Longview LEOFF Disability Board
Special Meeting
February 2, 2022
AGENDA

HYBRID ZOOM MEETING

This meeting will be held both virtually by teleconference using Zoom and in-person at City Hall (Training Room – 2nd Floor). Dial one of the following numbers (try a different number if you receive a busy signal):

1-253-215-8782
1-408-638-0968
1-669-900-6833
1-346-248-7799
1-312-626-6799
1-646-876-9923
1-301-715-8592

Join Zoom Meeting
https://us02web.zoom.us/j/9755597252

Enter the meeting ID #975 559 7252

- Call to Order – 9:00 a.m.
- Roll Call
- Agenda Approval
- R3 Long Term Care Claim
- R39 Hearing Aids Reimbursement
- Approval of Bills
- Adjournment

JANUARY/FEBRUARY MEDICAL BILLS (Regular)

Member	Dental	Regular
R36	$0.00	$10,428.00
Total	**$0.00**	**$10,428.00**

The City of Longview Washington

Memorandum

TO: **LEOFF-1 DISABILITY BOARD**

FROM: **KAYLEE CODY, LEOFF-1 ADMINISTRATOR**

SUBJECT: R3 REQUEST FOR REIMBURSEMENT OF LONGTERM CARE EXPENSES

R3 is currently receiving skilled nursing care at Beacon Hill. The retiree's spouse reported to me that Humana called the retiree and asked him if he wanted to return home; he has dementia and advised that he did, and Humana terminated the nursing facility stay. When the retiree was returned home, his spouse could not provide the level of care necessary and she had to call an ambulane twice for assistance.

R36 is now requesting preapproval to move to Delaware Plaza Memory Care. R3 has not submitted any invoices or quotes at this time; however, the retiree's spouse advised that the cost for Delaware Plaza is $6,900 a month with a $1,500 application fee. R3 is covered by a longterm care insurance policy and has submitted a claim to UNUM – there is a 90 day waiting period for benefits if approved.

Action needed on this claim:

1. Make determination as to whether R3 qualifies for reimbursement of long-term care expenses (both expenses incurred at Beacon Hilll skilled nursing facility and Delaware Plaza Memory Care).

Documents included for review:

1. UNUM Longterm Care Claim Form Physician's Statement completed by R3's attending physician
2. Genworth Cost of Care – Averages for Longview, WA

01825537

unum

LONG TERM CARE
ATTENDING PHYSICIAN STATEMENT
The Benefits Center
P.O. Box 100196, Columbia, SC 29202-9976
Phone: 1-800-693-4988 Fax: 1-800-268-1377
Call toll-free Monday through Thursday, 8 a.m. to 6 p.m.
Friday, 8 a.m. to 5 p.m. (Eastern Time)

ATTENDING PHYSICIAN STATEMENT (PLEASE PRINT)

A. Patient Information

Name of Patient (Last Name, Suffix, First Name, MI): PA3

Social Security Number:

Date of Birth (mm/dd/yy):

Home Telephone Number:

Height: 6 6 in

Weight: 1 5 5 lbs

Instructions: Please complete, sign and date this form. The purpose of this form is to assist us in making a disability determination. Please complete all questions on this form and provide copies of supporting reports, such as office notes, medical records, medication logs, consultations and/or testing. Be sure to sign and date this form in Section F.

What is the primary diagnosis that may impact your patient's functional capacity?

Pneumonia

ICD Code: J18.9

Is your patient still working? ☐ Yes ☒ No ☐ N/A

Date of first visit for this current condition(s) (mm/dd/yy): 12/26/21

Date of last office visit (mm/dd/yy): 1/14/22

Date of next office visit (mm/dd/yy): as needed

Has the patient been treated for the same/similar condition in the past? ☒ Yes ☐ No ☐ Unknown

If yes, please provide treatment dates (mm/dd/yy): From 12/16/21 Through 12/23/21

Please list any other diagnoses that may impact your patient's functional capacity.

Secondary Diagnosis: Intracranial Hemorrhage ICD Code: S06.309A

Secondary Diagnosis: Weakness ICD Code: R53.1

Has the patient been hospitalized? ☒ Yes ☐ No

If yes, please provide most recent date hospitalized (mm/dd/yy): 12/26/21 through (mm/dd/yy): 12/31/21

Has the patient had any surgeries in the past 12 months? ☐ Yes ☐ No

If yes, what procedure was performed?

CPT Code:

Date Surgery Performed (mm/dd/yy):

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Friday, 8 a.m. to 5 p.m. (Eastern Time)

ATTENDING PHYSICIAN STATEMENT (Continued)

Patient's Name R3 Date of Birth (mm/dd/yy)

B. Functional Capacity

In general, an insured's entitlement to benefits for Long Term Care insurance is based on a loss of independence with Activities of Daily Living (ADLs) and/or the presence of a cognitive impairment requiring another person's assistance/supervision. Assistance with an ADL can mean either the stand-by or hands-on assistance of another individual.

Please provide your opinion below as to what ADL loss, if any, your patient has experienced and indicate when this loss began and how long you anticipate this loss will last. We have provided general definitions of ADLs at the end of this packet for your reference.

ADL	When did the loss begin? (mm/yy)	Based on the date of loss noted when do you anticipate recovery of the ability to perform the ADL?
Bathing ☐ No Loss	12/15/21	☐ <30 days ☐ 30-60 days ☐ 61-89 days ☐ 90 days or greater ☑ Not Anticipated ☐ Independent as of (mm/yy)
Dressing ☐ No Loss	12/15/21	☐ <30 days ☐ 30-60 days ☐ 61-89 days ☐ 90 days or greater ☑ Not Anticipated ☐ Independent as of (mm/yy)
Toileting ☐ No Loss	12/15/21	☐ <30 days ☐ 30-60 days ☐ 61-89 days ☐ 90 days or greater ☑ Not Anticipated ☐ Independent as of (mm/yy)
Transferring ☐ No Loss	12/15/21	☐ <30 days ☐ 30-60 days ☐ 61-89 days ☐ 90 days or greater ☑ Not Anticipated ☐ Independent as of (mm/yy)
Continence ☐ No Loss	12/15/21	☐ <30 days ☐ 30-60 days ☐ 61-89 days ☐ 90 days or greater ☑ Not Anticipated ☐ Independent as of (mm/yy)
Eating ☑ No Loss		☐ <30 days ☐ 30-60 days ☐ 61-89 days ☐ 90 days or greater ☐ Not Anticipated ☐ Independent as of (mm/yy)
Ambulating/ mobility ☐ No Loss	12/15/21	☐ <30 days ☐ 30-60 days ☐ 61-89 days ☐ 90 days or greater ☑ Not Anticipated ☐ Independent as of (mm/yy)

Is your opinion based on: ☑ Clinical Observation ☑ Functional Evaluation/Testing ☐ Patient/Family Report

If you have indicated your patient requires/required assistance with ADLs, please check the causes below for the ADL loss:

- ☑ Balance
- ☑ Strength
- ☐ Deconditioning
- ☑ Cognitive/Perceptual
- ☐ Paralysis
- ☑ Fine motor control
- ☐ Weakness/numbness explain: _____
- ☐ ROM Limitation explain: _____
- ☑ Gait
- ☐ Other: _____

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ATTENDING PHYSICIAN STATEMENT (Continued)

Patient's Name R3

Date of Birth (mm/dd/yy)

C. Cognitive Capacity

Please provide your opinion below as to what cognitive impairment, if any, your patient has experienced. We have provided a general Long Term Care definition of cognitive impairment at the end of this packet for your reference.

Does your patient have a cognitive impairment? ☒ Yes ☐ No

If NO, please proceed to Section D.

What is the cognitively impairing diagnosis (please be specific): Dementia - multifactorial - I first saw this pt. 1/14/22

When was your patient first seen for cognitive issues and by whom? (mm/dd/yy)

Has any cognitive testing been completed? ☐ Yes ☐ No If yes, please attach testing with this completed form.

Check type of testing completed:

- ☒ CT/MRI date 12/16,29/21 8/20/21 7/14/21
- ☐ MMSE date/score
- ☐ MOCA date/score SLUMS 8/30 1/5/22
- ☐ Neurology consultation
- ☐ Speech Therapy
- ☐ Neuro-psychological evaluation

BIMS 3/15

If no cognitive testing has been performed, please attach clinical findings that support a cognitive impairment.

Has there been a workup for reversible causes of cognitive impairment? ☒ Yes ☐ No If yes, please attach this workup

see Hosp. tal records

Is your patient's cognitive impairment to the degree that it puts him/her at risk for health and safety? ☒ Yes ☐ No

If YES, when did the cognitive impairment begin to impair your patient to the degree that it put him/her at risk for his/her health and safety? (mm/dd/yy) 12/15/21

If YES, please indicate why supervision is needed as well as what activities your patient needs assistance/supervision with? (check all that apply)

Why:

- ☒ Short term memory loss
- ☒ Long term memory loss
- ☒ Poor Judgment
- ☒ Impaired executive function
- ☐ Wandering behavior
- ☒ Confusion
- ☒ Impaired orientation to person/place/time

What activities:

- ☐ Managing Finances
- ☐ Managing Medications
- ☐ Using the telephone/devices
- ☐ Handling Transportation
- ☐ Shopping
- ☐ Preparing Meals
- ☐ Housework/home management

Do you know whether or not your patient is still driving? ☐ Yes ☒ No, not driving ☐ Unknown

If your patient is currently driving, do you agree that he/she should be driving? ☐ Yes ☐ No

Is your patient currently receiving supervision to protect his/her self or others due to cognitive impairment? ☒ Yes ☐ No

How many hours per day _____ and days per week _____ do you recommend supervision be provided?

When did supervision begin? (mm/dd/yy) _____ Who provides the supervision? _____

He is in Beacon Hill Rehabilitation

unum

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ATTENDING PHYSICIAN STATEMENT (Continued)

Patient's Name _____ Date of Birth (mm/dd/yy) _____

D. Plan of Care

Date care to begin (mm/dd/yy) at discharge Date care to be reassessed (mm/dd/yy) _____

Please check type of medical care to be provided by a skilled agency or licensed professional and indicate frequency to be provided.

- ☐ Skilled Nursing Visits _____
- ☐ Physical Therapy _____
- ☑ Occupational Therapy _____
- ☐ Speech Therapy _____
- ☐ Respiratory Therapy _____
- ☐ Hospice _____
- ☐ Other _____

Will need walker, WC + Hospital Bed

Please check type of non-medical care that can be provided by an unskilled, non-licensed agency or individual and indicate frequency to be provided.

- ☐ Personal Care/HHA _____
- ☐ Companion Care _____
- ☐ Respite Care _____
- ☐ Homemaker Services _____

E. Other Treating Providers, Facilities or Hospitals

Please provide complete name, contact information and specialty for any other treating providers your patient is seeing for his/her disabling condition(s) or for any referrals you have made to other providers including other physicians, therapist or clinical programs.

Name	Specialty	City, State

F. Signature of Attending Physician

The above statements are true and complete to the best of my knowledge and belief.

Physician Name (Last Name, First Name, MI, Suffix) Please Print

Timothy Randall, M.D.

Medical Specialty _____ Degree _____

Address PeaceHealth Medical Group Lakefront

City 1718 E. Kessler Blvd., P O Box 3002 Longview, WA 98632 State _____ Zip _____

Telephone Number (360) 747-5800 Fax Number _____ Physician's Tax ID Number: _____

Are you related to this patient? ☐ Yes ☐ No
If yes, what is the relationship?

Signature of Physician X _____ Date 1/31/22

CL-1158 (09/14)

Cost of Care

Genworth

Longview, WA

Monthly Cost	2021
Home Health Care	
Homemaker Services	$6,054
Homemaker Health Aide	$6,054
Based on annual rate divided by 12 months (assumes 44 hours per week).	
Adult Day Health Care	
Adult Day Health Care	n/a
Based on annual rate divided by 12 months.	
Assisted Living Facility	
Private, One Bedroom	$5,300
As reported, monthly rate, private, one bedroom.	
Nursing Home Care	
Semi-Private Room	$7,817
Private Room	$8,790
Based on annual rate divided by 12 months.	

The information shown above is based on a specific scenario generated by the Genworth 2021 Cost of Care. Future years are calculated by assuming an annual 3% growth rate. For more information and location comparison, visit genworth.com/costofcare.

206401A3D 01/31/22

The City of Longview Washington

Memorandum

TO: **LEOFF-1 DISABILITY BOARD**

FROM: **KAYLEE CODY, LEOFF-1 ADMINISTRATOR**

SUBJECT: R39 REQUEST FOR REIMBURSEMENT OF HEARING AIDS EXPENSES

R39 is requesting reimbursement for hearing aids at a cost of $5,700. A letter from the audiologist is enclosed for review. The retiree did not submit the audiology report.

Action needed on this claim:

1. Make determination as to whether R39 qualifies for reimbursement for hearing aids in the amount of $5,700.

Documents included for review:

1. Letter from audiologist regarding R39's hearing loss

walla walla clinic
AUDIOLOGY
320 WILLOW, SUITE #6 • (509) 525-3720
WALLA WALLA, WASHINGTON 99362

January 4, 2022

City of Longview Retirement Board

RE: R39

To Whom It May Concern:

R39 was fit binaurally in December of 2017 with Phonak Audeo B90-13 hearing devices. These devices are weak and no longer meeting the patient's needs. The devices manufacturer warranty expired on 02/28/2021. The devices have been submitted for in office repairs multiple times. R39 was most recently seen 11/11/2021 for hearing device follow-up. The receiver had broken on the left side and was no longer able to provide amplification.

Binaural hearing aid fittings are known to increase patient safety and support speech perception in noise. Hearing loss management also contributes to cognitive and social-emotional wellbeing.

Thus a request for approval of replacement devices appropriate for the patients hearing loss is being submitted for review. The maximum anticipated cost of amplification and support services was estimated at $5700.00 for a set of devices.

Proposed Device Replacement
Phonak Audeo P90-R
Binaural $5,700.00

Thank you for your consideration in this matter.

Sincerely,

Tawnya Kelly, H.A.S