City of Longview

1525 Broadway
Longview, WA 98632
www.ci.longview.wa.us

LEOFF-1
Disability Board

Agenda

Wednesday, August 30, 2023 | **8:30 AM** | **2nd Floor, City Hall**

The City Hall is accessible for persons with disabilities. Special equipment to assist the hearing impaired is also available. Please contact the City Executive Office at 360.442.5004 48 hours in advance if you require special accommodations to attend the meeting.

To attend the meeting virtually use the link or information below:
Click here to join the meeting
Meeting ID: 269 837 824 466
Passcode: 998pKy

Or call in (audio only)
+1 213-631-2692
Phone Conference ID: 315 649 02#

1 CALL TO ORDER

2 FLAG SALUTE

3 ROLL CALL

4 AGENDA APPROVAL

5 PUBLIC COMMENT

6 APPROVAL OF MINUTES

23-001372 July 26, 2023 Regular Meeting Minutes

7 PRESENTATION

23-001432 Randy Parr, Allied Hearing Aid Specialists

8 MEDICAL REIMBURSEMENT REQUESTS

23-001433 R-58 Pre-approval for Extraction of Tooth and Replacement Bridge

9 APPROVAL OF BILLS

23-001430 August 2023 Medical Bills (Regular) - Total $18,417.27

23-001431 August 2023 Medicare B Reimbursement - Total $8,336.30

10 CONTINUED BUSINESS

23-001373 Long Term Care Form

11 ADJOURNMENT

NEXT REGULAR MEETING
September 27, 2023 at 8:30 a.m.

City of Longview

Agenda Summary

July 26, 2023 Regular Meeting Minutes

Attachments:
1. July 26, 2023 Regular Meeting Minutes

City of Longview

1525 Broadway
Longview, WA 98632
www.ci.longview.wa.us

LEOFF-1
Disability Board

Minutes

Wednesday, July 26, 2023 | **8:30 AM** | **2nd Floor, City Hall, Small Conference Room**

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1 CALL TO ORDER

Chairperson Kendall called the meeting to order at 8:33 a.m.

2 FLAG SALUTE

The flag salute was recited.

3 ROLL CALL

Present: Don Barnd, Police Retiree Representative
Jim Morkert, Fire Retiree Representative
Ruth Kendall, City Council Representative
Mike Wallin, City Council Representative

Absent: Chet Makinster, Member-at-large

Also Present: Tiffany Ostreim, Board Secretary
Jim McNamara, City Attorney - via Telephone
Kris Swanson, City Manager

4 AGENDA APPROVAL

No changes were made to the Agenda.

5 PUBLIC COMMENT

No public comment.

6 APPROVAL OF MINUTES

23-001347 June 28, 2023 Regular Meeting Minutes

A motion was made by Member Wallin, seconded by Member Barnd to approve the minutes of June 28, 2023. The motion carried unanimously.

7 OLD BUSINESS

8 MEDICAL REIMBURSEMENT REQUESTS

9 APPROVAL OF BILLS

23-001348 July 2023 Medical Bills (Regular) - Total $19,355.54

A motion was made by Member Wallin, seconded by Member Morkert to approve the bills as presented, reasonable, and medically necessary. The motion carried unanimously.

23-001349 July 2023 Medicare B Reimbursement - Total $8,266.30

A motion was made by Member Wallin, seconded by Member Morkert to approve the bills as presented, reasonable, and medically necessary. The motion carried unanimously.

10 CONTINUED BUSINESS

23-001350 Long Term Care Form
Reimbursement of hearing aids

The Board discussed hearing aids and reviewed policies from City of Olympia, City of Kirkland, Skagit County, City of Vancouver, King County, a local company "Allied Hearing", L & I, Kaiser, and AWC Trust.

Member Wallin offered to reach out to Randy Parr of Allied Hearing for a briefing on standards or categories of hearing aids. Concensus of the Board.

The Board discussed the current Long Term Care Form. Items 8 and 9 are confusing for those completing the form. The Board reviewed forms from the City of Vancouver, City Kirkland and King County. The Board preferred the example from the City of Vancouver, Physician Statement.

A motion was made by Member Barnd to adopt the City of Vancouver, Physician Statement Form.

The Board discussed the process the city follows and any requirements of Unum Life Insurance Company. The Board requested staff obtain the process of the City of Vancouver before adopting.

Member Barnd withdrew his motion.

11 ADJOURNMENT

With no further business to discuss, Chairperson Kendall adjourned the meeting at 9:00 a.m.

Next Meeting

The next regular meeting of the LEOFF-1 Board is scheduled for August 30, 2023 at 8:30 a.m.

_____ _____

Ruth Kendall, Chairperson *Tiffany Ostreim, Board Secretary*

City of Longview
Agenda Summary Sheet

1525 Broadway
Longview, WA 98632
www.mylongview.com

Update on reimbursement of hearing aids

SUMMARY STATEMENT:

The Board has reviewed and discussed hearing aid policies and reimbursement costs from City of Olympia, City of Kirkland, Skagit County, City of Vancouver, King County, local Allied Hearing, L & I, Kaiser and AWC Trust.
July 26, 2023 the Board recommended a briefing with Randy Parr of Allied Hearing, a local hearing aid business, be scheduled.

Randy Parr is scheduled to attend the LEOFF-1 Board meeting August 30, 2023.

Brief Hearing Aid Industry Overview

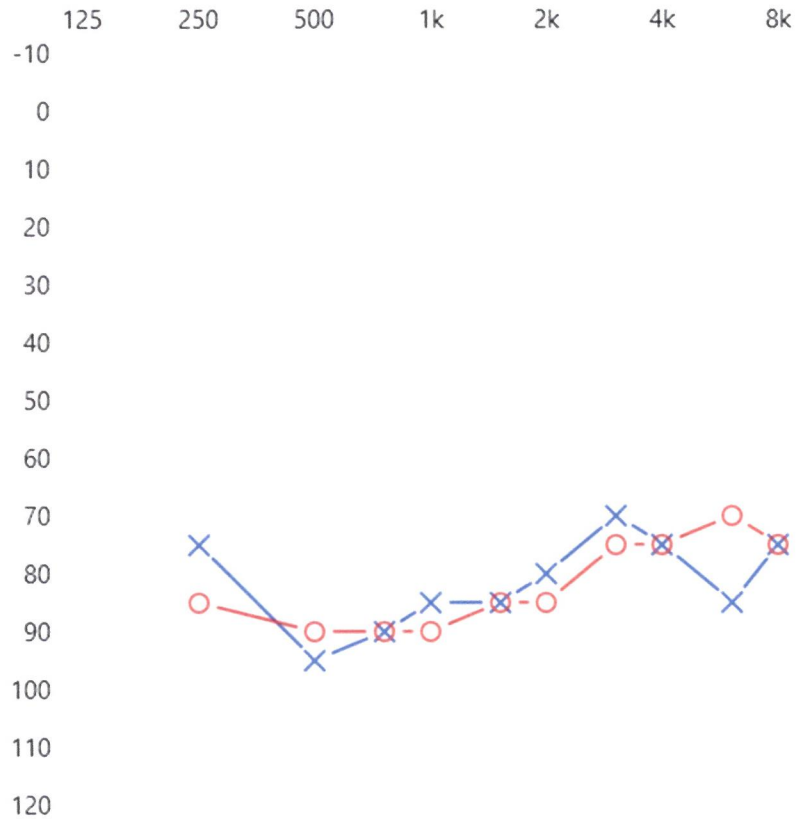
856 15th Ave
Longview WA
360-423-3608

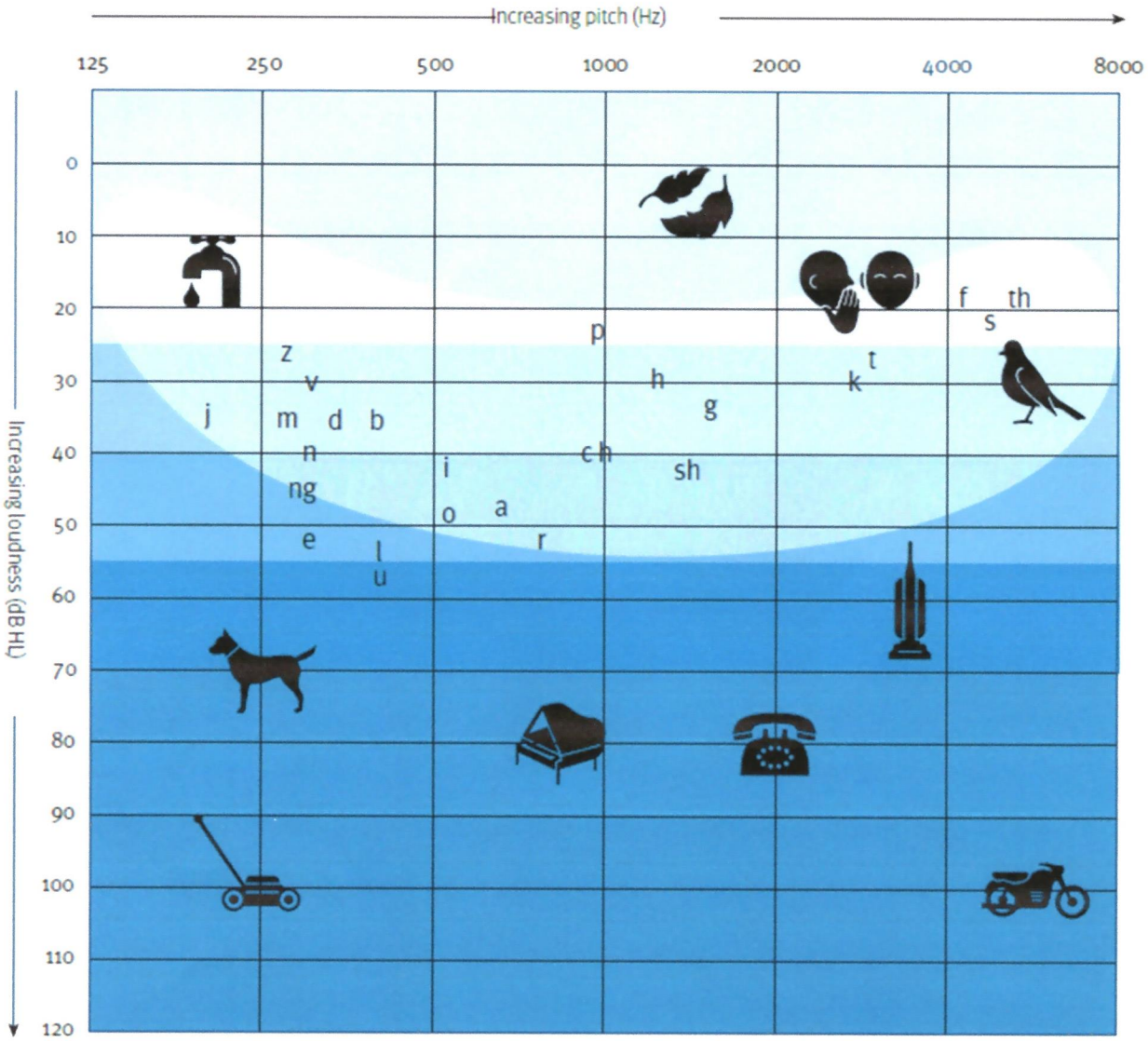
By Randy Parr

August 30, 2023

Latest Audiogram

5/21/2014 :




Increasing pitch (Hz)
125
250
500
1000
2000
4000
8000
Increasing loudness (dB HL)
0
10
20
30
40
50
60
70
80
90
100
110
120
j
z
v
m
d
b
n
ng
e
l
u
i
o
a
r
p
ch
h
sh
g
k
t
f
th
s

	What's included	What you're missing
Level 9 ★★★★★	Premium performance in 8 environments and our most sophisticated features that automatically let you focus on speech and know where it's coming from in crowds and loud background noise (where you spend __ % of your time). Enjoy the ability to hear in quiet as well as delightful music automatically. Plus engage in conversations in the car with a special program that pinpoints and amplifies speech from any direction no matter where you are sitting.	Nothing. You've got everything available to suit your unique lifestyle.
Level 7 ★★★★	Advanced performance in 6 environments with the ability to help you focus on speech coming from the front and sides in challenging situations, and hear in quiet situations, plus an automatic music program and a manual car program that can be pre-set to focus on speech from one location.	The most sophisticated features to focus on speech from different directions in noisy conversations in loud noise and the car.
Level 5 ★★★	Standard performance in 4 environments that includes features to help you in multiple quiet and noisy environments.	Automatic optimization for conversation in small groups and automatic engagement of a music program.
Level 3 ★★	The essentials in 2 environments. Limited ability to adjust automatically to accommodate more challenging listening situations. The flexibility to customize your experience with the fully featured Remote Plus app and control your streamed audio, calls and virtual assistants with tap control.	Automatic adjustment for comfort in quiet and noisy situations without speech.

Automatic program

8 environments


Conversation in quiet


Conversation in noise


Quiet

Noise


Conversation in a small group


Music


Conversation in a crowd


Conversation in loud noise

6 environments


Conversation in quiet


Conversation in noise


Quiet

Noise


Conversation in a small group


Music

4 environments


Conversation in quiet


Conversation in noise


Quiet

Noise

2 environments


Conversation in quiet


Conversation in noise

Manual programs


Conversation in loud noise


360 conversation in car

Various manual programs can be set


Conversation in loud noise

Car with speech

Various manual programs can be set

Various manual programs can be set

Various manual programs can be set

Sound performance by technology level

Low complexity

Level 9

Premium

★★★★★

Pinna Effect 2

Binaural microphone mode that is designed to compensate for cues typically lost with hearing aids, which are needed for localization.

Level 7

Advanced

★★★★

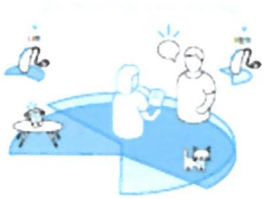
Pinna Effect 2

Binaural microphone mode that is designed to compensate for cues typically lost with hearing aids, which are needed for localization.

Level 5

Standard

★★★



Pinna Effect 2

Binaural microphone mode that is designed to compensate for cues typically lost with hearing aids, which are needed for localization.

Level 3

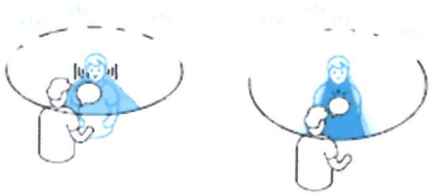
Essential

★★

Pinna Effect

Minimizes the impact of acoustic cues typically lost with hearing aids.

High complexity

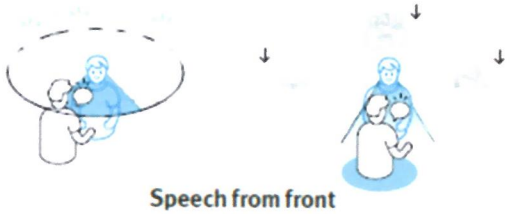


Speech from front

AutoFocus 360 identifies and focuses on speech from the front to provide a greater increase of speech than other technology levels. Dynamic noise reduction is active and adjustable to further reduce surrounding noise. For face-to-face conversations, in loud noise, and when the wearer is stationary, HyperFocus engages within the conversation in loud noise environment.

Speech from side **Speech from back**

AutoFocus 360 can identify and focus on speech from any direction while reducing interfering noise.



Speech from front

AutoFocus identifies, focuses on and increases speech from the front. Dynamic noise reduction is active and adjustable to further reduce surrounding noise.

Speech from side and back

AutoFocus applies a wide front beam to capture speech partially from the sides.

All high complexity situations

Applies a wide front beam capturing the speech from the front.

All high complexity situations

Applies a wide front beam capturing speech from the front.

Make	Tech Level	Warranty	Price Each	Price Per Set
Unitron	3	1-Year	$ 1,250.00	$2,500.00
Unitron	5	2-Years	$ 1,600.00	$3,200.00
Unitron	7	2-Years	$ 2,100.00	$4,200.00
Unitron	9	3-Years	$ 3,150.00	$6,300.00

Option	Price Each	Price Per Set
Rechargable		$250
C-Shell	$150	$300
Remote control		$300
T-Coil	N/C	N/C

Why do prices vary so much between dealerships?

1. Acquisition cost
   A. Manufacturer contracts
   B. Size of dealership
2. Overhead Costs
   A. Rent
   B. Advertising
   C. Employees
3. Name Brand
4. Pricing Philosophy

Group	Country	Key HA Brands	Local Dealers	Estimated World Market %
Sonova	Switzerland	Phonak Unitron	Allied Hearing	25%
Demant	Denmark	Oticon Bernafon Sonic	Allied Hearing HearingLife	24%
Sivantos (Formerly known as Siemens)	Denmark and Singapore	Signia Rexton Widex	Allied Hearing Miracle Ear	23 %
GN	Denmark	ReSound Beltone Interton	Allied Hearing	16%
Starkey	USA	Starkey Micro-Tech NuEar	Allied Hearing Obermeyer & Schrepel Peacehealth Medical Group	11%

Big 5 global hearing aid manufacturers February 2019 Hearing Review Magazine.

City of Longview

Agenda Summary

R-58 Pre-approval for Extraction of Tooth and Replacement Bridge

Attachments:
1. R-58 Dental Pre-Approval documentation

The City of Longview Washington

Memorandum

TO: **LEOFF-1 DISABILITY BOARD**

FROM: **DANA BECK, INTERIM LEOFF-1 ADMINISTRATOR**

SUBJECT: R-58 REQUEST PRE-APPROVAL FOR BRIDGE TO REPLACE FRACTURED #11 TOOTH.

R-58 is requesting pre-approval of extraction of #11 tooth and replacement bridge. The total estimate is $10,708.00. Yearly max dental insurance $2500.00. Out of pocket $8208.00. Could be less out of pocket if procedure carries into 2024.

Action needed on this claim:

1. Approve R-50 for #11 tooth extraction and new bridge estimated cost of $8208.00.

Documents included for review:

1. Reasonable & Medically Necessary Services forms
2. Estimates from Cabel McDonald, DDS $4232.00
3. Estimates from Dr. Eric Littlefield $6476.00

R-58

City of Longview

LEOFF-1

Reasonable and Medically Necessary Services

Completion of this form by the physician (or dentist) recommending treatment is required for the LEOFF-1 Disability Board to consider reimbursement requests for services not covered by insurance (dental, massage, acupuncture, etc). The retiree is responsible for submitting the form to the LEOFF-1 Disability Board with a completed claim form, invoice or estimate, explanation of benefits from insurance (denial of claim), & proof of payment. ***Procedures that are purely cosmetic and not medically necessary are not eligible for reimbursement. The City of Longview cannot pay providers directly – the retiree is responsible for making payment. Only procedures/services that are determined to be reasonable and medically necessary by the LEOFF-1 Board will be considered for reimbursement.***

PATIENT/RETIREE NAME: R-58

1. Name of physician/dentist and business/clinic address: Dr. Eric Littlefield 911 th Ave Suite A Longview, WA 98632

2. Condition requiring treatment: Broken tooth, #11, under bridge. Non-Restorable #11.

3. Summary of recommended services: Section bridge at 9/10 + keep remaining crown on #9. If Remove #11 and place implant in the #11 spot. If Large enough then cantilever bridge #11-10. If small implant, then use the existing implant #12 to make bridge #12-10. Double abutments.

4. Are the recommended services purely cosmetic (yes/no): No.

5. Are the recommended services reasonable and medically necessary (yes/no): YES

6. Explain why you determined that the recommended services are reasonable and medically necessary:
Left untreated, pt will not only lose #11 + the #10 portic, but #9, as well.

7. Please provide the dates on which services were provided (if already provided):

8. If the treatment has not yet been provided, are there alternative treatment options? After Removal of #10 + 11, a removable partial denture could be made. Do nothing + have missing teeth up front would place more stress on remaining teeth + be Risky.

R-58

9. What are the approximate costs of alternative treatment, if applicable?
Not Recommended

10. Explain why these alternative treatment options were not chosen:
Pt has class II malocclusion + heavily restored anterior teeth. The alternate options do not allow for proper occlusion with anterior guidance.

I swear under penalty of perjury that the above statements are true.

DMD

Physician/Dentist Signature

8/4/2023

Date

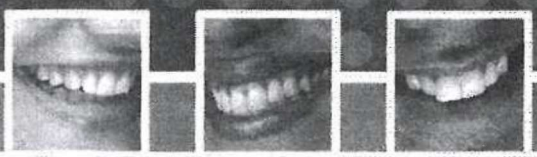
Patient/retiree authorization for the release of this form to the City of Longview LEOFF-1 Disability Board (Board Secretary Kaylee Cody):

Patient/Retiree Signature

Date

Eric W. Littlefield, DMD

Name
Birthdate R-58



.: TREATMENT CASE Treatment Plan (1)6-21-2023

DATE	VISIT	TOOTH	SURF	CODE	PROV	DESCRIPTION	FEE	PATIENT	PRIMARY
06/21/2023	3	10		D6245	DMD1	Pontic-porcelain/ceramic	1300.00	0.00	0.00
06/21/2023	3	11		D6057	DMD1	Custom abutment-incl placement	1000.00	0.00	0.00
06/21/2023	3	11		D6058	DMD1	Abtmt supp FPC	1588.00	0.00	0.00
06/21/2023	3	12		D6057	DMD1	Custom abutment-incl placement	1000.00	0.00	0.00
06/21/2023	3	12		D6058	DMD1	Abtmt supp FPC	1588.00	0.00	0.00
						Visit 3 Totals:	6476.00	0.00	0.00
06/21/2023	4	11		D2705	DMD1	Crown Seat	0.00	0.00	0.00
						Visit 4 Totals:	0.00	0.00	0.00

:: INSURANCE PROVIDER(S) ::

Primary	Secondary
Delta Dental of Washington	

:: TOTALS ::

Fee	Patient	Primary
6476.00	0.00	0.00

:: FINANCIAL SUMMARY ::

Treatment Plan Total	6476.00
Estimated Deductible to be Applied	0.00
Estimated Insurance Payment	0.00
Estimated Patient's Portion	0.00

:: DENTAL INSURANCE BENEFITS ::

		Patient		Family	
		Primary	Secondary	Primary	Secondary
Annual plan benefits		2500.00	0.00	0.00	0.00
Paid Benefits YTD		307.00	0.00	307.00	0.00
Pending Insurance Estimate YTD		0.00	0.00	0.00	0.00
Estimated Benefits Remaining YTD		2193.00	0.00	2193.00	0.00
Benefits Expire		12/31/2023	NA		
Deductible Owed YTD	Standard	50.00	0.00	0.00	0.00
	Preventative	0.00	0.00	0.00	0.00
	Other	0.00	0.00	0.00	0.00

Alternate Cases:

Case notes:

I understand this is only an estimation of my dental coverage. Guarantor is responsible for all treatment cost not covered by insurance. Estimated portion is due at time of service.

X_____ Date _____

911 14TH Avenue, Suite A
Longview WA 98632 PHONE (360)577-0770

REPORT DATE 03/02/2023

DELTA DENTAL

P.O. Box 75983 | Seattle, WA 98175-0983

R-58

Delta Dental of Washington Confirmation of Treatment and Cost

DATE OF SERVICE	SUBMITTED PROCEDURE CODE	PAID PROCEDURE CODE	DESCRIPTION OF SERVICE	TOOTH	SURFACE	SUBMITTED AMOUNT	APPROVED AMOUNT	ALLOWED AMOUNT	PAYMENT LEVEL %	DDWA PAYS	PATIENT PAYS	PROCESSING POLICIES
	D6057	D6057	Custom Abut	12		1,000.00	896.00	846.00	60.00	507.60	388.40	
	D6057	D6057	Custom Abut	11		1,000.00	896.00	896.00	60.00	537.60	358.40	
	D6058	D6058	Imp Abt Prc Crn	12		1,588.00	1,504.00	1,504.00	60.00	902.40	601.60	
	D6058	D6058	Imp Abt Prc Crn	11		1,588.00	1,504.00	1,504.00	60.00	552.40	951.60	938
	D6245	D6245	Pontic Porcln	10		1,300.00	0.00	0.00	60.00	0.00	0.00	948
	D9120	D9120	FPD Sectioning			234.00	0.00	0.00	0.00	0.00	0.00	D1B
TOTALS:						6,710.00	4,800.00	4,750.00		2,500.00	2,300.00	

cost will change depending on when tx is done. $6,234 worst case

PROCESSING POLICIES

938 - Plan maximum has been reached.

948 - The information provided for this treatment appears to be inconsistent with the claim submission or the patient's history. The amount indicated is the patient's responsibility under their plan.

D1B - In the absence of a valid tooth number, quadrant or arch treated, a benefit determination cannot be made. Upon receipt of additional information on a corrected claim, benefits for this treatment will be reconsidered.

CONFIRMATION OF TREATMENT AND COST

The treatment on the reverse side of this form has been processed for a confirmation of treatment and costs only. Please review the Rules of Confirmations below. You may use this form to request payment by filling in the dates the treatment was completed.

Delta Dental Mailing Address: **P.O. Box 75983 Seattle, WA 98175-0983**

RULES OF CONFIRMATION OF TREATMENT AND COST

BENEFIT LIMITATION This confirmation will be subject to the benefit limitations and program variations when submitted and processed for payment. These are listed in your Member Dentist Manual or patient's benefit booklet.

COORDINATION OF BENEFITS Confirmations are not coordinated with any other carriers. The "DDWA Pays" amount may be reduced due to a primary carrier's payment to ensure that the combined benefit payment does not exceed 100% of the allowed amount.

ELIGIBILITY The confirmed amount depends on the patient's continued eligibility. The most recent verified month of eligibility is indicated on the reverse side.

NON-MEMBER DOCTORS If this confirmed treatment plan is to be performed by a dentist who is not a member of Delta Dental of Washington, payment for the DDWA share of covered benefits may be issued jointly to the subscriber and dentist.

City of Longview

LEOFF-1

Reasonable and Medically Necessary Services

Completion of this form by the physician (or dentist) recommending treatment is required for the LEOFF-1 Disability Board to consider reimbursement requests for services not covered by insurance (dental, massage, acupuncture, etc). The retiree is responsible for submitting the form to the LEOFF-1 Disability Board with a completed claim form, invoice or estimate, explanation of benefits from insurance (denial of claim), & proof of payment. ***Procedures that are purely cosmetic and not medically necessary are not eligible for reimbursement. The City of Longview cannot pay providers directly – the retiree is responsible for making payment. Only procedures/services that are determined to be reasonable and medically necessary by the LEOFF-1 Board will be considered for reimbursement.***

PATIENT/RETIREE NAME: R-58

1. Name of physician/dentist and business/clinic address: Cabel McDonald, DDS
855 11th Ave Ste B Longview, WA 98632

2. Condition requiring treatment: Tooth # 11 fractured

3. Summary of recommended services: Extraction of #11 with ridge preservation and implant placement @ 6mths. Fixed bridge to be placed.

4. Are the recommended services purely cosmetic (yes/no): NO

5. Are the recommended services reasonable and medically necessary (yes/no): yes

6. Explain why you determined that the recommended services are reasonable and medically necessary:
The patient has a bridge in this area. By missing #11 he actually loses #10 also. This makes eating/chewing difficult.

7. Please provide the dates on which services were provided (if already provided):

8. If the treatment has not yet been provided, are there alternative treatment options? yes

R-58

9. What are the approximate costs of alternative treatment, if applicable?

See attached

10. Explain why these alternative treatment options were not chosen:

Refer to General Dentist.

I swear under penalty of perjury that the above statements are true.

Physician/Dentist Signature

8/21/2023
Date

Patient/retiree authorization for the release of this form to the City of Longview LEOFF-1 Disability Board (Board Secretary Kaylee Cody):

Patient/Retiree Signature

Date

The Oral Maxillofacial Surgery Offices of:
Cabel A. McDonald DDS PLLC
& Associates

R-58

August 21, 2023

The following is an estimation of your recommended treatment based on verification with your insurance company. Estimated insurance benefits are listed below. This estimate is not a guarantee of payment from your insurance company. If you have any questions regarding the following information, please call the office at (360)425-7220.

Description	Th#	Fee	Allowed	Insurance	Balance	
Detailed/Extensive Oral Evaluation		192.00	132.00	132.00	0.00	
X-Rays First Periapical	11	43.00	25.00	25.00	0.00	
Total for no phase		**235.00**	**157.00**	**157.00**	**0.00**	
Surgical Extraction-Erupted Tooth	11	336.00	239.00	151.20	87.80	*
Bone Graft Ext. Site Ridge Pres.	11	584.00	584.00	0.00	584.00	
Prf	11	584.00	0.00	0.00	584.00	
X-Rays First Periapical	11	43.00	25.00	25.00	0.00	
Guided Tissue Reg. Resorbable Barr.	11	584.00	584.00	0.00	584.00	
Total for Phase One		**2,131.00**	**1,432.00**	**176.20**	**1,839.80**	
Cone Beam Ct Capture		167.00	157.00	157.00	0.00	
Total for Phase Two		**167.00**	**157.00**	**157.00**	**0.00**	
Endosseous Implant	11	2,579.00	2,106.00	1,263.60	842.40	
X-Rays First Periapical	11	43.00	25.00	25.00	0.00	
X-Rays Each Additional Film	11	32.00	18.00	18.00	0.00	
Total for Phase Three		**2,654.00**	**2,149.00**	**1,306.60**	**842.40**	
X-Rays First Periapical	11	43.00	25.00	25.00	0.00	
Total for Phase Four		**43.00**	**25.00**	**25.00**	**0.00**	
Uncover Implant	11	0.00	0.00	0.00	0.00	
X-Rays First Periapical	11	43.00	25.00	25.00	0.00	
Total for Phase Five		**43.00**	**25.00**	**25.00**	**0.00**	
Write-off		-1,041.00			0.00	
Total		**4,232.00**	**3,945.00**	**1,846.80**	**2,682.20**	

* $50.00 deductible applied † $2,500.00 annual maximum applied

Total fee for above procedures: $4,232.00

City of Longview

Agenda Summary

August 2023 Medical Bills (Regular) - Total $18,417.27

Attachments:
1. August 2023_Reimbursment Spreadsheet

August 2023 MEDICAL BILLS (Regular)			
Member	**Dental**	**Regular**	
R-09		$638.60	
R-36	822.8	$1,147.50	
R-37		$6,800.00	
R-38		$7,392.00	
R-42		$434.96	
R-43		$425.00	
R-56		$43.26	
R-61		$230.00	
R-63		$483.15	
TOTAL	$822.80	$17,594.47	$18,417.27

City of Longview

Agenda Summary

August 2023 Medicare B Reimbursement - Total $8,336.30

Attachments:
1. August Medicare B voucher list

Medicare Premiums		August 2023	
Code	Vendor #	Year	RATE
R59	000092	2023	$31.50
R2	000122	2023	$243.00
R5	000233	2023	$361.20
R6	000278	2023	$164.90
R34	000447	2023	$156.90
R8	000465	2023	$164.90
R9	000466	2023	$164.90
R11	000632	2023	$164.90
R36	000634	2023	$164.90
R28	000664	2023	$164.90
R13	000666	2023	$164.90
R37	000701	2023	$164.90
R14	000706	2023	$164.90
R39	000740	2023	$164.90
R40	000744	2023	$164.90
R16	000789	2023	$164.90
R17	000827	2023	$164.90
R64	000883	2023	$164.90
R19	000963	2023	$164.90
R44	001021	2023	$164.90
R51	001106	2023	$164.90
R29	001124	2023	$164.90
R47	001226	2023	$164.90
R21	001245	2023	$164.90
R49	001402	2023	$164.90
R50	001481	2023	$151.90
R23	001511	2023	$164.90
R57	001599	2023	$151.90
R24	001631	2023	$164.90
R25	001644	2022	$134.00
R53	001685	Quarterly	$0.00
R63	001694	2023	$164.90
R55	001714	2023	$164.90
R56	001732	2023	$164.90
R58	001823	2023	$164.90
R26	002066	2023	$164.90
R27	210058	2023	$164.90
R18	210122	2023	$164.90
R42	210489	2023	$70.00
R48	211292	Quarterly	$0.00
R12	211809	2023	$479.30
R43	216727	2023	$164.90
R1	217402	2023	$164.90
R38	217404	2023	$164.90
R31	218105	2023	$141.90
R33	218134	2022	$164.90
R46	218350	2023	$164.90
R41	223804	2023	$164.90
R61	224982	2023	$164.90
R22	225194	2022	$148.50
R15	226325	2023	$164.90
			$8,336.30

Update of Long-Term Care Form

The Board has reviewed and discussed the current long term care form. Items 8 and 9 are confusing for those completing the form. The Board has reviewed forms from City of Olympia, City of Kirkland, and King County.

July 26, 2023 the Board preferred the example from the City of Vancouver, Physician Statement. The Board requested staff obtain the process of the City of Vancouver before adopting their long-term care form.

City of Vancouver Police and Fire Pension Board Rules and Regulations:

Long Term Care: Payment for reasonable expenses incurred by a member needing Long Term Care shall be available for coverage for:
1) Home Health Care;
2) Long Term Custodial Care;
3) Nursing Home Care; and/or
4) Hospice Care (cumulatively referred to as "Long Term Care") as set forth below.

It is the intent of this policy to reduce the amount paid for skilled nursing facility care, as well as to afford members a greater choice of Long-Term Care services. Therefore, members may seek payment for Long Term Care services, including but not limited to nursing home care, when appropriate as set forth below. Any request for coverage of Long-Term Care shall be subject to the following conditions:

a. The request for coverage for Long Term Care must be prescribed by a physician and be required due to medical necessity;

b. Any payment for Long Term Care services requires the member to provide evidence of medical necessity for at least the level of care provided by nursing home care services;

c. Coverage for Long Term Care must receive Board pre-approval, unless at the Board's sole discretion, circumstances reasonably prevented prior Board approval;

d. Payment for Long Term Care services will not exceed the average annually calculated semi-private room rate amount for Nursing Home Care services in Clark County, Washington, unless a private room is medically necessary;

e. When seeking approval for payment, members must submit:

i. City of Vancouver request for Long Term Care Application Request Form completed in full by member and health care provider;

ii. Medical documentation evidencing medical necessity for at least the level of care provided by nursing home care services, the estimated length of time that care is needed and the recommended level of care needed;

iii. Quotes from at least two (2) comparable facilities/providers in the county for which the member is requesting services, outside of Clark County, Washington; and

iv. All explanations of benefits insurance documentation forms showing amounts paid and/or rejected, including submissions to Medicare and any existing Long Term Care insurance.

f. The Board shall not provide payment for miscellaneous personal expenses such as toiletries, laundry, hair products, etc.

g. The Board reserves the right to direct that an independent assessor evaluate the member's need for Long Term Care and/or may require periodic reports from the facility and/or attending physician to continue the benefit.

h. The Board reserves the right, at its sole discretion based on the record before it, to approve or disapprove reimbursement for Long Term Care expenses incurred by a member.

1. Home Health Care: In addition to the conditions set forth above in O (a – h), the Board will only provide coverage for Home Health Care provided by a licensed, bonded Home Health Care provider. Requests for services for Home Health Care must include a written treatment plan from the member's physician which may be reviewed by the Board. The Board will not provide coverage for a caretaker who ordinarily resides in the member's home, or is a member of the family of either the member or the member's spouse, unless such individual is also a licensed and bonded Home Health Care provider.

2. Long Term Custodial Care/Assisted Living: In addition to the conditions set forth above in O (a – h), the Board may provide coverage for Long Term Custodial Care/Assisted Living services by a state licensed and bonded provider on a case-by-case basis. These services shall include assistance in the areas of daily living: walking, bathing, dressing, eating, etc.

3. Nursing Home Care/Skilled Nursing Care: In addition to the conditions set forth above in O (a – h), the Board will only provide coverage for Nursing Home Care to a member evidencing the medical need of a skilled nursing facility. The treating facility must be State licensed in the State or country where the facility is located.

4. Hospice Care: In addition to the conditions set forth above in O (a - h), the Board will only provide coverage for Hospice Care for a terminally ill member. In addition, the member must be admitted to a DSHS-certified or Medicare-approved program.

City of Longview

LEOFF-1

Medical Report and Request for Long-Term In-Home Nursing Assistance, Confinement in a Nursing Home or Similar Facility, or in a Hospital Extended Care Facility

Name of Member: _____

1. Name and address of attending physician: _____

_____

_____

2. The following are the dates on which the member was examined relative to his/her present condition, including the most recent examination: _____

_____

_____

3. The following is a summary of the relevant medical, mental, functional, neurological history of this member as known to me: _____

_____

_____

_____

_____

4. The following are my findings as to the medical condition of this member, including diagnosis and prognosis. _____

_____

_____

_____

		Yes	No
5.	Home health care is necessary due to the foregoing diagnosis:	☐	☐
6.	Nursing home confinement is necessary due to the foregoing diagnosis:	☐	☐
7.	Hospital extended facility confinement is necessary due to the foregoing diagnosis:	☐	☐

8. Is the member able to perform the following Activities of Daily Living (ADLs)?

	Yes	No
Bathing	☐	☐
Dressing	☐	☐
Feeding	☐	☐
Toileting	☐	☐
Transferring	☐	☐
Continence	☐	☐
Cognitive Impairment	☐	☐
Other*	☐	☐

*Describe "other" (i.e., self medicate, etc.) _____

_____

9. The following are my opinions on the specific medical and other assistance this member needs: _____

_____

_____

_____

_____

10. The following is my opinion regarding the estimated length of time this member will require the care identified in 5, 6, or 7, above: _____

_____

_____

_____

11. I have also met, spoken with or consulted the following persons regarding this member:

_____

_____

_____

Dated this _____ day of _____.

_____ _____

Physician's Signature Phone Number

_____

Physician's Name (Please type or print clearly)

CITY OF VANCOUVER HUMAN RESOURCES
415 W Sixth St – 3rd Floor/P.O. Box 1995
Vancouver WA 98668-1995
360.487.8403 phone 360.487.8418 fax
E-Mail - Julie.moore@cityofvancouver.us

Application Request

(To Be Completed by Member, Family Member or Legal Rep – please check one)

☐ Home Health Care ☐ Skilled Nursing Home Care Services ☐ Other_____

Name:	SSN:	Telephone Number:

Complete address including zip code:	Pension Board: ☐ Police ☐ Fire	Status: ☐ Active ☐ Retired

Medical Insurance: ☐ Medicare ☐ Kaiser Permanente ☐ Blue Cross ☐ Other _____	Veteran? ☐ Yes - Branch of Svc _____ ☐ No

QUICK PERSONAL ASSESSMENT TOOL

(TO BE COMPLETED BY MEMBER, FAMILY MEMBER OR LEGAL REPRESENTATIVE)

Assistance Needed:	Full Assistance	Some Assistance	No Assistance
Taking Medications	☐	☐	☐
Eating	☐	☐	☐
Toileting	☐	☐	☐
Bathing or Showering	☐	☐	☐
Dressing	☐	☐	☐
Transferring	☐	☐	☐
Continence	☐	☐	☐
Shaving, Hair Care	☐	☐	☐
Preparing Meals	☐	☐	☐
Transportation	☐	☐	☐
Housekeeping	☐	☐	☐
Personal Laundry	☐	☐	☐

Current Living Situation: ☐ Home (alone) ☐ Home (with services) ☐ Lives with family
☐ Hospital ☐ Other _____

Walking Ability: ☐ Independent ☐ Walker ☐ Cane ☐ Wheelchair ☐ Not Mobile

Memory Loss: ☐ Frequent loss ☐ Occasional loss ☐ No memory loss
☐ Dementia Diagnosis ☐ Alzheimer's Diagnosis

ADDITIONAL INFORMATION

What recent conditions or events have occurred causing you to consider a change in your circumstance? Please be specific.

I hereby certify, under the penalty of perjury in the State of Washington, that this application contains no willful misrepresentation and that the information is true and complete to the best of my knowledge and belief.

Signature: _____ Date: _____

Print Name: _____ Relationship to Member: _____

CITY OF VANCOUVER HUMAN RESOURCES
415 W Sixth St – 3rd Floor/P.O. Box 1995
Vancouver WA 98668-1995
360.487.8403 phone 360.487.8418 fax
E-Mail - Julie.moore@cityofvancouver.us

Physician's Statement

LEOFF I Member Name:	SSN:	Birth Date:

*The LEOFF I member, as listed above, has applied to the City of Vancouver Pension Board for approval of medical services. Please complete and sign the **PHYSICIAN** section of the form as listed below.*

Diagnosis:	Prognosis:

Assistance Needed:	Full Assistance	Some Assistance	No Assistance
Taking Medications	☐	☐	☐
Eating	☐	☐	☐
Toileting	☐	☐	☐
Bathing or Showering	☐	☐	☐
Dressing	☐	☐	☐
Transferring	☐	☐	☐
Continence	☐	☐	☐
Shaving, Hair Care	☐	☐	☐
Preparing Meals	☐	☐	☐
Transportation	☐	☐	☐
Housekeeping	☐	☐	☐
Personal Laundry	☐	☐	☐

Walking Ability: ☐ Independent ☐ Walker ☐ Cane ☐ Wheelchair ☐ Not Mobile

Memory Loss: ☐ Frequent loss ☐ Occasional loss ☐ No memory loss
☐ Dementia Diagnosis ☐ Alzheimer's Diagnosis

Based on the needs of this patient, I would recommend the following type of service (please check one):

☐ Home Health Care ☐ Skilled Nursing Home Care Services ☐ Other_____

Based on the needs of this patient, I would recommend the following level of care (please check one):

☐ Skilled Care: nursing care performed under the orders of a doctor, supervised by a licensed registered nurse or practical nurse available around the clock on a daily basis. A person with professional training or skills must perform most daily procedures.

☐ Intermediate Care: nursing care performed under the orders of a doctor and under supervision of a licensed registered nurse or practical nurse. The patient is provided with skilled care on a periodic basis. These periodic procedures cannot be done without professional training or skill.

☐ Custodial Care: primarily meets the personal needs of the patient and can be provided by a person without professional training or skill.

Frequency of Need: _____ (#) hours a day, _____ (#) days a week

Duration (how long do you anticipate need): ☐ Less than 2 weeks ☐ 3 – 4 weeks
☐ 1 – 3 months ☐ 4 – 6 months ☐ over 6 months ☐ not sure ☐ other_____

ADDITIONAL INFORMATION

Please provide any additional opinions on the specific medical and other assistance this patient needs:

Physician's Signature: _____ Date: _____

Typed or Printed Name_____ Phone: _____

Physical Address, including zip code:	Mailing Address, including zip code:

Please **SEND** this form to: City of Vancouver Human Resources/Pension Board, Attn: Julie Moore
P.O. Box 1995, Vancouver, WA 98668-1995 **OR** Fax: (360) 487-8418