-directed services: who would get the authorization and who would bill for these traditional outpatient services?	For physician-directed services within a licensed Mental Health clinic, the authorization would be made to the organization. For billing purposes, the supervising physician and their National Provider Identifier (NPI) would be listed in the rendering provider fields on the claim. Magellan is only responsible for traditional outpatient services for members in fee-for-service Medicaid.
7. How will we know if a member is eligible and if they should go through Magellan?	Providers may check eligibility through the secure section of the www.MagellanProvider.com provider website. Members will not receive an ID card from Magellan.
8. Do all outpatient mental health/substance abuse codes require service authorization?	No, medication management does not need service authorization. For traditional outpatient therapy, the first 26 sessions in the first year of treatment (individual, family or group therapy for psychiatric and for substance abuse) do not need prior authorization. Also, the first seven hours of psychological testing every six months do not need prior authorization. If more than seven

	hours are requested during a six month period, the provider will need to submit an SRA to Magellan for authorization.
9. How do you obtain service authorization for the initial session if you do not yet have clinical information on the member?	Many services have a code for a service specific intake. The assessment does not require prior authorization, so this is how a provider can get clinical information prior to sending in a service authorization request. Services with specific assessment codes include: • Therapeutic Day Treatment for Children • Day Treatment/Partial Hospitalization • Psychosocial Rehabilitation for Adults • Intensive Community Treatment • Intensive In-Home • Mental Health Skill-building Service • Behavior Therapy (EPSDT) Please refer to the Community Mental Health and Rehabilitative Services (CMHRS) and/or Early and Periodic Screening, Diagnosis and Treatment (EPSDT) manual posted on the DMAS website for more detailed information about service assessments.
10. If an authorization request is denied, what are your timeframes for reconsideration ("re-reviews") and how do you handle the member during the reconsideration period?	Providers and members have 30 days from the date on the non-authorization letter to submit a request for reconsideration. *Urgent* reconsiderations will be resolved within three business days of receipt of request. Verbal notice will be given and written notice will be sent within 3 business days of the request. *Standard* reconsiderations will be resolved within 30 calendar days of receipt of request. Written notice will be sent within 30 calendar days of the request. Please refer to the "Reconsideration Process for Notice of Action" section in your non-authorization letter for additional details.
11. Treatment Foster Care Case Management authorizations are often	Magellan will review the SRA and authorize a time span based on the clinical information provided. Treatment Foster Care

for one year; will Magellan offer the same?	Case Management may be authorized for up to one year at time.
12. How should we request authorizations?	Providers must complete requests using the Magellan SRA for authorizations through the secured provider web portal, www.MagellanProvider.com. If your agency has its own SRA form you would like use, you must first get approval from Magellan prior to submitting. You may send in your request using the "contact us" link on the homepage of the Magellan of Virginia website.
13. What documentation will be used for authorizations?	Each service has separate requirements. Please refer to each Service Request Authorization form on www.MagellanofVirginia.com for information regarding requirements for specific services.
14. Will authorizations be given immediately?	For inpatient admissions, if our clinical algorithm (VA/DMAS Registration Auth) is able to authorize your request, you will receive the authorization immediately. Otherwise, it will be a maximum of three hours if the member is at an ER or within one business day if already admitted. For all other services, you will receive an authorization decision within three business days of a completed service authorization request.
Clinical	
1. How do Magellan care managers work with CSAs, ICCs, and other providers on individual case planning?	Magellan collaborates with members, providers and involved parties to coordinate care for our members. We will assist in determining what level of care would be appropriate to meet the member's needs and facilitate connections to appropriate Magellan network providers for those services. This includes assistance with discharge planning and complex care coordination.
2. What if members have questions or issues with medication or other treatments?	If a member has questions about medication, Magellan would refer the member to consult with his/her treating physician. Magellan is available for provider referrals and education about different services and levels of care.

3. What is Magellan's referral process for difficult cases?	Providers are responsible for transitioning cases and discharge planning. Magellan will work with providers and members to help identify the best match. Magellan will be able to assist in finding network providers and provide case consultation when needed**.**
4. Do we need to submit a registration for Substance Abuse (SA) Crisis services? How do we get paid for this service?	SA Crisis services do not require registration with Magellan. Providers will file claims for SA Crisis services with Magellan using the appropriate procedure and modifier code. The codes can be found on www.MagellanofVirginia.com under "For Providers" and "Claims, Eligibility, Auths, Rates."
5. Are denials be issued to providers? How are providers informed?	Yes, denials are issued to members/guardians, attending facilities, or others with appropriate release of information documented. Non-authorization letters are mailed to members explaining the reason the request was unable to be authorized. Providers also receive a copy of the member's letter by mail. Letters are sent to the mailing address on file.
6. Is there step-down help with denials (in a timely fashion)?	If a provider or member wishes to discuss alternative levels of care for a member, Magellan's Care Management staff are available by phone. It is, however, still the provider's responsibility to manage discharge planning of a member.
7. How long do we have to submit a retro request for services?	When retroactive eligibility is obtained, the request for authorization must be submitted no later than 30 days from the date that the individual's Medicaid was activated. Please refer to the CMHRS manual, Appendix C, Page 5.
8. How does Magellan handle overlaps (when one provider has an existing authorization and a new provider submits a request for the same member and service)?	In most cases, Magellan's system is set up to block duplicate service requests until the member has been discharged in our system. In the event that a provider ("requesting provider") submits a Service Request Authorization ("SRA") for a member and dates of service requested overlap with an existing authorization for the same service with another provider ("existing provider"), Magellan will pend the SRA request and make an outreach call to the requesting provider to inform them of the overlap. The requesting provider should contact the member and the existing provider to resolve the overlap concern.

	If the requesting provider is unable to reach the member and existing provider by the end of the next business day (6:00pm), the requesting provider should notify Magellan by phone. Magellan will then call the existing provider and the requesting provider's SRA will remain pended for two more business days (the length of pend will not exceed three business days). If Magellan does not reach the existing provider by phone, Magellan staff will leave a voice message for the existing provider requesting a return phone call within two business days. The message for the existing provider will indicate that if Magellan does not hear from the existing provider within two business days, the existing provider's authorization will be discharged to accommodate the new request. If Magellan receives notification from the member or existing provider to discharge the existing provider's authorization, Magellan will continue with the review of the requesting provider's SRA to determine if the member meets Medical Necessity Criteria. If the member contacts Magellan to discharge the existing provider's authorization, Magellan will make one courtesy call to the existing provider to informing them of the discharged authorization at the member's request. If, at the end of the three business day pend, Magellan has not heard from the existing provider or member, Magellan will discharge the existing provider's authorization and continue with the review of the requesting provider's SRA to determine if it meets Medical Necessity Criteria. If, during the three business day pend, the existing provider informs Magellan that they continue to service the member and Magellan does not receive a phone call from the member requesting to be discharged from the existing provider, then Magellan will non-authorize the requesting provider's SRA. Please refer to the CMHRS manual (rev. 5/07/2014), Appendix C, Page 2-3 for more information.
9. Where do I find the DMAS manuals referenced in this FAQ document?	All DMAS manuals can be found here: www.virginiamedicaid.dmas.virginia.gov under the "Provider Resources" tab and "Provider Manuals."

	Providers are encouraged to access manuals from this website to ensure that the most current version.
Quality/Compliance/Outcomes	
1. What are the differences between Magellan Treatment Record Reviews and DMAS Audits?	Magellan's treatment record reviews (TRR) are not audits and will not replace any DMAS audit process. Magellan TRRs are intended to review the quality of care and provide feedback and assist with guiding care toward evidence-based clinical practices for specific diagnoses. These reviews are meant to assist with identifying opportunities for improvement in both service provision and documentation. In the case of a DMAS audit, those reviews involve regulatory compliance and will retract funds when results are non-compliant.
2. I am a Residential Treatment Center (RTC)-Level C provider. How do I report serious/adverse incidents to Magellan?	All serious incidents must be reported to Magellan within one business day after a serious incident occurs. Serious incidents should be faxed to Magellan at 1-888-656-5396. RTC-Level C providers should refer to 42 CFR § 483.374 for detailed federal regulations regarding facility reporting requirements. For information about what to include in your incident report please refer to www.MagellanofVirginia.com under "For Providers" and "2013-2014 Communications" to view the memo dated July 28, 2014 titled "Incident Reporting - specific to Residential Level C Providers".
3. I am not an RTC-Level C provider. Do I have to report serious/adverse incidents to Magellan?	Yes. Effective September 1, 2016, Magellan providers for all levels of care have the responsibility to notify Magellan of member adverse outcomes within one business day following knowledge of the incident.
Contracting	
1. I am employed by an organization part-time, and am in private practice part-time. What kind of contract do I need to complete?	Your employer would complete the contract for any services billed through the organization. You would complete an individual contract, and be credentialed individually, for any services provided separately through your private practice.
2. What if I add another location to our contract?	If you are contracted with Magellan as an individual or group practice you may add additional service locations using the

	provider website at www.MagellanHealth.com/provider . If you are contracted as an organization, depending on the type of services being added, you may require licensure from the Department of Behavioral Health and Developmental Services (DBHDS) or another applicable licensing entity. In addition, some services/provider types are subject to additional screening activities, including an application fee, per Federal regulations. Please submit your request via the "contact us" link on the home page of www.MagellanofVirginia.com or contact the Network Department at 1-800-424-4536 to help guide you through this process.
3. What if I want to add another Level of Care/Service to an existing contracted and credentialed location?	In most cases, each service requires licensure from an applicable licensing entity. In addition, some services/provider types are subject to additional screening activities, including an application fee, per Federal regulations. Please submit your request via the "contact us" link on the home page of www.MagellanofVirginia.com or contact the Network Department at 1-800-424-4536 to help guide you through this process.
4. I am currently a participating provider with Magellan for your commercial/EAP business. Do I need to complete a new contract for the Virginia Medicaid/FAMIS program?	Yes. You will need to complete a Virginia Medicaid addendum, the Virginia Medicaid Participation Agreement, and other applicable documentation. If you are an organization, Magellan will also send a "Sites and Services" form to verify services offered at each of your locations. Your re-credentialing cycle will not change by adding the Medicaid line of business to your contract.
5. Whom can I contact if I have additional questions about contracting?	You may call a Magellan of Virginia Provider Network Management Specialist at 1-800-424-4536, or send an email using the "Contact Us" link on the home page of the Magellan of Virginia website.
Credentialing	
1. I am already enrolled with DMAS as a provider. Do I need to complete your credentialing packet?	Yes, all individual professionals, group practice members and organizations must be credentialed and contracted with Magellan for the purposes of requesting authorizations and billing to Magellan.

2. Are there any Non-Participating provider benefits?	No, there are no non-participating benefits. A provider may not get authorizations nor render services until they are credentialed and contracted with Magellan.
3. If an individual practitioner is already registered with CAQH, can we just add Magellan to our list?	If you are currently registered with CAQH, log on and complete your application; send all required documents to CAQH. Please ensure that you have re-attested to your information and have authorized Magellan to access your application.
4. Your application asks for a Medicaid ID number, which is the same as our NPI in Virginia. Are you looking for us to enter this same number twice?	As our credentialing forms are used nationally, the Medicaid ID field is different depending upon the State/Commonwealth. We recognize that the Medicaid ID in Virginia is simply your National Provider Identifier (NPI). You may simply enter the number in the NPI field on the forms.
5. I heard that Magellan can take up to 180 days to process a credentialing application. Will I be allowed to bill for services during the credentialing process?	No. The 180 days is the maximum allowed by law. Once a completed application is received, including all supplemental documents, the credentialing process generally can be completed within 90 days. Certain factors, such as the need for a site visit, may lengthen the processing time. However, it is important to understand that until both the contracting and credentialing processes are completed, you will not be considered in-network and will therefore be unable to bill for services. Once you are an approved provider, Magellan will not backdate your effective date to cover the period in which you were considered out of network, as this is not allowed per federal provider enrollment and screening requirements.
6. I do not provide fee-for-service mental health services for DMAS currently. *(I only provide DD/ID waiver services.)* Do I need to complete your credentialing application?	No. Magellan administers the traditional and non-traditional behavioral health services for all members covered through any DMAS behavioral health fee-for-service, regardless of the population served. Magellan also administers the non-traditional behavioral health services for members enrolled with a Medicaid/FAMIS Managed Care plan. If you are a behavioral health provider licensed by the Department of Health Professions and/or a provider whose service is licensed through the Department of Behavioral Health and Developmental Services and/or a provider of Treatment Foster Care licensed through Department of Social Services, you will need to credential and contract with Magellan.

	If you are not a behavioral health provider and you do not bill for behavioral health services for fee-for-service Medicaid members, you do not need to enroll with Magellan.
7. Will Magellan allow "delegated" credentialing?	Magellan will review on a case-by-case basis those providers wishing to maintain delegated credentialing. Please contact a Magellan network representative at 1-800-424-4536 or submit your request via the "contact us" link on the Magellan of Virginia website to discuss the requirements.
8. What if our organization provides only in-home service and the home is where the individual receives services? Does my organization still need to be credentialed by Magellan?	Yes, each individual location, as listed on your organization's license, are required to go through the credentialing process. You would list each organizational address that is affiliated your agency's license on your credentialing application.
9. Are the staff requirements for Magellan any different from what DBHDS requires?	Magellan's adheres to the requirement set forth by DMAS and all applicable regulations. Please refer to the appropriate DMAS manual for further guidance.
10. I did not receive a credentialing application. How do I get one sent to me/my organization?	You may call a Magellan network representative at 1-800-424-4536, or send an email using the "Contact Us" link on the homepage of the Magellan of Virginia website.
11. My organization is not accredited by any of the accrediting bodies mentioned in the application. Will my organization still be allowed to participate?	Accreditation is recommended, but not required for participation with Magellan. If you are licensed and in good standing with the Department of Behavioral Health and Developmental Services (DBHDS) or other accepted licensing entity, Magellan will honor the license in lieu of an accreditation. If you are an organizational provider (for example, a Federally Qualified Health Clinic or Rural Health Clinic) and do not have accreditation nor are licensed by DBHDS or another accepted licensing entity, a Magellan site visit may be required for initial credentialing and every three years thereafter.
12. Do I need to complete an application for my school-based locations?	Yes, each active, licensed service location that provides behavioral health services will need to be reported to Magellan in order to be credentialed.

13. My organization only provides community based/in-home services. Do we need to have professional liability insurance?	All providers are required to have a minimum of $1 million per occurrence and $1 million aggregate coverage for both General and Professional Liability. DMAS has confirmed this is the minimum allowed.
14. Does Magellan require client visits to meet physician directed requirements or can we credential providers independently and use the psychiatric services model?	Magellan adheres to the DMAS rules and regulations for delivery of services. DMAS will continue to require client visits to meet physician directed requirements.
Claims/Billing	
1. What filing options do I have to submit claims to Magellan?	There are several options for submitting claims to Magellan, including our Claims Courier application on the provider website as well as Direct Submit and clearinghouse options. Please visit the "Getting Paid" section on www.magellanhealth.com/provider for more information.
2. Whom do I contact about questions related to direct billing or clearinghouses with Magellan?	Information on clearinghouses, as well as the direct submit process and signing up for testing, is available on www.MagellanHealth.com/provider under the "Getting Paid" section. We encourage providers who bill moderate to high volume claims register for the Direct Submit option.
3. DMAS has allowed billing of non-licensed staff, under the supervision of a licensed individual. Will Magellan allow this process to continue?	The model for billing is the same as under DMAS. Only the licensed supervising individual needs to be listed on the claim. Providers should refer to the appropriate DMAS manual for additional guidance at www.virginiamedicaid.dmas.virginia.gov.
4. What is your turnaround time for claims payment?	The Magellan standard is that 90 percent of all claims are paid within 30 days of the date the claim is received. Our claims system processes continually, as claims are received from providers, and the funds are approved by DMAS. You may refer to the Virginia Provider Handbook Supplement, "Provider Reimbursement" section for more information on the billing cycle.

5. What is the process for claims denials and voids?	Claim denials are sent on the provider Explanation of Benefits (EOB) or the electronic remittance, whichever the provider receives. Electronic submissions are the preferred method for claims submission, payment and remittance advice. Magellan doesn't void claims unless a stop-payment is done on a Magellan check. If there is a need for a change to a claim, the claim should be sent as a corrected claim and the original claim will be adjusted, not voided. Corrected claims can be submitted electronically on the Claims Courier application by selecting the appropriate "corrected claim field." Corrections can only be made to place of service, billed amounts or number of units. Click "View Submitted Claims Online", search for transaction, update and hit "resubmit". For claims submitted using direct submit or a clearinghouse, HIPAA 837 5010 claims submission information can be found under the "Getting Paid" section on www.magellanhealth.com/provider. For paper submissions, please write "corrected claim" on the bill. Highlighting the changes will ensure Magellan understands the changes being made. Send to Magellan Health, Attn: Claims Dept. (VA DMAS) P.O. Box 1099, Maryland Heights, MO 63043. Please note: Only claims that were originally paid and have changes should be sent as corrected. An originally denied claim should just be submitted as a new claim, even if there are changes.
6. What is the timely filing limit if we have a corrected claim?	You have one year from the date on the Explanation of Benefits (EOB) to resubmit a corrected claim. You have 30 days from the date on the EOB or date on the denial letter to submit a claim reconsideration. You may reference the Magellan Provider Handbook Supplement, pages 64-66 for more detailed information.

7. What is the process for submitting overpayments on claims?	Magellan implemented an automatic retraction process April 1, 2015, eliminating 30 day notices and began retracting claims within one remit cycle of an identified overpayment. If a providers self-identify an overpayment and the funds have not been retracted by Magellan, they can initiate the retraction process by: 1. For EDI transactions, providers may submit voided claims electronically using the value "8" (VOID) in CLM05-3. A Magellan claims processor will review and initiate the retraction process internally. 2. For refunds via check, please send documentation to identify the claim (**member ID, claim number(s) and date(s) of service)** and the reason for the refund. Mail the check and the documentation to: **Magellan Health (VA DMAS)** **Attn: Recoveries Lockbox** **P.O. Box 785346** **Philadelphia, PA 19178-5346**
8. I have a "pay to" account set up through CAQH. Can you obtain my payment information from that account?	At this time, Magellan is not able to obtain CAQH payment information. Information on our electronic funds transfer (EFT) process can be found on www.MagellanHealth.com/provider under the "Getting Paid" section.
9. How are claims processed for dual-eligible?	Claims for dual-eligible members should be submitted to Medicare for reimbursement. The claims will then be sent to DMAS for processing for the Medicaid portion via the "crossover" process. There are a few cases in which you may submit dual eligible claims directly to Magellan. Please refer to the November 23, 2016 provider communication "Medicare Crossover Claims Process" posted on the Magellan of Virginia website under "For Providers" and "2016 Communications".
10. Can I bill partial units?	Magellan will only able to accept whole units. Services may allow you to accumulate partial hours throughout the week, however, you must bill only whole hours. Time billed must match the documented time rendering the service in the

	member's clinical record and in accordance with DMAS requirements. Provider should refer to the appropriate DMAS manual for further guidance.
11. I noticed electronic funds transfer (EFT) information isn't requested in the Magellan provider enrollment forms. How is this information shared with Magellan?	You can sign up for electronic funds transfer (EFT) on the secure section of the Magellan provider website, www.magellanhealth.com/provider. Magellan will send you instructions along with your username and password to establish a login for the website.
12. Where can I find a list of codes and rates for billing to Magellan?	The reimbursement rates and procedure codes are posted on www.MagellanofVirginia.com under "For Providers" and "Claims, Eligibility, Auths, Rates." The rates are updated, at a minimum, annually.
13. Is this contract for five years?	Yes, the contract between Magellan and DMAS is for five years, beginning 12/1/2013 through 11/30/2018. Providers and the community will be notified in a timely manner of any future changes.
14. How long will it take to know if a claim is denied?	Magellan is required to process 90 percent of all claims within 30 days. Providers submitting electronically should monitor claims reports, if submitting claims through Magellan's Claims Courier, Direct Submit applications. If submitting via a clearinghouse, you will receive a file stating the denial reasons.
Training/Provider Outreach	
1. Does Magellan host in-person training sessions for providers?	Magellan hosts webinars and trainings as topics are identified. Please refer to our website, www.MagellanofVirginia.com for any upcoming webinar/training information.
2. I missed a provider training forum/webinar. Will it be repeated?	You can find recorded versions of past webinars, as well as any slides/handouts from our provider forums, on our website, www.MagellanofVirginia.com under "For Providers" and "Training."

As a reminder, Magellan of Virginia hosts a weekly call each Friday beginning at 1 p.m. The call is open to all providers to address questions and issues. We encourage providers to visit the

Friday Provider Call page on Magellan of Virginia's website to review weekly agendas with program announcements, questions to be covered during the call and quarterly FAQs. Providers may submit questions using the contact us link feature on the Magellan of Virginia homepage. Questions should be submitted by the close of business each Wednesday for discussion on Friday. Any questions that require more research will be held over and answered on a subsequent call. We look forward to your participation.