Fire Pension Board Meeting Agenda

October 15, 2025, 9:30 a.m. via Microsoft Teams

1.) Approval of minutes for August 20, 2025

2.) Bills and Pension Rolls:

PENSION ROLL		
Budgeted Amount	$709,000.00	
July 2025	$55,823.93	
Remaining budget	**$284,689.07**	**40.15%**
MEDICAL CLAIMS		
Budgeted amount	$1,946,000.00	
July 2025	$227,839.08	
July 2025 HMA fees	$11,356.35	
Remaining budget	**$753,651.65**	**38.73%**
PENSION ROLL		
Budgeted Amount	$709,000.00	
August 2025	$55,998.53	
Remaining budget	**$228,690.54**	**32.26%**
MEDICAL CLAIMS		
Budgeted amount	$1,946,000.00	
August 2025	$75,578.36	
August 2025 HMA fees	$12,775.95	
Remaining budget	**$665,297.34**	**34.19%**

3.) Action Item:

Member #85	Request for reimbursement of $439.17 for incontinence supplies.
Member # 71	Request for reimbursement of $1162.50 for dental work (remove and repair implant) as dental limit is exceeded and denied by HMA.
Member #137	Request for preapproval for stem cell injections (not covered by Medicare or HMA) for 1 to 4 times per month for 12 visits in the amount of $3800.

Fire Pension Board Minutes
City Of Everett
August 20, 2025

DRAFT

The regular meeting of the Fire Pension Board was called to order at 9:30 a.m. on August 20, 2025. Board Members Neyens, Schwab, Jorve and alternate Oas were present. Board Member Franklin and Vitalich were excused. Chelsi Bardwell, Human Resources; David Hall, Board Attorney; and Rick Gray, Finance were also present.

APPROVAL OF MINUTES

The minutes of the meeting of July 21, 2025, were approved.

BILLS AND PENSION ROLLS

PENSION ROLL		
Budgeted Amount	$709,000.00	
June 2025	$57,624.67	
Remaining budget	**$340,513.00**	**48.03%**
MEDICAL CLAIMS		
Budgeted amount	$1,946,000.00	
June 2025	$85,093.53	
June 2025 HMA fees	$14,905.35	
Remaining budget	**$992,847.08**	**51.02%**

Moved by Neyens, seconded by Oas, to approve the pension roll claims as presented.

Roll was called with all members voting yes, except Board Members Franklin and Vitalich who were excused.

Motion carried.

Moved by Neyens, seconded by Oas, to approve the medical claims as presented.

Roll was called with all members voting yes, except Board Members Franklin and Vitalich who were excused.

Motion carried.

DRAFT

ACTION ITEM

Member #101	Request for reimbursement of $158 (at $79 per month) for anti-fungal compound nail lacquer and a request to pre-approve the same anti-fungal at $79 per month for up to one year (or estimated $790 for an additional 10 months).

Moved by Neyens, seconded by Oas, to approve the request for reimbursement of $158 and pre-approve the same anti-fungal for up to one year (or estimated $790).

Roll was called with all members voting yes, except Board Members Franklin and Vitalich who were excused.

Motion carried.

The Board meeting adjourned at 9:35 a.m.

_____
Marista Jorve, Board Secretary

EVERETT
WASHINGTON

City of Everett
Police and Fire Pension Boards

Request to the Board

To be completed by LEOFF 1 member (or family) for submittal to the board.

Member Name [redacted] _____ *(please print)*

1. Diagnosis: __chronic incontinence_____

2. Prognosis: _chronic and incurable_____

3. Type of Treatment(s) or Procedure: __incontinence supplies_____

4. Cost of treatments/service: $ ___439.17_____

5. Request to the board for this specific treatment or procedure:

   Reimbursement request for incontinence supplies (briefs, barrier cream, wipes, and chucks pads in the amount of $439.17_____

   (Examples can be found at everettwa.gov/pensionboards)

Return to:
City of Everett
Police and Fire Pension Boards
2930 Wetmore Ave, Ste 1-A
Everett, WA 98201
Leoff1@everettwa.gov

[redacted]

* Final Report *

Intermountain Healthcare
Healing for Life

September 09, 2025

Re: [redacted]

To whom it may concern,

[redacted] requires incontinence supplies for his incontinence issues.

Respectfully,

DOUGLAS ROMNEY, MD

181 E Medical Tower Dr
Murray, UT 84107
(801)314-4300
(801)314-4300

Order Summary

Order placed August 29, 2025 Order # 111-8603968-5676208

Ship to

[redacted]

Payment method

Visa ending in [redacted]

View related transactions

Order Summary

Item(s) Subtotal:	$327.54
Shipping & Handling:	$0.00
Subscribe & Save:	-$49.13
Total before tax:	$278.41
Estimated tax to be collected:	$21.30
Grand Total:	**$299.71**
FSA or HSA eligible: (inc. tax and shipping)	$299.71

Delivered September 3

Depend Fresh Protection Adult Incontinence Underwear for Men, Disposable, Maximum, Extra-Large, Grey, 68 Count (2 Packs of 34), Packaging May Vary

Sold by: Amazon.com

Supplied by: Other

Return or replace items: Eligible through October 3, 2025

$54.59

Auto-delivered: Every 1 month

Delivered September 3

Depend Fresh Protection Adult Incontinence Underwear for Men, Disposable, Maximum, Extra-Large, Grey, 68 Count (2 Packs of 34), Packaging May Vary

Sold by: Amazon.com

Supplied by: Other

Return or replace items: Eligible through October 3, 2025

$54.59

Auto-delivered: Every 1 month

Order Summary

Order placed September 16, 2025 Order # 113-8718498-8368251

Ship to

[redacted]

Payment method

Visa ending in [redacted]

View related transactions

Order Summary

Item(s) Subtotal:	$39.97
Shipping & Handling:	$0.00
Subscribe & Save:	-$4.00
Subscribe & Save:	-$2.00
Total before tax:	$33.97
Estimated tax to be collected:	$2.75
Grand Total:	**$36.72**
FSA or HSA eligible: (inc. tax and shipping)	$36.72

Arriving October 1

50 Pack Incontinence Bed Pads Disposable for Adults 125 Gram - 3XL 36" x 36" Super Absorbent Waterproof Bed Liner, Pee Pads for Adults - Chucks Pads

Sold by: All Sett Health

Supplied by: Other

$39.97

Auto-delivered: Every 2 months

Order Summary

Order placed September 19, 2025 Order # 113-7388173-0430668

Ship to

[redacted]

Payment method

Visa ending in [redacted]

View related transactions

Order Summary

Item(s) Subtotal:	$43.50
Shipping & Handling:	$0.00
Subscribe & Save:	-$2.18
Subscribe & Save:	-$2.18
Total before tax:	$39.14
Estimated tax to be collected:	$3.16
Grand Total:	**$42.30**

Arriving October 1

Calmoseptine Ointment Tube to Heal Skin Irritations - 4 Oz (Pack of 5)

Sold by: eSaving Shop

Supplied by: Other

$43.50

Auto-delivered: Every 3 months

Order Summary

Order placed September 24, 2025 Order # 111-4927458-8637010

Ship to

[redacted]

Payment method

Visa ending in [redacted]

View related transactions

Order Summary

Item(s) Subtotal:	$62.38
Shipping & Handling:	$0.00
Subscribe & Save:	-$6.24
Total before tax:	$56.14
Estimated tax to be collected:	$4.30
Grand Total:	**$60.44**

Arriving October 1

2

FitRight Aloe Personal Cleansing Cloth Wipes, Scented, 8 x 10 inch Adult Large Incontinence Wipes, 68 count, pack of 12

Sold by: Amazon.com

Supplied by: Other

$31.19

Auto-delivered: Every 1 month

From: [redacted]
Subject: Pension
Date: Jul 9, 2025 at 3:06:56 PM
To: [redacted]

https://www.everettwa.gov/DocumentCenter/View/37933/Request-to-the-Pension-Board-Form?bidId=

EVERETT
WASHINGTON

City of Everett
Police and Fire Pension Boards

Request to the Board

To be completed by LEOFF 1 member (or family) for submittal to the board.

Member Name [redacted]
(please print)

1. Diagnosis: Remove implant & Repair & Dentalwork
2. Prognosis: _____
3. Type of Treatment(s) or Procedure: see attached sheet from Dr Wagner
4. Cost of treatments/service: $ 1162.50
5. Request to the board for this specific treatment or procedure:

_____
_____
_____
_____

(Examples can be found at everettwa.gov/pensionboards)

Return to:
City of Everett
Police and Fire Pension Boards
2930 Wetmore Ave, Ste 1-A
Everett, WA 98201
Leoff1@everettwa.gov

12 August 2025

[redacted]

Board Members,

Find enclosed some dental work copies and charges we paid that HMA denied. But just in case I didn't understand the explanation of said dental coverage for this year, as explained to us, I am submitting the aforementioned paperwork for your consideration.

[redacted]

EVERETT
WASHINGTON

City of Everett
Fire & Police Pension
2930 Wetmore EVERETT,
WA 98201
(425) 257-7024

CLAIM FORM

PENSION BOARD APPROVAL:
I certify that the named patient is authorized to receive the described medical care at the expense of the City of Everett Uniformed Personnel Pension Fund. Payment is approved by board action this date. I am authorized to authenticate and certify said claim.

City Clerk or Secretary of Board _____ Date _____

TO BE COMPLETED BY EMPLOYEE

EM[redacted]	☐ ACTIVE ☒ RETIRED	DATE OF BIRTH [redacted]	TELEPHONE NO. [redacted]	☐ POLICE ☒ FIRE
[redacted]			SOCIAL SECURITY NO. [redacted]	☒ MALE ☐ FEMALE

THIS SPACE FOR OFFICE USE ONLY

ACCOUNT NUMBER	VOUCHER NO.	VENDOR NO.	DESCRIPTION	AMOUNT
☐ 6375380000250 ☐ 6385380000250			☐ MED SERV ☐ RX ☐ CHIRO SERV ☐ REIMB ☐ OTHER	

I certify that the information and charges here shown are true and correct, and that these services and/or medications were received by me and that I am liable for these charges. I hereby authorize all doctors, pharmacists, hospitals or other instiutions rendering care and treatment to furnish the Fire/Police Pension Board with full information regarding treatment rendered (including copies of their records). I also authorize any Union, Trust Fund, Employer or Insurance Carrier to furnish the Fire/Police Pension Board with information regarding benefits to which I may be entitled. A photostatic copy of this authorization shall be considered as effective and valid as the original. I hereby assign benefit to the supplier/vendor below.

DATE _____ EMPLOYEE'S SIGNATURE ➢ _____

STATEMENT OF ATTENDING PHYSICIAN OR OTHER SUPPLIER/VENDOR CHARGES

DIAGNOSIS AND CONCURRENT CONDITIONS
(IF DIAGNOSIS CODE OTHER THAN ICDA USED, GIVE NAME)

REPORT OF SERVICES (IF PREVIOUS FORM SUBMITTED TO THIS CARRIER, YOU NEED SHOW ONLY DATES AND SERVICES SINCE LAST REPORT)

DATE OF SERVICES	PLACE OF SERVICES	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODE IF USED (IF CODE OTHER THAN CPT ★★ USED, GIVE NAME	CHARGES
6-2-25	Ivinsut	Restoeative Dental	↓	
6-16-25	Ivins, UT	"		
		ItmA Denied - With	discount	
		We payed	$ 1162.50	

DO NOT WRITE IN THIS SPACE

DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION

TOTAL CHARGES $ _____

TOTAL PAYMENTS $ 1162.50

DATE SUPPLIER/VENDOR NAME (PRINT) SIGNATURE TELEPHONE

STREET ADDRESS CITY OR TOWN STATE OR PROVIDENCE ZIP CODE

514-409 (REV. 6/06)

PENSION BOARD

WAGNER DENTAL-IVINS
272 E CENTER ST
IVINS, UT 84738

07/15/2025 10:22:58

CREDIT CARD

VISA SALE

Card #	XXXXXXXXXXX4034
Chip Card:	VISA CREDIT
AID:	A0000000031010
SEQ #:	2
Batch #:	963
INVOICE	2
Approval Code:	66532D
Entry Method:	Chip Read
Mode:	Issuer

SALE AMOUNT $1162.50

CUSTOMER COPY

Wagner Dental Ivins
272 E Center St
Ste 205
Ivins, UT 84738
(435)652-8111

STATEMENT

09/30/2025
Account Number 7693

Amount Due	Date Due	Amount Enclosed
1305.25	Upon Receipt	

[redacted]

CREDIT CARD TYPE _____

_____

3 DIGIT CSV _____

EXPIRES _____

AMOUNT APPROVED _____

NAME _____

SIGNATURE _____

Total:	$1,305.25
-Ins Estimate:	$0.00
=Balance:	**$1,305.25**

0-30	31-60	61-90	over 90
1305.25	0.00	0.00	0.00

Date	Patient	Code	Tooth	Description	Charges	Credits	Balance
				Balance Forward			0.00
06/02/2025	[redacted]	D2799	20	interim crown - further treatment or completion of diagnosis necessary prior to final impression	200.00		200.00
06/02/2025		D2950	20	core buildup, including any pins when required	250.00		450.00
06/02/2025		Adjust		Cash Discount		10.00	440.00
06/02/2025		Adjust		Cash Discount		12.50	427.50
06/02/2025		Claim		Pri Claim $450.00 HMA Received 07/14/2025 NO PAYMENT			
06/16/2025		D7953		bone replacement graft for ridge preservation - per site	450.00		877.50
06/16/2025		D7210	29	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	300.00		1,177.50
06/16/2025		Adjust		Discount		15.00	1,162.50
06/16/2025		Claim		Pri Claim $750.00 HMA Received 07/14/2025 NO PAYMENT			
06/17/2025		D0001		Follow-Up (unsent)	0.00		1,162.50
07/15/2025		Pay		Credit Card $1,162.50		1,162.50	0.00

THIS IS NOT A BILL

[DR-]

DETAILED CLAIM BREAKDOWN FOR [redacted]

Provider: KIRK GRANT WATKINS MD
Claim #: 8630980901

[redacted]

	Plan Paid:	**$20.56**	Amount You May Owe: $0.00

DETAILED CLAIM BREAKDOWN FOR [redacted]

Provider: MICHAEL WAGNER DMD
Claim #: 8651878801

Date & Type of Service	Amount Billed	Member Discount	Amount Not Covered	Reason Code	Amount Covered	Other Insurance Paid	Paid At	What Your Plan Paid	Deductible Amount	Co-Insurance Amount	Co-pay Amount
							Paid		**Patient Responsibility**		
06/02-06/02/2025 DENTAL MAJOR	$250.00	$0.00	$250.00	DX	$0.00	$0.00	100%	$0.00	$0.00	$0.00	$0.00
06/02-06/02/2025 DENTAL MAJOR	$200.00	$0.00	$200.00	SQ	$0.00	$0.00	100%	$0.00	$0.00	$0.00	$0.00
TOTALS	**$450.00**	**$0.00**	**$450.00**		**$0.00**	**$0.00**			**$0.00**	**$0.00**	**$0.00**

COB Credit:	**$0.00**		
Adjustments:	**$0.00**		
Plan Paid:	**$0.00**	Amount You May Owe:	$450.00

THIS IS NOT A BILL

DETAILED CLAIM BREAKDOWN FOR [redacted]

Provider: STEVEN T HARMON DO
Claim #: [redacted]

[redacted]

DETAILED CLAIM BREAKDOWN FOR [redacted]

Provider: MICHAEL WAGNER DMD
Claim #: 8652103201

Date & Type of Service	Amount Billed	Member Discount	Amount Not Covered	Reason Code	Amount Covered	Other Insurance Paid	Paid		Patient Responsibility		
							Paid At	What Your Plan Paid	Deductible Amount	Co-Insurance Amount	Co-pay Amount
06/16-06/16/2025 DENTAL RESTORATIVE	$300.00	$0.00	$300.00	DX	$0.00	$0.00	100%	$0.00	$0.00	$0.00	$0.00
06/16-06/16/2025 DENTAL RESTORATIVE	$450.00	$0.00	$450.00	DX	$0.00	$0.00	100%	$0.00	$0.00	$0.00	$0.00
TOTALS	**$750.00**	**$0.00**	**$750.00**		**$0.00**	**$0.00**			**$0.00**	**$0.00**	**$0.00**
							COB Credit:	**$0.00**			
							Adjustments:	**$0.00**			
							Plan Paid:	**$0.00**	Amount You May Owe:		$750.00

Reason Code/Description	
CX	CHARGE REDUCED TO THE MEDICARE ALLOWANCE, THE PATIENT IS NOT RESPONSIBLE FOR THIS AMOUNT.
DX	THE DENTAL MAXIMUM BENEFIT HAS BEEN MET.
SQ	DENTAL PLAN REQUIRES BOTH THE PREP AND SEAT DATE. ONCE RECEIVED CLAIM WILL BE RE-CONSIDERED. _____

other side also

EVERETT
WASHINGTON

City of Everett
Police and Fire Pension Boards

Request to the Board

To be completed by LEOFF 1 member (or family) for submittal to the board.

Member Name [redacted]
(please print)

1. Diagnosis: osteoarthritis

2. Prognosis: 1 to 4 times per month for 12 visits. Treatment can range from 3 to 12 months.

3. Type of Treatment(s) or Procedure: Stem Cell Injections

4. Cost of treatments/service: $ _____

5. Request to the board for this specific treatment or procedure:

Fire #137 member is requesting board approval for Stem Cell Injections. This is not covered by Medicare nor HMA.

(Examples can be found at everettwa.gov/pensionboards)

Return to:
City of Everett
Police and Fire Pension Boards
2930 Wetmore Ave, Ste 1-A
Everett, WA 98201
Leoff1@everettwa.gov

EVERETT
WASHINGTON

City of Everett
Fire & Police Pension
2930 Wetmore EVERETT,
WA 98201
(425) 257-7024

CLAIM FORM

PENSION BOARD APPROVAL:
I certify that the named patient is authorized to receive the described medical care at the expense of the City of Everett Uniformed Personnel Pension Fund. Payment is approved by board action this date. I am authorized to authenticate and certify said claim.

City Clerk or Secretary of Board _____ Date _____

TO BE COMPLETED BY EMPLOYEE

EMPLOYEE'S NAME [redacted]

☐ ACTIVE ☒ RETIRED

[redacted]

TELEPHONE NO. [redacted]

SOCIAL SECURITY NO. [redacted]

☐ POLICE ☒ FIRE

☒ MALE ☐ FEMALE

THIS SPACE FOR OFFICE USE ONLY

ACCOUNT NUMBER	VOUCHER NO.	VENDOR NO.	DESCRIPTION	AMOUNT
☐ 6375380000250 ☐ 6385380000250			☐ MED SERV ☐ RX ☐ CHIRO SERV ☐ REIMB ☐ OTHER	

I certify that the information and charges here shown are true and correct, and that these services and/or medications were received by me and that I am liable for these charges. I hereby authorize all doctors, pharmacists, hospitals or other instiutions rendering care and treatment to furnish the Fire/Police Pension Board with full information regarding treatment rendered (including copies of their records). I also authorize any Union, Trust Fund, Employer or Insurance Carrier to furnish the Fire/Police Pension Board with information regarding benefits to which I may be entitled. A photostatic copy of this authorization shall be considered as effective and valid as the original. I hereby assign benefit to the supplier/vendor below.

DATE 9-1-25 EMPLOYEE'S SIGNATURE [redacted]

STATEMENT OF ATTENDING PHYSICIAN OR OTHER SUPPLIER/VENDOR CHARGES

DIAGNOSIS AND CONCURRENT CONDITIONS
(IF DIAGNOSIS CODE OTHER THAN ICDA USED, GIVE NAME)

REPORT OF SERVICES (IF PREVIOUS FORM SUBMITTED TO THIS CARRIER, YOU NEED SHOW ONLY DATES AND SERVICES SINCE LAST REPORT)

DATE OF SERVICES	PLACE OF SERVICES	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODE IF USED (IF CODE OTHER THAN CPT ★★ USED, GIVE NAME	CHARGES
3.27.25		LETTER INCLUDED		

DO NOT WRITE IN THIS SPACE

DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION
JUNE 2025

TOTAL CHARGES $ 3800.

TOTAL PAYMENTS $ _____

DATE 8-11-25 SUPPLIER/VENDOR NAME (PRINT) OLYMPIC SPINE & SPORTS THERAPY SIGNATURE TELEPHONE

STREET ADDRESS 6603 220TH ST. SW CITY OR TOWN MOUNTLAKE TERRACE STATE OR PROVIDENCE WA ZIP CODE 98043-2186

514-409 (REV. 6/06) SUITE 102

PENSION BOARD

Outlook

[Draft] **Approval for stem cell treatment**

From [redacted]
Draft saved Sun 9/21/2025 12:04 PM
Cc [redacted]

Hello Rick

On March 27, 2025 I had an Xray on my right hip due to pain. Xrays showed osteoarthritis. Private care doctor sent me to Everett Bone and Joint. They sent me to
Proliance for cortisone injection That injection did not help. EBJ said the next step is a hip replacement.

My age, [redacted] questions that procedure..

I called my Doctor Melissa Stanley and was instructed to check out Sound Pain Solutions in Edmonds, and other Physical Therapy. I am using
SPS and Engineered Sports Therapy in Everett. SPS recommended stem cell injections., at a cost of $3800.00.

I spoke to Dave Neyens, EFD Retired, and he suggested I get Board approval.

I have been retired since 1997 and have used very little draw from the Pension fund. I even use $3 readers instead of my allowance permitted.

Thank you for your consideration.

[redacted]
EFD Retired

Providence Internal Medicine North Everett
1330 ROCKEFELLER AVE STE 210
EVERETT WA 98201-1676
Phone: 425-261-4940
Fax: 425-259-8600

Providence

March 31, 2025

[redacted]

Dear [redacted]

This is to follow up with you on your recent diagnostic tests. Here are your hip xray results. You do have moderate right and mild left hip osteoarthritis. Follow up with the orthopedist as we discussed.

Resulted Orders
XR Hip Right 2 - 3 Vw

Narrative
EXAM:
RIGHT HIP RADIOGRAPHY

EXAM DATE: 3/27/2025 12:12 PM

CLINICAL HISTORY: Right hip pain, concern for osteoarthritis ICD-10-CM - M25.551 Pain in right hip.

COMPARISON: None.

TECHNIQUE: 2 views.

Impression
FINDINGS/IMPRESSION:
No acute fracture or malalignment. Moderate right and mild left hip degenerative change.

RADIA

Dictated By: Bang, Dae Hee MD 2025-03-30 06:57:59.683
Signed By: Bang, Dae Hee MD 2025-03-30 06:59:00.0
Transcribed By: Bang, Dae Hee 2025-03-30 06:59:00.937

SITE ID: 200
Patients are advised to discuss imaging findings and recommendations with the ordering provider.

If you have questions or concerns, please don't hesitate to contact me.

Sincerely,

Providence
Medical Group

6/24/25

[redacted]

The information below provides further details of your recent referral.
This referral has been electronically signed by Melissa E. Stanley

REFERRAL PRIORITY: Routine

Patient Information	
Name	[redacted]
DOB	
Legal Sex	
Address	
Phone #	
Payor/Plan	
Referred To	
Provider/Location	Sound Pain Solutions - Edmonds 6603 220TH ST SW STE 102 MOUNTLAKE TERRANCE WA 98043-2186 206-508-4463
Specialty	Pain Medicine
Referred By	
Department	Providence Internal Medicine North Everett
Provider	Melissa E. Stanley
Address	1330 ROCKEFELLER AVE STE 210 Everett WA 98201-1676
Phone	425-261-4940
Additional Information	
Diagnoses: M25.551 (ICD-10-CM) - 719.45 (ICD-9-CM) - Right hip pain	
Referral Status Auth Number (if applicable)	Approved - No Authorization Required
Number of Visits	6
Service Dates	06/19/2025-06/19/2026

This is not a guarantee of payment. This is a referral for specialty care. All claims will be

Melissa E Stanley, ARNP

Olympic Spine and Sports Therapy
6603 220th St. SW Suite 102
Mountlake Terrace, WA 98043-2186
Phone: (425) 774-2411
Fax: (425) 672-7065

Patient: [redacted] **Acct #:** [redacted] **DOB:** 0[redacted]
Ins Co: **WA MEDICARE-NORIDIAN** **Pol #:** **NONE** [redacted]

Date **07/29/2025**

Provider: **Mark Shelley, DC, DACNB**

Subjective:
(Per 1997 Evaluation & Management Guidelines)

Patient History:

CC: [redacted] Male who presented on 7/29/2025 for a new patient evaluation for the symptoms listed below.

History of Present Illness:

Symptom #1: Right Hip Pain	Severity (0-10, 10=worst): **5/10**
Symptom #2: Low Back Pain	Severity (0-10, 10=worst): **5/10**
Symptom #3: Right Anterior Lateral Thigh Pain	Severity (0-10, 10=worst): **5/10**

Onset: **3 months ago**
How often do you have this pain? **Daily**
Is it constant or does it come and go? **constant**
Is condition getting progressively worse? **No**
Does the pain radiate ("shooting down" or "shooting up")? **Yes - down right leg**
Quality: **Achy and Stiffness**
What makes your condition worse? **Bending**
What makes your condition better? **Rest and Heat**
What time of day are symptoms worse? **no difference**
What time of day are symptoms better? **no difference**
Is there any known cause of your symptoms? **"old age"**
Is there any color change or temperature change to the skin? **No**
When your symptoms are at worst, describe what happens: **Weakness in right leg**
Have you experienced symptoms like these before? **No**
Have you missed any work due to this condition? **No - retired**
Have you had to modify or restrict your activities at work? **No - retired**

Past Medical, Family & Social History:
Avg sleep per night: **8 hours**
How often do you wake up at night? **1** times
Are you awakened due to pain? times
Smoking: **Never**
Caffeine drinks: **1 cup per day**
Alcohol: **2 cups per day**
Exercise: **4 times per week** *(type:* yardwork)
Stress Level: **2** *(0=no stress, 10=max stress)*

Olympic Spine and Sports Therapy
6603 220th St. SW Suite 102
Mountlake Terrace, WA 98043-2186
Phone: (425) 774-2411
Fax: (425) 672-7065

Previous Accidents/Injuries: None Listed
Previous Hospitalizations: December 1956 - Strep Throat Hospitalization
Previous Surgeries: None Listed

Review of Systems:
Current Medical Conditions: None Listed
Musculoskeletal: Low Back Pain and Hip Pain
Past Medical history: Osteoarthritis in the right hip

Past Medical History:

Medications: **None Listed**
Supplements: **None Listed**
Allergies: **No**
On Blood thinners?: **No**

Family History: Pancreatic Cancer - Brother

Objective:
GENERAL APPEARANCE: [redacted] Male presents appearing well developed, well nourished and in no acute distress.

VITALS: ***Height:*** **5' 11"** ***Weight:*** **175** LBS
BP: **155/72** ***PR:*** **78** BPM

CONSTITUTIONAL: Patient denies recent fever and unexpected weight loss.

NEUROLOGICAL / PSYCHIATRIC:
Patient is oriented to time, place, person and situation.
Mood is neutral. Affect is appropriate.
Sensation: see sensation testing under appropriate extremities.
Muscle Stretch Reflexes: see reflex testing below under appropriate extremities.

MUSCULOSKELETAL:
Gait was evaluated by watching the patient walk 10+ feet and was noted to be **uneven with a decreased right stance phase**.
Station was noted as **wide**.
Assistive Device Used: **None**.
RIGHT UPPER EXTREMITY:

Inspection: No masses or effusions.
Pathological Reflexes: Hoffman's test - **Normal**.

LEFT UPPER EXTREMITY:
Inspection: No masses or effusions.
Pathological Reflexes: Hoffman's test - **Normal**

RIGHT LOWER EXTREMITY:
Inspection: No masses or effusions
Strength Testing:

Ankle DF:	4.5/5	Ankle PF:	5/5
Foot Inv:	5/5	Foot Ev:	5/5
EHL:	4.25/5	EDL:	4.25/5
FD:	5/5	QP:	5/5

Reflexes: *Pat:* 1+/2+ *Achilles:* 0/2+
Sensory: Sensation grossly intact - WNL
Pathological Reflexes: *Plantar Reflex* - **Normal**
Ankle Clonus - **Normal**
Withdrawal Reflex - **Normal**

Pain with Digital Pressure & Hypertonicity: Psoas, Tensor Fascia Latae, Gluteus Maximus, Gluteus Medius, Rectus Femoris and Vastus Lateralis
Location of Pain:
Specific Motor Impairment
Decreased strength was noted in the following muscles based on a specific muscle strength assessment: Psoas, Tensor Fascia Latae, Gluteus Maximus and Gluteus Medius
Range Of Motion:

- Hip Extension decreased
- Hip Internal/Medial Rotation decreased
- Hip External/Lateral Rotation decreased

LEFT LOWER EXTREMITY:
Inspection: No masses or effusions
Strength Testing:

Ankle DF:	5/5	Ankle PF:	5/5
Foot Inv:	5/5	Foot Ev:	5/5
EHL:	5/5	EDL:	5/5
FD:	5/5	QP:	5/5

Reflexes: *Pat:* 1+/2+ *Achilles:* 0/2+
Pathological Reflexes: *Plantar Reflex* - **Normal**

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Ankle Clonus - **Normal**
Withdrawal Reflex - **Normal**

POSTURE:
Head translation anterior.
Thorax translation left.

PALPATION:
Pain with Digital Pressure & Hypertonicity: left thoracic paraspinals, left lumbar paraspinals, bilateral lumbosacral paraspinals, L3, L4, L5 and sacrum

SPINAL RANGE OF MOTION:
ROM was tested and measured using the Goniometer. The ROM tests are as shown below.
CERVICAL SPINE

Cervical ROM:	Flex:	**36**/65	Ext:	**19**/50
	Left Lat Flex:	**19**/40	Right Lat Flex:	**16**/40
	Left Rot:	**40**/70	Right Rot:	**29**/70

The patient reported pain with the following ranges of motion: **NONE**.
LUMBAR SPINE

Lumbar ROM:	Flex:	**92**/95	Ext:	**10**/25
	Left Lat Flex:	**20**/25	Right Lat Flex:	**22**/25
	Left Rot:	**30**/45	Right Rot:	**27**/45

The patient reported pain with the following ranges of motion: **flexion and right lateral flexion**.
Location of Pain: Right Hip.

Radiographic Findings

Cervical Spine: Examination of the **cervical spine**, utilizing views obtained in the AP, Lateral and AP Open Mouth positions revealed the following:
Moderate to severe multilevel degenerative changes were noted from C3 through C6.
A Retrolisthesis was noted at C3 on C4 and C5 on C6.
Biomechanical analysis revealed -36 degrees of cervical curve. -42 degrees is considered ideal. C2 measured 53 mm anterior translated from C7 and was translated -14 mm right from neutral relative to S1. Zero translation is considered ideal.

Thoracic Spine: Examination of the **thoracic spine**, utilizing views obtained in the AP and Lateral positions revealed the following:
Moderate to severe multilevel degenerative changes were noted from T7 through T 10.
Vertebral body compression deformities were noted from T6 through T 10.
Compression fractures noted at T9-T11.

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Biomechanical analysis revealed a 60 degree curve. 44 degrees is considered ideal. T2 was 48 mm anterior translated from T11. Zero translation is considered ideal.

Lumbar Spine: Examination of the **lumbar spine**, utilizing views obtained in the AP, Lateral, Flexion and Extension positions revealed the following:
Moderate multilevel degenerative changes were noted from L1 through L5.
A 11.6° lumbar curvature apexed at L2 was noted.

A Grade 1 Spondylolisthesis was noted at L4 on L5.
A Retrolisthesis was noted at L1 on L2.
Biomechanical analysis of the lumbar spine revealed -40 degrees of lumbar curve. -40 degrees is considered ideal. T12 translation measured 18 mm anterior translated from S1.
The sacral base angle measured 43 degrees with 40 degrees considered ideal.

Pelvis:
Mild to moderate degenerative joint disease was noted in the left hip. Moderate to severe degenerative joint disease was noted in the right hip.

Impression: The 7/29/25 radiographs and examination support the diagnosis of degenerative changes and impaired by mechanics of the spine and hips.
There was no apparent evidence of osseous or periosteal injury. Lytic and blastic changes were absent.
No contraindications to conservative physical medicine procedures were noted.

Outcome Disability Questionnaires
The Low Back Disability Questionnaire (Rev. Oswestry), Walking Limitations, Hip Disability Questionnaire and Knee Disability Questionnaire were filled out by [redacted] and scored as follows:

Diagnosis:
See end of report.

Assessment:
Based on [redacted] evaluation, I have identified the following factors that may delay his response to treatment:
- Right hip osteoarthritis moderate to severe
- Probable right L5 nerve root compression
- No improvement from cortisone injection
- Moderate degenerative changes in lumbar spine

Prognosis:

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[redacted] prognosis is guarded to fair.

Plan:

ORDER: ***Chiropractic Adjustments*** to normalize altered intersegmental motion and reduce associated muscle hypertonicity & pain.
Treatment Procedure: **98941 - Adjustments 3-4 Regions and 98943 - Extremity Adjustment**
Frequency: **2x per week.**
Duration: **6 weeks.**

ORDER: ***Myoneural Manual Medicine*** procedures in order to facilitate neuromuscular control of atrophied and/or neurologically compromised structures.
Treatment Procedure: **90901 - Trigenics Intermit**
Frequency: **2x per week.**
Duration: **6 weeks.**

ORDER: **Class II *Laser Therapy*** to activate the biophotostimulatory effect to local connective tissues in order to decrease pain, increase circulation & accelerate soft tissue repair.
Treatment Procedure: **S8942 - Fx405 Class II Laser Therapy**
Frequency: **2x per week.**
Duration: **6 weeks.**

ORDER: ***Non-Surgical Spinal Decompression*** to reduce intradiscal pressure and facilitate central migration of herniated nucleus material.
Treatment Procedure: **S9090 - Bilateral Hip Decompression**
Frequency: **2x per week.**
Duration: **6 weeks.**

ORDER: ***Physical Rehabilitative Therapy*** for the purpose of strengthening weak musculature, stretching overly tight musculature, re-establishing neuromuscular control to weakened structures.
Rehabilitative Therapy will include the following: **Flexion Intolerance Training, Floor Core Exercises and Compression, Reactivation, Stretching**.
Treatment Procedure: **97110 - PRT Therapeutic Exercise**.
Frequency: **0x/week for 1 week, 2x/week for 2 week, 1x/week for 2 weeks**
Duration: **5 weeks.**
Time: ***15 minutes.***
ORDER: *Durable Medical Equipment* and or *Medical Supplies* listed below have been prescribed in order to facilitate a home care program and encourage transition to active versus passive therapy.

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Patient: [redacted] [redacted] [redacted] [redacted]
Ins Co: WA MEDICARE-NORIDIAN **Pol #:** NONE [redacted] [redacted]

Date 07/29/2025

Provider: Mark Shelley, DC, DACNB *** continued from previous page ***

I certify that the following supplies are medically necessary for the optimal improvement of this patient's condition:

* **Stick Roller, Dual Compression Ball (PNUT), Compression Ball, Oxi-Cell (Supplement), Stabilized R-Lipoic Acid (Supplement) and D3 Supreme (Supplement)**

In addition to the following treatments, [redacted] has been referred to Jean Roberto-Don, ND for an evaluation for Soundwave therapy, Bioelectric therapy, and PRP injection.

ORDER: *Progress Examinations* will be performed at 12 visit or 6-week intervals, whichever occurs soonest.

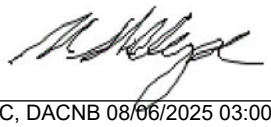
GOALS:
1) Decrease pain to a 1 out of 10 on a 0 to 10 scale.
2) Within functional limits, restore active range of motion, strength and flexibility to the affected body regions.
3) Normal gait and gait endurance.
4) Increase tolerance to activities of daily living, recreational and occupational activities without an increase in pain or functional limitations.

OUTCOME MEASURES:
We will utilize the following subjective and objective outcome assessment measures in order to assess patient progress and response to treatment:
1) Visual analog scale (VAS)
2) Revised Oswestry - Low Back Disability Questionnaire
3) Neck Disability Index

CERTIFICATION:
I certify that this Plan of Care is medically necessary in order to improve the patient's condition.

Provider: Mark Shelley, DC DACNB *NPI*: 1124105275

Electronically Signed



Mark Shelley, DC, DACNB 08/06/2025 03:00 PM

Physical Med. Treatment Plan Projections for: [redacted] Date: 7/29/2025

Treatment Recommendation	Therapy	Estimated Charge Per Session or Service	(No Print) Insurance Allowed Amount	(No Print) Expanded	Estimated Total Charges	Patient Co-pay	Patient Co-insurance	Estimated Patient Responsibility
12	Chiropractic Manipulative Treatment **3-4 Region - Medicare**	$65.00	$41.91	$502.92	$502.92	[redacted]	0%	$0.00
12	Chiropractic Extremity Adjustment	$35.00	$12.87	$154.44	$154.44		0%	$0.00
6	Physical Rehabilitation **1 unit**	$55.00	$31.05	$186.30	$186.30		0%	$0.00
1	Established Patient Progress Examination **212**	$80.00	$76.03	$76.03	$76.03		0%	$0.00
12	FX405 Laser	$110.00			$1,320.00			$1,320.00
1.5	Neuropathy Infrared Home Rental - 4 Weeks	$294.00			$441.00			$441.00
12	Non-Surgical Spinal Decompression	$69.00			$828.00			$828.00
12	Trigenics (Myoneural Manual Medicine) - **Intermediate**	$100.00			$1,200.00			$1,200.00
1	Stick Roller	$20.00			$20.00			$20.00
1	Peanut	$16.00			$16.00			$16.00
1	Compression Ball	$5.60			$5.60			$5.60
1	D-Supreme	$87.99			$87.99			$87.99
1	Stabilized R-Lipoic Acid	$58.66			$58.66			$58.66
1	Oxi-cell	$47.72			$47.72			$47.72
	[redacted]				**Estimated Patient Portion**			$4,024.97

NeoGen, Pressure Wave, and PRP Treatment Plan Projections for: [redacted] **Date:** **7/29/2025**

Treatment Recommendation	Therapy	Estimated Charge Per Session or Service	(No Print) Insurance Allowed Amount	(No Print) Expanded	Estimated Total Charges	Patient Co-pay	Patient Co-insurance	Estimated Patient Responsibility
1	**99212** - Office/Outpatient (Established) 15-29 Minutes **- Patient**	$68.00			$68.00	[redacted]		$68.00
1	**99213** - Office/Outpatient (Established) 30-44 Minutes - **Patient**	$112.20			$112.20			$112.20
1	**97139 -** PRP - Platelet Rich Plasma - **Patient - 1 Series**	$800.00			$800.00			$800.00
12	**NeoGen - Electrostimulation (unattended) - Patient**	$118.00			$1,416.00			$1,416.00
12	**1010T** Pressure Wave Therapy	$120.00			$1,440.00	[redacted]		$1,440.00
	[redacted]				**Estimated Pat Portion**			$4,084.40