Claiming and Reimbursement Manual Billing (Paper Invoices)

Financial Services Bureau

- DMH will reimburse contractors for manual billings for:
  - Clinical Consultation
  - Training
  - One-Time Costs

CLINICAL CONSULTATION

- MHIP requires the review of patient progress and revising treatment plans, when necessary.
- DMH will reimburse for clinical consultation, by a Licensed and Board-Certified Psychiatrist, through the submission of manual/paper invoices.

- DMH will reimburse at the rate of $200 per hour for a maximum of 2 hours per week for clinical consultation.
- Invoices for clinical consultation must be submitted within 15 calendar days after the end of the month in which services were rendered.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
HEALTHY WAY L.A. - MENTAL HEALTH INTEGRATION PROGRAM (MHIP)
TEAM CONSULTATION INVOICE

ATTACHMENT III-B

Agency Name: ______________________

Provider Number: ______________________

Month and Year of Submission: ______________________

	Week 1		Week 2		Week 3		Week 4		Week 5	
	1st Consultation	2nd Consultation	1st Consultation	2nd Consultation	1st Consultation	2nd Consultation	1st Consultation	2nd Consultation	1st Consultation	2nd Consultation
Date of Psychiatric Team Consultation										
Name of Consulting Psychiatrist										
Total Number of HWLA Clients Discussed										
Total Number of Participating Staff										
Total Hours will be Reimbursed: (No more than 2 hours / per week)										
Rate per hour	200	200	200	200	200	200	200	200	200	200
Total Reimburseable Cost	$	$	$	$	$	$	$	$	$	$

Total Hours will be Reimbursed this Month: $ __________ **Amount Reimbursed this Month: $** __________

I hereby certify that all information contained above is true and correct to the best of my knowledge. All supporting documentation will be submitted to County along with this invoice, as specified in this Exhibit B (Attachment III, Claiming and Reimbursement) of the 1115 Waiver Demonstration Project Agreement.

Print Name/Title: ______________ / ______________ **Phone No.:** ______________

Signature: ______________________ **Date:** ______________

LAC-DMH Program Approval: ______________________ **Date:** ______________
(signature)

Return invoice to:

County of Los Angeles
Department of Mental Health
550 South Vermont Ave., 8th Floor
Los Angeles, CA 90020
ATTN: Provider Reimbursement Unit

TRAINING AND
ONE-TIME FUNDING COSTS

- DMH will reimburse for staff time spent attending MHIP training and for one-time funding costs for the implementation of MHIP.
- Contractors will be reimbursed at a rate of $36.33 per hour, not to exceed 25 hours per staff person, for each staff person who attends MHIP training.

- Invoices for training and one-time funding costs must be submitted within 15 calendar days after the end of the month in which training was received and one-time expenditures were incurred.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

HEALTHY WAY L.A. - TRAINING AND/OR ONE-TIME FUNDING COSTS INVOICE

Agency Name: ______________________________

Provider Number: ______________________________

Month and Year of Submission: ____________________

TRAINING COSTS

Date of Training: ____________________

Type of Training: ____________________

a		b		c	d	e=c*d
EMPLOYEE NAME		LICENSURE TYPE (i.e., Ph.D, Psy.D, LCSW, MD, DO, NP or PA)		NUMBER OF HOURS**	HOURLY RATE FOR TRAINING	TOTAL AMOUNT PER PERSON ($)***
						$0.00
						$0.00
						$0.00
						$0.00
						$0.00
					$36.33	$0.00
						$0.00
						$0.00
						$0.00
						$0.00
						$0.00
Total Reimbursable Per Training:						$0.00

ONE-TIME FUNDING COSTS*

*Expenditures require prior DMH approval.

- ☐ **Materials or other tools needed to implement practice model.** $ __________
- ☐ **Additional training, technical assistance or consultation needed to implement practice model.** $ __________
- ☐ **Development, translation and printing of outreach materials for Tier 2 population.** $ __________
- ☐ **Other Describe:** ____________________ $ __________

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Total Reimbursable One-time Funding Cost: $ 0

I hereby certify that all the information contained above are services and costs eligible under the terms and conditions for the reimbursement of Training and/or One-Time Funding Costs and is true and correct to the best of my knowledge. All supporting documentation, (e.g., dated receipts), will be submitted to the County along with this invoice as specified in Exhibit B (Attachment III, Claiming and Reimbursement) of the 1115 Waiver Demonstration Project Agreement.

Print Name/Title: ____________________/____________________ **Phone No.:** ____________________

Signature: ______________________________ **Date:** ____________________

LAC-DMH Program Approval: ______________________________ **Date:** ____________________
(signature)

Return invoice to:

County of Los Angeles
Department of Mental Health
550 South Vermont Ave., 8th Floor
Los Angeles, CA 90020
ATTN: Provider Reimbursement Unit

**The total hours of training per staff shall not exceed 25 hours for all trainings combined.

***The total amount shall not exceed $908.25 per qualified staff for all trainings combined.

Claiming/Reimbursement
Paper Invoice Submission

All manual/paper invoices must be submitted to:

County of Los Angeles
Department of Mental Health
550 South Vermont Avenue, 8th Floor
Los Angeles CA 90020
Attn: Provider Reimbursement Unit

All questions and inquiries regarding reimbursement shall be directed to:

Sherry Trujillo, Fiscal Officer

Los Angeles County

Department of Mental Health

Accounting Division

Provider Reimbursement Unit

(213) 738-4692