8/1/2023

DISABILITY BOARD AGENDA
210 W. 6TH AVE, KENNEWICK CITY HALL
CASCADE CONFERENCE ROOM

11:45 AM

1. **CALL TO ORDER**
2. **ATTENDANCE**
3. **PUBLIC COMMENT**
4. **APPROVAL OF MINUTES**
   a. Approval of July 11, 2023 Meeting Minutes
5. **FIRE CLAIMS**
   Summary of claims for signature.
   a. Fire Claims for Consideration
6. **POLICE CLAIMS**
   Summary of claims for signature.
   a. Police Claims for Consideration
7. **UNFINISHED BUSINESS**
   a. Follow up on Police Member #20 Claim.
8. **NEW BUSINESS**
   a. Consideration of Dental Repair Reimbursement for Police Member #2
   b. Consideration of Dental Repair Reimbursement for Police Member #5
   c. Consideration for Prior Approval for Dental Repair for Police Member #5
9. **BOARD COMMENTS/DISCUSSION**

NEXT MEETING DATE:

a. September 5th, 2023 @ 11:45 AM

DISABILITY BOARD
REGULAR MEETING
July 11, 2023

CALL TO ORDER

Jim Kraft called the regular meeting of the Kennewick Disability Board to order at 11:48 a.m. at the Kennewick City Hall Building, 210 W. 6th Ave, in the Cascade Conference Room & Teleconference.

Members Present: Jim Kraft, Police Representative; Gary Williams, Fire Representative; Bill McKay, Mayor; Kathryn Armstrong, Member at Large

Staff Present: Christie Brown, Secretary; Dan Legard, Finance Director

Member Absent: Brad Beauchamp, Council Member

PUBLIC COMMENT

None presented.

APPROVAL OF MINUTES

Kathryn Armstrong moved, seconded by Gary Williams to approve the minutes of the June 6th, 2023 meeting. The motion passed unanimously.

FIRE CLAIMS

Gary Williams presented the Fire claims in the amount of $6766.00. Kathryn Armstrong moved, seconded by Gary Williams to pay all claims as presented. The motion passed unanimously.

POLICE CLAIMS

Jim Kraft presented the Police claims in the amount of $3490.01. Gary Williams moved, seconded by Kathryn Armstrong to pay all claims as presented. The motion passed unanimously.

OLD BUSINESS

None presented.

NEW BUSINESS

A motion was made by Gary Williams, seconded by Bill McKay to reimburse Police Member #12 in the amount of $2420.00 for dental work.

COMMENTS/DISCUSSION

ADJOURNMENT

The meeting adjourned at 11:54 a.m.

NEXT MEETING
Tuesday
August 1, 2023
@
11:45 AM

APPROVED:

DRAFT – FOR CONSIDERATION 8-1-2023

Prepared by Christie Brown, Disability Board Secretary

MEETING DATE: AUGUST 1, 2023

FIRE PENSION BOARD

FROM: CHRISTIE BROWN, SR. ACCOUNTING SPECIALIST/ DISABILITY BOARD SECRETARY

RE: FIRE PERSONNEL BUDGET NO. J2517210 . 520012

VENDOR#	LAST NAME	FIRST NAME	TOTAL
29			$ 6,449.00
19			$ 198.99

$ 6,647.99

JIM KRAFT, POLICE REPRESENTATIVE

GARY WILLIAMS, FIRE REPRESENTATIVE

KATHRYN ARMSTRONG, MEMBER AT LARGE

BILL MCKAY, COUNCIL MEMBER

BRAD BEAUCHAMP, COUNCIL MEMBER

LEOFF-1 CLAIMS - FIRE AUGUST 2023

Meeting Date	ID	Vendor #	Date of Service	Insurance PD	Claim #	Amount	Provider Type
8/1/2023		29	06/01/2023-06/30/2023		LONG TERM CARE	$ 6,449.00	FARMINGTON SQUARE MEMORY CARE
8/1/2023		19	7/17/2023		PRESCRIPTION	$ 198.99	BRAND DIRECT HEALTH
					TOTAL	$ 6,647.99	
					TOTAL	**$ 6,647.99**	

LEOFF I – CERTIFICATION CLAIM FORM – FIRE

I hereby certify under penalty of perjury that this is a true and correct claim for necessary medical expenses incurred by me, and that no payment has been received by me on account thereof.
I further certify that I am an active/retired member of the Kennewick Fire Department; that the following claim was required by an allowable provider; **I am enclosing the required explanation of benefits**; and that I am eligible for reimbursement under the following plan(s):

Asuris [ ] Medicare [ ] Other [X] Per board approval

Date of Service	Condtion or Illness Or Prescription Name	Provider of Service	Bill Charged	Co-pay Amount
June 2023	Chronic Dementia / Alzheimers	PHI	$6449.00	

PHI

TOTAL: $6449.00

7/17/2023
Date

Board Use Only

PHI

INVOICE

Invoice Period: 06/2023

Charges	From	
Personal Care Package Tier 1	06/01/23 - 06/30/23	$56.00
	Total Charges	**$6,656.00**
TOTAL DUE for PHI		**$6,449.00**

Please make check payable to PHI and include the above resident's name and unit number. Payments for EFT, Credit Card, or Debit Card are now available! Use the Resident & Family Portal button on our homepage at PHI to setup your preferred payment method.

If you have any questions regarding this invoice please contact our office. Thank you!

Remit Payment To: PHI

Friendly Reminder:
Please remit payment by the 1st of the month to avoid late fees.
If you have questions regarding your bill, please call PHI

PAID 5/26/23

PHI

PHI

PHI

INVOICE

Invoice Period: 06/2023

Send To: PHI

IMPORTANT NOTICE

Happy Father's Day

Print date: May 23, 2023

Account Summary

Prior Balance	Payments	Credits	Charges	TOTAL DUE
$6,449.00	($6,449.00)	($207.00)	$6,656.00	$6,449.00

Account Detail

Prior Balance			**$6,449.00**
Payments		**Date**	
Check # PHI	:CHECKscan Payment	05/04/23	($6,449.00)
		Total Payments	**($6,449.00)**
Credits		**From**	
MC Rent Adjustments		06/01/23 - 06/30/23	($207.00)
		Total Credits	**($207.00)**
Charges		**From**	
Memory Care Rent		06/01/23 - 06/30/23	$5,300.00
Memory Care Level 3		06/01/23 - 06/30/23	$1,300.00

LEOFF I – CERTIFICATION CLAIM FORM – FIRE

I hereby certify under penalty of perjury that this is a true and correct claim for necessary medical expenses incurred by me, and that no payment has been received by me on account thereof.
~~**I further certify**~~ that I am an active/retired member of the Kennewick Fire Department; that the following claim was required by an allowable provider; **I am enclosing the required explanation of benefits**; and that I am eligible for reimbursement under the following plan(s):

Asuris [ ] Medicare [ ] Other [X] city Fire pension

Date of Service	Condtion or Illness Or Prescription Name	Provider of Service	Bill Charged	Co-pay Amount
July 17th 2023	Cerefolin NAC	PHI	$198.99	0

TOTAL: $198.99

PHI

July 17 2023
Date

Board Use Only

PHI

PHI

Medical Expense Report

PHI

DATE RANGE: 7/1/2023 - 7/7/2023

PHI

Item #1

PRODUCT INFORMATION

DISPENSED DATE	RX NUMBER	DRUG NAME PRODUCT CODE	SIG	QTY	DAYS SUPPLY	PRESCRIBER
7/5/2023	PHI	Cerefolin NAC Levomefolate/Methylcob/N-Acetylcys/Algae-S 6/2/600/90.314 mg Tab PHI	TAKE 1 TABLET BY MOUTH EVERY DAY	90	90	PHI

PAYMENT INFORMATION

ORDER	PRODUCT PRICE	DATE(S) PAID	AMOUNT(S) PAID FOR PRODUCT+	SHIPPING FEE	SALES TAX	PAYMENT TYPE*
PHI	$195.99	7/5/2023	$195.99	$3.00	$0.00	FULL PAY

TOTAL AMOUNT PAID: $198.99

*If PAYMENT TYPE is 3 PAY, the amount charged was only 1/3 of the total Product Price that appears above. The second and third payments were automatically charged on the same date for the next two months. The 3 PAY Program has a convenience fee of $6.00 and is applied to the first payment.

+AMOUNT PAID FOR PRODUCT does not include sales tax or shipping fee. Payments have been scheduled as noted. The Amount Paid total reflects only amounts paid to date or within the date range noted above.

MEETING DATE: AUGUST 1, 2023

POLICE PENSION BOARD

CC: CHRISTIE BROWN, ACCOUNTING SPECIALIST/ DISABILITY BOARD SECRETARY

RE: POLICE PERSONNEL BUDGET NO. J2517210 . 520012

VENDOR#	LAST NAME	FIRST NAME	TOTAL
15			$ 247.00
12			$ 2,420.00
			$ 2,667.00

JIM KRAFT, POLICE REPRESENTATIVE

GARY WILLIAMS, FIRE REPRESENTATIVE

KATHRYN ARMSTRONG, MEMBER AT LARGE

BILL MCKAY, COUNCIL MEMBER

BRAD BEAUCHAMP, COUNCIL MEMBER

LEOFF-1 CLAIMS - POLICE AUGUST 2023

Meeting Date	ID	Vendor #	Date of Service	Insurance	Claim #	Amount	Provider
8/1/2023		15	7/11/2023		EYE EXAM & GLASSES	$ 247.00	MID -COLUMBIA EYECARE CENTER
8/1/2023		12	2/14/2023		DENTAL	$ 2,420.00	FIRST FAMILY DENTAL
					Total:	**$ 2,667.00**	

LEOFF I – CERTIFICATION CLAIM FORM – Police

I hereby certify under penalty of perjury that this is a true and correct claim for necessary medical expenses incurred by me, and that no payment has been received by me on account thereof.
I further certify that I am an active/retired member of the Kennewick Police Department; that the following claim was required by an allowable provider; **I am enclosing the required explanation of benefits;** and that I am eligible for reimbursement under the following plan(s):

Asuris [ ] Medicare [ ] Other [ ] _____

Date of Service	Condition or Illness Or Prescription Name	Provider of Service	Bill Charged	Co-pay Amount
July 11-2023	Eye exam and glasses	PHI	247.00	247.00

TOTAL: 247.00

PHI

7/12/23
Date

Board Use Only

PHI

Treatment & Management of Eye Disease & Injury/Contact Lens Center - Surgical Co-Management

PHI

PHI

ICE: 7-11-23

INSURANCE: None Medicare Medirr Premera/BCBS Kaiser Regence/Asuris 1st Choice VSP CHPW Molina UHC DSHS Other _____

EVAL/MGMT	NEW	EST	FEE
Evl/Mg Srv Lv1	99201	99211	
Evl/Mg Srv Lv2	99202	99212	
Evl/Mg Srv Lv3	99203	99213	
Evl/Mg Srv Lv4	99204	99214	
Evl/Mg Srv Lv5	99205	99215	
Intermediate	92002	92012	
Comprehensive	92004	92014	

ADDITIONAL SERVICES			
Emergency Services	99058		
Report Fee	99080		
L&I Report	1040M		
Post-Surgery: Catarac	66984-55	RT	LT
Post-Surgery: YAG	66821-55	RT	LT
Refraction	92015		

PRODUCTS/OTHER SERVICES: 39 photos; light sensitive

SALES TAX	
TOTAL FEE	247
PAYMENT	247
BALANCE DUE	0
CA CK/CC	

SURGICAL PROCEDURES		FEE
Dilation of Lacrimal Puncta	68801-50	
Punctal Plugs-Insertion	68761-E1	
	68761-E2	
	68761-E3	
	68761-E4	
Removal of Corneal Epithelium	65435	
Foreign Body Removal Corneal	65222	
Foreign Body Removal Conjunct	65210	
Foreign Body Embedded, Eyelid	67938	
Epilation by Forceps	67820	
Placement of Amniotic Membran	65778 RT	
	65778 LT	
Supplies for Amniotic Membran	V2790	

MEDICAL PROCEDURES		FEE
Visual Fields	92083	
Gonioscopy	92020	
Ext. Ophthalmoscopy, Intial	92225 RT	
	92225 LT	
Ext. Ophthalmoscopy, Subsequent	92226 RT	
	92226 LT	
Fundus Photography	92250	
Screening Photos	92250-52	
Ant. Segment Photos	92285	
OCT Anterior	92132	
OCT-Nerve Fiber	92133	
OCT-Macular Analysis	92134	
Color Test	92283	
Pachymetry	76514	
Dark Adaptation	92284	

		FEE
Electroretinography	92273	
Visual Evoked Potential	95930	
MPOD	92250M	
Tear Lab	83861	
Inflamma Dry	83516	
Adenoplus	87809	
Blephex		
Lipiflow	0207T	
CTL for Disease RT/LT	92071	
Scleral Fit RT/LT	92072	
Scleral Fit RT/LT	92311	
Both Eyes	92312	
CL Fitting Fee	92310	

OPTICAL SERVICES		#1	#2
Single Vision	V2101		
Bifocal	V2201	100	
Trifocal	V2301		
Progressive	V2781		
Prism	V2715		
Oversize	V2770	110	
Photochrome	V2744	145	
AR Coating	V2750		

		#1	#2
Rimless/Drill	V2799		
Edge/Polish	V2799		
Trivex	V2430		
UV Coating	V2755		
High Index	V2783		
Frame	V2020	260	
DSHS Disp Fee			
SV / BF / TF			

Contact Lenses		RT	LT
SCL - Sphere	V2520		
SCL - Toric	V2521		
SCL-Multifocal	V2522		
Extended Wear	V2523		

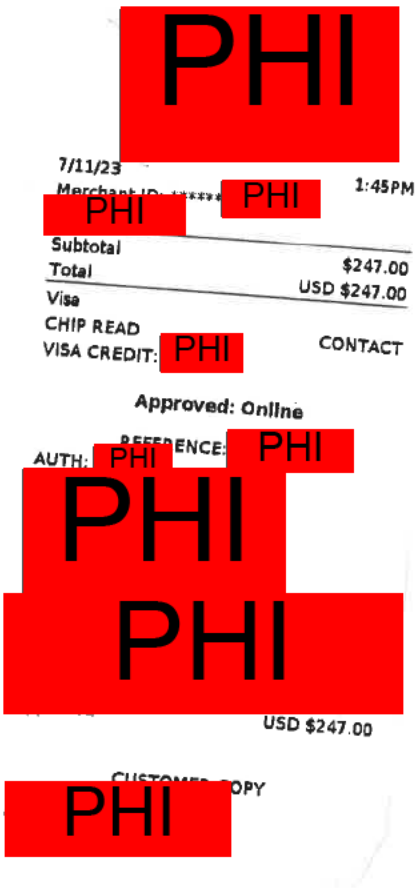
		RT	LT
RGP - Sphere	V2510		
RGP - Toric	V2511		
RGP-Multifocal	V2512		
Scleral Lenses	V2531		

DIAGNOSIS:

Vision: Myopia Hyperopia Astigmatism Presbyopia Amblyopia
Cataracts: NSC PSC Cortical ANterior PCO
Glaucoma: Suspect Open Narrow
Macula: Suspect Dry Wet Plaquenil Use Macular Pucker
Retina: Floaters PVD Tear Dystrophy Degeneration
Diabetes: Controlled NPDR PDR DME
Vascular: HTN BRVO CRVO CRAO

Surface: DES MGP KCS PK Blepharitis
Cornea: Abrasion Ulcer
Conjunctiva: Abrasion Pinguecula Pterygium Neoplasm
Red Eye: Allergic Bacterial Viral Iritis
Foreign Body: Cornea Conjunctiva
Eyelids: Trichiasis Ptosis Neoplasm Edema Eczema
Other: _____

PHI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7/11/23
1:45PM
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PHI
Subtotal
$247.00
Total
USD $247.00
Visa
CHIP READ
VISA CREDIT:
PHI
CONTACT
Approved: Online
AUTH:
PHI
PHI
PHI
PHI
USD $247.00
PHI

12

LEOFF I – CERTIFICATION CLAIM FORM – POLICE

I hereby certify under penalty of perjury that this is a true and correct claim for necessary medical expenses incurred by me, and that no payment has been received by me on account thereof.
I further certify that I am an active/retired member of the Kennewick Police Department; that the following claim was required by an allowable provider; **I am enclosing the required explanation of benefits**; and that I am eligible for reimbursement under the following plan(s):

Asuris [ ] Medicare [ ] Other [ ] _____

Date of Service	Condtion or Illness Or Prescription Name	Provider of Service	Bill Charged	Co-pay Amount
2-14-23	Fractured infected tooth	PHI	2420.00	2420.00

PHI

TOTAL: 2420.00

6-1-23
Date

Board Use Only

Last payment on this claim
8/12/22

To whom it may concern,

PHI attended for extraction #30 on 5/16/2022. The tooth was determined to be non-restorably fractured and abscessed. I have advised that this tooth be replaced with an implant upon sufficient healing time.

Thank you

PHI

PHI

STATEMENT

05/31/2023

PHI

Amount Due	Date Due	Amount Enclosed
0.00	Upon Receipt	

PHI

CREDIT CARD TYPE _____

_____

3 DIGIT CSV _____

EXPIRES _____

AMOUNT APPROVED _____

NAME _____

SIGNATURE _____

PLEASE RETURN THIS PORTION WITH YOUR PAYMENT

Total:	$276.00
-Ins Estimate:	$276.00
=Balance:	**$0.00**

0-30	31-60	61-90	over 90
276.00	0.00	0.00	0.00

PHI

PHI

Date	Patient	Code	Tooth	Description	Charges	Credits	Balance
	PHI			Balance Forward			614.00
02/14/2023		D9230		inhalation of nitrous oxide/analgesia, anxiolysis	53.00		667.00
02/14/2023		D6010	30	surgical placement of implant body: endosteal implant	2,074.00		2,741.00
02/14/2023		Pay		Credit Card PHI $2,420.00		2,420.00	321.00
02/14/2023		Claim		Pri Claim $2,127.00 FFD Membership Plan Received 02/14/2023 NO PAYMENT Writeoff: $321.00			
02/14/2023		InsPay		Insurance Payment for Claim 02/14/2023 Payment: $0.00 Writeoff: $321.00		321.00	0.00
02/14/2023		Stmt		Statement-InPerson			

PHI

PHI

PHI

LEOFF I – CERTIFICATION CLAIM FORM – POLICE

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I further certify that I am an active/retired member of the Kennewick Police Department; that the following claim was required by an allowable provider; **I am enclosing the required explanation of benefits**; and that I am eligible for reimbursement under the following plan(s):

Asuris [ ] Medicare [ ] Other [✓] PHI

Date of Service	Condtion or Illness Or Prescription Name	Provider of Service	Bill Charged	Co-pay Amount
7-12-2023	Crown front Tooth	PHI	$818.00	$818.00

TOTAL: $818.00

7-19-2023
Date

PHI

Board Use Only

PHI

7-12-2023

PHI

Appointment on 7-12-23
Limited Exam , Xray of # 8, Build up and crown completed .

#8 existing MLFI composite fill. Recurrent decay on all surfaces...IFL chip in the composite material...Necessitates removing all remaining decay and fill. After decay and fill removed 50% tsr b/u f/c required

PHI

This means my front tooth fell apart.

TIME 09:44 AM

PHI

DATE 7/12/2023

ACCOUNT HISTORY REPORT

FOR

PHI

From Jul 12, 2023 To Jul 12, 2023

Account Aging	
Current:	$0.00
30 Days:	$0.00
60 Days:	$0.00
90 Days:	$0.00
Contract:	$0.00
Balance Due:	$0.00
Estimated Insurance:	$0.00
Balance Due Now:	**$0.00**

Date	Name	Provider	Type	Description	Debit	Credit
	PHI	PHI	>>>>>>>>> Sum of all account activity prior to 7/12/2023			
7/12/2023			Service	02740 1-Crown Porcelain/Ceramic Tooth 8	$1,589.00	
7/12/2023			Service	00220 Periapical single, first Tooth 8	$47.00	
7/12/2023			Acct Pmt	Visa		$818.00
					$1,636.00	$818.00

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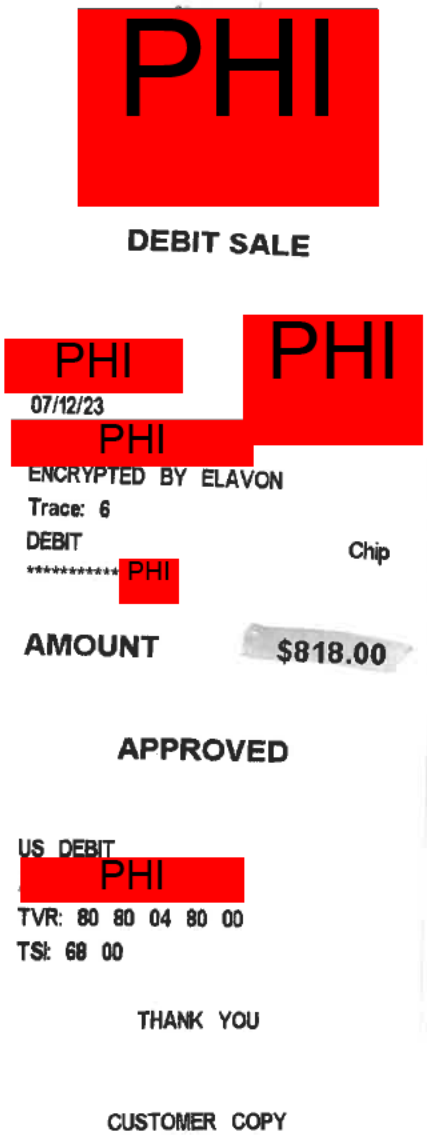
PHI

DEBIT SALE

PHI PHI

07/12/23

PHI

ENCRYPTED BY ELAVON

Trace: 6

DEBIT Chip

********** PHI

AMOUNT $818.00

APPROVED

US DEBIT

PHI

TVR: 80 80 04 80 00

TSI: 68 00

THANK YOU

CUSTOMER COPY

LEOFF I – CERTIFICATION CLAIM FORM – Police

I hereby certify under penalty of perjury that this is a true and correct claim for necessary medical expenses incurred by me, and that no payment has been received by me on account thereof.
I further certify that I am an active/retired member of the Kennewick Police Department; that the following claim was required by an allowable provider; **I am enclosing the required explanation of benefits**; and that I am eligible for reimbursement under the following plan(s):

Asuris [ ] Medicare [ ] Other [ ] _____

Date of Service	Condition or Illness Or Prescription Name	Provider of Service	Bill Charged	Co-pay Amount
7/18/23	Tooth implant	PHI	$ 2,327.79	$ 2,327.79

PHI

TOTAL: 2,327.79

7/19/23
Date

Board Use Only

July 19, 2023

Dear Board Members;

Attached (issue #1) is an itemized billing for the last remaining treatment I will require in the restoration of a tooth (implant) I lost due to dry mouth conditions caused by my CPAP machine. As your records will reflect, this has been an ongoing situation for the last several months and was previously approved for reimbursement by the board.

PHI

Thank you for your attention to this matter and I look forward to hearing from you.

PHI

PHI

July 18, 2023

PHI

ID: PHI

Account Aging	
Current:	$0.00
30 Days:	$0.00
60 Days:	$0.00
90 Days:	$0.00
Contract:	$0.00
Balance Due:	$0.00
Estimated Insurance:	$0.00
Balance Due Now:	**$0.00**

Date	Patient	Provider	Transaction	Tth	Surface	Fee
7/18/2023	PHI		DELCN - DELIVER CROWN (Standard Fee $0.00) (Adjust $0.00) (Fee $0.00)			$0.00
7/17/2023			Credit Adj - 7% senior discount for ($175.21)			
			Acct Pmt - Visa Credit Card for ($2,327.79)			
			D6058 - ABUTMENT SUPPORTED PORC/CERAMIC CROW (Standard Fee $1,709.00) (Adjust $0.00) (Fee $1,709.00)	13		$1,709.00
			D6057 - CUSTOM ABUTMENT (Standard Fee $794.00) (Adjust $0.00) (Fee $794.00)	13		$794.00

	SubTotal:	$2,503.00
	Tax:	$0.00
	Charge(s):	$2,503.00
-	Payment(s):	$2,327.79
-	Adjustment(s):	$175.21
	Balance Due:	$0.00

Contract Balance	Estimated Insurance	Previous Balance	Charge(s)	Payment(s)	Adjustment(s)	Balance Due Now
$0.00	$0.00	$0.00	$2,503.00	$2,327.79	($175.21)	**$0.00**

Future Family Appointments:

Patient:	Next Appointment:	Patient:	Next Appointment:	Patient:	Next Appointment:
PHI					

Thank You for Visiting our Office. We appreciate your patronage. Have a Great Day!

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PHI

#5

To: Director of Benefits

PHI

Date: July 18, 2023

PHI

PHI presented today with a report of an incident approximately two weeks ago that caused damage to his lower right first molar. He reported that during a meal he bit down on an olive pit that accidentally was in the meal. When he chewed down on the pit, the crown on his lower right side fractured causing loss of porcelain with a sharp edge and an open contact between his teeth.

The crown for tooth #30 and the underlying core filling require replacement for the following reasons:

- being structurally weakened it may fracture more in future causing shards of sharp porcelain to come off and the risk of further damage
- there is an open contact between the teeth causing food impaction. A short term annoyance, a long term potential for localized bone loss

An estimate for the work listed above will be included with this letter. Thank you for your consideration.

PHI

PHI

Proposed Treatment Plan

7/18/2023

PHI

PHI

ID: PHI

Phase	Date Plan	Appt	Provider	Service		Tth	Surf	Fee	Ins.	Pat.
1	7/18/2023		PHI	D2740	CROWN-PORCELAIN/CERAMIC S	30		$1,454.00	$0.00	$1,454.00
1	7/18/2023			D2950	CORE BUILDUP, INCLUDING ANY	30		$311.00	$0.00	$311.00
1	7/18/2023			D0220	INTRAORAL-PERIAPICAL FIRST			$45.00	$0.00	$45.00
					Subtotal for This Phase:			$1,810.00	$0.00	$1,810.00
					Subtotal:			$1,810.00	$0.00	$1,810.00

Insurance coverage is only an estimation. Guarantor is responsible for all treatment not covered by insurance.

Total Proposed:	$1,810.00
Total Completed:	$0.00
Total Accepted:	$0.00
Proposed Insurance:	$0.00

Insurance coverage is only an estimation. Guarantor is responsible for all treatment not covered by insurance.

THIS PLAN HAS BEEN PROPOSED. I AM NOT OBLIGATED TO HAVE ANY OF THE ABOVE TREATMENT COMPLETED. AT TREATMENT TIME, I HEREBY AUTHORIZE IDEAL DENTISTRY TO PERFORM THE WORK DESCRIBED.

Patient or Guarantor's Signature _____ Date _____

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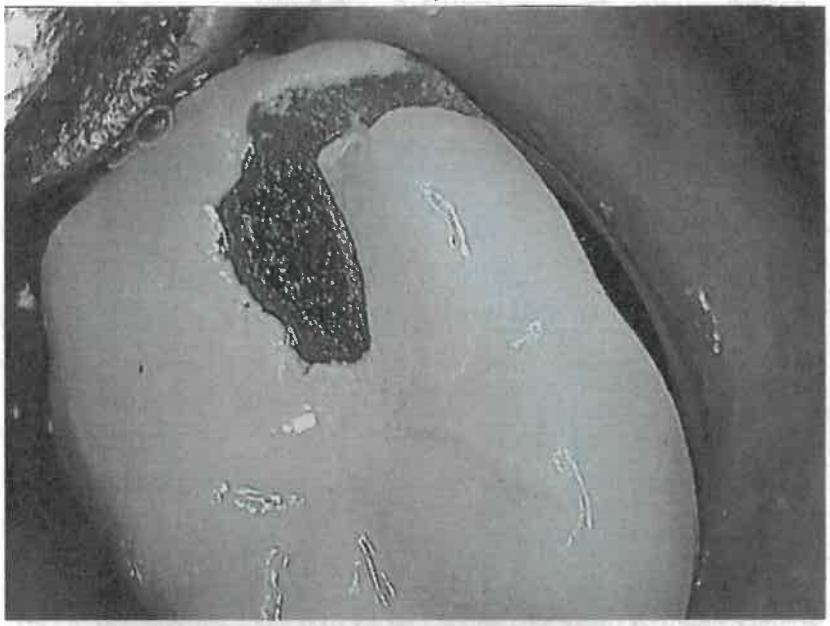
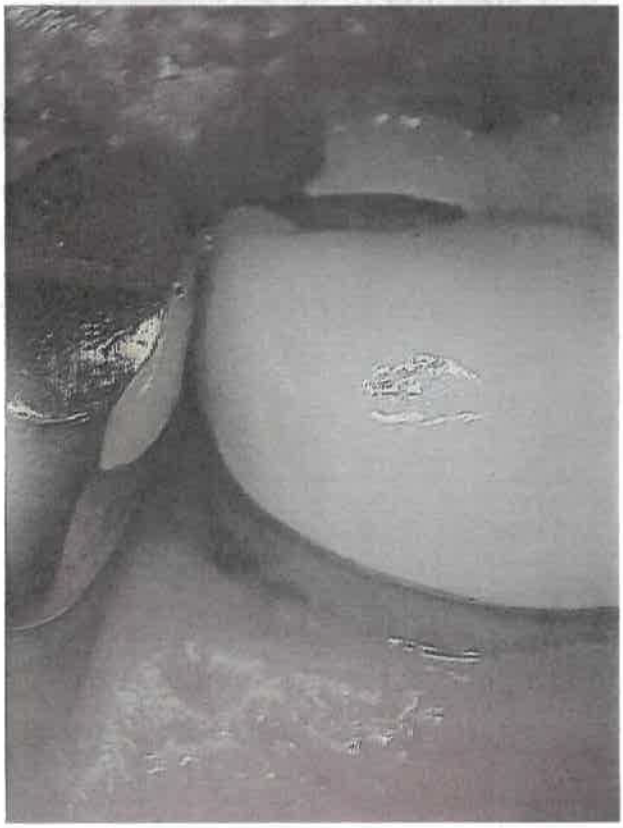
PHI

07/18/2023

crown frature





See Reverse Side also