10/1/2024

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

4:30 PM

1. **CALL TO ORDER:**
2. **ATTENDANCE:**
3. **PUBLIC COMMENT:**
4. **APPROVAL OF MINUTES:**
   a. Approval of September 3, 2024 Minutes
5. **FIRE CLAIMS:**
   a. Fire Claim for Consideration
6. **POLICE CLAIMS: NONE**
7. **UNFINISHED BUSINESS: NONE**
8. **NEW BUSINESS:**
   a. Police Member #5 is requesting reimbursement for two claims
   b. Introduce Jessica Platt as Finance Director
   c. Staff Report: Regarding inconsistencies in agenda materials and minutes and supporting materials at the September 2024 meeting
9. **BOARD COMMENTS/DISCUSSION:**
10. **ADJOURNMENT:**

NEXT MEETING DATE: November 5, 2024

DISABILITY BOARD
REGULAR MEETING
September 3, 2024- DRAFT

1. CALL TO ORDER: Police Representative Jim Kraft called the regular meeting of the Kennewick Disability Board to order at 4:39 p.m. at the Kennewick City Hall Building, 210 W. 6th Ave, in the Cascade Conference Room. *(Note: the meeting was delayed due to previous meeting in the Cascade Conference room running longer than planned).*

2. ATTENDANCE: In addition to Police Representative Jim Kraft, present were Mayor Gretl Crawford, Mayor Pro Tem Chuck Torelli, Deputy City Manager Dan Legard, Secretary Christie Brown, Deputy City Clerk Brandi Ralston and Fire Representative Gary Williams.

3. PUBLIC COMMENT: None

4. APPROVAL OF MINUTES: The minutes of August 6, 2024, were unanimously approved as presented.

5. FIRE CLAIMS: None

6. POLICE CLAIMS: The Board discussed the documentation provided by member #15 for eyeglass lenses. A motion was by Mr. Kraft and seconded by Mayor Crawford for the Secretary to send a letter to the member asking them to provide prescription documentation for lenses. **The motion was unanimously approved as presented.**

Mayor Crawford noted that she would like to be sent a copy of Title 18.

7. UNFINISHED BUSINESS: Fire Member #28* provided documentation of a second opinion that was requested by the board at the August 6, 2024 meeting. **A motion was made by Mayor Crawford and seconded by Gary Williams to accept the competitive rate of $6298 and the second exam fee of $84 for a total reimbursement of $6382. The motion was unanimously approved as presented**. *Post meeting clarification was made to correct the member number that should have been presented. See October 2024 meeting minutes for further explanation.

8. NEW BUSINESS: Mrs. Brown noted that at the July 2nd meeting a claim was approved for a police member, the member has submitted the required documentation and the reimbursement will be submitted with the next claims cycle.

9. COMMENTS/DISCUSSION: Mr. Legard introduced Mrs. Ralston as the new Disability Board Secretary.

ADJOURNMENT: Mr. Kraft concluded the meeting at 4:51.

DRAFT
Brandi Ralston, CPRO
Deputy City Clerk

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
8.16.24	Cerefolin	BDH	# 198.99	0

TOTAL: # 198.99

Print Nam[redacted] Sep 10, 2024
Date

Board Use Only				

P.O. Box 1017
Bedminster, NJ 07921-1017
Tel: 866.331.6440

NCPDP: 5732323
NPI: 1982936886

Medical Expense Report

[redacted]

10

DATE RANGE: 8/1/2024 - 8/19/2024
DOB: [redacted]

Item #1

PRODUCT INFORMATION						
DISPENSED DATE	**RX NUMBER**	**DRUG NAME PRODUCT CODE**	**SIG**	**QTY**	**DAYS SUPPLY**	**PRESCRIBER**
8/16/2024	036745457r/3	Cerefolin NAC Levomefolate/Methylcob/N-Acetylcys/Algae-S 6/2/600/90.314 mg Tab 00525055590	TAKE 1 TABLET BY MOUTH DAILY	90	90	KARLSON, KATIE

PAYMENT INFORMATION						
ORDER	**PRODUCT PRICE**	**DATE(S) PAID**	**AMOUNT(S) PAID FOR PRODUCT+**	**SHIPPING FEE**	**SALES TAX**	**PAYMENT TYPE***
1773097	$195.99	8/16/2024	$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: October 1, 2024

FIRE PENSION BOARD

FROM: BRANDI RALSTON, PUBLIC RECORDS OFFICER DISABILITY BOARD SECRETARY

RE: FIRE PERSONNEL BUDGET NO. J2517210 . 520012

VENDOR#	Date of Service	Claim Type	Provider Type	TOTAL
19	8/16/2024	Perscription RX	Brand Direct Health	$ 198.99

$ 198.99

JIM KRAFT, POLICE REPRESENTATIVE

GARY WILLIAMS, FIRE REPRESENTATIVE

KATHRYN ARMSTRONG, MEMBER AT LARGE

GRETEL CRAWFORD, MAYOR

CHUCK TORELLI, COUNCIL MEMBER

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
4/4/24	Spinal Surgery Prerequisite	Behavioral Health Specialists Med Group	$100.00	$66.66
7/17/24	Dental Injury	Dr Rowe	$240.87	$240.87

[redacted]: $307.53

[redacted] 9/9/24
Date

Board Use Only

September 9, 2024

TO: Kennewick Disability Board
RE: Attached Requests for Reimbursement

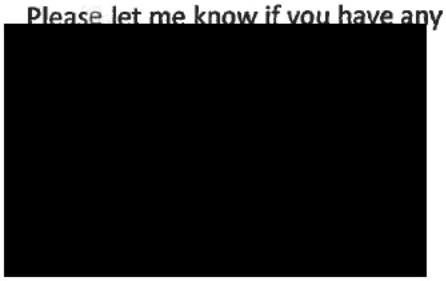
Dear Board:

Attached, you will find two requests for reimbursement for medical/dental services not covered by our insurance.

Issue #1: In May of this year, a temporary spinal cord stimulator was surgically implanted in my back at Apex Spine. Part of the pre-requisite for getting this implanted was undergoing a "psychological evaluation" (via phone). No one has ever owned up to who actually "required" this-Apex says it was the insurance company, but they say no, wasn't them, but at any rate, I was charged $100.00 for this (up front) and the provider refused to bill our insurance, even though there was coverage. They wanted the full $100 bucks so that's what they got. I turned the bill into our insurance for re-imbursement, which turned into a very lengthy process (it was initially sent to the wrong address and, rather than forward it on, they ash canned it). I was eventually sent a "re-imbursement" check by our insurance company for $33.34 and advised this is all they would pay for this service (see attached). No wonder the provider wouldn't accept our insurance. I didn't receive the (attached) EOB regarding this matter until about a month ago. I am enclosing all the documentation regarding this matter that was forwarded to me.

Issue #2: While eating a salad in late June, I bit down on a piece of walnut shell and injured a molar on the lower right side of my jaw. After three weeks, it hadn't quit hurting, so I saw my dentist, Dr. Rowe. He examined and x-rayed it but couldn't come to a definitive diagnosis so advised me to let a few more weeks go by and see how it did. After two more weeks, the tooth was still hurting so I re-visited Dr. Rowe. Using his drill, he created a small gap between the molar and the tooth opposed to it so less pressure would be exerted on the effected tooth. That has helped, but it's still bothering me. Dr. Rowe now feels fairly certain that the tooth was cracked when I bit down on it and may have to be extracted at a later date if it becomes chronic. There was no charge for the second visit. Needless to say, there was no insurance coverage for any of this, so it was entirely out of pocket. Again, I believe I have attached all the paperwork the board will need to evaluate this matter for re-imbursement. **Please note the fact that for the time being, I am not seeking further treatment for the tooth but, depending on how chronic it gets, it might need further treatment in the future which could include extraction and implantation of a prosthetic tooth.**

Please let me know if you have any questions. Thank you for your consideration in this matter.



Receipt

Invoice number BAC5F692-0001
Receipt number 2004-6881
Date paid April 4, 2024
Payment method Visa - 6908

Behavioral Health Specialists Medical Group
+1 877-583-5633
billing@advantagepointbehavioral.com

Bill to
[redacted]

$100.00 paid on April 4, 2024

Please contact us with any questions about your due amount.

After verifying your insurance benefits, this is your financial responsibility for your services rendered through Advantage Point Behavioral.

If you have any questions, please contact the billing coordinator at billing@advantagepointbehavioral.com

Description	Qty	Unit price	Amount
Advantage Point Behavioral Assessment	1	$100.00	$100.00

Subtotal	$100.00
Total	$100.00
Amount paid	**$100.00**

Cancellations, Reschedules & No Shows. We require a notice for cancellations and reschedules 24 hours prior to your appointment. Your provider has reserved this time for you so please be advised that No Shows without providing reasonable notice will be charged a $25 booking fee.

PADGETT, AMY

Claim Number: 201552661301

Out-of-network provider; Temporary State of Emergency Benefit Applied For Service Dates Through May 11, 2023	Date of Service	Amount the providers billed the plan	Total cost (amount the plan approved)	Plan's share	Your share
Psychiatric diagnostic evaluation(billing code 90791)	4/4/2024	$33.34	$33.34	$33.34	$0.00
Preparation of report of patient's psychiatric status(billing code 90889) Reimbursement for this service is included in the allowed amount of another procedure.	4/4/2024	$33.33	$0.00	$0.00	$33.33
Assessment of emotional or behavioral problems(billing code 96127) Reimbursement for this service is included in the allowed amount of another procedure.	4/4/2024	$33.33	$0.00	$0.00	$33.33
	TOTALS:	$100.00	$33.34	$33.34	$66.66

WAHL, JR, MELVIN M.

Claim Number: E66134411100

Out-of-network provider; Temporary State of Emergency Benefit Applied For Service Dates Through May 11, 2023	Date of Service	Amount the providers billed the plan	Total cost (amount the plan approved)	Plan's share	Your share
Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medica (billing code 99205) The claim needs to be submitted to Premera for processing	6/11/2024	$401.00	$0.00	$0.00	$0.00
	TOTALS:	$401.00	$0.00	$0.00	$0.00

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: July 22, 2024

Member number: [redacted]

Claim number: [redacted]

Name: [redacted]

Provider: Amy Padgett LCSW
2222 STONEHENGE LN
LEWISVILLE, TX 75056

Your request was denied

We've denied the payment of medical services/items or Part B drug listed below requested by you or your provider:

Claim Line	Date of Service	Type of Service	Charge	Denial Code
2	04/04/2024	Preparation of report of patients psychiatric status (90889)	$33.33	fd8
3	04/04/2024	Assessment of emotional or behavioral problems (96127)	$33.33	fd8

Why did we deny your request?

We denied the payment of medical services/items or Part B drug listed above because:

Denial Code	Denial Explanation
fd8	Reimbursement for this service is included in the allowed amount ofanother procedure.

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 to review our decision by asking us for an appeal.

Regence MedAdvantage Appeal: Ask Regence MedAdvantage 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" 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 (888) 319-8904 to learn how to name your representative. TTY users call 711. Both you and 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.

Regence

Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

MEDICARE ADVANTAGE MEMBER REIMBURSEMENT FORM

Thank you for choosing Regence for your health care coverage.

To submit a claim online, go to the "Member Dashboard / Claims" section and select the yellow "Submit a Claim" button.

For services abroad please utilize the International Claim Form located at www.bcbsglobalcore.com.

To mail your claim, please review the filing instructions located at the end of this form before you begin for helpful information regarding how to complete your claim so that it will process quickly and accurately.

Contact customer service using the toll-free number on your Regence Member Identification card if you have any questions, or communicate with the Live Help team on regence.com for on-line assistance. We are happy to serve you.

MEMBER INFORMATION

[redacted]

Does the patient have coverage from any other health plan?

☑ No. Please skip to Claim Details.

☐ Yes. Please attach the Explanation of Benefits (EOB) statement from the primary plan with this claim, and complete the following information.

Name of Other Health Plan	ID Number / Policy Number of Other Health Plan	Telephone Number of Other Health Plan

CLAIM DETAILS

Name of Provider	Address where services were rendered	Date(s) of Service (mm/dd/yyyy)
Behavior Health Spec.	unk	4/6/24

Diagnosis (describe illness and symptoms requiring treatment): N/A - no illness

Total Charges: $ 100.00

Briefly describe the service(s) you received:

Mental Health Assessment for Spinal cord stimulator

Have the charges been paid in full?

☐ No. ☑ Yes.

In what setting were these services performed?

☐ Inpatient Hospital ☐ Outpatient Hospital ☐ Office/Clinic ☐ Surgery Center ☐ Skilled Nursing Facility

☑ Home ☐ Other_____

If applicable, list the contact information of the physician that prescribed/ordered these services:

Name	Address	Telephone Number
See Above		877-583-5633

INTERNATIONAL SERVICES

Is this claim for expenses incurred outside the U.S.A.?

☑ No. Please skip to Accident/Injury.

☐ Yes. Please refer to instructions above for submitting an International Claim.

ACCIDENT / INJURY		
Is this claim due to an accidental injury? ☑ No. Please skip to Signature. ☐ Yes. Please complete this section.	Date of accident (mm/dd/yyyy)	Where did the accident occur? ☐ Home ☐ Work ☐ School ☐ Auto ☐ Other
How did the accident happen?		
Description of injury:		
Please Note: If there is another party that may be responsible to pay for these services, such as homeowner's or auto insurance, please finish submitting your claim then contact an agent in our Other Party Liability department at 877-633-7877 to assist you further.		

SIGNATURE		
To be accepted, this form must be fully completed (as appropriate to the claim being submitted) signed, and have an itemized bill attached.		
Patient Signature (or legal guardian if patient cannot legally [redacted]	Relationship to Patient ☑ Self ☐ Other	Date (mm/dd/yyyy) 4/10/24
[redacted]se, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.		

I certify that the above statements are correct and hereby authorize any physician, hospital, employer, union, insurance company, or prepayment organization to supply my employer and its agents any information required in connection with this claim. A photocopy of this authorization shall be as valid as the original.

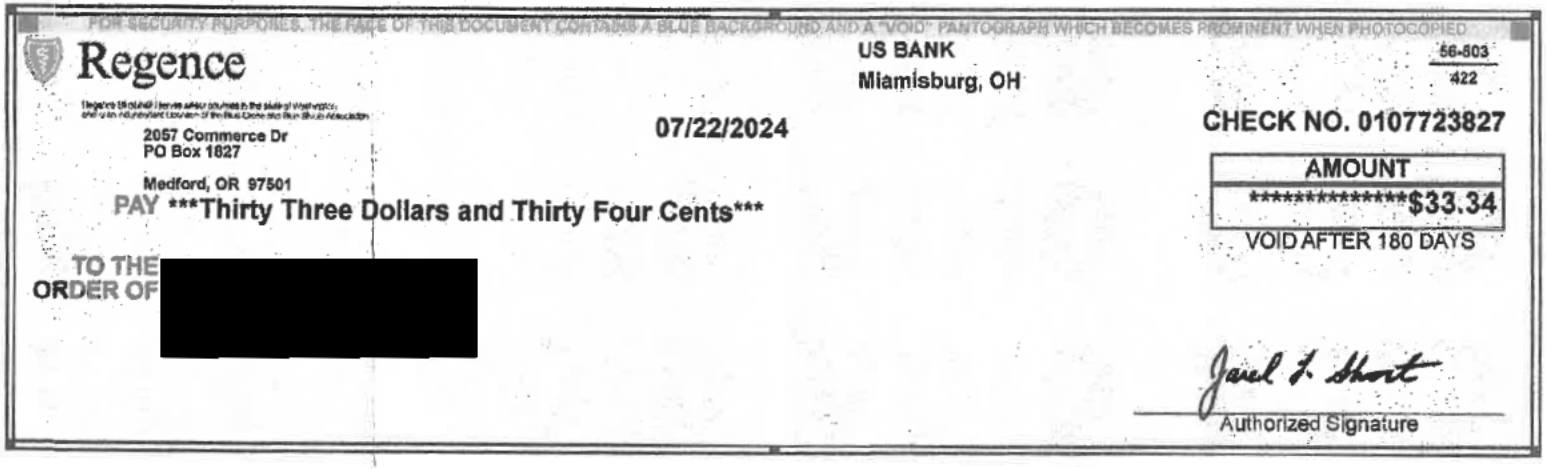
[redacted] 4/10/24
Date

Thank you for choosing Regence as your health plan administrator. We recommend that you make copies of everything that is submitted for your personal records.

Mail medical receipts to:
Regence BlueCross BlueShield of Utah
PO Box 1827
Medford, OR 97501

Mail Pharmacy receipts to:
Regence MedAdvantage
PO Box 20970
Lehigh Valley, PA 18002-0970

* Note: This provider refused to bill my insurance.



FOR SECURITY PURPOSES, THE FACE OF THIS DOCUMENT CONTAINS A BLUE BACKGROUND AND A "VOID" PANTOGRAPH WHICH BECOMES PROMINENT WHEN PHOTOCOPIED

Regence

Regence BLUESHIELD | Serves select counties in the state of Washington and certain Independent Licensees of the Blue Cross and Blue Shield Association

2057 Commerce Dr
PO Box 1827

Medford, OR 97501

US BANK
Miamisburg, OH

56-503
422

07/22/2024

CHECK NO. 0107723827

AMOUNT
**********$33.34

VOID AFTER 180 DAYS

PAY ***Thirty Three Dollars and Thirty Four Cents***

TO THE ORDER OF [redacted]

Jael L. Short
Authorized Signature

⑈0107723827⑈ ⑆042205038⑆ 130109175211⑈

Ideal Dentistry

To: Director of Benefits

From: Bradley Rowe, DDS

Date: July 22, 2024

RE: [redacted]

Primarily, [redacted] presented 07/17/24 with a report that during a meal approximately three weeks ago he bit down on a piece of walnut shell that was accidentally in his food. This incident caused his lower right first molar to become instantly painful to biting and has remained generally sensitive and achy. At this time we suspect the impact may have caused either a root fracture or at least some localized bruising of the periodontal ligament. This situation may self-resolve confirming bruising, but unfortunately the tooth may require further treatment. We will monitor the situation and present relevant information as it is necessary.

Secondarily, he has mild generalized chronic periodontitis which was diagnosed 02/08/23. Unless he has biannual periodontal maintenance visits from this point onward (which include a periodontal maintenance cleaning, a periodic examination and bitewing and periapical radiographs), it is likely that his condition will decline and he will risk losing function with the loss of teeth. The purpose of these efforts is to monitor bone levels, prevent tissue and attachment loss.

An estimate for the periodontal maintenance visits for the next 12 months will be listed and included with this letter. Thank you for your considerations.

Bradley E. Rowe, DDS

Phone: 509.737.8700 Fax: 509.737.1133
1408 Louisiana Street, Suite 101 Kennewick, WA 99336
idealdentistry.biz

Ideal Dentistry

1408 N Louisiana St
Ste 101
Kennewick, WA 99336
(509)737-8700

July 17, 2024

[redacted]

ID: 4654

Account Aging	
Current:	$240.87
30 Days:	$0.00
60 Days:	$0.00
90 Days:	$0.00
Contract:	$0.00
Balance Due:	$240.87
Estimated Insurance:	$0.00
Balance Due Now:	**$240.87**

Date	Patient	Provider	Transaction	Tth	Surface	Fee
7/17/2024	Douglas		Credit Adj - 7% senior discount for ($18.13)			
	Douglas	Bradley Rowe, DDS	D0140 - LIMITED ORAL EVALUATION-PROBLEM FOCUSED (Standard Fee $167.00) (Adjust $0.00) (Fee $167.00)			$167.00
	Douglas	Delicia Olsen, RDH	D0220 - INTRAORAL-PERIAPICAL FIRST FILM (Standard Fee $46.00) (Adjust $0.00) (Fee $46.00)			$46.00
	Douglas	Delicia Olsen, RDH	D0230 - INTRAORAL-PERIAPICAL-EACH ADDITIONAL FIL (Standard Fee $46.00) (Adjust $0.00) (Fee $46.00)			$46.00

SubTotal:	$259.00
Tax:	$0.00
Charge(s):	$259.00
- Adjustment(s):	$18.13
Balance Due:	$240.87

Contract Balance	Estimated Insurance	Previous Balance	Charge(s)	Payment(s)	Adjustment(s)	Balance Due Now
$0.00	$0.00	$0.00	$259.00	$0.00	($18.13)	**$240.87**

Future Family Appointments:

Patient:	Next Appointment:	Patient:	Next Appointment:	Patient:	Next Appointment:
[redacted]	1/21/2025@ 8:00am				

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