City of Longview

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

LEOFF-1
Disability Board

Agenda

Wednesday, February 28, 2024 | **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 ROLL CALL

3 CHANGES TO THE AGENDA

4 PUBLIC COMMENT

5 APPROVAL OF MINUTES

24-00118 JANUARY 31, 2024 REGULAR MEETING MINUTES

6 MEDICAL REIMBURSEMENT REQUESTS

24-00174 R-22 REQUEST FOR PRE-APPROVAL OF LONG-TERM CARE(LTC) FACILITY COST AND REIMBURSEMENT OF LTC IN-HOME CARE RECEIVED SINCE SEPTEMBER 2023.

24-00194 R13 REQUEST FOR PRE-APPROVAL OF HEARING AID EXPENSES

7 APPROVAL OF BILLS

24-00111 FEBRUARY 2024 MEDICARE B REIMBURSEMENT - TOTAL $9,004.40

24-00112 FEBRUARY 2024 MEDICAL BILLS (REGULAR) - TOTAL $15,875.40

8 NEW BUSINESS

9 ADJOURNMENT

NEXT REGULAR MEETING:
Wednesday, March 27, 2024 at 8:30 a.m.

City of Longview

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

LEOFF-1
Disability Board

Minutes

Wednesday, January 31, 2024 | **8:30 AM** | **2nd Floor, City Hall, Small Conference Room**

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:
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1 CALL TO ORDER

Vice-Chair Barnd called the meeting to order at 8:30 a.m.

2 ROLL CALL

Present: Don Barnd, Police Retiree Representative
Jim Morkert, Fire Retiree Representative
Chet Makinster, Member-at-Large
MaryAlice Wallis, City Council Representative
Erik Halvorson, City Council Representative

Also Present: Tiffany Ostreim, Board Secretary
Kelly Jensen, Deputy Clerk
Dana Beck, Payroll Specialist
Kris Swanson, City Manager

3 ELECTION OF VICE-CHAIR

24-00126 Vacancy caused by Chairperson leaving Board/succession of Vice-Chair moving to Chair

Vacancy caused by the Chairperson leaving the Board. Vice Chairperson Barnd moved to Chair position.
Chair Barnd called for nominations for the position of interim Vice Chair until the annual election of officers in March.
Member Morkert nominated Member Wallis as Vice Chair. No other nominations were made for the Vice Chair. Member Wallis was elected unanimously.

4 CHANGES TO THE AGENDA

None

5 PUBLIC COMMENT

None

6 APPROVAL OF MINUTES

24-00115 November 29, 2023 Regular Meeting Minutes

A motion was made by Member Wallis, seconded by Member Halvorson to approve the November 29, 2023 Regular Meeting Minutes. The motion carried unanimously.

LEOFF Bylaws, Section 4 Medical Services, General Guidelines - Medical claims of a member shall be submitted to the Board within one year (365 days) following the original billing for services. Claims submitted after that period of time will be denied except for medical incapacity or death.

7 MEDICAL REIMBURSEMENT REQUESTS

None

8 APPROVAL OF BILLS

24-00116 December 2023 Medicare B Reimbursement - Total $8,700.10
January 2024 Medicare B Reimbursement - Total $9,234.00

Dana Beck, Payroll Specialist, explained the 2023 and 2024 Medicare rates.

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

24-00117 December 2023 Medical Bills (Regular) - Total $14,388.26
January 2024 Medical Bills (Regular) - Total $23,313.49

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

9 NEW BUSINESS

RCW 41.16 established the Firefighters' Pension Fund which is a separate fund and outside the purview of the Law Enforcement Officers' and Firefighters' (LEOFF-1) Disability Board.

10 ADJOURNMENT

With no further business to discuss, Chair Barnd adjourned the meeting at 8:45 a.m.

Next Meeting

The next regular meeting of the LEOFF-1 Board is scheduled for February 28, 2024 at 8:30 a.m.

_____ _____

Don Barnd, Chair *Tiffany Ostreim, Board Secretary*

City of Longview

Agenda Summary

R-22 REQUEST FOR PRE-APPROVAL OF LONG-TERM CARE(LTC) FACILITY COST AND REIMBURSEMENT OF LTC IN-HOME CARE RECEIVED SINCE SEPTEMBER 2023.

Attachments:
1. R-22 Long Term Care Approval memo
2. R-22 Long Term Care Approval documentation

The City of Longview Washington

Memorandum

TO: **LEOFF-1 DISABILITY BOARD**

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

SUBJECT: R-22 REQUEST FOR PRE-APPROVAL OF LONG-TERM CARE(LTC) FACILITY COST AND REIMBURSEMENT OF LTC IN-HOME CARE RECEIVED SINCE SEPTEMBER 2023.

R-22's family is requesting reimbursement for in-home LTC services. The family is currently looking at LTC facilities for R-22 and are asking for pre-approval of reimbursement for facility expenses not covered by UNUM LTC Policy.

Action needed on this claim:

1. Make determination as to whether R-22 qualifies for reimbursement of LTC in-home care, from September of 2023 to present. R-22 has UNUM LTC insurance, and a claim has been submitted, we are waiting for the approval or denial of claim. If approved, there is a 90-day elimination period before the coverage begins.

2. Make determination as to whether R-22 qualifies for reimbursement of LTC facility costs. R-22 has UNUM LTC insurance, and a claim has been submitted, waiting for the approval or denial of claim.

Documents included for review:

1. Reasonable & Medically Necessary Services Form
2. City's Medical Report & LTC form
3. Medical Release Form (HIPPA release form)
4. City's Physician's Statement
5. City's Application Request for Skilled Nursing Home Care
6. Email stating UNUM's coverage, if approved.

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-22

1. Name of physician/dentist and business/clinic address: Rebecca Jones, MD
3805 E Bell Rd Ste 2400 Phoenix, AZ 85032

2. Condition requiring treatment: Frontal temporal Dementia

3. Summary of recommended services: Memory care or 24/7
In home care

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:
FTD is a terminal disease causing progressive cognitive and physical decline

7. Please provide the dates on which services were provided (if already provided):
7/21/2021 – Current

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

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

In home assistance for 7 days a week, 4 hours a day is approx $150+ a day or $4500/month. We are researching memory care facilities now.

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

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

R Jones, MD
Physician/Dentist Signature

1-10-2024
Date

Patient/retiree authorization for the release of this form to the City of Longview LEOFF-1 Disability Board (LEOFF Administrator Dana Beck and Board Secretary Tiffany Ostreim):

Patient/Retiree Signature

2-10-24
Date

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: R-22

1. Name and address of attending physician:

Rebecca Jones
3805 E. Bell Rd ste 2402
Phoenix, Az 85032

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

7/21/2021	12/29/2021	9/29/2022	5/10/2023	11/9/2023
9/23/2021	3/23/2022	10/12/2022	10/4/2023	
9/29/2021	9/8/2022	11/8/2022	~~4/5/2~~	

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

The patient has Fronto-Temporal Dementia

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

FTD is a terminal neurodegenerative disease that causes progressive cognitive decline

	Yes	No
5. Home health care is necessary due to the foregoing diagnosis:		No, not if in a facility
6. Nursing home confinement is necessary due to the foregoing diagnosis:	yes	
7. Hospital extended facility confinement is necessary due to the foregoing diagnosis:		NO

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

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

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

Cannot manage any aspects of life independently

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

Memory care unit

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:

For the remainder of his life

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

Family members

Dated this 10th day of January 2024

Physician's Signature R Jones, MD Phone Number 602-482-2114

Physician's Name (Please type or print clearly) Rebecca Jones

Medical Information Release Form

(HIPAA Release Form)

Name: R-22 **Date of Birth:** 6/26

Release of Information

[X] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[X] Child(ren)_____

[X] Other City of Longview

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: 2/10/24

Witness: Sheila R. Coleman Date: 2/10/24

The City of Longview Washington

CITY OF LONGVIEW FINANCE
1525 Broadway – 1st Floor/P.O. Box 128
Longview, WA 98632-7080
360.442.5023 phone 360.442.5950 fax
E-Mail – dana.beck@cl.longview.wa.us

Physician's Statement

LEOFF I Member Name:	SSN:	Birth Date:
R-22	-1780	6/26/

*The LEOFF I member, as listed above, has applied to the City of Longview LEOFF-1 Disability Board for approval of medical services. Please complete and sign the **PHYSICIAN** section of the form as listed below.*

Diagnosis:	Prognosis:
Fronto temporal Dementia	Terminal

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 Memory unit

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: 24 (#) hours a day, 7 (#) 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 permanent

ADDITIONAL INFORMATION

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

Physician's Signature: R Jones, MD Date: 1-10-24

Typed or Printed Name: Rebicca Jones Phone: (602-482-2114

Physical Address, including zip code:	Mailing Address, including zip code:
3805 E Bell Rd Ste 2400 Phoenix, AZ 85032	same

Please **SEND** this form to: City of Longview Finance/LEOFF-1 Disability Board, Attn: Dana Beck
P.O. Box 128, Longview, WA 98632-7080 **OR** Fax: (360) 442-5950

The City of Longview Washington

CITY OF LONGVIEW FINANCE
1525 Broadway – 1st Floor/P.O. Box 128
Longview, WA 98632-7080
360.442.5023 phone 360.442.5950 fax
E-Mail – dana.beck@ci.longview.wa.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: R22 Member Daughter/POA	SSN: -1786	Telephone Number: Daughter
Complete address including zip code: Scottsdale, AZ 85257	LEOFF-1 Disability Board: ☒ Police ☐ Fire	Status: ☐ Active ☒ Retired
Medical Insurance: ☐ Medicare ☐ Kaiser Permanente ☒ Humana ☐ 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.

My father has been diagnosed with dementia and is steadily declining. He needs to be moved into a Memory care facility full-time according to his doctor and several other people who know/support him. We have a care taker come a few times a week but he needs full attention and assistance. We are hoping to find and move him in the next few months.

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: 2/7/24

Print Name: _____ Relationship to Member: Daughter PoA

The City of Longview Washington

CITY OF LONGVIEW FINANCE
1525 Broadway – 1st Floor/P.O. Box 128
Longview, WA 98632-7080
360.442.5023 phone 360.442.5950 fax
E-Mail – dana.beck@ci.longview.wa.us

Physician's Statement

LEOFF I Member Name:	SSN:	Birth Date:
R-22	1786	6/26/

*The LEOFF I member, as listed above, has applied to the City of Longview LEOFF-1 Disability 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 N

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: 24 (#) hours a day, 7 (#) 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 Permanent

ADDITIONAL INFORMATION

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

Physician's Signature: R Jones, MD Date: 1-10-24

Typed or Printed Name: Rebecca Jones Phone: 602-482-2116

Physical Address, including zip code:	Mailing Address, including zip code:
3805 E Bell Rd Ste 2400 Phoenix, AZ 85032	same

Please **SEND** this form to: City of Longview Finance/LEOFF-1 Disability Board, Attn: Dana Beck
P.O. Box 128, Longview, WA 98632-7080 **OR** Fax: (360) 442-5950

The City of Longview Washington

CITY OF LONGVIEW FINANCE
1525 Broadway – 1st Floor/P.O. Box 128
Longview, WA 98632-7080
360.442.5023 phone 360.442.5950 fax
E-Mail – dana.beck@ci.longview.wa.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:
R-22 - Member [illegible]ghter PoA	[illegible]-1786	Daughter - [illegible]7

Complete address including zip code:	LEOFF-1 Disability Board:	Status:
Daughter's Address - [illegible] Scottsdale, AZ 85257	☒ Police ☐ Fire	☐ Active ☒ Retired

Medical Insurance:	Veteran?
☐ Medicare ☐ Kaiser Permanente ☒ Humana ☐ Other _____	☐ 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.

My father was diagnosed with dementia. He is still physically able to get around but is declining steadily in his memory. He needs reminders & help daily to shower, brush teeth, and do basic tasks. A nurse comes to his apartment twice a day to give him his medications. We have been paying for a caretaker to come help him with some of these activities, plus to drive him to run errands, get haircuts, help with appointments, etc. and would like to update this service to seven days a week until we can find a memory care unit. He is partially functional to be on his own but needs consistent routine and support to take care of himself. He has gotten lost and we have had to do 3 police searches in the past few years. He is no longer able to drive. We will be moving him to Memory Care soon but need assistance until then.

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: 2/7/23

Print Name: _____ Relationship to Member: Daughter PoA

R-22

Dana Beck

From: n>
Sent: Tuesday, February 20, 2024 8:55 AM
To: Dana Beck; Tiffany Ostreim
Cc:
Subject: Re:

I just got off the phone with UNUM. The lady was super helpful and I have started the claim process with them.

She said they had a 90 day elimination period, but because we started care last year, she said once the claim is filed, that he should start getting the benefits. I used the September 2023 date as a start date as you had said we could go back 6 months for reimbursement (even though care started earlier).

Another person from the claims department will call sometime in the next week (I am unfortunately traveling for work and will not be able to talk to them next Monday - Wed (2/26-2/28) but she has that noted. Hopefully they will call before then to start processing everything. I will let you guys know after everything is set as well.

She said that the state of WA policy provides a daily benefit amount of $338.64 for care ($10,159.20) a month to cover the costs of the facility and his care.

I am not sure when that will start, but I will keep you posted once I talk to the claims agent and get everything going. Let me know if you have any other questions and thank you again for all of your help!

On 2/20/24, 8:53 AM, "Dana Beck" <Dana.Beck@ci.longview.wa.us <mailto:Dana.Beck@ci.longview.wa.us>> wrote:

Yes. This invoice will work. Were you able to contact UNUM? I'm not sure if they cover this kind of LTC. If they do, can you submit previous claims? These are questions the board will ask and the answers depend on the reimbursement.

Dana Beck
Payroll Specialist
City of Longview
Finance Department
Dana.Beck@ci.longview.wa.us <mailto:Dana.Beck@ci.longview.wa.us>
Phone: 360-442-5023

-----Original Message-----
From:
Sent: Tuesday, February 20, 2024 7:09 AM
To: Dana Beck <Dana.Beck@ci.longview.wa.us <mailto:Dana.Beck@ci.longview.wa.us>>; Tiffany Ostreim <Tiffany.Ostreim@ci.longview.wa.us <mailto:Tiffany.Ostreim@ci.longview.wa.us>>
Cc:
Subject: FW:

City of Longview

Agenda Summary

R13 REQUEST FOR PRE-APPROVAL OF HEARING AID EXPENSES

Attachments:
1. R-13 Hearing Aid purchase memo
2. R-13 Hearing Aid supporting documentation

The City of Longview Washington

Memorandum

TO: **LEOFF-1 DISABILITY BOARD**

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

SUBJECT: R13 REQUEST FOR PRE-APPROVAL OF HEARING AID EXPENSES

R13 is requesting pre-approval for hearing aids estimated cost of between $3,933.50 to $7,672.50. An audiogram and Reasonable & Medically Necessary form from the audiology appointment have been submitted for consideration, as well as a Binaural Pricing List.

Action needed on this claim:

1. Make determination as to whether R13 qualifies for reimbursement of hearing aids in the estimated amount of $3,933.50 to $7,672.50.

Documents included for review:

1. Audiogram
2. Reasonable & Medically Necessary Services Form
3. Binaural Pricing List

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: _____

1. Name of physician/dentist and business/clinic address: Luke Hinson, Au.D. 1801 1st Ave, #3A Longview, WA 98632

2. Condition requiring treatment: High-frequency sensorineural hearing loss at both ears.

3. Summary of recommended services: It is recommended the pt. obtain binaural amplification in order to achieve better speech understanding.

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 pt's audiogram shows a high-frequency sensorineural hearing loss at both ears. Based on the pt's audiogram and complaints of understanding speech hearing aids are deemed medically necessary to treat the hearing loss.

7. Please provide the dates on which services were provided (if already provided):
Audiogram completed on: 02/05/2024; HA eval: 02/12/2024

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

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

N/A

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

N/A

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

Luke W. Flinn, M.D. 02/12/2024

Physician/Dentist Signature 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 02/15/24

Date

[redacted]

MRN: 60069637 CSN: 510129786
DATE: 2/5/2024, APPT: 9:00 AM, ARR:
PROV: Hinson, Luke W, Au.D RVSU AUDIO
GUAR: P/F INS: Humana Medicare

[redacted]

0022718

Age:

Date of birth:

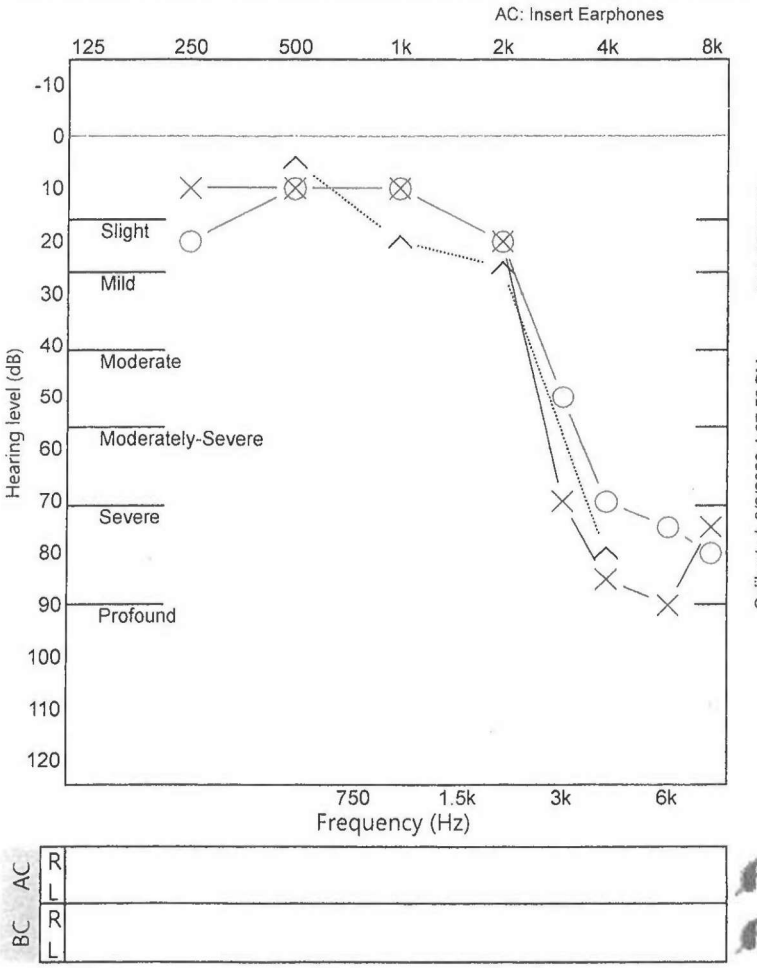
Report Date: 2/5/2024

Tester: LWH

PeaceHealth Medical Group
Ear, Nose & Throat

Report Comments:
HL - longstanding, specifically noticeable with speech clarity

AUDIOMETRY 2/5/2024



S/N: 1831980

Calibrated: 2/2/2023 4:37:52 PM

Legend

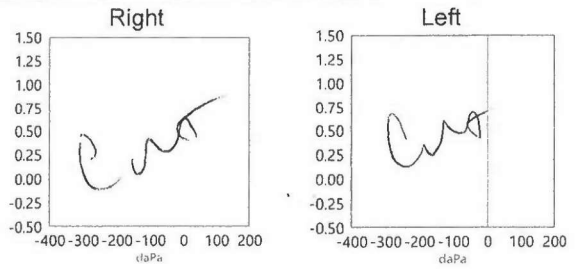
L		R		Masked	
×		○	AC	□	△
>	<	<	BC	⊐	⊏
S	S	S	SF	⊠	∅
M		M	MCL		
U		U	UCL		
↘	↓	↙	NR		

PTA (dB HL) / AI (%)

	AC	BC	AI
Right	13		67
Left	13		65

PTA AC: 500, 1k, 2k
BC: 500, 1k, 2k
Aud Method: Standard

IMMITTANCE 2/5/2024



Tymp	Right
Tone	Hz
SC	ml
TPP	daPa
ECV	ml
TW	daPa
Type	

Tymp	Left
Tone	Hz
SC	ml
TPP	daPa
ECV	ml
TW	daPa
Type	

Reflex	Threshold (dB HL)					Decay (s)	
	500	1k	2k	4k	BBN	500	1k
R Ipsi							
L Ipsi							
R Contra							
L Contra							

Stimulus Ear

Probe tone: 226 Hz

Speech	SDT		SRT		WRS / SRS 1				WRS / SRS 2				MCL	UCL
	dB HL	[m]	dB HL	[m]	%	dB HL	[m]	S/N	%	dB HL	[m]	S/N	dB HL	dB HL
Right			10		100.0	50	[20]							
Left			20		92.0	60	[30]							
Bin														
Note	[1] NU-6 List 2B							[2] NU-6 List 4B						
Aided														
Note	[1]							[2]						

Reliability
Good

Stenger	
T:	S:

Signed by:

L. Hinson, Au.D, AuBAC, CCC-A
#1006267028

Page 1 of 1

Binaural Pricing

Pricing is Semi- Unbundled

Includes fitting fee and in house service to match the Warranty

HEARING AIDS:

Premium (3 year repair/ L&D Warranty) ---- $7472.50

Advanced (2 year repair/ L&D Warranty) ---$5876.50

Select (2 year repair/ L&D Warranty) ----- $4634.00

Basic (1 year repair/ L&D Warranty) ---- $3733.50

A Pair of Ear molds: ---------- Add $200.00

~~Rechargeable --------Add $300.00~~

Hearing aids may be returned within **60** days of fitting date,
subject to a ($150.00 per device) restocking fee.

**Custom ear molds and Fitting Service fees are non-refundable

City of Longview

Agenda Summary

FEBRUARY 2024 MEDICARE B REIMBURSEMENT - TOTAL $9,004.40

Attachments:
1. Medicare B February 2024 voucher list

Medicare Premiums February 2024

Code	Vendor #		Year	
R59		000092	2024	$508.00
R2		000122	2024	$257.50
R5		000233	2024	$382.70
R6		000278	2024	$174.70
R34		000447	2024	$164.70
R8		000465	2024	$174.70
R9		000466	2024	$174.70
R11		000632	2024	$174.70
R28		000664	2024	$174.70
R13		000666	2024	$174.70
R37		000701	2024	$174.70
R14		000706	2024	$174.70
R39		000740	2024	$174.70
R40		000744	2024	$174.70
R16		000789	2023	$164.90
R17		000827	2024	$174.70
R64		000883	2023	$164.90
R19		000963	2024	$174.70
R44		001021	2023	$164.90
R51		001106	2024	$170.70
R29		001124	2024	$174.70
R47		001226	2024	$174.70
R21		001245	2024	$174.70
R49		001402	2024	$174.70
R50		001481	2024	$151.90
R23		001511	2024	$174.70
R24		001631	2024	$174.70
R25		001644	2022	$134.00
R53		001685	Quarterly	$0.00
R63		001694	2024	$174.70
R55		001714	2024	$174.70
R56		001732	2024	$174.70
R58		001823	2024	$174.70
R26		002066	2024	$174.70
R27		210058	2024	$174.70
R18		210122	2023	$184.50
R42		210489	2023	$0.00
R48		211292	Quarterly	$543.70
R12		211809	2024	$257.50
R43		216727	2023	$174.70
R38		217404	2024	$174.70
R31		218105	2024	$147.70
R33		218134	2022	$164.90

R46	218350	2024	$174.70
R41	223804	2023	$164.90
R61	224982	2024	$174.70
R22	225194	2024	$200.90
R15	226325	2023	$184.50
			$9,004.40

Received 2024 form retro for January premiums.

City of Longview

Agenda Summary

FEBRUARY 2024 MEDICAL BILLS (REGULAR) - TOTAL $15,875.40

Attachments:
1. Reimbursment February 2024 Spreadsheet

February 2024 MEDICAL BILLS (Regular)			
Member	**Dental**	**Regular**	
R-02		$887.00	
R-34		$415.00	
R-37		$6,800.00	
R-38		$7,392.00	
R-39	$21.40		
R-43		$360.00	
R-48		$0.00	
TOTAL	$21.40	$15,854.00	$15,875.40