5/7/2024

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 April 2, 2024 Meeting Minutes
5. **FIRE CLAIMS**
   Summary of claims for signature.
6. **POLICE CLAIMS**
   Summary of claims for signature.
   a. Police Claims for Consideration
7. **UNFINISHED BUSINESS**
8. **NEW BUSINESS**
   a. Police Member #32 is requesting reimbursement of $420.20 for eye wear.
9. **BOARD COMMENTS/DISCUSSION**

NEXT MEETING DATE:

a. June 4, 2024 @ 11:45 a.m.

DISABILITY BOARD
REGULAR MEETING
April 2, 2024

CALL TO ORDER

Chuck Torelli called the regular meeting of the Kennewick Disability Board to order at 11:45 a.m. at the Kennewick City Hall Building, 210 W. 6th Ave, in the Cascade Conference Room.

Members Present: Gary Williams, Fire Representative; Kathryn Armstrong, Member at Large; Gretel Crawford, Mayor; Chuck Torelli, Council Member

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

Member Absent: Jim Kraft, Police Representative

PUBLIC COMMENT

None presented.

APPROVAL OF MINUTES

Kathryn Armstrong moved, seconded by Gary Williams to approve the minutes of the March 5, 2024 meeting. The motion passed unanimously.

FIRE CLAIMS

Gary Williams presented the Fire claims in the amount of $198.99. Kathryn Armstrong moved, seconded by Chuck Torelli to pay all claims as presented. The motion passed unanimously.

POLICE CLAIMS

Gary Williams presented the Police claims in the amount of $176.08. 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 Kathryn Armstrong, seconded by Gary Williams to reimburse Police Member #25 in the amount of $483.30 for lodging, and airline tickets to Seattle, WA for medical appointments at the University of Washington Medical Center.

Board Member requested the Board Secretary do some research on a prescription that the insurance company will not pay for.

COMMENTS/DISCUSSION

ADJOURNMENT

The meeting adjourned at 11:54 a.m.

NEXT MEETING
Tuesday
May 7, 2024
@
11:45 AM

APPROVED:

DRAFT – FOR CONSIDERATION 5/7/2024

Prepared by Christie Brown, Disability Board Secretary

MEETING DATE: MAY 7, 2024

POLICE PENSION BOARD

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

RE: POLICE PERSONNEL BUDGET NO. J2517210 . 520012

VENDOR#	LAST NAME	FIRST NAME	TOTAL	
18			$	6.53
			$	**6.53**

JIM KRAFT, POLICE REPRESENTATIVE

GARY WILLIAMS, FIRE REPRESENTATIVE

KATHRYN ARMSTRONG, MEMBER AT LARGE

GRETEL CRAWFORD, MAYOR

CHUCK TORELLI, COUNCIL MEMBER

LEOFF-1 CLAIMS - POLICE MAY 7, 2024

Meeting Date	ID	Vendor #	Date of Service	Insurance	Claim #	Amount	Provider
5/7/2024		15	3/15/2024		RX PHARMACY	$ 6.53	ELK DRUG
					Total:	**$ 6.53**	

#15

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
3-15-2024	folic acid	Elk Drug	6.53	6.53

TOTAL: 6.53

[redacted] apr22-2024
Date

Board Use Only

221257 03/15/24 Ref: 0 CS /MW #90
[redacted]
$6.53
FT – 7338040
FOLIC ACID 1 MG TABS 62135 – 210 – 10
DS: 90 CASH CHARTWELL

[redacted]

ELK DRUG
Rx 221257 [redacted]

[redacted]

FOLIC ACID 1 MG TABS
EA [CHARTWELL]
NDC: 62135 – 210 – 10 Qty: 90

[redacted]

CASH

Your Cost: $6.53

Sale

ELK DRUG
SINCE 1888

Elk Drug
[redacted]

Receipt: 76920
Date: 03/18/24 03:43pm
Cashier: ANGELA
Register: POS Lane2
Customer: [redacted]

Item	Flags	Qty	Price	Value
Rx 232958-00	RF			$0.00
Rx 221257-01	RF			$6.53
Rx 219486-02	RF			$0.00
Rx 232996-00	RF			$0.00

Flags: T=Taxable F=FSA R=Rx P=Promo

Rx count:4

Subtotal	$6.53
Exempt	$0.00
Total	$6.53
Tender Credit	$6.53

Visa Card - Approved
Amount:$6.53
[redacted]
Transaction:CREDIT
Approval:09072D
Response Code:00
Entry Method:Contactlcc
Chip AID:A0000000031010
Trace Code:448415549
Cryptogram:TC 8AB6A8B305EBD8FC

FSA Total:$6.53

Customer Copy

#32

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 [L] Regence Other [ ] _____

Date of Service	Condtion or Illness Or Prescription Name	Provider of Service	Bill Charged	Co-pay Amount
3/8/2024	Eye Glasses	Blink Eyecare	$420.20	~~420.20~~ $100.00 covered $320.20 Not
		TOTAL:	~~$420.20~~	$100.00 cvd $320.20 Not

[redacted] 4/8/2024

Print Name Signature Date

Board Use Only

[redacted]

Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."

Notice of Denial of Payment

Date: 2024-03-28 [redacted]

[redacted] Date(s) of Service: 2024-03-08

Provider Name: [redacted] [redacted]

Your request was denied

We've denied the payment of the medical services/items listed below requested by your doctor:

CPT Code	Description of Service	Denial Code
V2782	LENS,INDEX 1.54-1.65PLAST OR1.60-1.79GLS,PER LENS	7K
V2781	PROGRESSIVE LENS, PER LENS	5N
V2750	ANTI-REFLECTIVE COATING PER LENS	7K
V2702	DELUXE LENS FEATURE	7K

Why did we deny your request?

We denied the payment of medical services/items listed above because:

Denial Code	Denial Description
7K	Service is not a covered benefit.
5N	Service code is not a covered service

You should share a copy of this decision with your doctor so you and your doctor can discuss next steps. If your doctor requested coverage on your behalf, we have sent a copy of this decision to your doctor.

You have the right to appeal our decision

You have the right to ask Regence MedAdvantage (PPO) to review our decision by asking for an appeal.

Plan Appeal: Ask Regence MedAdvantage (PPO) for an appeal within **60 days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline. See section titled "How to ask for an appeal with Regence MedAdvantage (PPO)" for information on how to ask for a plan level appeal.

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: 1-800-541-8981 to learn how to name your representative. TTY users call 711. Both you and the the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us. Keep a copy for your records.

Important Information About Your Appeal Rights

There are 2 kinds of appeals with Regence MedAdvantage (PPO)

Blink Eyecare Transaction Receipt

From: [redacted]

To: [redacted]

Date: Friday, March 8, 2024 at 04:08 PM PST

Blink Eyecare

[redacted]

Transaction ID	4361702102
Transaction Result	A01 - Approved (ZIP MATCH)
Transaction Date	03/08/2024
Transaction Time	07:07:52 PM
Transaction Type	Sale
Cardholder Name	[redacted]
Card Brand	Visa
Card Class	Credit
Account Number	[redacted]
Requested Amount	420.20 USD

Amount 420.20 USD

Authorization ID	00405D
Entry Method	Keyed
Entry Mode	Virtual Terminal
Verification Method	No CVM

No Signature Required

Patient Name: [redacted]

Optician: [redacted] Date: 3/8

blink EYECARE [redacted]

[redacted]

Plan Name circle: Choice/Signature

Frame Cost	$ 329
Frame Benefit	- 200
Total	129
Frame discount	x 20%
Frame Total	
Frame eye size 61+	
Frame Total	$ 103.20

Lens Features:

Single Vision	
Digital	
Bifocal/Trifocal	
Progressive: Custom Y/N	$ 165.00
NVF Computer	

Material:

Plastic	
Poly	
Trivex	$ 47.00
1.67 High Index	
1.70/1.74 High Index	

Add-ons:

AR Blue Premium	$ 85.00
Photocromatic	
Scratch Coating	Included
Tints: Solid/Grd	
Polarized	
Mirror	
UV	
Roll/Polish	
Polish	
Other	

Lenses Total	$ 317.00
Lens Discount	
Lenses Total	
Frame/Lenses Total	
Material Copay	
Exam Fees	
Grand Total	

All sales are final, no refunds will be issued.

Orders are custom & processed immediately.

I approve Blink to place this order: _____

Manufactor Warranty on:

Frames: _____

Lenses: _____

*Please don't try to repair your frames if they break, as it could void the warranty.

*We want you to be 100% satisfied with your eyeglasses. Please contact us within 90 days if we have not accomplished that.

*Still thinking about that second pair? You are eligible for a discount up to 50% within 30 days.

Lenses only = $ 317.00

Optician Note:

w/ New Eco frame includes polarized Sun clip = $ 420.20

ECO-Eyewear.com

Send payments to:
Blink Eyecare [redacted]

Invoice

Service Date	Invoice Date	Invoice #
03/08/2024	03/08/2024	[redacted]

Patient	Patient #
[redacted]	[redacted]

Provider	Tax ID
[redacted]	

Bill To
[redacted]

Code	Description	Price	Qty	Disc	Tax	Adjs	Paid	Balance
V2020	Eco [redacted]	$329.00	1	$0.00	$0.00	-$225.8	$0.00	$103.20
	Billed to Insurance - [redacted] ($329.00)							
	Transfer In - Exceeds VSP allowance : $103.20							
V2702	Lab Supplied Custom Measurements	$20.00	1	$0.00	$0.00	-$10.00	$0.00	$10.00
	Billed to Insurance - [redacted] ($20.00)							
	Transfer In - Exceeds VSP allowance : $10.00							
V2750	Lab Supplied Anti-Reflective Premium	$165.00	1	$0.00	$0.00	-$80.00	$0.00	$85.00
	Billed to Insurance - [redacted] ($165.00)							
	Transfer In - Exceeds VSP allowance : $85.00							
V2781	Custom Progressive iD Mystyle 2 Hoya	$297.50	1	$0.00	$0.00	-$122.5	$0.00	$175.00
	Billed to Insurance - [redacted] ($297.50)							
	Transfer In - Exceeds VSP allowance : $175.00							
V2782	Lab Supplied Trivex	$90.00	1	$0.00	$0.00	-$43.00	$0.00	$47.00
	Billed to Insurance - [redacted] ($90.00)							
	Transfer In - Exceeds VSP allowance : $47.00							
PAYMENT	[redacted]							-$420.20

Sub-Total	$901.50
Discounts	$0.00
Tax	$0.00
Total Amount	$901.50
Adjustments	-$481.30
Payments Received	$420.20
Credits Granted	$0.00
Balance Due	**$0.00**

MONTHLY REPORT

Medical and Hospital Claims Processed in March 2024

[redacted]

Regence

Regence BlueShield serves select counties in the state of Washington and is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence is a HMO/PPO/PDP plan with a Medicare contract. Enrollment in Regence depends on contract renewal.
2057 Commerce Dr, PO Box 1827, Medford, OR 97501

www.regence.com

This is not a bill:

- This monthly report of claims we have processed tells what care you have received, what the plan has paid, and how much you have paid out of pocket (or can expect to be billed).
- If you owe anything, your doctors and other health care providers will send you a bill.
- This report covers medical and hospital care only. We send a separate report on Part D prescription drugs.
- If you notice something suspicious that might be dishonest billing, you can report it by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.)

Regence Customer Service

If you have any questions or need help, call us at 1 (888) 319-8904. TTY users should call 711. Our hours are 8 a.m to 8 p.m. Monday through Friday. From Oct. 1 through March 31, we are available from 8 a.m. to 8 p.m. seven days a week.

Live online chat assistance is also available from 8 a.m to 5 p.m. Monday through Friday. To access online chat log in at www.regence.com and click the Contact Us link.

Y0062_PPO EOB_C

Details for claims processed in March 2024

Look over the information about your claims - does it seem correct?

- If you have questions or think there might be a mistake, start by calling the doctor's office or other service provider. Ask them to explain the claim.
- If you still have questions, call us at Customer Service (phone numbers are in the a box on page 1).

You have the right to make an appeal or complaint

- Making an appeal is a formal way of asking us to *change our decision* about your coverage. You can make an appeal if we deny a claim. You can also make an appeal if we approve a claim but you disagree with how much you are paying for the item or services. For information about making an appeal, call us at Customer Service (phone numbers are in a box on page 1).

Remember, this report is NOT A BILL:

- If you have not already paid the amount shown for "your share," wait until you get a bill from the provider.
- If you get a bill that is higher than the amount shown for "your share," call us at Customer Service (phone numbers are in a box on page 1).

[redacted]

Claim Number: [redacted]

In-network provider	Date of Service	Amount the providers billed the plan	Total cost (amount the plan approved)	**Plan's share**	**Your share**
Assessment for prescriptive eye wear using a range of lens powers(billing code 92015)	3/8/2024	$0.00	$0.00	$0.00	$0.00
Eye and medical examination for diagnosis and treatment, established patient, 1 or more visits(billing code 92014)	3/8/2024	$264.00	$70.00	$70.00	$0.00
	TOTALS:	$264.00	$70.00	$70.00	$0.00

[redacted]

Claim Number: [redacted]

In-network provider	Date of Service	Amount the providers billed the plan	Total cost (amount the plan approved)	Plan's share	Your share
Progressive Lens Per Lens(billing code V2781)	3/8/2024	$595.00	$51.25	$51.25	$175.00
Lens Sphcyl Bifocal 4.00d/.1(billing code V2203) This service is included in another billed procedure for this date of service.	3/8/2024	$0.00	$0 DENIED (See Below)	$0.00	$0.00 Because the claim was denied, you may be responsible for paying this amount. Look below for information about your appeal rights.
Vision Svcs Frames Purchases(billing code V2020)	3/8/2024	$329.00	$200.00	$94.50	$103.20
Miscellaneous Vision Service(billing code V2702) Service is not a covered benefit.	3/8/2024	$20.00	$0 DENIED (See Below)	$0.00	$10.00 Because the claim was denied, you may be responsible for paying this amount. Look below for information about your appeal rights.
Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate, per lens(billing code V2782) Service is not a covered benefit.	3/8/2024	$90.00	$0 DENIED (See Below)	$0.00	$47.00 Because the claim was denied, you may be responsible for paying this amount. Look below for information about your appeal rights.

continue

[redacted]

Claim Number: [redacted] In-network provider	Date of Service	Amount the providers billed the plan	Total cost (amount the plan approved)	Plan's share	Your share
Anti-Reflective Coating(billing code V2750) Service is not a covered benefit.	3/8/2024	$165.00	$0 DENIED (See Below)	$0.00	$85.00 Because the claim was denied, you may be responsible for paying this amount. Look below for information about your appeal rights.
	TOTALS:	$1,199.00	$251.25	$145.75	$420.20

Things to know about your denied claim

- We have denied all or part of this claim and **you have the right to appeal.** Making an appeal is a formal way of asking us to change the decision we made to deny your claim. If we agree to change our decision, it means we will approve rather than deny it, and we will pay our share.
- **The provider can also make an appeal, and if this happens you may not have to pay.** You may wish to contact the provider to find out if they will ask for an appeal. If the provider properly asks for an appeal, you will not be responsible for payment, except for the normal cost-sharing amount, and you don't need to make an appeal yourself.
- **When we deny part or all of a claim, we send you a letter** ("Notice of Denial of Payment") explaining why the service or item is not covered. This letter also tells what to do if you want to appeal our decision and have us reconsider.
- IMPORTANT: If you do not have this letter, call us at Customer Service (phone numbers are in a box on Page 1)
- **If you have questions or need help with your appeal, you can contact:**
  - Our Customer Service (phone numbers are in a box on Page 1).
  - 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.)

(2) The attending physician must submit an initial treatment plan within 30 calendar days of commencement and treatment, and if the treatment continues, report member progress at least once every three months. If the member's treatment is expected to exceed 12 months, a second treatment plan must be submitted. The Board will review the progress reports and treatment plans to determine whether treatment should continue, or if the patient should be re-evaluated.

(3) Failure to seek evaluation from the Board physician prior to incurring expenses for that treatment may result in the Board's rejection of a member's claim for payment.

(4) Only services deemed necessary will be paid, provided those services are not a result of member dissipation and abuse. Such determination will be made by the Board after considering medical evaluation by the Board physician.

18-36-040: Optical Exams, Eyeglasses, and Contact Lenses: Each LEOFF I member is entitled to the services of a participating physician or a participating optometrist for an eye examination once each year. Note: A year is defined as that 12-month period following the purchase date of the eyeglasses or contact lenses.

(1) Claims for eyeglasses, frames and eye exams will be paid; however, there will be a limit of $100 per year on the cost of frames.

(2) Contact lenses claims will be paid up to a limit of $200 per year.

(3) Members will be reimbursed once a year for either one pair of glasses or contact lenses, but not both.

(4) Benefits are paid for necessary services only and shall exclude tinting, coloring, photo-gray, photo-sun, or other options. Tinting of glasses or contacts will not be paid for, unless such request is required for the line of duty, or is accompanied by a physician's prescription.

(5) Progressive lenses are not considered a covered expense.

(6) Glasses or contacts broken or damaged in the line of duty will be replaced regardless of other reimbursement in the same calendar year. An explanation from the employee and confirmation from one or more witnesses will be required. Replacement of eyeglasses or contacts due to breakage, loss, or theft while off duty (active members) or for retirees will not be paid for by the Board; provided the replacement would be reimbursement for a second set of glasses or lenses within a calendar year.

(7) Radial/laser keratotomy and blepharoplasty surgical procedures will be evaluated by the Board on a case-by-case basis.

18-36-050: Diet Programs/Fitness Clubs: The City of Kennewick's Disability Board encourages and supports physical fitness for its members and is aware of the importance physical fitness provides in the prevention of injury and disease. The Board will pay for all necessary medical costs but will not pay for any food supplement, membership in weight loss programs, physical fitness clubs, health spas or other such programs. The Board will pay for counseling services if prescribed by a physician and performed by a licensed psychologist, psychiatrist, or Dietician/Nutritionist.

18-36-060: Alcohol and Drug Treatment:

(1) All claims submitted for alcohol and drug treatment must have a letter from the Board physician recommending the individual seek treatment.

(2) Any member needing or being requested to go to an inpatient facility for drug or alcohol treatment is required to have Board approval prior to admission. This approval is in