LEOFF 1 Disability Board Best Practices

Prepared for the Association of Washington Cities
By W. Scott Snyder, Ogden Murphy Wallace

AWC
ASSOCIATION OF WASHINGTON CITIES

LEOFF I
DISABILITY BOARD
BEST PRACTICES

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SECTION I

Medical Benefits: Mandatory and Discretionary

LEOFF SYSTEM CREATED IN 1970 FOR PURPOSE OF:

Provid[ing] for an actuarial reserve system for the payment of death, disability, and retirement benefits to law enforcement officers and firefighters and to the beneficiaries of such employees, thereby enabling such employees to provide for themselves and their dependents in case of disability or death, and effecting a system of retirement from active duty.

OMW

The Plan is administered by local City and County Disability Boards, as well as the Washington State Department of Retirement Systems.

OMW

CITIES OVER 20,000 IN POPULATION

RCW 41.26.110(1)(a)

Five-member Board consisting of:

1. Two Council Members appointed by the Mayor;
2. A firefighter and a police officer, employed by or retired from the agency and elected by the retirees;
3. A citizen representative elected by the other four representatives; and
4. Voting: Only LEOFF I officers/firefighters vote; any officer/firefighter of a City eligible for election.

OMW

JURISDICTIONS UNDER 20,000 IN POPULATION

CLAIMS HANDLED BY THE COUNTY DISABILITY BOARD

OMW

COUNTY DISABILITY BOARD

RCW 41.26.110(1)(b)

Five-member Board consisting of:

1. One County Council person appointed by Council.
2. One City/Town Council Member elected by Mayors of City/Town under Board's jurisdiction.*

* Counties under 60,000 population - resident or Council Member.

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3. One active/retired firefighter elected by LEOFF I firefighters under Board jurisdiction.
4. One active/retired law enforcement officer elected by LEOFF I officers under Board jurisdiction.
5. One citizen elected by Board members.

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WHAT HAPPENS WHEN NO LEOFF I POLICE/FIREFIGHTERS LEFT?

1. County - 2 police or 2 firefighters members
2. Cities ? ? ? ?

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FIRST CLASS CITIES

Existing firefighters' Pension Boards (RCW 41.16.020) and Boards of Trustees of Relief and Pension Fund of Police Departments (RCW 41.20.010) assume Disability Board role.

OMW

Political realities:

The Board has broad discretion and its membership makes a difference.

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THE *BAKENHUS* DOCRINE

Washington's firm public policy that pension benefits are vested. Benefits vest to the system in place on the first day that an employee performs services and vesting continues through every day of work.

THE LEOFF SYSTEM "IS WHAT IT IS"

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KEY CONCEPT

Understanding the distinction between:

1. "Minimum" medical service to which a plan member is absolutely entitled; and
2. "Necessary" expenses provided at the Board's discretion.

MINIMUM EXPENSES

The reasonable charges for underlying minimum medical services "shall be paid."

The Board's only determination is whether a charge for services is "reasonable." The Board may also review whether the medical expenses were a result of "dissipation or abuse," and deny benefits.

WHAT ARE MINIMUM MEDICAL SERVICES?

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MINIMUM MEDICAL SERVICES

(19) "Medical services" for Plan 1 members shall include the following as minimum services to be provided. Reasonable charges for these services shall be paid in accordance with RCW 41.26.150.

(A) Hospital Expenses: These are the charges made by a hospital, in its own behalf, for

(i) Board and room not to exceed semiprivate room rate unless private room is required by the attending physician due to the condition of the patient.

(ii) Necessary hospital services, other than board and room, furnished by the hospital.

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(b) Other medical expenses: The following charges are considered "other medical expenses," provided that they have not been considered as "hospital expenses."

(i) The fees of the following:

(A) A physician or surgeon licensed under the provisions of chapter 18.71 RCW;

(B) An osteopathic physician and surgeon licensed under the provisions of chapter 18.57 RCW;

(C) A chiropractor licensed under the provisions of chapter 18.25 RCW.

(ii) The charges of a registered graduate nurse other than a nurse who ordinarily resides in the member's home or is a member of the family of either the member or the member's spouse.

(iii) The charges for the following medical services and supplies:

(A) Drugs and medicines upon a physician's prescription;

(B) Diagnostic X-ray and laboratory examinations;

(C) X-ray, radium, and radioactive isotopes therapy;

(D) Anesthesia and oxygen;

(E) Rental of iron lung and other durable medical and surgical equipment.

(F) Artificial limbs and eyes, and casts, splints, and trusses;

(G) Professional ambulance service when used to transport the member to or from a hospital when injured by an accident or stricken by a disease;

(H) Dental charges incurred by a member who sustains an accidental injury to his or her teeth or who commences treatment by a legally licensed dentist within ninety days after the accident;

(I) Nursing home confinement or hospital extended care facility;

(J) Physical therapy by a registered physical therapist;

(K) Blood transfusions, including the cost of blood and blood plasma not replaced by voluntary donors;

(L) An optometrist licensed under the provisions of chapter 18.53 RCW.

COURT INTERPRETATION OF MINIMUM MEDICAL SERVICES

The courts have applied a “plain meaning” construction and strictly interpreted the wording of the statute.

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EXAMPLE: Eyeglasses.

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AGO No. 49, 1975

Eyeglasses to be included in minimum medical services. AG analogized that since other medical expenses included drugs and medicines, the legislature intended for eyeglasses to be covered.

BUT

Stegmeier v. City of Everett. A Court of Appeals applies rule of strict construction. Appellant argued that because drugs and medicines prescribed by a doctor were covered by the legislature, the legislature intended to cover eyeglasses prescribed by a physician. The Court holds statutory language is clear and eyeglasses are not a minimum medical service covered by LEOFF I.

HOWEVER

The *Stegmeier* court emphasized that local Boards have the discretion to approve eyeglasses as “necessary” medical services.

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DENTAL SERVICES

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APPLICATION TO DENTAL SERVICES

AGO NO. 7, 1985.

An employer's obligation for dental repair depends on the facts of the case. Repair of accidental injuries to teeth or other dental work is a "minimum medical service" and must be paid. Statute specifically includes as a minimum medical service: "Dental charges incurred by a member who sustains an accidental injury to his or her teeth…"

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BUT

Once again, a local Board has the ability to approve other dental expenses as "necessary" medical services.

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NECESSARY MEDICAL SERVICES

RCW 41.26.150 requires an employer to pay "the necessary medical expenses not payable from some other source."

- Local disability boards, **in their discretion** determine what is **necessary.**

A local Disability Board's discretion to designate "necessary medical expenses" is very broad. Reviewed under an "arbitrary or capricious" standard. The courts give great deference to a Board's determinations. The cases reviewing a local Board's exercise of discretion reflect the tension between the local agency employer's desire to limit medical expenses and the local Board's broad grant of authority.

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EXERCISE OF DISCRETION BY:

- Case by case determination, or
- Adoption of guidelines, or a menu of necessary medical services. "Within boards discretion" and not legislation. *Snohomish County Fire Dist. No. 1 v. Snohomish County*, 128 Wn. App. 418 (2005).

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THE WELL-CARE EXAMPLE

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SNOHOMISH COUNTY FIRE DISTRICT NO. 1

v. SNOHOMISH COUNTY

The fire district seeks declaratory judgment against County Disability Board asserting that the Board exceeded its authority by approving "well care" dental services such as examinations and cleanings.

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The Court of Appeals underlines the distinction between minimum medical services available under RCW 41.26.030(19) and necessary medical services approved at the Board's discretion under RCW 41.26.150.

The fact that minimum medical services included only damaged teeth and medical devices such as bridges did not prohibit the Board, **in its discretion** from authorizing additional well care services such as cleaning and x-rays as "medically necessary."

FINDING COMMON GROUND

1. Balancing the needs of the beneficiaries and the cost to the system of well care.

2. Maximizing insurance/Medicare benefits.

ROLE OF INSURANCE

RCW 41.26.150 provides that both minimum and necessary medical services "…will be reduced by any amount received or eligible to be received by the member" from public health care programs such as social security and employer group hospitalization or medical coverage.

Employers are also subrogated to the right of any member against a third party for medical services incurred due to an injury.

BREMERTON PUBLIC SAFETY ASSOCIATION

v. CITY OF BREMERTON

Retiree association seeks declaratory judgment to establish that a city could not require retirees to pay premium for Medicare Part B, nor reduce medical coverage payments made as a LEOFF I benefit by the amount Medicare Part B would have paid if retiree did not enroll.

THE COURT OF APPEALS HOLDS THAT RCW 41.26.150

"…unambiguously authorizes the city to deduct medical costs payable under Medicare Part B coverage from the amount it must pay for retirees' medical service, even if the retiree did not apply for or pay premiums for this coverage."

Retirees argued that the city and Disability Board were solely responsible for “necessary medical services” of the retiree and therefore the city and Disability Board could not obligate the retiree to pay for Medicare premiums. The Court holds the statute clearly provides otherwise.

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BUT

Once again, local Boards have the discretion to pay for Medicare premiums if they elect to do so or the expenses themselves.

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RULING REGARDING INSURANCE OFFSETS APPLIES TO BOTH MINIMUM MEDICAL COSTS AND NECESSARY MEDICAL COSTS.

PREFERRED PROVIDERS

AGO No. 18, 1980.

A LEOFF Disability Board may authorize particular providers of medical services for “necessary” medical services.

AG's opinion paves the way for local Disability Boards to approve designated providers for "necessary" medical services **BUT NOT "**minimum" medical services.

A Board could encourage use of "Preferred Provider" or panel doctors by designating panel members as designated providers of necessary medical services.

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MEDICARE/MEDICAID

Member required to enroll:

Effect of failure to enroll:

- Should members be incentivized by the payment of premiums?

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INSURANCE

Payment of deductibles:

- Required for minimum services and discretionary for necessary services.

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Paves the way for the use of insurance plans to assist with costs containment. Plans typically provide a different level of benefits through preferred providers.

Minimum services must be paid regardless of whether the services were provided by an approved to designated provider **BUT** may still apply the offset which Medicare Part B or insurance would have paid in appropriate situations.

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COST CONTAINMENT TOOLS

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Offset Medicare Part B and employer provided health care insurance.

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Procedures: ("reasonable charges")

1. Require preauthorization for non-emergency treatments.
2. Require treatment plans for ongoing services:
   counseling, chiropractic, and physical therapy.

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Designate Providers: Encourage use of preferred providers and in-plan services for "necessary medical services."

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BALANCE COST NOW VERSUS COST LATER

Well Care:

1. Dental - cleaning and preventative care
2. Vaccinations/immunizations (flu, shingles)
3. Bone scans

Delay Nursing Home Costs by use of:

- Adult Family Homes
- Group Homes

Don’t incentivize most expensive Nursing Home option.

End of life:

Transition from hospital to hospice and in-home care.

SECTION 2 - ALPHABET SOUP:

OPMA, PRA, HIPAA and Chapter 70.02 RCW

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Open Public Meetings Act (OPMA), the Public Records Act (PRA), the Health Insurance Portability and Affordability Act (HIPAA) and Washington's version of Healthcare Information Protection, chapter 70.02 RCW.

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DISCONNECT

The Open Public Meetings Act executive sessions and the Public Records Act exemptions do not match up.

PRA:

Expressly includes exemptions from release provided by other statutes.

OPMA:

OPMA is expressly controlling in the event of conflict with any other statute.

PRA REQUESTS

Seattle Firefighters Union Local No. 27 v. Hollister.

NO LONGER GOOD LAW!

The court holds that firefighters' disability related records were disclosable under the PRA. Applying the standard test for privacy, the court held that release of records containing personal health care information relating to back injury, asthma, emphysema, ulcers and arterial problems would not be "highly offensive to the reasonable person." !!!

HIPAA AND CHAPTER 70.02 RCW

Chapter 70.02 RCW -- legislatively overturns *Hollister*, provides an exemption in the event of a PRA request

BUT

WHAT ABOUT THE OPMA?

HIPAA PREEMPTION

Regulations issued by the federal government under HIPAA "shall supersede any contrary provision of state law, including a provision of state law that requires medical or health plan records (including billing information) to be maintained or distributed in written rather than electronic form."

Whether a state law provision is "contrary" to HIPAA privacy standards has a common sense meaning: Where a "covered entity would find it impossible to comply with both state and federal requirements," the state law is contrary to the federal law.

A contrary state law is also one that "stands as an obstacle to the accomplishment and execution of the purposes and objectives" of HIPAA.

Even if it is theoretically possible to comply with both state law and federal regulations, the state law will not apply if it makes it difficult to achieve the purpose of the HIPAA Privacy Standards.

EXCEPTIONS

The following state law provisions are not preempted:

Public Health Reporting

State laws providing for reporting of disease or injury, child abuse, birth or death, public health surveillance, or public health investigation.

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HEALTH PLAN REGULATION

HIPAA does not “limit the ability of a state to require a health plan to report or to provide access to, information for management audits, financial audits, program monitoring and evaluation, facility licensure or certification, or individual licensure or certification.”

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MORE STRINGENT STATE PRIVACY LAWS

HIPAA does not supersede a state law which provides more stringent standards. If the state law is more pro-patient privacy, the state law applies.

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OPMA (RCW 42.30)

Possible executive session topics:

- Deliberations of the local Disability Board regarding a contested matter between two parties -- as in settling a dispute between an employer/city and a beneficiary.

BUT

- OPMA does not provide for a specific executive session related to Private Healthcare Information (PHI).

- Under federal law, HIPAA preempts OPMA to extent PHI would be released.

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DE-IDENTIFICATION

Federal regulations identify 17 points of identification which must be removed. A LEOFF Disability Board is the determining agency of a "third party payor" under both Chapter 70.02 RCW and HIPAA.

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Local Disability Boards are therefore charged with making public as little identifying private healthcare information as is necessary to make its decision.

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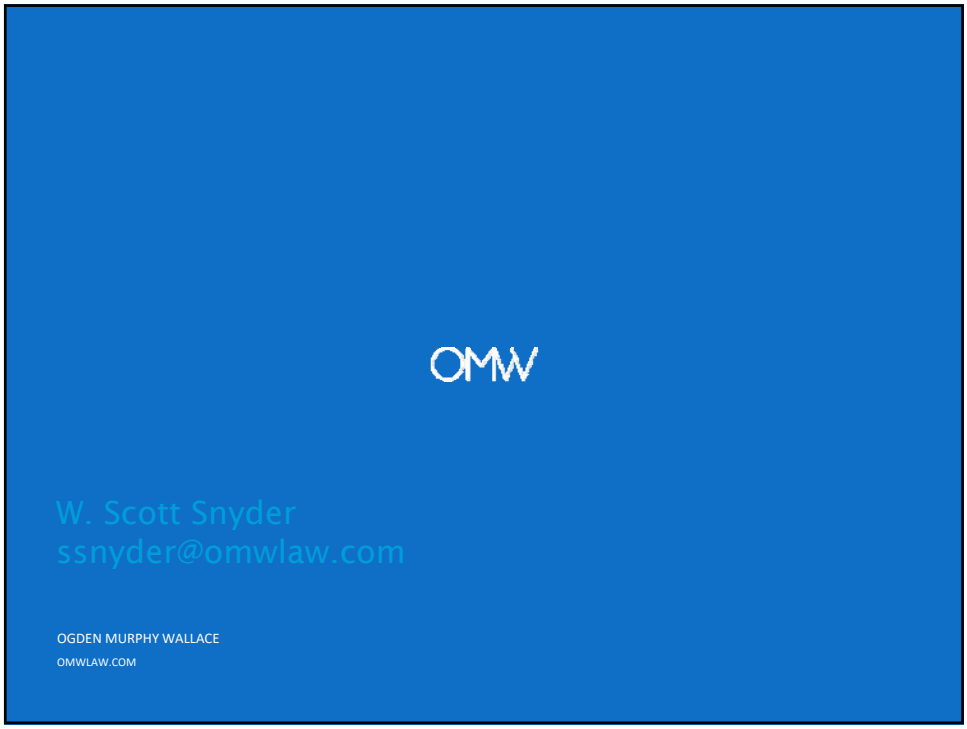

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Section I: Medical benefits: Mandatory and discretionary

Introduction

The LEOFF system was originally created in 1970 to provide a statewide retirement system for law enforcement officers and firefighters. The system was established for the purpose of

> "provid[ing] for an actuarial reserve system for the payment of death, disability, and retirement benefits to law enforcement officers and firefighters and to the beneficiaries of such employees, thereby enabling such employees to provide for themselves and their dependents in case of disability or death, and effecting a system of retirement from active duty.[1]

The original plan, known now as LEOFF I provides for temporary and permanent disability benefits and retirement, as well as the payment of medical expenses of its members. The plan is administered by local Disability Boards, city and county,[2] as well as the Washington State Department of Retirement Systems.[3]

At this point in time, the primary focus of the LEOFF I system and local Disability Boards is the payment of medical expenses and the provision for nursing home and other elder care. Given the aging demographics of its members, local Disability Boards for the most part have ceased to make determinations of temporary and permanent disability. These functions originally occupied much of the Board's attention. A copy of the DRS model rules is included in Appendix A. Note that the rules must be adhered to in disability determinations but local boards may adopt expanded rules[4] to assist them in their role. None of these rules address the role of local boards in designating "necessary" medical services or approving expenses, minimum or necessary.

As you are aware, limitations on tax revenues, increasing life expectancies for members and the increasing costs of medical care and pharmaceuticals rendered maintenance of Plan I benefits problematic. Accordingly, the LEOFF II system was established in 1977. The focus of LEOFF I Disability Boards is on law enforcement officers and firefighters who were first employed after March 1, 1970 and before 1977.

Bakenhus Doctrine

Underlying any discussion of the LEOFF I system is the judicial doctrine known as the Bakenhus Doctrine. The Bakenhus Doctrine states Washington's firm public policy that pensions are contracts and once an individual has paid into a pension system, his or her benefits are vested and the system cannot be amended to reduce the benefits to which the member was originally entitled.[5] Put in simple terms, the LEOFF I system "is what it is." Any idiosyncrasies or problems with the system are inherent to it and must be dealt with under the terms of the statute.

Focus of materials and presentation

The focus of these materials is the administration of the provisions of RCW 41.26.030 and 150. These provisions define the "minimum" medical benefits to which a retiree is entitled and which must be funded by the Disability Board as well as "necessary" medical expenses which each Board in its discretion determines. "Necessary" expenses can be approved, disapproved or provided for in a Board's broad discretion. In addition, we will focus on practical tools such as the use of Medicare Part B and health insurance to control medical costs and expenses. We will also review the adoption of state[6] and federal[7] laws which define a patient's health care privacy rights, limitations on transmittal of personal health care information and security measures required of third party payors.

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[1] RCW 41.26.020
[2] RCW 41.26.100
[3] RCW 41.26.115
[4] WAC 415-105-010 and 020.
[5] *Bakenhus v. City of Seattle*, 48 Wn. 2d 536 (en banc 1956).
[6] Chapter 70.02 RCW
[7] Health Insurance Portability and Accountability Act Public Law, 104-191 (1996).

Administering benefits for medical services

Minimum vs. necessary expenses

The key to understanding the LEOFF Disability Board's authority is an appreciation of the distinction between "minimum" medical services to which Plan I members are absolutely entitled and "necessary expenses" provided at the local board's discretion. The "reasonable" charges for minimum medical services "shall be paid" as provided in RCW 41.26.150.[8] A Board exercises no discretion other than a determination of whether a charge for the services is "reasonable." The statute is specific in its definition of these minimum services:

(19) "Medical services" for plan 1 members, shall include the following as minimum services to be provided. Reasonable charges for these services shall be paid in accordance with RCW 41.26.150.
- (a) Hospital expenses: These are the charges made by a hospital, in its own behalf, for
  - (i) Board and room not to exceed semiprivate room rate unless private room is required by the attending physician due to the condition of the patient.
  - (ii) Necessary hospital services, other than board and room, furnished by the hospital.
- (b) Other medical expenses: The following charges are considered "other medical expenses, provided that they have not been considered as "hospital expenses."
  - (i) The fees of the following:
    - (A) A physician or surgeon licensed under the provisions of chapter 18.71 RCW;
    - (B) An osteopathic physician and surgeon licensed under the provisions of chapter 18.57 RCW;
    - (C) A chiropractor licensed under the provisions of chapter 18.25 RCW.
  - (ii) The charges of a registered graduate nurse other than a nurse who ordinarily resides in the member's home, or is a member of the family of either the member or the member's spouse.
  - (iii) The charges for the following medical services and supplies:
    - (A) Drugs and medicines upon a physician's prescription;
    - (B) Diagnostic X-ray and laboratory examinations;
    - (C) X-ray, radium, and radioactive isotopes therapy;
    - (D) Anesthesia and Oxygen;
    - (E) Rental of iron lung and other durable medical and surgical equipment.
    - (F) Artificial limbs and eyes, and casts, splints, and trusses;
    - (G) Professional ambulance service when used to transport the member to or from a hospital when injured by an accident or stricken by a disease;
    - (H) Dental charges incurred by a member who sustains an accidental injury to his or her teeth or who commences treatment by a legally licensed dentist within ninety days after the accident;
    - (I) Nursing home confinement or hospital extended care facility;
    - (J) Physical therapy by a registered physical therapist;
    - (K) Blood transfusions, including the cost of blood and blood plasma not replaced by voluntary donors;
    - (L) An optometrist licensed under the provisions of chapter 18.53 RCW….

Courts have interpreted these provisions based on the plain meaning of the statute. For example, dental charges under the minimum standards are limited to those incurred by a member "who sustains an accidental injury to his or her teeth."[9] Routine or preventive dental work is not included as a minimum medical expense while repairs due to accidental injury to dentures, bridges or other prosthetic dental work are covered. Charges defined as minimum medical expenses must be paid. The Board also has broad discretion to determine what is "accidental injury or damage," or to define routine or preventive dental work as a "necessary" medical service under the Board's discretion to define and approve necessary medical expenses.

Similarly, the costs of an optometrist are provided for by statute as minimum medical services.[10] Glasses and contacts, however, are not included in minimum medical expenses required to be paid. But again, payment for

[8] RCW 41.26.030(19).
[9] RCW 41.26.030(19)(b)(iii)(H)
[10] RCW 41.26.030(22)(b)(iii)(L)

glasses, contacts, and other services could be approved in the Board's discretion as necessary medical services.[11]

As the Court of Appeals indicated in the *Stegmeier* case, medicines are specifically referenced in the statute but glasses are not. The Court distinguished what must be paid (minimum medical services) from what a Board has the discretion to pay (necessary medical expenses). *Stegmeier* supersedes an Attorney General's opinion opining that glasses were the equivalent of medicines and were therefore covered minimum medical expenses.

Necessary medical expenses

RCW 41.26.150 requires an employer to pay "the necessary medical expenses not payable from some other source."[12] Local disability boards, in their discretion, determine what is necessary. The only limitation created by the statute is that the service should not be brought on for a sickness or disability by "dissipation or abuse."[13] The dissipation or abuse limitation applies to the specific illness and health benefits which attach to addiction and not to the retiree's underlying right to retirement benefits.[14]

A Disability Board may require the retiree to be examined "at any time" by the Board's physician.[15] Failure to submit to examination forfeits the retiree's right to benefits under this section "for the period of the refusal." The Board then designates the medical services available to the retiree. The Board may do so on a case by case basis. The adoption of guidelines, such as a menu of necessary medical services, is a practical approach adopted by many Boards.

The Disability Board's discretionary authority to designate "necessary medical expenses" is very broad. The Board's determinations are reviewed on an "arbitrary and capricious" standard and courts give deference to the Board's determinations.[16]

The cases involving the Board's exercise of discretion have frequently reflected the tension between the local agency's/employer's desire to limit medical expenses and local boards' broad discretionary grant of benefits. There is legitimate room for discussion, particularly regarding attempts to balance the advantages of well care, examinations and preventive dental care, for example, against the greater costs that the board, retirees and local agencies could incur if the conditions were left undiscovered or untreated. Local government has the obligation to fund the Board and pay the costs it approves, so long as the Board is within its statutory authority.

Insurance

In addition to balancing the advantages of preventive and well care, dialogue between the local boards and the employer/local agencies should also consider the role of insurance.

RCW 41.26.150 includes provisions regarding the role of health insurance, subrogation rights as well as Medicare. For example:

1. Both the minimum medical services and necessary medical services, payable under RCW 41.26.150, "…will be reduced by any amount received or eligible to be received by the member" under a variety of public health programs, primarily social security. In insurance terms LEOFF I benefits are "secondary" to other insurance rights.
2. The agency/employer is subrogated to any rights of the member against a third party who may be liable for injuries or the payment for costs of any medical service.[17]

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[11] *Stegmeier v. City of Everett,* 21 Wash. App. 290, 584 P2d. 488 (1978). See Appendix B.
[12] 41.26.150(1).
[13] Ibid.
[14] AGO 63 (1971), See Appendix B.
[15] RCW 41.26.150(1)(a)
[16] See Appendix B for examples.
[17] RCW 41.26.150(3)

3. The employing local government may elect to provide for group hospitalization and/or medical insurance. Whether by social security or a health care plan, the benefits which could be received by a member are "deemed to be amounts received or eligible to be received by the member…" and are subject to offset.[18]

Finally, the Board may elect in its discretion to reimburse retirees for premiums paid for medical insurance that supplements Medicare (donut hole coverage) as well as the retiree's payment for Medicare Part B coverage as "necessary" medical expenses.

The Washington Court of Appeals Division II, [19] has affirmed these offsets and the plain meaning of the statute. In a declaratory judgment action brought by an association representing retirees the Court held that a city could require retirees to pay for Medicare Part B or reduce medical payments by the city by the amount Medicare Part B would have paid. The court again applied a plain meaning reading to the statute and found that the city may offset medical costs payable under Medicare Part B coverage from its payments for a retiree's medical services, "even if the retiree did not apply or pay for premiums for the coverage."[20] It is important to note that this ruling is applicable both to minimum medical costs as well as necessary medical costs. The court was careful, however, to indicate that the city, through the LEOFF Disability Board, has the discretion to pay or not to pay for Medicare Part B premiums for the retiree.

The Attorney General has opined that a Board may also require that "necessary" services be provided through a designated provider.[21]

[18] RCW 41.26.150(4)
[19] *Bremerton Public Safety Assn. v. City of Bremerton*, 104 Wash. App. 226 (Div II 2001). See Appendix B.
[20] BPSA @ 234.
[21] AGO No. 18 (1980).

Section 2: The OPMA, PRA, HIPAA, and Chapter 70.02 RCW

Introduction

The interplay of the Open Public Meetings Act (OPMA)[22], the Public Records Act (PRA)[23], and Health Insurance Portability and Accountability Act (HIPAA)[24] and Washington's version of healthcare information protection[25] create a confusing situation for local disability boards.

As you are no doubt aware, the OPMA's executive session authorization and the PRA's exemptions do not match up. While the PRA provides that an exemption under another statute from release is incorporated in its Public Records Act (PRA) exemptions, the OPMA has the opposite result:

In the event of conflict with another statute, the OPMA provides that it controls.[26] No executive session privilege exists to discuss private healthcare information.[27]

The PRA was interpreted in the past to require release of healthcare information regarding LEOFF I retirees.[28] The Court of Appeals found that records relating to back injuries, asthma, emphysema, ulcers and heart problems were not offensive to the average person and given the public's legitimate interest in public pensions, no privacy right existed.

The adoption of HIPAA and Chapter 70.02 RCW have legislatively overturned this bizarre ruling. LEOFF I Disability Boards need to comply with HIPAA and restrictions on release of healthcare information while complying with the Washington's OPMA requirements.

HIPAA Preemption[29]

HIPAA provides that the regulations issued by the federal government under HIPAA "shall supersede any contrary provision of State law, including a provision of State law that requires medical or health plan records (including billing information) to be maintained or transmitted in written rather than electronic form."

Whether a state law provision is "contrary" to the HIPAA Privacy Standards has a common sense meaning: where a "covered entity would find it impossible to comply with both the state and federal requirements," the state law is contrary to the federal law.[30] The regulations also define a contrary state law as one that "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of part C of title XI of the Act or section 264 of Pub. L. 104-191, as applicable." In other words, even if it is theoretically possible to comply both with state law and the federal regulations, the state law will not apply if it makes it difficult to achieve the purpose of the HIPAA Privacy Standards.

HIPAA contains a variety of exceptions indicating that certain state laws are contrary to the Privacy Standards will continue to have effect and are not preempted.

- **Public health reporting**: HIPAA provides that it does not "invalidate or limit the authority, power or procedures established under any law providing for the reporting of disease or injury, child abuse, birth or death, public health surveillance, or public health investigation or investigation."[31]

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[22] Chapter 42.30 RCW
[23] Chapter 42.56 RCW
[24] Public Law 104-191 (1996)
[25] Chapter 70.02 RCW
[26] RCW 42.30.140
[27] RCW 42.30.110
[28] *Seattle Firefighters Union v. Hollister*, 48 Wash. App. 129 (1987). See Appendix B.
[29] For a more complete discussion of HIPAA preemption, see the Washington State Hospital Association guide on "HIPAA Preemption and Washington Law: Application and Analysis"
[30] 45 CFR 160.202
[31] 42 USC 1178(b)

- **Health plan regulation**: HIPAA does not "limit the ability of a state to require a health plan to report, or to provide access to, information for management audits, financial audits, program monitoring and evaluation, facility licensure or certification, or individual licensure or certification." [32]
- **More stringent state privacy laws**: HIPAA states that the HIPAA Privacy Standards "shall not supersede a contrary provision of State law, if the provision of State law imposes requirements, standards, or implementation specifications that are more stringent than the requirements, standards, or implementation specifications imposed under the regulation." In other words, if the state law is more pro-patient privacy, the state law will apply.

Open Public Meetings Act (RCW 42.30)

The Open Public Meetings Act ("OPMA") intends for the actions and deliberations of public agencies and its subdivisions be conducted at an open, publicly noticed meeting. [33] The OPMA potentially would conflict with HIPAA if a public meeting of a covered entity (health care provider or plan) involved the discussion of protected health information ("PHI") or health care information. While the OPMA does not provide for a specific executive session "carve out" in RCW 42.30.110 related to PHI, the obligation of covered entities to protect patient privacy under HIPAA and Washington's Health Care Information Act (RCW 70.02) still apply and would preempt any potential attempts to make PHI accessible to the general public under the OPMA. As such, covered entities subject to the OPMA must take the necessary steps to prevent the unauthorized disclosure of PHI in public meetings. Such steps may include calling an executive session if possible, removing all PHI, or by properly de-identifying PHI.

What does this practically mean? LEOFF Disability Boards meetings must be open to the public with the exception of contested hearings regarding the payment of health benefits. A contested hearing falls within one of the carve-outs under the OPMA and may be closed to the general public.[34]

While the meetings may be open, complying with HIPAA requires the "de-identification of protected healthcare information."[35] Federal regulations identify seventeen points of identification which must be removed. A LEOFF Disability Board as the determining agency of a "third party payor" under both chapter 70.02.RCW and HIPAA is charged with making public as little identifying private healthcare information as is necessary to make its decision.

The interplay of the statutes provides a checklist for LEOFF Boards in considering the payment of minimum and necessary medical payments:

1. The action needs to be taken at a public meeting noticed in accordance with the OPMA.[36]
2. Prior to the board meeting, a board designee should de-identify healthcare information. Practically, this means removing names, addresses, dates, telephone numbers, social security numbers and then a wide variety of other potential sources of healthcare information. By doing so, the LEOFF Board can comply with both the OPMA and HIPAA.
3. Adopt and enforce HIPAA's security measures.

HIPAA provides significant penalties for disclosure of private healthcare information. This is a technical area beyond the scope of this presentation. You should consult your city, county, or other attorney. In a nutshell, however, security measures include:

1. Locking file cabinets;
2. Limited access rights to computer data;
3. Shredding of unneeded paperwork with personal healthcare information (PHI);
4. Email encryption of PHI; and
5. Laptop encryption of PHI.

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[32] 42 USC 1178(c)
[33] RCW 42.30.010
[34] RCW 42.30.140(2)
[35] 45 CFR 164.514
[36] RCW 42.30.070, *et seq*

Agencies with fire departments should be familiar with these protocols. EMS services and the data and records they generate are subject to HIPAA. The procedures of your fire department may be a good source of assistance.

Appendix A

Chapter 415-105 WAC – Local Disability Board Procedures

(Last update: 8/3/99)

WAC sections

General provisions	
415-105-010	Preamble.
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415-105-040	Disability leave.
415-105-050	Examination, review and determination.
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Cessation of disability while under age fifty	
415-105-160	Purpose – Under age fifty.
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415-105-010 – Preamble.

These rules are not intended to weaken the authority of the local disability board nor to prevent the disability board from adopting additional rules or procedures necessary for performing its duties.

[Statutory Authority: RCW 41.50.050. WSR 99-16-075, § 415-105-010, filed 8/3/99, effective 9/3/99. Statutory Authority: RCW 41.26.115. WSR 81-23-032 (Order 81-03), § 415-105-010, filed 11/16/81.]

415-105-020 – Purpose.

These rules are adopted under the authority of section 1, chapter 294, Laws of 1981 (RCW 41.26.115) to provide a basis for uniform administration of disability retirement matters. These rules must be followed by each disability board.

[Statutory Authority: RCW 41.50.050. WSR 99-16-075, § 415-105-020, filed 8/3/99, effective 9/3/99. Statutory Authority: RCW 41.26.115. WSR 81-23-032 (Order 81-03), § 415-105-020, filed 11/16/81.]

415-105-030 – Board doctor.

(1) Each board must appoint a board doctor. The board must not approve a disability retirement without prior examination of the applicant by the board doctor or a specialist selected by the board doctor. The board doctor must be a practicing physician licensed under the provisions of chapter 18.71 RCW; or, if the board doctor practices outside the state of Washington, then he/she must be a physician licensed by the state in which he/she practices.

(2) The board doctor and any selected specialist must be knowledgeable about the normal, routine duties, functions and general demands of the position the applicant held at the time the applicant discontinued service.

(3) The board must furnish the examining physician with the applicant's job and/or position description. The board must inform the physician that the board's decision to grant or deny a disability retirement allowance is to be measured against the actual, normal, routine duties that the applicant performs.

(4) The board doctor or approved specialist will provide medical services requested by the board including examinations pursuant to RCW

41.26.120(1); 41.26.125(1); 41.26.130(5); and 41.26.150 (1)(a).

[Statutory Authority: RCW 41.50.050. WSR 99-16-075, § 415-105-030, filed 8/3/99, effective 9/3/99. Statutory Authority: RCW 41.26.115. WSR 81-23-032 (Order 81-03), § 415-105-030, filed 11/16/81.]

415-105-040 – Disability leave.

(1) The applicant must prove the existence of:

(a) A disabling condition; and

(b) Whether or not the condition was incurred in the line of duty.

(2) The application must include the name of each physician contacted by the applicant within the last six months for the disabling illness or injury. The applicant must advise each examining physician that:

(a) The board has requested the evaluation;

(b) Any reports of the evaluation will be reviewed by the board;

(c) That the doctor-patient privilege may not be invoked with respect to the evaluation; and

(d) The physician may be requested by the board to testify as to his or her findings.

(3) The disability board is authorized to demand the appearance of the applicant and to request the appearance of any other persons it deems appropriate.

(4) Following receipt of an application for disability benefits, the board must:

(a) Review the application and all relevant information about the applicant's fitness for duty;

(b) Consider the duties of the applicant's position; and

(c) Consider any other pertinent evidence.

The board must either grant or deny disability leave based on the evidence or continue the matter pending receipt of additional information.

(5) If the information before the board is insufficient to determine whether or not the applicant is disabled, the matter can be continued to the next regular meeting or set for consideration at a special meeting. The board must advise the applicant of:

(a) The additional information needed;

(b) The applicant's obligation to provide the additional information; and

(c) The date by which the information must be provided.

(6) The applicant may waive any or all of the disability leave granted pursuant to RCW 41.26.120(4) and 41.26.125(4).

(7) The board is not to use the minimum medical and health standards (MMHS) to determine whether or not an applicant is unfit for duty. The MMHS established pursuant to RCW 41.26.046 govern entry or reentry into LEOFF System membership and were provided only to safeguard the fiscal integrity of the pension system.

[Statutory Authority: RCW 41.50.050. WSR 99-16-075, § 415-105-040, filed 8/3/99, effective 9/3/99. Statutory Authority: RCW 41.26.115. WSR 81-23-032 (Order 81-03), § 415-105-040, filed 11/16/81.]

415-105-050 – Examination, review and determination.

(1) The board must have the applicant examined during the fifth or sixth month of disability leave. The examination is to be performed by the board doctor or a specialist selected by the board doctor. The board shall not approve the disability retirement without this examination unless:

(a) The applicant establishes that the disabling condition will exist for at least six months; and

(b) The applicant voluntarily waives disability leave.

(2) Following receipt of the examination report, the board must:

(a) Review the medical evidence and all relevant information about the applicant's fitness for duty;

(b) Consider the duties of the applicant's position; and

(c) Consider any other pertinent evidence.

The board must either grant or deny disability retirement based on the evidence or return the applicant to duty for a reasonable period of trial service.

(3) If the board cannot determine with reasonable certainty whether or not the applicant is disabled, the board may issue a written order that the applicant is to return to duty for a reasonable period of trial service to determine the applicant's fitness for active duty.

(a) The length of the trial service period must be supported by medical evidence.

(b) During the period of trial service the applicant is to return to the same duties in the same position held at the time of discontinuance of service.

(c) If the applicant is found to be disabled, the board is not to grant a second six-month period of disability leave, but is to return the applicant to disability leave status for the remainder, if any, of the initial six-month leave period.

[Statutory Authority: RCW 41.50.050. WSR 99-16-075, § 415-105-050, filed 8/3/99, effective 9/3/99.

Statutory Authority: RCW 41.26.115. WSR 87-07-015 (Order 87-3), § 415-105-050, filed 3/11/87; WSR 81-23-032 (Order 81-03), § 415-105-050, filed 11/16/81.]

415-105-060 – Granting disability retirement.

(1) The applicant is required to prove that he or she is disabled and unable to perform with average efficiency the duties of the position held at the time of discontinuance of service.

(2) The board must determine, based on the evidence, that the applicant is disabled from performing his or her duties and the disability has been continuous since the beginning of the disability leave period.

(3) The board may make a finding of six months continuous disability prior to the actual conclusion of the six-month period if:

(a) The regular meeting of the board does not precede the end of the six-month disability leave period by more than forty days; and

(b) Medical evidence shows the disability is expected to continue through the full six-month period.

(4) The applicant is not entitled to a disability retirement allowance if:

(a) The employer advises the board that there is an available position for which the applicant is qualified and to which a person of the same grade or rank is normally assigned; and

(b) The board determines that the applicant is capable of discharging the duties of the position with average efficiency.

[Statutory Authority: RCW 41.50.050. WSR 99-16-075, § 415-105-060, filed 8/3/99, effective 9/3/99. Statutory Authority: RCW 41.26.115. WSR 87-07-015 (Order 87-3), § 415-105-060, filed 3/11/87; WSR 81-23-032 (Order 81-03), § 415-105-060, filed 11/16/81.]

415-105-070 – Decision and order.

(1) After granting or denying a disability retirement allowance, the board must enter a written decision and order that includes:

(a) Appropriate findings of fact supported by credible evidence sufficient to sustain the decision; and

(b) Conclusions of law.

(2) When a disability retirement allowance is granted, the decision and order and all supporting documentation must be sent to the director of the department of retirement systems.

(a) The accompanying findings of fact shall include at least the following:

(i) The applicant's length of service with the employer and the position held at discontinuance of service;

(ii) The names of the examining physicians and the dates of the examinations;

(iii) The nature of the disability;

(iv) Whether or not the disability was incurred in the line of duty;

(v) Whether or not the disability was incurred in other employment;

(vi) Dates encompassing disability leave;

(vii) Dates related to authorized return to duty on a trial basis and the factual basis for the decision; and

(viii) Dates encompassing waiver of disability leave, if applicable, and that applicant established that the disability will be continuous for at least six months.

(b) The supporting documentation shall include a copy of at least the following:

(i) The application for disability benefits showing the applicant's current mailing address;

(ii) The job description accurately reflecting the duties of the position the applicant held at discontinuance of service;

(iii) Employer statement(s), if any, relevant to the applicant's position and/or fitness for duty;

(iv) All medical and other evidence considered by the board; and

(v) The minutes and/or transcript of all meetings at which the applicant's disability status was considered.

[Statutory Authority: RCW 41.50.050. WSR 99-16-075, § 415-105-070, filed 8/3/99, effective 9/3/99. Statutory Authority: RCW 41.26.115. WSR 87-07-015 (Order 87-3), § 415-105-070, filed 3/11/87; WSR 81-23-032 (Order 81-03), § 415-105-070, filed 11/16/81.]

415-105-072 – Burden of proof to cancel disability allowance.

The disability board has the burden of proof in any proceeding to cancel a disability retirement allowance.

[Statutory Authority: RCW 41.50.050. WSR 99-16-075, § 415-105-072, filed 8/3/99, effective 9/3/99.]

415-105-074 – Determination to cancel disability allowance.

The board need not rely solely on medical evidence in making its determination. To cancel a disability retirement allowance, the board must demonstrate that:

(1) The retiree is reasonably able to perform the ordinary duties of his or her former position or a position within the retiree's former rank with average efficiency; and

(2) There has been a material change in the circumstances upon which the retirement was based; and

(3) No other physical or mental disability now prevents the retiree from performing the ordinary duties of his or her position or rank.

The board may not cancel a disability retirement allowance based on a determination that the medical condition was incorrectly diagnosed at the time of the initial disability hearing. If the medical condition for which the retiree was granted disability retirement has improved, but the retiree is still not physically or mentally able to perform his or her duties with average efficiency, the retiree shall continue to receive the disability retirement allowance. The board must send a copy of all determinations and the examination reports and other evidence on which they are based to the department of retirement systems.

[Statutory Authority: RCW 41.50.050. WSR 99-16-075, § 415-105-074, filed 8/3/99, effective 9/3/99.]

415-105-080 – Notice of denial of benefits and right to appeal.

(1) The board must immediately notify the applicant if the board:

(a) Denies disability leave or retirement; or

(b) Cancels a previously granted disability leave or retirement.

(2) The board must advise the applicant of his or her right to appeal the board's decision to the director of the department of retirement systems pursuant to RCW 41.26.200.

(3) Notification and advice must be in writing and served by personal service or mail unless the applicant or the applicant's authorized representative attends the meeting and is advised in person of the board's decision and the applicant's right to appeal.

[Statutory Authority: RCW 41.50.050. WSR 99-16-075, § 415-105-080, filed 8/3/99, effective 9/3/99. Statutory Authority: RCW 41.26.115. WSR 81-23-032 (Order 81-03), § 415-105-080, filed 11/16/81.]

415-105-090 – Reexamination after retirement.

(1) Every retiree under 49.5 years of age must be medically reexamined every six months by the board doctor or approved physician, except as provided in subsection (4) of this section.

(2) The retirement allowance of any retiree who fails to submit to a medical examination as required in subsection (1) of this section shall be discontinued until the retiree complies with the reexamination requirement. If the retiree continues for one year to refuse to undergo reexamination, the board shall cancel his or her retirement allowance.

(3) If the retiree resides more than one hundred miles from his or her former employer, the board may authorize the retiree to be examined by a physician in the retiree's local area. The board must approve the local area physician and provide him or her with information about the purpose of the examination and the issues to be addressed in the physician's report to the board.

(4) If the board doctor or approved physician finds that no possibility exists for the retiree's recovery and return to duty, the board may determine that subsequent medical examinations are not required. The determination may be made at the time of retirement or at any time thereafter, but must be based on a current (within ninety days) recommendation of the examining physician. The board must notify the department of retirement systems when it makes a determination of permanent disability. A copy of the physician's report must accompany the notice.

(5) If the examination shows that the retiree is fit to perform the duties of the rank or position held at retirement, the retiree shall be entitled to a hearing before the board. The notification and hearing shall comply with the requirements of the Administrative Procedure Act, chapter 34.05 RCW. Unless the retiree waives his or her right to the hearing, the board must hold the hearing before it can cancel the disability retirement allowance.

[Statutory Authority: RCW 41.50.050. WSR 99-16-075, § 415-105-090, filed 8/3/99, effective 9/3/99. Statutory Authority: RCW 41.26.115. WSR 87-07-015 (Order 87-3), § 415-105-090, filed 3/11/87; WSR 81-23-032 (Order 81-03), § 415-105-090, filed 11/16/81.]

415-105-100 – Purpose – Age fifty and older.

These rules are adopted under RCW 41.26.115 to implement the provisions of RCW 41.26.130(3) and 41.26.135 and establish procedures to be followed by the applicant and the disability board. These rules apply only to a disability retiree age fifty and older who seeks a determination that his/her disability has ceased.

[Statutory Authority: RCW 41.50.050. WSR 99-16-075, § 415-105-100, filed 8/3/99, effective 9/3/99. Statutory Authority: RCW 41.26.115. WSR 87-07-015 (Order 87-3), § 415-105-100, filed 3/11/87.]

415-105-110 – Application to disability board – Age fifty and older.

(1) When a disability retiree over age fifty believes that his/her disability has ceased, he/she may make application to cancel the disability retirement allowance. Such application shall be made to the disability board that originally considered the application for disability retirement.

(2) The application must be in writing and contain the following information:

(a) The retiree's name, birthdate, Social Security number, mailing address, telephone number, former LEOFF employer, and the name and mailing address of the retiree's legal representative, if any;

(b) The nature of the disability and the date the disability ceased;

(c) The names, addresses and telephone numbers of all physicians and other health care practitioners who have been contacted by the retiree or his/her representative in the last year for medical care, consultation or evaluation;

(3) The application must be accompanied by the following documents:

(a) Copies of any written documents supporting the retiree's claim that his/her disability has ceased and that no other physical or mental disability now prevents the retiree from performing the ordinary duties of his/her position or rank;

(b) A copy of the local disability board order granting disability retirement if the original disability board order was summarily affirmed by the director or the LEOFF retirement board; or

(c) A copy of the director's order or the LEOFF retirement board's order if the director or the LEOFF retirement board entered the final order granting disability retirement.

[Statutory Authority: RCW 41.50.050. WSR 99-16-075, § 415-105-110, filed 8/3/99, effective 9/3/99. Statutory Authority: RCW 41.26.115. WSR 87-07-015 (Order 87-3), § 415-105-110, filed 3/11/87.]

415-105-120 – Burden of proof in disability board proceedings.

The retiree has the burden of proof in the proceedings before the disability board.

[Statutory Authority: RCW 41.50.050. WSR 99-16-075, § 415-105-120, filed 8/3/99, effective 9/3/99. Statutory Authority: RCW 41.26.115. WSR 87-07-015 (Order 87-3), § 415-105-120, filed 3/11/87.]

415-105-130 – Standard for determination.

To obtain a determination that a disability has ceased, the retiree must demonstrate that:

(1) He/she is reasonably able to perform the ordinary duties of his/her former position or position within his/her former rank with average efficiency; and

(2) There has been a material change in the circumstances upon which the original disability determination was based; and

(3) No other physical or mental disability now prevents the retiree from performing the ordinary duties of his/her position or rank.

A retiree may not obtain a determination that his/her disability has ceased by demonstrating that the medical condition was incorrectly diagnosed at the time of the initial disability hearing. The disability board need not rely solely on medical evidence in making its determination. If the medical condition for which the retiree was granted disability retirement has improved, but the retiree is still not physically or mentally able to perform his/her duties with average efficiency, he/she shall continue to receive a disability retirement allowance and shall not be entitled to service retirement.

[Statutory Authority: RCW 41.26.115. WSR 87-07-015 (Order 87-3), § 415-105-130, filed 3/11/87.]

415-105-140 – Examination by board physician.

(1) Before acting on an application, the disability board shall have the retiree examined by the board doctor as provided in WAC 415-105-030. If the board doctor has seen the retiree before in any capacity except evaluation on behalf of the disability board, the board doctor must refer the retiree to another physician who has not seen the retiree in any capacity except evaluation on behalf of the disability board.

(2) Before the retiree is examined, the disability board must furnish the board doctor or other

physician with a current job description for the rank or position held by the member at the time he/she was granted disability retirement and a copy of these regulations.

(3) The board doctor or other physician will examine the retiree to determine if he/she is able to perform with average efficiency the duties of the rank or position held by the retiree at the time of discontinuance of service and that he/she meets the requirements of WAC 415-105-130.

[Statutory Authority: RCW 41.50.050. WSR 99-16-075, § 415-105-140, filed 8/3/99, effective 9/3/99. Statutory Authority: RCW 41.26.115. WSR 87-07-015 (Order 87-3), § 415-105-140, filed 3/11/87.]

415-105-150 – Disability board order.

(1) The board must review the application, the medical evaluation by the board doctor, and any other relevant evidence. The board must determine whether the retiree has met the standards set out in WAC 415-105-130 and is physically and mentally capable of performing his/her duties with average efficiency.

(2) If the board determines that the retiree's disability has ceased, it shall enter its written decision and order including appropriate findings of fact and conclusions of law. The disability board must:

(a) Enter a decision which specifies the date the disability retirement allowance will cease;

(b) Immediately send a copy of the decision and order to the department of retirement systems.

[Statutory Authority: RCW 41.50.050. WSR 99-16-075, § 415-105-150, filed 8/3/99, effective 9/3/99. Statutory Authority: RCW 41.26.115. WSR 87-07-015 (Order 87-3), § 415-105-150, filed 3/11/87.]

415-105-160 – Purpose – Under age fifty.

These rules are adopted under RCW 41.26.115 to implement the provisions of RCW 41.26.130(3) and establish procedures to be followed by the applicant and the disability board in cases in which the applicant is under age fifty and believes that his/her disability has ceased.

[Statutory Authority: RCW 41.50.050. WSR 99-16-075, § 415-105-160, filed 8/3/99, effective 9/3/99. Statutory Authority: RCW 41.26.115. WSR 87-07-015 (Order 87-3), § 415-105-160, filed 3/11/87.]

415-105-170 – Application to the disability board – Under age fifty.

A disability retiree under age fifty who believes that his/her disability has ceased may apply for a determination that the disability has ceased. The application must be:

(a) Made to the disability board which originally found the member to be disabled; and

(b) In writing; and

(c) Contain the information stated in WAC 415-105-110(2).

Thereafter, the rules and procedures stated in WAC 415-105-120 through 415-105-140 shall be in effect.

[Statutory Authority: RCW 41.50.050. WSR 99-16-075, § 415-105-170, filed 8/3/99, effective 9/3/99. Statutory Authority: RCW 41.26.115. WSR 87-07-015 (Order 87-3), § 415-105-170, filed 3/11/87.]

415-105-180 – Disability board hearing and order.

(1) The board must review the application, the medical evaluation of the board doctor, and any other relevant evidence. The board must then determine whether the retiree has met the standards set out in WAC 415-105-130 and is physically and mentally capable of performing his/her duties with average efficiency. If the board determines that the retiree's disability has ceased, both the retiree and the former employer shall be entitled to a notice and a hearing. Both the notice and the hearing shall comply with the requirements of chapter 34.05 RCW.

(2) After the hearing, the board must enter its written decision and order, including appropriate findings of fact and conclusions of law. The board order must either deny the retiree's application or cancel his/her disability retirement allowance and restore him/her to duty pursuant to RCW 41.26.140(2).

(3) Any person aggrieved by a determination or order of a disability board that the applicant's disability has not ceased may file an appeal with the director pursuant to RCW 41.26.140(6).

[Statutory Authority: RCW 41.50.050. WSR 99-16-075, § 415-105-180, filed 8/3/99, effective 9/3/99. Statutory Authority: RCW 41.26.115. WSR 87-07-015 (Order 87-3), § 415-105-180, filed 3/11/87.]

Appendix B

Appellate decisions relating to LEOFF 1

***Stegmeier v. City Of Everett,* 21 Wash. App. 290 (Div I, 1978)**

Holding: Court applies rule of strict construction finding that the definitions of minimum medical services set forth in RCW 41.26.030(22) relating to optometrist services do not include prescription eye glasses. This is a case that defines the minimum, non-discretionary medical service that must be provided by a disability board. The appellant argued that because drugs and medicines prescribed by a doctor were covered, the legislature intended to cover eye glasses prescribed by a physician. The court held that the statutory language is clear and the board's refusal must therefore be considered under its "discretion" to provide "necessary" medical services and its decision to deny payment for eye glasses was not arbitrary and capricious. The court noted but did not give credence to the retiree's argument that other retired officers had been approved payment.

***Snohomish County Fire District No. 1 v. Snohomish County*, 128 Wash. App. 418 (Div. 1, 2005)**

A fire district sought a declaratory judgment that the county's disability board had exceeded its authority in approving "well care" dental services such as examinations and cleanings.

Holding: The Court of Appeals distinguished the minimum medical services available under RCW 41.26.030(19) and necessary medical services approved at the Board's discretion under RCW 41.26.150. The fact that minimum medical services included only damage to teeth and medical devices such as bridges, did not prohibit the Board, **in its discretion** from authorizing additional medical services as "medically necessary."

Comment: This is another case which distinguishes minimum from necessary medical expenses and emphasizes the Board's discretion to determine what it "medically necessary." Local disability boards must strike a balance, in their discretion, regarding what "well care" services are appropriate and when paying for such well care costs will reduce their overall costs in the long haul.

***Bremerton Public Safety Assn. v. City of Bremerton*, 104 Wash. App. 226 (Div. II, 2001).**

An association representing retirees brought a declaratory judgment action seeking to establish that a city could not require retirees to pay for Medicare Part B nor reduce the medical coverage payments made by the Disability Board by the amount Medicare Part B would have paid.

Holding: The Court of Appeals held that RCW 41.26.150
...unambiguously authorizes the city to deduct medical costs payable under Medicare Part B coverage from the amount it must pay for retirees' medical service, even if the retiree did not apply or pay premiums for this coverage.

The retirees argued that the city and Disability Board were solely responsible for "necessary medical services" of the retiree and that therefore, the city and Disability Board could not obligate the retiree to pay Medicare premiums. The court again held that the statute clearly provided otherwise.

Comment: This case emphasizes that while the employer must pay for necessary medical services for the retiree, that obligation is limited to services "that are not payable from another source listed in RCW 41.26.150(2).

***Seattle Firefighters Union Local No. 27 v. Hollister*, (Div. I 1987).**

The court held that firefighters' disability related records were disclosable under the Public Records Act (then the Public Disclosure Act). Applying the standard test for privacy, whether release of the documents would be highly offensive to reasonable people, the court held that records containing information relating to back injury, asthma, emphysema, ulcers and arterial problems did not rise to this level and therefore should be disclosed.

Comment: This case has been legislatively nullified. Revisions to the PRA emphasize that other statutory disclosure exemptions contained in other statutes are incorporated in the PRA. The enactment of Chapter 70.02 RCW restricting release of patient information as well as the adoption of HIPAA have legislatively provided clear privacy protections for patients.

Attorney General's opinions[37]

AGO No. 16, 1970. This opinion was issued shortly after the adoption of the initial LEOFF act. It sets out some basic considerations:

1. The cost of operation of a county disability board including the cost of medical exams are to be paid out of the county's current expense fund. Unanticipated expenditures would be paid for through the statutory provisions for budget amendments for non-debatable emergencies.
2. A disability board is not authorized to determine the medical insurance coverage to be provided by a public employer with respect to law enforcement officers and firefighters employed by the public agency.
3. The primary function of a disability board is to designate the hospital and medical services that are available to a sick or disabled law enforcement officer or firefighter and to evaluate the officer's physical condition for the purpose of determining disability.

This AG's opinion was issued just after the adoption of the LEOFF act. It covers issues which are now taken for granted. Of primary importance is its emphasis on a public entity's obligation to fund the operations of the board and to provide monies to pay the obligations which Board authorizations incur.

AGO No. 2, 1975. This AG's opinion emphasizes that the provisions of RCW 41.26.150 are subject to the constitutional principles enunciated by the Washington Supreme Court in *Bakenhus v. Seattle,* 48 Wn. 2d 695 (1956) and the cases which followed.

Comment: Washington public policy as defined by our Supreme Court, strongly favors a strict contract approach to vested pension rights. Because of their nature as deferred compensation, pension rights vest under the legislation in effect on the "commencement of employment or service and continue to vest with each day of employment or service.[38]

AGO No. 49, 1975. This AG's opinion, later overruled by *Stegmeier*, held that eyeglasses were minimum medical services within the definition of minimum medical services. Note, however, that a disability board still has discretion to approve eyeglasses as "necessary" medical services.

AGO No. 63, 1971. A portion of this opinion relating to workers compensation is of little value given the age of current LEOFF I retirees. AG's opinion also stated that while benefits may be denied where a disability was caused by "dissipation or abuse" that limitation applies only to medical benefits and not to the basic "disability leave" or "disability retirement" allowance itself.

The attorney general also opined that an employer could not restrict access to the benefits available under Chapter 41.26 RCW by conditioning eligibility for benefits on law enforcement officers or firefighters not engaging in hazardous off-duty activities.

This opinion, like the *Bakenhus* doctrine, emphasizes that these statutory rights are vested and cannot be limited or access prohibited by a public agency except in accordance with the strict letter of the statute.

AGO No. 12, 1981. This AG's opinion opines that a Plan II member, first employed after October 1, 1077, may be elected to and serve as a member of a municipal LEOFF Disability Board, but a municipal Plan II firefighter or law enforcement officer may be not serve on a county disability board.

[37] Opinions of the Washington Attorney General do not carry the force of law but are given significant credence by the courts. Division III in particular gives deference to the AG's opinion.
[38] *Boen v. State Wide City Employees Retirement System,* 72 Wn. 2d 397 (1967).

AGO No. 7, 1985. This AG's opinion opines: "Teeth" includes not only natural teeth but also previously installed dental work such as bridges, false teeth, fillings and the like. The obligation of an employer to pay for dental repair depends on the particular facts of the case. Accidental injuries to teeth or to other dental work is a minimum medical service and must be paid. Other damage to teeth and dental work "may be paid as a necessary medical expense if the board so exercises its discretion."

AGO No. 18, 1980. This opinion stands for the following propositions:

1. Non-prescription drugs such as insulin and aspirin which are prescribed by a physician are minimum medical services required to be paid by a board.
2. Syringes used to inject insulin are not drugs or medicine within the meaning of the statute.
3. A LEOFF Disability Board may authorize particular providers of medical services for "necessary" medical services.

Comment: The third proposition is the important one for LEOFF Disability Boards. This opinion forms a basis for boards to provide insurance through preferred providers.

AGO No. 12, 1986. The full cost of nursing home care is required to be paid by a county pursuant to the provisions of RCW 41.26.030(22) and .150. Cannot refuse to pay for non-medical expenses such as food.

RULES, POLICIES AND PROCEDURES

of the

Skagit County
Disability Retirement Board

for the

State of Washington
Law Enforcement Officers' and
Fire Fighters' Retirement System

PREAMBLE

The purpose of these rules and regulations is to establish the general operating procedures and to reduce to writing the administrative policies of the Skagit County Disability Board. The Board recognizes that conditions may exist or come into existence, which are not encompassed by these rules and regulations. In such cases, the Board reserves the right to take whatever action is necessary consistent with applicable statues and State regulations.

SCOPE

These rules and regulations shall be applicable to all firefighters or law enforcement officers, active and/or retired, eligible under LEOFF-I covered by Chapter 41.26 RCW, unless specifically provided herein.

EFFECT OF RULES AND REGULATIONS

All fire and police personnel of Skagit County, outside of those employed by the City of Mount Vernon, covered by LEOFF-I shall be subject to the policies and procedures contained herein and shall at all times follow the procedures contained herein to avoid possible loss of benefits. In the event any policy or procedure as applied to the particular member shall be found to be contrary to State law, such member shall not be relieved of any other requirement contained herein and any such finding shall not relieve the member from the responsibility to comply with all other procedures and policies contained herein.

> A member's failure to follow these procedures may subject him/her to the loss of benefits **otherwise due under the LEOFF-I Act.**

PART 1 DEFINITIONS

1.1 Application: A filed request by a member for Board approval of disability leave or retirement.

1.2 Claim: A filed request by a member to the Board for approval of reimbursement of expenses incurred for medical services or treatment; or pre-approval of a medical appliance, which exceeds $150.00; or pre-approval of a surgical procedure or successive treatment.

1.3 Conditional Return: A return to duty by a member for the purpose of determining whether the member's disability persists.

1.4 Disability: The existence of a physical or mental condition which renders the member unable to discharge, with average efficiency, the duties of the grade or rank to which the member belongs, or the position in which the member regularly serves. If a member is able to perform the regular duties of any available position to which a member of his/her grade is normally assigned, with average efficiency, the member is not considered disabled.

1.5 Disability Leave Allowance: Disability leave allowance is not granted for any specific amount of time. Such leave may encompass a period of one hour to a maximum of six months. During this time, the member is to receive an allowance equal to his/her regular salary on the first day of such leave or the applicable portion thereof, from his/her employer.

1.6 In Line of Duty: Means that the member's disability occurred as a direct result of the performance of the member's duties.

1.7 Member: A current or retired firefighter or law enforcement officer eligible under LEOFF-I for benefits provided under **RCW 41.26**.

1.8 Treatment Plan: Shall include but not be limited to current medical diagnosis, significant history, prescribed medications, description of treatment or therapy, pictorial of the treatment area/areas and description of how the condition being treated affects the member's ability to perform required duties.

PART 2 THE BOARD

2.1 Board Members:

A. **Membership:** The Skagit County Disability Board shall consist of five members in accordance with **RCW 41.26.1 1 0(1) (b):**

1. One member shall be from and appointed by the Skagit County Board of Commissioners.

2. One member shall be from and appointed by the Mayors of the following cities and towns: Anacortes, Burlington, Concrete, La Conner, Sedro Woolley.

3. The firefighters shall elect one active firefighter or retired firefighter.

4. The law enforcement officers shall elect one active law enforcement officer or retired law enforcement officer.

5. One member appointed by the other four members shall be from the public at large who resides in Skagit County.

B. **Term and Vacancy:** Board members shall serve a two-year term or until a successor is appointed or elected as set forth below:

1. The terms of the law enforcement officer representative and the member at large shall commence at the Board's regular March meeting in each odd number year.

2. The terms of the firefighter, County and small Cities representatives shall commence at the Board's regular meeting in March in each even numbered year.

3. In the event of a vacancy, a successor shall be appointed or elected in the same manner as with an original appointment or election to serve the remainder of the unexpired term or to begin a new term; provided, that if there is a vacancy with the firefighters or law enforcement officer's representative, nominations and an election shall be conducted pursuant to a schedule set by the Board.

C. **Voting:** Each Board member shall have one vote that must be cast by that member in person.

D. **Chair:** The Chair shall preside at all meetings and hearings of the Board and may call special meetings. The Chair shall have the privilege of discussing matters before the Board and voting thereon except where doing so constitutes a violation of the appearance of fairness doctrine or a conflict of interest. The Chair shall have all the duties normally conferred by parliamentary procedures on such officers and shall perform such other duties as may be requested by the Board. When the Chair and the Chair Pro-Tem are not available, the longest serving member on the Board present, if there is a quorum, will preside over the meeting.

E. **Election of Chair:** The members of the Board will elect a Chair and, if necessary, a Chair Pro Tem to serve in the absence of the Chair. The Chair Pro Tem shall assume the duties and powers of the Chair in the Chair's absence.

F. **Quorum:** Three members of the Board shall constitute a quorum.

2.2 **Powers of the Board:** The Board shall have the powers granted by the State legislature or necessarily implied from such grant of powers **in RCW Chapter 41.26** and **WAC Chapters 415-104 and 415-105**.

2.3 **Board Clerk, Appointment of:** The Department of Human Resources of Skagit County will designate from its employees a Clerk of the Board.

2.4 **Clerk Duties:** The duties of the Board Clerk shall include:

A. Notification of members of meeting and location;

B. Preparation and distribution of agendas for meetings, previous meeting minutes and packets to the Board members five (5) calendar days prior to the meeting when information is available timely to distribute.

C. Preparation of informal packets for each Board member relative to the application for benefits and other Board matters;

D. Provide assistance and information to claimants upon request;

E. Provide claimants with the necessary forms upon request;

F. Ensure that the Board obtains benefits under insurance or health care plans provided by the employer prior to authorization of payment;

G. Arrange for medical or other appointments for claimant as required by the Board;

H. Notification of claimant of doctor's appointment when required by the Board;

I. Preparation of vouchers as required by the Board;

J. Preparation and distribution of necessary correspondence to the State Department of Retirement Systems, employers, and claimants;

K. Sign vouchers for expenditures that have been approved by the Board as recorded in the Board proceedings;

L. Preparation of annual budget as directed by the Board;

M. Order supplies as needed, and

N. Other tasks as directed by the Board.

2.5 Election of the Firefighter/Law Enforcement Representative: Only active and retired members who are subject to the jurisdiction of the Board have the right to nominate, elect or be elected as representative.

2.6 Nominations and Voting: By November 15 of the year before the term expires, any active or retired firefighter or law enforcement officer may submit to the Board Clerk nominations for the respective representative. If no nominations are received, the current elected officer shall serve an additional term. The Clerk will prepare and mail ballots to each agency that will distribute the ballots to members eligible to vote. Each ballot shall be returned to the Clerk in a sealed specially marked envelope provide by the Clerk, no later than February 15th. The ballots shall be opened and counted by the Clerk at a specified time, place and date and may be witnessed by any interested member. In the event that there is only one nominee, the person shall automatically be the representative.

2.7 Conflict of Interest: If any person(s) on the board concludes that he/she has a conflict of interest or an appearance of fairness problem with respect to a matter pending before the Board so that he/she cannot discharge his/her duties, he/she shall disqualify himself/herself from participating in the deliberations and the decision making process with respect to the matter.

PART 3 GENERAL PROVISIONS OF BOARD MEETINGS

3.1 Time of Meetings: The Board shall meet regularly once a month on the third Thursday beginning at 10:00 a.m. in an available room of the Skagit County Administration Building, with the date and time determined in advance by the Board with notice as required by law. If necessary, special meetings may be called by the Chair or a majority of the Board of which notice shall be given in accordance with **RCW 42.30.080**.

3.2 Open to Public: The Board may, in its discretion, allow the public to attend all regular Board meetings. However, the Board, under **RCW 42.30.140(2),** may close those portions of the meeting relating to consideration of specific applications or claims where

consideration of the application or claim may include discussion of sensitive personal information relating to the member.

3.3 Recording of Meetings: No one attending any Board meeting may videotape or tape-record any portion of the meeting without prior approval of the Board.

3.4 Parliamentary Procedure: "Roberts Rules of Order" shall guide the Board where rules or State law does not otherwise govern conditions.

3.5 Examination of Records: Information relating to a member's claim or application shall be released under the following conditions.

A. Only as required by RCW 42.17, by court order or by written permission of the member. Upon request to the Board Clerk, members may examine their disability file at the Board office during times scheduled by the Board Clerk.

B. A person requesting examination of Board records or minutes must submit a written request and arrange with the Board Clerk an appointed time for viewing the materials. Request for examination of Board records must comply with the Public Records Statute (RCW 42.17.250 et seq.). If a request would violate a member's privacy rights, all identifying details in the records must be deleted or the member's permission must be obtained before release of the records.

C. A copy of a record of proceedings, minutes, Board action, disability file records (with member's permission), or any part thereof, will be furnished to a requesting party upon request and payment thereof of copy fees charges pursuant to RCW 42.21.080.

3.6 Oral Proceedings and Transcripts: The Board may hold a full hearing on any matter when deemed necessary or on a motion for reconsideration under Board Rule 4.2. At such a hearing:

A. Any person testifying before the Board may have his or her attorney present.

B. Opportunity shall be afforded all parties to respond and present relevant evidence and argument on all issues involved.

C. Unless precluded by law, informal disposition may also be made of any contested case by stipulation, agreed settlement, consent order or default.

D. The record of a hearing shall include:

1. All pleadings, motions and intermediate rulings;

2. Evidence received or considered;

3. A statement of matters officially noticed, if any;

4. Questions and offers of proof, objections and rulings thereon, if any;

5. Proposed findings and exceptions, if any; and

6. Any decision, opinion or report by the Disability Board.

E. The Board Clerk shall record all oral proceedings before the Board. Transcriptions may be furnished to a requesting party upon request to the Board Clerk and the requesting party will assume payment of the costs thereof for transcriptions.

F. Findings of fact shall be based exclusively on the record of the hearing.

G. The disability Board may:

1. Administer oaths and affirmations, examine witnesses and receive evidence.

2. Issue subpoenas as provided in **Board Rule 3.7**;

3. Rule upon offers of proof and receive relevant evidence;

4. Take or allow depositions to be taken for good cause shown at the discretion of the Board; and

5. Regulate the course of the hearing.

3.7 Subpoenas: The Board may compel the attendance of a witness at any hearing as follows:

A. The Board may issue a subpoena on its own motion or on request of any party upon the showing of good cause.

B. If an individual fails to obey a subpoena, or obeys a subpoena but refuses to testify when requested concerning any matter under examination or investigation at the hearing, the Board may petition the Superior Court of the County where the hearing is being conducted for enforcement of the subpoena. The petition shall be accompanied by a copy of the subpoena and proof of service, and shall set forth in what specific manner the subpoena has not been complied with, and shall ask for an order of the court to compel the witness to appear and testify before the Board.

C. Witnesses subpoenaed to attend a hearing shall be paid the same fees and allowances, in the same manner and under the same conditions, as provided for witnesses in the courts of this state by **RCW 2.40** and by **RCW 5.56.010**, as now or hereafter amended, provided that the Board shall have the power to fix the allowance for meals and lodging in like manner as is provided in **RCW 5.56.010**, as now or hereafter amended, as to courts. Such fees, allowances and costs of

producing records required to be produced by the subpoena shall be paid by the Board or by the party requesting the issuance of the subpoena.

PART 4 PROCESSING APPLICATIONS AND CLAIMS

4.1 Submission of Claims: All applications and claims shall be submitted to the Board Clerk and shall comply with the following procedures:

A. They shall be made on forms provided by the Board

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B. They shall be submitted to the member's employer/department head for their information.

C. To be considered in connection with any application or claim, they shall be complete, legible and submitted to the Board Clerk at least 10 calendar days prior to a scheduled Board meeting. Material not submitted in a timely manner may be considered at the discretion of the Board at that meeting or placed on the next available agenda.

D. Handwritten items may be considered, at the discretion of the Board, as admissible evidence for a claim. Illegible material will not be considered.

4.2 Reconsideration of Board Decisions: Any member aggrieved by a decision of the Board may file with the Board, a request under the following circumstances.

A. Any request for reconsideration must be based on new information not available at the time of the hearing.

B. Such a request must be filed in writing within 14 days of the date of the decision. Upon receipt of such a written request, the Board will set a date and time for considering the reconsideration request at the next available Board meeting. Notice will be sent to the member at least 10 days prior to the scheduled date of the meeting where the request for reconsideration will be considered.

C. At the scheduled meeting, a member and/or representative will be afforded approximately 15 minutes to present the new information to the Board. Any written material, which the member wants the Board to consider, must be submitted to the Board Clerk at least ten (10) days prior to the meeting date. Written material submitted after that date, including at the time of a hearing, would be considered at the discretion of the Board. Following presentation of new information, the Board may rule on the request for reconsideration, or may schedule an additional hearing if the Board believes a new hearing is warranted.

4.3 Board Approved Physician:

A. The Board shall approve a licensed and practicing physician or physicians to conduct all required medical examinations.

B. The approved physician is required to be knowledgeable concerning the duties, functions, and general requirements of the member being examined. The Disability Board shall furnish to the approved physician the job description of the member. The member shall be required to furnish all other pertinent medical history and x-rays to the physician.

4.4 Appeal Procedure:

A. Any member aggrieved by an order of the Board, which is within the jurisdiction of the State Retirement Systems, shall comply with the provisions of **RCW 41.26.200** in perfecting such an appeal to the State Retirement Systems Director.

B. In the event a final determination of the local Disability Retirement Board is not within the jurisdiction of the State Retirement Systems Director, the interested member may seek review of the order with the Skagit County Superior Court within the appropriate time frame.

C. In accordance with **RCW 41.26.125(3**), the Director of the State Retirement Systems does not review a Board finding that a disability was not incurred in the line of duty. Direct review, however, may be sought from the United States Department of the Treasury, Internal Revenue Service, concerning any federal tax consequences of a Board finding that a disability was not incurred in the line of duty.

PART 5 DISABILITY LEAVE AND RETIREMENT

5.1 General Information: Applications for disability leave shall be submitted on forms provided by the Board together with all supporting information required on the form. (Skagit County LEOFF-I Disability Form #1).

5.2 Required Information: All applications for disability retirement shall include statements from two (2) doctors and the employer's statement and report on the application for disability retirement, and:

A. If the disability claimed is a result of an accident, a detailed statement, including date, time and place of the accident, shall be submitted with the application.

B. If the disability claimed was incurred in the line of duty, proper evidence must be submitted substantiating the claim, per **WAC 415-105-040(2):**

"The burden of proving the existence of a disabling condition, and whether or not the condition was incurred in the line of duty, shall be upon the applicant."

5.3 Length of Disability Leave: Where the duration of a disability leave is uncertain, the Board will estimate the duration of the leave when considering the application. In such cases the Board may later act to modify the duration of leave allowed.

5.4 Disability Retirement – Application: An application for disability retirement shall be deemed to be an application for disability leave not to exceed six months and disability retirement benefits, unless otherwise provided.

5.5 Disability Retirement – Examination: When the Board receives an application for a disability retirement, arrangements shall be made to have the applicant examined before the sixth month of leave by a physician designated by the Board. The Board's consulting physician may review all information submitted by the applicant, and he/she shall submit an analysis, in writing, of the applicant's condition to the Board.

5.6 Disability Retirement – Re-examination: Applicants for disability retirement will be re-examined by a physician designated by the Board during the fifth or sixth month of disability leave in order to determine their eligibility for disability retirement, except in conditions where:

A. The Board designated physician assures the Board that the applicant's condition is continuous and unrecoverable, such that it has not and will not be corrected before the end of the sixth month, whereby **Rule 5.5** will not necessarily apply; or

B. If the applicant establishes that the disabling condition is continuous and unrecoverable for the duration of six months leave and voluntarily waives all or any portion of disability leave; and

C. No applicant will be granted a disability retirement unless these conditions are met.

5.7 Postponement of Decision: The Board may, in its discretion, postpone any decision and request additional information or a hearing under Board **Rule 3.6**.

5.8 Decision on Granting Disability Retirement: If the evidence shows to the satisfaction of the Board that the member is disabled and that the disability will be continuous from the date of commencement of disability leave for a period of six months, the Board shall enter its written decision and order which contains the following presented in clear and concise terms:

A. Findings of Fact supported by substantial evidence in the record that support the granting of a disability retirement allowance. Findings of Fact shall include:

1. Whether the disability was incurred in other employment, if applicable;

2. Dates encompassing disability leave and/or date relating to an approved conditional return to duty;

3. Whether applicant waived disability leave under Board **Rule 5.9**;

4. Conclusions of Law supported by the facts of the case; and

5. A finding of whether or not the disability was incurred in the line of duty.

B. Such written decision and order with supporting documentation shall thereafter be forwarded to the State Retirement Board for review.

5.9 Waiver of Right to Disability Leave: If a member establishes that the disabling condition is continuous and unrecoverable for the duration of six months leave and longer, the member may voluntarily sign a written waiver of his/her rights to all or part of the six months disability leave in order to have his/her disability retirement application acted on at an earlier date than would otherwise be permitted. When the Board receives an application for a disability retirement where the applicant voluntarily waives his/her right to disability leave, arrangements shall be made to have the applicant examined as soon as practicable by the Board designated physician.

5.10 Decision Denying Benefits: If an application for disability leave/retirement is denied, the Board shall enter a written decision and order which shall contain Findings of Fact and Conclusions of Law. The applicant and employer will be promptly notified of the decision and of the applicant's right to request reconsideration to the Board under **Rule 4.2**, if applicable, or to appeal to the State Retirement Board. **See Rule 4.4**.

PART 6 OBLIGATIONS OF MEMBERS WHILE ON LEAVE

6.1 Authorization to Return to Active Service from Disability:

A. It shall be incumbent upon any member granted disability leave to seek authorization from his/her physician and employer to return to active service at the earliest possible time the member believes he/she is fit for active service. In the event the Board finds the member has not sought authorization from his/her physician and employer to return to active service immediately upon cessation of disability, the Board shall require the member to report to a Board approved physician to determine the member's ability to return to active service. Thereafter, the Board shall determine whether or not the member's disability leave allowance shall be continued.

B. In the event the medical and other relevant evidence is inconclusive, the Board may specify, in a written order, a reasonable period for a trial return to service to determine the member's fitness for duty. The reasonable length of such a trial period

shall be supported by medical evidence. A trial return to service does not entitle a member to a second six month disability leave for the same disability if, based upon this period of service, he/she is found to be still disabled.

6.2 Member Cooperation in Board Evaluation: While on disability leave, the member shall be obligated to comply with the directives of the Board. Such directives may include, but are not limited to, requests for medical or psychological evaluation or testing; and requests for submittal of other relevant reports and orders to appear before the Board. If the Board finds compliance with such requests was within the control of the member and he/she failed to comply, it will presume compliance with the requests would have shown the member to have recovered. This presumption can be overcome by competent medical evidence provided by the member to the Board. Each member shall, as a condition precedent to returning to active service or being placed on disability retirement, sign a sworn statement that all information provided to the Board is truthful. Any person knowingly submitting a false statement to the Board shall be guilty of a felony pursuant to **RCW 41-26.300**.

6.3 Member's Address: If a member in receipt of disability leave allowance moves to a location more than one hundred (100) miles from the location of the Disability Board, any travel expenses incurred to appear before the Board or its designated physician shall be borne by the member. A member shall keep the Board advised of his/her current address.

6.4 Determination of Fitness: Any medical standards issued by the State Department of Retirement Systems or used by an employer which are designed to set minimum health qualifications before a firefighter or law enforcement officer is hired are not the applicable standards for determining eligibility for disability leave or retirement benefits.

6.5 Treatments: During the period of leave, the Board shall have the authority to inquire of any examining physician what physical, medical or therapeutic treatments might be employed to rehabilitate the applicant and, based upon the physician's response, to direct the applicant to participate in appropriate rehabilitation treatments. If the applicant fails or refuses to submit to such treatments, the Board may terminate the applicant's disability benefits.

6.6 Return to Duty: The original claim signed by a member will serve as his/her agreement that, if the member returns to duty for a trial period, any further leave due to the same disability is to be considered as a continuation of the prior leave claim and does not begin a new six month leave period.

6.7 Trial Return to Duty: The member or employer will contact the Board at the end of the trial return period. If the member has not been able to perform his/her duties with average efficiency during the trial period, the Board will then make its decision on the member's retirement pursuant to **Part 5**. If the member is performing his/her duties with average efficiency, the trial period will cease.

6.8 Missed Appointments: A member who is unable to attend an Independent Medical Examination must contact the Disability Board Clerk prior to 48 hours before the scheduled appointment to cancel and/or reschedule the examination.

A. A member who fails to provide 48 hours notice that they cannot attend a scheduled medical appointment will be responsible for rescheduling the appointment with the specified physician and paying the charge for the previous missed appointment.

B. Members must resolve missed appointment charges prior to disability benefits being awarded. Award of disability benefits may also be held in abeyance until the missed charge is resolved with the physician and the make-up appointment is completed.

PART 7 MEMBERS ON DISABILITY RETIREMENT

7.1 Re-entry from Retirement: In the event a member is placed on retirement, in addition to the Findings described in **Rule 5.8**, the Board may determine that the member's disability is continuous and unrecoverable such that no possibility exists for return to active service or there is no possible rehabilitation that will restore the member to fitness for active service. In the event the Board finds that periodic examination is needed, it shall be incumbent upon the Board to order such re-examination.

A. In the event the retired member is residing at a location more than 100 miles from his/her former place of employment, the member shall request authorization from the Board if the member wishes to be examined by a physician in his/her immediate area. The physician shall first be approved by the Board and, prior to such evaluation, the examining physician shall be apprised by the Board of the basis upon which the examination is to be conducted and the issues to be addressed within the evaluation report. The retirement allowance of any member who fails to submit to medical examination as provided above, shall be discontinued or suspended until the member provides required medical information to justify continuation of a retirement allowance. In the event such refusal continues for one (1) year, his/her retire allowance shall be cancelled. Failure of the member to respond affirmatively to the request for re-examination shall be deemed a continuing refusal.

7.2 Periodic Re-examination of Retiree: Each member placed on disability retirement who is under 49.5 years of age is subject to periodic review, to include a medical examination approximately every six months to determine whether disability retirement should continue.

7.3 Discontinuation of a Retirement Allowance: Where a periodic re-examination determines that a retired member may no longer be disabled or the member requests to return to active service, the member shall be notified by mail of the Board's action to discontinue or cancel his/her retirement. The notification shall contain notice of the time, place and nature of a hearing to be held under the rules of **Part 3**. The purpose of the hearing will be to determine whether the member remains disabled.

7.4 Findings of Fact, Decision and Conclusion: Every decision and order for disability retirement shall be in writing or stated in the record and shall be accompanied by Findings of Fact and Conclusions of Law. The member shall be notified of the decision and order by first class and/or certified mail.

PART 8 MEDICAL EXPENSE CLAIMS PROCEDURES

General: All claims for medical expense reimbursement must comply with **Parts 8 and 9** of these rules

8.1 Medical Services: "Medical services" are defined in **RCW 41.26.030(22)** to be the minimum services legally required to be furnished or authorized by the Board. Medical services not listed in that section may, in the discretion of the Board be considered for authorization on a case-by-case basis.

8.2 Submission of Medical Expense Claims: All medical expenses incurred and claimed for reimbursement by the member will be submitted through the member's health insurance provider before the claim is sent to the Board for consideration. The medical expense claim submitted for reimbursement is to be that portion not covered by the health insurance provider. Evidence of insurance benefits allowed and paid must be submitted with the claim.

8.3 Injury Prior to Incurring Treatment Services: Some medical procedures, equipment, appliances and treatments as listed in PART 9., require Board pre-approval prior to incurring medical services. It is the member's responsibility to submit all pre-approval documents and/or treatment plans to the Board. Members are advised to consult first with their health insurance providers or their employer to learn what is or is not covered in existing health insurance before incurring treatment services. Elective medical procedures, surgery and/or appliances/supplies may not be covered by the health insurance provided by the employer or authorized by the Board.

8.4 Board of Authorization of Reimbursement for Medical Expenses: The Board considers only the medical necessity of the treatment/service/equipment prescribed and the reasonableness of the charges. After the Board reviews and authorizes reimbursement of a medical expense, payment of the claim is to be made by the member's employer. The employer will arrange payment to the provider or reimburse the member if proof of payment by the member is provided with the claim.

8.5 Member's Responsibility to Prepare Claims: Members must support claims for reimbursement for medical/diagnostic services with information from the health care provider which describes the service, explains the medical necessity for such service and includes a billing statement which lists the charges. To do this, each member is responsible for maintaining contact with the employer about the medical health insurance coverage provided by the employer.

8.6 **Forms:** Claims for payment of medical services shall be submitted on forms provided by the Board together with any supporting information. These forms, along with instructions for medical expense reimbursement are provided to the employer by the Board Clerk and are available to the member from the employer's designated personnel office.

8.7 **Time for Filing:** All claims must be submitted to the Board with six (6) months of the member's receipt of the original billing. The Board will only approve claims submitted after this time if they are submitted late due to circumstances not within the control of the member. No claim will be allowed before the expenses are actually incurred, except as specifically authorized in these rules.

8.8 **Medicare Benefits:**

A. Members are advised to contact The Social Security Administration regarding eligibility for Medicare health insurance coverage, Part A and B. If eligible for Medicare coverage, it is each member's responsibility to obtain this insurance for medical expenses. Any portion of a claim eligible to be covered by Medicare or other health insurance available to the member will first reduce claims for medical expenses **(See Rule 8.9)**. Members are cautioned that, if they are eligible for Medicare coverage and do not obtain this coverage, neither the employer nor the Board is obligated to authorize payment for medical expenses, which would otherwise have been covered under Medicare. **RCW 41.26.150(2).**

B. If the employer does not pay for Medicare premiums, members may seek reimbursement for Medicare Part B premiums, as well as premiums for medical insurance that supplements Medicare, by submitting a claim to the Board for consideration of reimbursement upon compliance with **Rules 8.4, 8.5, 8.6 and 8.7, RCW 41.18.060 and RCW 41.20.120.**

8.9 **Offset for Third Party Payments and Subrogation:**

A. Payment of claims shall be reduced by any amount received or eligible to be received under Workmen's Compensation, Social Security, Medicare, insurance provided by another employer or spouse's employer, pension plan or other similar source in accordance with **RCW 41.26.150(2).**

Members possessing insurance benefits covering the expenses of necessary medical services, which would otherwise be the obligation of the employer, shall first present the claim to the appropriate insurance carrier and only thereafter make claim to the Board for those costs not paid by the insurer.

B. Employers shall have the subrogation rights described in **RCW 41.26.150(3**). The employer may provide for the payment of approved medical claims by insurance, self-funded medical benefit plan, enrollment of the member in an HMO (Health

Maintenance Organization), PPO (Preferred Provider Organization) or any other method offered by the employer.

8.10 Criteria for Authorizing Reimbursement: For each claim, the Board shall determine if the criteria listed in **Rule 8.11** and in any other applicable provision of these Rules are met. If there is a doubt as to the reasonableness of a medical service charge, the burden is on the claimant to establish reasonableness.

8.11 General Provisions: The following rules apply to all claims for "medical services and supplies" as described in **RCW 41.26.030(22)** and as authorized under these Rules.

A. Medical Services and Supplies: The Board will allow claims under the provisions set forth in **RCW 41.26.030(22)** and **41.26.150**. Thus, claims for "medical services and supplies" will be approved only if they meet the following conditions.

1. The sickness or disability for which services are rendered was not brought on by dissipation or abuse.

2. The services and/or supplies are medically necessary and are,

a. Essential to, consistent with, and provided for by the diagnosis or the direct care and treatment of an illness, accidental injury or condition harmful to or threatening the member's life or health;
b. Consistent with standards of good medical practice within the organized medical community;
c. Offered in the most appropriate setting, supply or service, which can be safely provided; and
d. Not primarily for the convenience of the member, his/her physician, or other provider.

3. The charges are reasonable and considered to be usual and customary unless a provision of these Rules provides for reimbursement of a lesser amount.

4. If the member belongs to a pre-paid health plan, he/she could not have obtained reasonably equivalent services at no additional charge through such plan. The Board will decide which services are reasonably equivalent.

5. If the member is being treated by more than one physician or specialist, the member must advise the Board of the primary physician or specialist and the collateral, supplemental treatment must be described in the treatment plan.

B. Board Determination of Medically Necessary Services and Supplies: The fact that the medical services or supplies were furnished, prescribed or approved by the member's physician or other provider does not, in and of itself, assure that the Board will determine that such services are medically necessary.

C. Employer Required to Provide Supporting Information: The member's employer shall provide the Board with any supporting information to assist the Board in determining whether the criteria set forth in these Rules is met. Such information may include reasons why the claim should be denied or limitations of a member's coverage by a third party payer. The member shall execute any required releases to enable the Board to obtain the information from the employer.

D. Interest: The Board will not approve claims for interest on delinquent accounts or charges for missed appointments.

E. Reimbursement of Costs of Reports Furnished to the Board: The Board will receive and review for approval member's claims for the cost of furnishing reports to the Board under the following conditions:

1. Progress Reports: As part of the Board approved payment for medical services, the Board requires a treatment plan and at least one (1) progress report from the service provider if treatment is continuous for six (6) months or more. The Board will not approve payment of separate charges for these reports as they are considered to be part of the approved treatment plan and are to be included in charges for individual treatment appointments or office visits.

2. Evaluation and Treatment Plans: Reports to the Board which provide information needed to consider continuation of member's disability retirement leave or to approve plan for treatment of the member's claimed disability or illness while on disability leave, should not be billed as a separate charge. The Board considers these reports to be the responsibility of the member's disability retirement leave application. See **Rule 6.5**. Further, the Board requires a treatment plan to be prepared and submitted for prior approval if the treatment is continuous for six (6) months or more. See **Rule 9.3.**

3. Reports of Examinations by Board Designated Physicians: The Board shall pay for the report and independent evaluation by a Board-designated physician who examines the member during the fifth or sixth month of disability leave to determine whether medical grounds exist for disability retirement. See **Rule 5.6**.

4. Periodic Medical Examination Reviews for Disability Retirees under Age 49.5. Fees charged for medical evaluation report letters for required re-examination of disability retirees under the age of 49.5 years shall be submitted to the member's health insurance provider. The Board will not consider authorizing payment for fees charged for such medical reports unless the member shows that he/she has first submitted such request to the member's health insurance provider. The Board will approve payment of the billing not reimbursed by the health insurance provider.

8.12 Additional Medical Services: Pursuant to the authority granted to the Board under **RCW 41.26.150(2)** to designate medical services payable by the employer in addition to those listed in **RCW 41.26.030(22),** the Board designates **Part 9** of these Rules to be additional medical services for which members may submit claims, subject to the conditions and limitations set forth in these Rules and applicable status.

PART 9 REIMBURSEMENT OF CLAIMS FOR MEDICAL TREATMENT AND PROCEDURES

9.1 General Rules: The Board will approve payment of claims for all medical services defined in **RCW 41.26.030(22)** under conditions set forth in **RCW 41.26.150** and **Part 8** of these Rules.

9.2 Emergency Treatment: Charges for emergency services and treatment not covered by the member's insurance provider will be approved in cases of sudden acute medical emergencies or accidental injuries provided claims are processed as required in **Part 8** of these Rules.

9.3 Continuous Treatment and Services: Treatment or services requiring continuous, consecutive and frequent treatment for mental health/psychological counseling, substance abuse and chiropractic treatment are subject to provisions set forth herein. Evaluations and treatment plans, including an estimate of duration and frequency of treatment, must be submitted for review and prior approval by the Board before the member undertakes treatment. Claims for reimbursement of the cost of continuous treatment undertaken at the members own volition without prior Board approval will be considered at the Board's discretion and may not be approved.

A. Members Covered by Health Insurance Provider: When the member is covered by a health insurance provider, the member is required to submit claims to their health insurance provider for payment. Certain health insurance providers pay for medical services up to a specified amount, subject to the contract entitlement. Once medical service costs exceed the members contract year entitlement, the portion of the claim not covered or rejected by the health insurance provider may be submitted to the Board for its consideration [Ref. Rule 9.3(C)].

1. If a group plan health insurance provider's physician certifies that specific medical services are unable to be provided through the provider's facilities, the member should seek a referral through the health insurance provider's physician to a physician or specialist outside of that group plan health facility.

2. When there is a referral, such group plan health insurance provider is required to pay up to an aggregate maximum dollar amount per contract year for specific services.

3. If a physician of a group plan health insurance provider refuses to make such a referral, the reasons for the refusal should be reported to the Board by the member or the physician since the reasons could bear upon the issue of the medical necessity of such services.

4. If such a referral is not provided with the claim, the Board will consider such services provided outside the member's group health plan as elective on the part of the member and shall deny such claim.

B. Member Covered by a (Non-Self Funded) Group Plan Health Provider: When the member is covered by a comprehensive group health insurance provider, the member is required to first seek medical services from those health insurance providers since they are known to have medical staff/specialists available.

C. Medical Expenses Exceeding Contract Year Entitlement of a Given Health Insurance Plan: In the event the cost of specific medical services will exceed the aggregate contract year entitlement provided by a health insurance provider, the member may be required to submit a treatment plan for the Board's review prior to approval of payment for services over and above the designated contract maximum.

D. Medical Treatment and Services Found Unreasonable: If continuous treatment or charges therefore are found to be unreasonable or excessive, the Board may require the member to undergo specific medical examination and provide a medical evaluation from a physician or specialist. If a member fails to undergo such an examination or provide such evaluation, the Board will continue such services as elective on the part of the member and will deny such claim.

E. More than one Physician for Same Injury, Illness or Condition: If the member is being treated simultaneously for the same injury, illness or condition by a physician or specialist in addition to his/her primary care physician or specialist, the member must advise the Board of his/her primary physician or specialist and provide the Board with the treatment plan which describes the supplemental and/or additional medical service. In addition, the Board may require a statement from the primary physician describing reasons for referral to other physicians or specialists.

9.4 Chiropractic Treatment or Services: Claims for chiropractic services are subject to the provisions set forth in Rule 9.3 and the following conditions:

A. Treatment Plan Required for Continuous Treatment: The Board requires an evaluation and treatment plan if the member has more than three (3) chiropractic visits per six (6) months for the same injury, illness or conditions.

B. Submission of Treatment Plan: The service provider is required to submit an initial individualized treatment plan, which is prepared within one (1) month of commencement of treatment upon request of the Board. Reports of the progress of

the member in the treatment program are to be submitted by the therapist at least once every six (6) months if treatment continues for six (6) months or more. If the member will be in treatment for more than six (6) months, a new treatment plan must be submitted within seven (7) months of the initial commencement of treatment. The Board will review the progress reports and treatment plans to determine whether charges for such treatment continue to be approved for payment.

C. Components of the Treatment Plan: A treatment plan is required as an individualized program to meet the unique treatment requirements of the member. The treatment shall include, but not be limited to, the following:

1. Current medical diagnosis;

2. Significant history;

3. Description of treatment or therapy, including treatment modality, frequency, length of treatment sessions, estimation of duration, approximate recovery time, criteria used to indicate progress and names and activities of other professionals who participate in the treatment;

4. Description of how the condition being treated affects the members ability to perform required regular day-to-day duties of the job or tasks of daily living with average or better efficiency; and

5. Submit a pictorial of the area or areas being treated.

D. Member Compliance to Submit Claims: Nothing in this Rule relieves the member from complying with the requirements of **Rule 8.7** in that claims must be submitted within six (6) months of the member's receipt of the original billing from the provider and of **Rule 9.3**.

9.5 Mental Health Services: Claims for mental health service, including psychological counseling services, are subject to provisions set forth in **Rule 9.3** and the following conditions:

A. Treatment Plan Required for Continuous Treatment: The Board requires an evaluation and treatment plan if the member has more than three (3) mental health visits for the same illness or condition.

B. Conditions for Approval of Mental Health Services: Claims for mental health services provided to a member during a continuous 12-month period would be approved only under the following conditions.

1. The mental health services that are provided by a psychiatrist, a licensed psychologist or a Master's Level Clinical Social Worker who are certified by the National Registry of Health Care Providers in Clinical Social Work or the

National Association of Social Workers or a licensed mental health counselor who is licensed by the Department of Health in the State of Washington or by any other state whose certification requirements are, at a minimum, equivalent to the certification requirements set forth by Washington State. It is the sole responsibility of the member seeking treatment to provide the necessary documentation to the Board establishing the treating provider's licensing and/or certification credentials.

2. The Member's physician or department administrative officer has recommended such services. **Exception**: The member may seek consultation with a mental health specialist, as defined in subsection I above, without administrative recommendation or a physician's referral for two (2) sessions. If treatment is to be continuous, submission of a treatment plan, prepared by the service provider, is required within the first month of treatment. Refer to **Rules 9.2 and 9.3**.

3. The service provider shall submit an initial individualized treatment plan that is prepared within one (1) month of the commencement of treatment or upon request of the Board. Updated treatment plans are to be submitted by the person providing treatment once every six (6) to ten (10) sessions in order for the Board to determine whether charges for such treatment should continue to be approved for payment.

4. One 50-minute unit of psychotherapy is payable at the following maximum rate:

a.	Psychiatrist	$135.00
b.	Psychologist	$110.00
c.	Clinical Social Worker	$ 90.00
d.	Certified Mental Health Counselor	$ 90.00
e.	Advanced Registered Nurse Practitioners	$110.00

5. The maximum number of visits allowed for a member per year shall be 52; however, the Board may authorize a member to exceed the allowable limit based on medical evidence of necessity.

C. Components of the Treatment Plan: A treatment plan is required as an individualized program to meet the unique requirements of the member. The treatment plan shall include, but not be limited to, the following:

1. Current medical diagnosis (DSM-IV digit diagnostic code plus other axis involved and any relationship to the condition). The code shall be translated into layman terms so that the Board will understand the diagnosis;

2. Significant history;

3. Prescribed medication dosage, frequency, side effects, estimated length of treatment; and

4. Description of treatment, treatment modality, frequency, length of treatment sessions, estimation of duration, approximate recovery time, criteria used to indicate progress and names and activities of other professionals who participate in the treatment.

D. Member Compliance to Submit Claims: Nothing in the Rules relieves the member from complying with the requirements of **Rule 8.7** and **9.3.**

9.6 Substance Abuse Services: Claims for outpatient treatment for substance abuse are subject to the provisions set forth in **Rule 9.3**. The Board will approve a member's cost of treatment for alcohol or drug abuse provided the following conditions are met:

A. The service provider is State approved per **Chapter 248-26 WAC**;

B. Total charges do not exceed a maximum cost of $9,600.00;

C. The member's physician, personnel officer or commanding officer;

1. Recommends such treatment; and

2. Provides a written statement.

D. The recommended treatment is prescribed by the member's physician and reviewed by the Board physician prior to approval of reimbursement by the Board;

E. The service provider submits to the Board a written treatment plan, which was prepared within five (5) business days of the member's admission to such program. The plan shall include a recommendation of the required length of time the member should remain in the program and/or facility. The Board, in determining whether the conditions set forth in **Rule 8.11(A)** are met for these services, will use the plan. The plan must be submitted with the member's claim for payment of such medical services;

F. Subject to the dollar limitation set forth above, the member must remain in the program for the recommended length of time and the service provider submits written confirmation to the Board. If the member leaves the program against medical advice or before the recommended length of treatment, the Board may approve payment of only a pro rata portion of the reasonable costs of such program based upon the time the member spent in the program;

G. The limitation on allowable costs shall apply to all costs of treatment of substance abuse, including those for hospital, physician and nurse services, medication and supplies allowable under **RCW 41.26.030(22)(a)(b)** and Board **Rule 8.11**;

H. Members applying for payment for repeated treatment shall provide to the Board a full written case review by a Board appointed physician/specialist or a certified alcohol/substance abuse evaluation service for approval;

1. Repeat patients are expected to pay for the new treatment and evaluation themselves unless the employer or insurance plan provides payment for additional substance abuse treatment programs; and

2. After a period of one (1) year following completion of repeated treatment, the Board may approve reimbursement if:

a. The member provides the Board with satisfactory evidence that he/she has continued his/her recovery process; and

b. The employer approves payment for repeated treatment.

I. Member's Compliance to Submit Claim: Nothing in the rule relieves a member from complying with the requirements in **Rule 8.7** and **9.3**.

9.7 Vision Benefits: Payments for eyeglasses and contact lenses prescribed by a licensed ophthalmologist or optometrist, plus the reasonable cost of necessary eye examination services of a licensed ophthalmologist or optometrist, will be approved pursuant to the authority granted to the Board under **RCW 41.26.150**, subject to the following limitations:

The Board will approve payment for one pair of eyeglasses or contact lenses, at the member's option or as prescribed, to correct vision when required for a prescription in accordance with the following schedule:

A. Eyeglass Lenses, Frames, and Contact Lenses: $450.00 maximum per set of frames and lenses or contact lenses not more than once every twelve (12) consecutive months. Lenses covered include single vision, bifocal and trifocal. Frames must be of average quality and serviceability unless other frames are prescribed;

B. Optional Features: Members may use the maximum allowance of $450.00 toward the purchase of optional features such as over sizing, tinting, coloring, photo sun, or other options and special requests not part of the above schedule. No separate or additional reimbursement will be made for optional features, regardless of whether optional features are medically necessary.

C. Maximum Allowable Amount: The maximum allowable amount for reimbursement by the Board will represent an average charge for vision services considered usual and customary within the applicable geographical area. Refer to **Rule S. II (A)(3);**

D. **Applied Offset:** Any payment by the employer will be applied to the net balance after any insurance reimbursement or other settlement is deducted. Refer to **Rule 8.3**; and

E. **Member Compliance to Submit Claims:** Nothing in this rule relieves the member from complying with the requirements of **Rule 8.7** and **9.3**.

9.8 **Medical Equipment and Supplies:** In addition to the rental of durable equipment as provided for in **RCW 41.26.030(22)**, the Board will consider for approval claims for the purchase of durable medical equipment and supplies under the following conditions:

A. **Hearing Aids:** Prior approval must be obtained from the Board before the member purchases or has a retrofit of a hearing aid device. All requests will be considered on an individual basis.

1. **Conditions for Pre-Approval of Hearing Aid Purchases:** Applications for pre-approval for purchase of hearing aid(s) must meet all of the following conditions and include the documentation required herein meeting the following requirements:

a. Medical examination by an otolaryngologist to rule out any treatable ear conditions;
b. Hearing evaluation by a state certified audiologist to include an audiogram and recommendations regarding the type of hearing aid(s);
c. A statement by the evaluating audiologist, as well as a copy of the audio logical evaluation, must be included in the application as proof that the member's hearing loss is progressive, permanent and/or not likely to improve with other treatment (e.g. medication, surgery, etc.);
d. The fitting of hearing aid(s) shall be done only by a state certified audiologist; and
e. A maximum cost estimate not to exceed $1,500 per hearing aid or $3,000 per pair during any three (3) year period based on equipment of average quality and serviceability. This cost estimate must also include at least a two (2) year warranty on the hearing aids.

2. **Replacement of Hearing Aids:** The Board will consider approval of payment of a member's replacement hearing aid(s) expenses not more frequently than once every thirty-six (36) months. However, replacement of hearing aid(s) will be approved on a case-by-case basis, including duty related incidents, if the member provides the Board with documentation of the medical necessity for the replacement.

3. **Repair of Hearing Aids:** Members requesting payment for repair of hearing aid(s) must document why the device(s) are no longer serviceable. (**Exception:** Payment will be approved for costs of regular maintenance and batteries at reasonable cost upon submission of appropriate expense forms).

4. **Retrofit of Hearing Aids:** Members requesting payment for retrofit of hearing aid(s) must document why the device(s) are no longer serviceable.

5. **Schedule of Limits of Approval of Payments:**

a. Reasonable charges or fees for services of licensed otolaryngologist or state certified audiologist for examination will be allowed;

b. Invoices or billing for payment for hearing aid(s) must first be submitted to the member's health insurance. The Board will then consider approval of the balances not covered by insurance or third party payor;

c. Any payment by the employer will be limited to the net balance after any insurance reimbursement or other settlement is deducted; and

d. The maximum amounts allowable will be the cost of the hearing aid(s) of average quality and serviceability. Any difference between the amount allowed by the Board and the cost of the hearing aid(s) purchased by the member shall be the responsibility of the member.

6. **Member Compliance to Submit Claims:** Nothing in this Rule relieves the member from complying with the requirements of **Rule 8.7** and **9.3**.

B. **Purchase of Durable Medical Equipment and Supplies:** The Board must receive and review a request for pre-approval to purchase durable medical equipment and/or supplies.

This will include purchase of wheelchairs, special equipment, medical or surgical equipment, orthotics, etc., which are prescribed by a physician as medically necessary for treatment of member's illness or disability.

Members must first submit claims for payment for durable medical equipment and/or supplies to their health insurance providers before sending them to the Board. The Board will approve payment of the billing not reimbursed by the health insurance provider.

C. **Other:** The Board will not approve any claims for equipment or supplies, which have a non-medical use or function.

9.9 Dental Benefits:

A. **Dental Benefits:** Dental related expenses up to an annual amount of $2,000.00 will be covered. Dental expenses above this amount will be the responsibility of the member. The plan period runs from January 1st through December 31st of each year. Effective January 1, 2007.

1. **General Check-Up:** The expense of one (1) general dental check up each year will be covered for each member.

2. **Dental Cleanings:** No more than two (2) dental cleanings each year will be covered for a member, unless it is determined, at the discretion of the Board, that a more frequent cleaning schedule is medically necessary in a particular case or for a particular member.

3. **Routine Dental and Periodontal:** The dental expenses incurred by a member for routine dental and periodontal work, as may be found by the Board to be medically necessary, will be covered.

4. **Cosmetic Dental Services:** No dental expenses incurred by a member for dental services or work which is purely cosmetic in nature will be approved or paid, except in unusual circumstances, and then only with the prior, written approval of the Board and based upon medical necessity.

5. **Teeth Whitening:** Dental expenses incurred by a member for teeth whitening will not be approved.

6. **Accidental Injury:** Dental expenses will be approved if incurred by a member who sustains an accidental injury to his or her teeth and commences treatment within 90 days after the accident, or if treatment is to cure or correct an existing health problem. An accidental injury does not include teeth broken or damaged by the act of normal chewing or biting or by the neglect of dental hygiene.

7. **Orthodontics:** Orthodontic work will not be approved unless the member can document through medical or dental examination that there is a direct relationship to an identifiable physical or medical disorder requiring medical treatment. In this case, the member must submit an application requesting the Board's pre-approval of any procedure under consideration to correct the condition. Such request for pre-approval will be considered on a case-by-case basis.

8. **Member Compliance to Submit Claims:** Nothing in this Rule relieves the member from complying with the requirements of **Rule 8.7** and **9.3**.

9. **Prosthodontics:** Dentures, fixed partial dentures (fixed bridges), removable partial dentures and the adjustment or repair of an existing prosthetic device will be covered for each member. The replacement of an existing prosthetic device is covered only once every 5 years if it unserviceable and cannot be made serviceable. Denture adjustments and relines done more than 6 months after the initial placement are covered. Subsequent relines or jump rebase (but not both) will be covered once in a 12 month period. The benefit

amount cannot exceed the total amount allocated for all dental expenses described above ($2,000).

10. **Restorative:** Amalgam, and in anterior teeth, resin-based composite or glass ionomer restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or factures resulting in significant loss of tooth structure (missing cusp) will be covered for each member. Resin based composite or glass ionomer restorations placed in the buccal (facial) surface of bicuspids will be covered. Stainless steel crowns are covered. Should a member choose to have a crown other than a stainless steel crown; the member will be responsible for the difference in cost. The benefit amount cannot exceed the total amount allocated for dental expenses as described above ($2,000).

9.10 **Additional Medical Services and Supplies:** The following services may be considered by the Board as additional medical services and approved for payment on an individual case-by-case basis subject to the requirements set forth in **Part 8** of the Rules and the following listed conditions:

A. **Acupuncture/Acupressure and/or Massage Therapy:** Claims for acupuncture/acupressure and/or massage therapy services are subject to the provisions set forth in **Rule 9.3**. Payments for acupuncture/acupressure and/or massage therapy provided to a member by an acupuncturist and/or massage therapist during a continuous six (6) month period will be approved under the following conditions:

1. The number of visits shall be limited to twelve (12) in a six (6) month period;

2. The services have been prescribed by a licensed physician;

3. A certified acupuncturist (C.A.), including an M.D. or D.O. as well as other providers awarded a diploma of acupuncture by the National Commission for the Certification of Acupuncturists (N.C.C.A.), or a licensed massage therapist, provides the services;

4. The member or provider first submits a claim for payment to the member's insurance provider or third party payor, as directed by the member's insurance provider;

5. If the member will be in treatment for more than three (3) visits for the same illness or condition, an evaluation and proposed treatment plan must be submitted by the prescribing physician to the Board for pre-approval as required by **Rule 9.3**; and

6. The Board may approve additional visits if, prior to the additional visits, the Board is presented with a report and recommendation from a physician documenting the medical necessity for such additional visits.

B. Birth Control Procedures, Devices and Supplies:

1. Vasectomies, tubal ligations and other surgical procedures for the purpose of birth control are not considered medically necessary.

2. If the procedure is medically necessary for the health of the member, application for pre-approval must be submitted to the Board along with the physician's statement attesting to the medical necessity. The Board will consider such applications on an individual case-by-case basis.

3. The member must first submit a claim for payment for medically necessary, pre-approved procedures to the insurance provider or third party payor or as directed by the member's insurance provider.

4. Claims for payment of devices and/or supplies used for birth control are not considered to be necessary medical expenses and will not be approved by the Board.

C. Cosmetic and Reconstructive Surgery:

1. **Cosmetic Surgery:** Surgery to improve appearance or to correct physical defects, such as a pre-existing or congenital condition, is defined as cosmetic surgery. Applications for cosmetic surgery will not be approved. Claims for reimbursement or payment for cosmetic surgery will not be approved.

2. **Reconstructive Surgery:** Surgery required as the result of accidental injury or incidental to a disease of an involved body part will be considered on an individual case-by-case basis.

D. Exercise and Physical Fitness Programs: The Board encourages and supports physical fitness for members and is aware of its importance in the prevention of injuries and disease. However, physical fitness is considered the responsibility of the individual member. Membership in exercise programs, physical fitness clubs and/or health spas is considered elective on the part of the member and not medically necessary.

E. Physical Therapy Programs: Physical therapy, required as a result of accidental injury to improve or correct the function of the involved body party will be approved for payment provided that the physician submits documentation that the therapy is medically necessary.

F. Home Health Care Services: If confined to his/her home following an accident or illness, a member is eligible for home health visits for intermittent skilled nursing care if the following requirements are met:

1. Services are prescribed by a physician;

2. Services are part of a written treatment plan prepared by the physician and reviewed and updated by a physician at least every six (6) months;

3. If services are provided in excess of six (6) months, the Board may require submission of a new treatment plan or may require the member to be examined by a Board approved physician;

4. Services are to be provided by a professional who is either licensed and/or certified by the state, by a professional credentialing agency, or provided by a Medicare participating home health agency;

5. Services of an informal caregiver, who ordinarily resides in the member's home or is a member of the family of either the member or the member's spouse, and who provides unpaid assistance to a spouse, relative or other claimant, are not eligible for approval of reimbursement;

6. If eligible for Medicare, the member has applied for or is receiving both Part A and Part B of Medicare coverage, whether paid by the employer or the member; and

7. The maximum daily cost shall not exceed $308.17 for necessary and otherwise qualified home health care expenses.

G. Hospice Care: Benefits will be provided for hospice care for a terminally ill member if the following requirements are met:

1. The member is admitted to a DSHS certified or Medicare approved program.

2. The care provided is part of a written plan of continuous care prescribed and reviewed by a physician.

3. If eligible for Medicare, the member has applied for or is receiving both Part A and Part B Medicare coverage, whether paid for by the employer or the member.

H. Long-Term Care Facilities, Adult Family Homes, Boarding Home and Nursing Home: Confinement in any of the above-entitled facilities is to be provided as a minimum required service. The Board will review and consider for approval placement and payment of charges for care in any of these facilities under the following conditions:

1. The Board may utilize the services of a Care Management Organization for the purpose of organizing the most effective and appropriate long-term care. Long-term care could include elements of home health, hospice, custodial care and home nursing services;

2. Placement is prescribed by a physician or advanced registered nurse practitioner;

3. The facility must have obtained and remained current on Adult Family, Boarding Home or Nursing home license from the State of Washington;

4. If the facility is located outside the State of Washington, it shall be the responsibility of the member to provide documentary evidence that the facility is licensed in the state or country where the facility is located and that the licensing requirements are similar, equal to or greater than those required by the State of Washington;

5. If placement exceeds six (6) months, the Board shall require a treatment plan from the facility;

6. If placement exceeds six (6) months, the Board shall require an updated progress report from a treating physician not less than every six (6) months;

7. If eligible for Medicare, the member has applied for or is receiving both Part A and Part B Medicare coverage, whether paid for by the employer or member;

8. The provider or member's claims for payment will be submitted directly to the member's insurance, third party payer or employer; and

9. Application for prior approval of long-term care services and placement will be considered on a case-by-case basis.

I. Organ Transplants: The Board shall approve payment for reasonable medical expenses associated with member organ/tissue transplants under the following conditions:

1. The transplant must be deemed medically necessary by a physician and approved by the Board;

2. Reasonable donor medical expenses, as a result of the procedure, are considered necessary medical expenses of the member; and

3. Procedures are limited to nationally-recognized licensed facilities.

J. Sexual Dysfunction/Impotence/Infertility: Services, supplies and procedures for reproductive and sexual disorders and defects are considered to be elective and not medically necessary. Some services and prescriptions for sexual dysfunction are determined to be reimbursable. However, the Board reserves the right to judge each case on its own merits, considering such factors as medical necessity, frequency of use, organic diagnosis by a physician and cost.

K. **Smoking Cessation:** The Board will approve reimbursement to members of a maximum of $300.00, **one time only**, following completion of a smoking cessation program and upon maintenance of program goals for one (1) year.

Members are requested to submit a description of the smoking cessation program selected and a treatment plan to the Board for pre-approval.

L. **Specialized Surgeries:**

1. **Eye Surgery:**

a. **Corneal Laser Surgery:** Should the member have a medical condition for which the physician has prescribed laser corneal surgery, the Board will consider the member's request for pre-approval.

2. **Other Surgeries:** From time to time, the Board may add Rules for other specialized surgeries and techniques, as may be required.

M. **Weight Loss Programs:** The Board may approve payment for a weight loss program that is prescribed, approved and monitored by a physician on a **one time basis**. The Board will consider payment of the claim for the member's pre-approved weight loss program, exclusive of costs of food supplements.

N. **Member Compliance to Submit Claims:** Nothing in this rule relieves the member from complying with the requirements of **Rule 8.7** and **9.3**.

PART 10 REVIEW OF BOARD RULES, AMENDMENTS AND REVISIONS

10.1 **Periodic Review:** These local Board rules, policies and procedures shall be reviewed and revised periodically, or as often as necessary, subject to the recommendation of the State Retirement Systems, to assure that:

A. **Conformance with State Law:** Provision's herein remain in conformance with Washington statutory and administrative codes.

B. **Benefit Fiscal Limitations:** Dollar amounts specified in the schedule of benefits reflect current and reasonable average charges in the local area.

Member claims are subject to the last revised rulings adopted and exceptions will not be made. Any newly revised rulings and statutes supersedes previous policies and makes obsolete any prior existing rule or statute; therefore, claims may not be made to apply to obsolete policies.

10.2 Chronology of Amendments/Revisions of Board Rules:

Adopted/Effective Date	Policy Revisions/Amendments
5/21/09	9.7 Vision Benefits
11/18/10	9.10 Home Health Care Services – removed F.7
3/17/11/ Jan 1, 2011	9.10(f)(7) lawsuit w/City of Anacortes settlement
4/19/12	2.1.A.2 removed Mount Vernon
4/19/12	2.1.B.1 and 2 changed from February to March
4/19/12	2.6 Changed from December to February 15th
1/17/13	9.8 Hearing Aids A1.E Change in maximum cost
2/01/13	9.10 F.7 Home Health care change in maximum daily cost
1/01/15	9.10 F.7 Home Health care change in maximum daily cost

RULES, POLICIES AND PROCEDURES

of the

King County Disability Retirement Board

for the

State of Washington
Law **E**nforcement **O**fficers' and
Fire **Fi**ghters' Retirement System

King County Disability Retirement Board
Chinook Bldg., MS: CNK-ES-0240
401 Fifth Avenue, Suite 234
Seattle, WA 98104-2333
Board office: (206) 263-6394
Board fax: (206) 296-7700

Board website: http://www.kingcounty.gov/employees/LEOFF1.aspx

Board e-mail: curtis.nakata@kingcounty.gov

PREAMBLE

The purpose of these rules and regulations is to establish the general operating procedures and to reduce to writing the administrative policies of the local disability Board. The Board recognizes that conditions may exist or come into existences which are not encompassed by these rules and regulations. In such cases, the Board reserves the right to take whatever action is necessary consistent with applicable statutes and State regulations.

SCOPE

These rules and regulations shall be applicable to all firefighters or law enforcement officers, active and/or retired, covered by Chapter 41.26 RCW, unless specifically provided herein.

EFFECT OF RULES AND REGULATIONS

All fire and police personnel of King County covered by LEOFF-I shall be subject to the policies and procedures contained herein to the extent consistent with applicable State statutory provisions and shall at all times follow the procedures contained herein to avoid possible loss of benefits. In the event any policy or procedure as applied to the particular member shall be held to be contrary to State law, such member shall not be relieved of any other requirement contained herein and any such finding shall not relieve the member from the responsibility to comply with all other procedures and policies contained herein.

A member's failure to follow these procedures may subject him/her to the loss of benefits otherwise due under the LEOFF act.

PART 1: DEFINITIONS

1.1 **"Application"** means a filed request by a member for Board approval of disability leave or retirement.

1.2 **"Claim"** means a filed request by a member to the Board for approval of reimbursement of expenses incurred for medical services or treatment; or the pre-approval of a medical appliance which exceeds $150.00; or pre-approval of a surgical procedure, or pre-approval of successive treatment.

1.3 **"Conditional return"** is a return to duty by a member for the purpose of determining whether the member's disability persists.

1.4 **"Disability"** means the existence of a physical or mental (psychological) condition which renders the member unable to discharge with average efficiency the duty of the grade or rank to which the member belongs, or the position in which the member regularly serves. If a member is able to perform the regular duties of any available position to which a member of his grade or rank is normally assigned, with average efficiency, the member is not considered disabled.

1.5 **"Disability Leave Allowance".** Disability leave allowance is not granted for any specific amount of time. Such leave may encompass a period of one hour to a maximum of six months. During this time, the member is to receive an allowance equal to his regular salary on the first day of such leave [Per AGO No. 78.8] or the applicable portion thereof, from his employer.

1.6 **"In line of duty"** means that the member's disability occurred as a direct result of the performance of the member's duties.

1.7 **"Member"** means a current or retired law enforcement officer or firefighter eligible for benefits provided under RCW 41.26.

PART 2: THE BOARD

2.1 Powers of the Board. The Board shall have the powers granted by the State legislature or necessarily implied from such grant of powers in RCW chapter 41.26, and WAC Chapters 415-105 and 415-104.

2.2 Board Members. The King County Board shall consist of five members in accordance with RCW 41.26.110(b): one member shall be from and appointed by the King County Council; one member shall be appointed by the Suburban Cities Association; one firefighter or retired firefighter shall be elected by the firefighters employed or retired in the county who are not employed by or retired from a city in which a disability board is established; one law enforcement officer or retired law enforcement officer shall be elected by the law enforcement officers employed in or retired from the county who are not employed by or retired from a city in which a disability board is established; and one member shall be from the public at large who resides within the county but does not reside within a city in which a city disability board is established, to be appointed by the other four members.

A. **Election of Firefighter/Law Enforcement Representative.** Nominations and elections are conducted by the Board Clerk pursuant to the written election procedures approved by the Board. Approved election procedures are to be kept on file by the Board Clerk. The election of the Firefighter and Law Enforcement Representative shall be conducted in alternate years.
B. **Term and Vacancy.** In the event of a vacancy, a successor shall be appointed or elected in the same manner as with an original appointment or election to serve the remainder of the unexpired term or to begin a new term.
C. **Voting.** Each Board member shall have one vote which must be cast by that member in person. Three members of the Board shall constitute a quorum.

D. **Chair.** The Chair shall preside at all meetings and hearings of the local disability board and may call special meetings. The Chair shall have the privilege of discussing matters before the Board and voting thereon except where doing so constitutes a violation of an appearance of fairness doctrine or a conflict of interest. The Chair shall have all the duties normally conferred by parliamentary procedures on such officers and shall perform such other duties as may be requested by the Board.

E. **Election of Chair.** The members of the Board will elect a Chair and, if necessary, a chair pro tempore to serve in the absence of the Chair. The chair pro tem shall assume the duties and powers of the Chair in the Chair's absence.

2.3 Board Clerk, Appointment of. The Board Chair shall appoint a person to serve as the Board Clerk who shall be subject to confirmation by the Board.

PART 3: GENERAL PROVISIONS OF BOARD MEETINGS

MEETING PROCEDURES:

3.1 Meetings, Agenda. The Board shall meet regularly once a month in the King County Courthouse, with the date and time determined by the Board. If necessary, special meetings may be called by the Chair or a majority of the Board.

3.2 The Board may, in its discretion, allow the public to attend all regular Board meetings. However, the Board, under RCW 42.30.140(2) may close those portions of meetings relating to consideration of specific applications or claims where consideration of the application or claim may include discussion of sensitive personal information relating to the member.

3.3 Video Recording. No one attending any Board meeting may video tape or tape record any portion of the meeting without the prior approval of the Board.

3.4 Examination of Records. Information relating to a member's claim or application shall be released under the following conditions:

A. Only as required by RCW 42.17, by court order, or written permission of the member. Upon request to the Board Clerk, members may examine their disability file at the Board office during times scheduled by the Board Clerk.
B. A person requesting examination of Board records, minutes or agendas must submit a written request and arrange with the Board Clerk an appointed time for viewing the materials. Requests for examination must comply with the Public Information Act. If a request would violate a member's privacy rights, all identifying details in the information must be deleted or the member's permission must be obtained before release of the information.
C. A copy of a record of proceedings, minutes, agendas, Board action, disability file records (with member's permission), or any part thereof will be furnished to a requesting party upon request and payment thereof of copy fees charged pursuant to RCW 2.21.080.

3.5 Oral Proceedings/Transcripts. The Board may hold a full hearing on any matter when deemed necessary or on a motion for reconsideration under Board Rule 4.2. At such a hearing:

A. Any person testifying before the Board may have his or her attorney present.

B. Opportunity shall be afforded all parties to respond and present relevant evidence and argument on all issues involved.

C. Unless precluded by law, informal disposition may also be made of any contested case by stipulation, agreed settlement, consent order, or default.

D. The record of a hearing shall include:

1. All pleadings, motions, intermediate rulings
2. Evidence received or considered
3. A statement of matters officially noticed, if any
4. Questions and offers of proof, objections, and ruling thereon, if any
5. Proposed findings and exceptions, if any; and
6. Any decision, opinion, or report by the Disability Board.

E. All oral proceedings before the Board shall be recorded by a court reporter. A copy of the record, or any part thereof, shall be transcribed by the court reporter. Transcriptions may be furnished to a requesting party upon request to the court reporter and payment of the costs thereof for transcriptions will be assumed by the requesting party. Transcriptions of oral testimony will not be ordered by the Board unless it is requested by the Board or the State retirement systems for review.

F. Findings of fact shall be based exclusively on the evidence and on matters officially noticed;

G. The Disability Board may:

1. Administer oaths and affirmations, examine witnesses, and receive evidence;
2. Issue subpoenas as provided in Board Rule 3.4;
3. Rule upon offers of proof and receive relevant evidence;

4. Take or cause depositions to be taken pursuant to rules promulgated by the Board;
5. Regulate the course of the hearing.

3.6 Subpoenas. The Board may compel the attendance of a witness at any hearing as follows:

A. The Board may issue a subpoena on its own motion or on the request of any party;

B. If an individual fails to obey a subpoena, or obeys a subpoena but refuses to testify when requested concerning any matter under examination or investigation at the hearing, the Board may petition the superior court of the county where the hearing is being conducted for enforcement of the subpoena. The petition shall be accompanied by a copy of the subpoena and proof of service, and shall set forth in what specific manner the subpoena has not been complied with, and shall ask an order of the court to compel the witness to appear and testify before the Board.

C. Witnesses subpoenaed to attend such a hearing shall be paid the same fees and allowances, in the same manner and under the same conditions, as provided for witnesses in the courts of this State by RCW 2.40 and by RCW 5.56.010, as now or hereafter amended: Provided, that the Board shall have the power to fix the allowance for meals and lodging in like manner as is provided in RCW 5.56.010, as now or hereafter amended, as to courts. Such fees and allowances, and the cost of producing records required to be produced by its subpoena, shall be paid by the Board, or by the party requesting the issuance of the subpoena.

PART 4: PROCESSING APPLICATIONS AND CLAIMS GENERALLY

4.1 Submission of Claims. Applications and claims required to be submitted to the Board shall comply with the following criteria:

A. Shall be made on forms provided by the Board.

B. Be first submitted through the member's employer/department; who will then forward completed forms to the Board office.

C. To be considered in connection with any application or claim, it must be complete, legible, and submitted to the Board office at least 10 calendar days prior to a scheduled Board meeting to be placed on the current meeting agenda. Untimely submitted material may be considered at the discretion of the Board or placed on the next available agenda.

D. Material which is handwritten will be considered at the discretion of the Board and may not necessarily be accepted as admissible evidence for a claim. Illegible material will not be considered.

4.2 Reconsideration of Board Decisions. The Board's decision to approve or deny applications or claims may be made without a full hearing solely on the basis of the written information submitted to the Board. Any member aggrieved by a decision made without a full hearing may file with the Board a request for reconsideration and receive an opportunity for a full hearing on the matter.

A. Such a request must be filed in writing within 14-days of notification of the decision. Upon receipt of such a written request, the Board will set a hearing date and time at the next available Board meeting. Notice will be sent to the member at least 10-days before the hearing date.

B. At a scheduled hearing, a member and/or a representative will be afforded approximately 15 minutes to present information or testimony before the Board. In addition to, or in lieu of, verbal testimony, any written material must be submitted to the Board office ten (10) days before the hearing date to be

included with the regular agenda. Written material submitted at the time of a hearing will be considered at the discretion of the Board.

4.3 Appeal Procedure.

A. Any member aggrieved by an order of the local Disability Board, which is within the jurisdiction of the State Retirement Systems, shall comply with the provisions of RCW 41.26.200 in perfecting such an appeal to the State Retirement Systems director.

B. In the event a final determination of the local Disability Retirement Board is not within the jurisdiction of the State Retirement Systems director, the interested member is hereby required to file his/her motion for review with the King County Superior Court within the appropriate time frame.

C. In accordance with RCW 41.26.125(3), the director of the State Retirement Systems does not review a Board finding that a disability retirement was not incurred in the line of duty. Direct review, however, may be sought from the United States Department of the Treasury, Internal Revenue Service, concerning any federal tax consequences of a Board finding that a disability was not incurred in the line of duty.

PART 5: DISABILITY LEAVE AND RETIREMENT

General Procedures

5.1 Applications for disability leave shall be submitted on forms provided by the Board together with all supporting information required on that form. (Refer to Part 3.)

5.2 All applications for disability retirement shall be submitted on forms provided by the Board, together with statements from two (2) doctors and the employer's statement and report on the application for disability retirement, and:

A. If the disability claimed is the result of an accident, a detailed statement, including date, time and place, shall be submitted with the application;
B. If the disability claimed was incurred in the line of duty, proper evidence must be submitted substantiating this claim, per WAC 415-105-040(2): "The burden of proving the existence of a disabling condition, and whether or not the condition was incurred in line of duty, shall be upon the applicant."

5.3 Where the duration of a disability leave is uncertain the Board will estimate the duration of the leave when considering the application. In such cases the Board may later act to modify the duration of the leave allowed.

5.4 Each application for disability retirement shall be deemed to be an application for disability leave not to exceed six months and disability retirement benefits, unless otherwise provided.

5.5 When the Board receives an application for a disability retirement, arrangements shall be made to have the applicant examined before the sixth month of leave by a physician designated by the Board. The report of the designated physician as well as all information submitted by the applicant shall then be reviewed by the Board's consulting physician and he shall submit an analysis, either orally or in writing, of the applicant's condition to the Board.

5.6 Applicants for disability retirement will be reexamined by a physician during the fifth or the sixth month of disability leave in order to determine their eligibility for disability retirement, except in conditions where:

A. The Board physician assures the Board that the applicant's condition is continuous and unrecoverable, such that it has not and will not be corrected before the end of the sixth month, whereby, Rule 5.5 will not necessarily apply, or
B. If the applicant establishes that the disabling condition is continuous and unrecoverable for the duration of six months leave and voluntarily waives all or any portion of disability leave.

No applicant will be granted a disability retirement unless these conditions are met.

5.7 The Board may, in its discretion, postpone any decision and request additional information or a hearing under Board Rule 3.6.

5.8 If the evidence shows to the satisfaction of the Board that the member is disabled and that the disability will be continuous from the date of commencement of disability leave for a period of six months, the Board shall enter its written decision and order which shall contain the following presented in clear and concise terms:

A. Findings of fact supported by substantial evidence in the record that support the grant of a disability retirement allowance. Findings of fact shall also include:
    1. Whether the disability was incurred in other employment, if applicable.
    2. Dates encompassing disability leave and/or dates relating to approved conditional return to duty.
    3. Whether applicant waived disability leave under Board Rule 5.9.
B. Conclusions of law on the basis of the facts in the case.

C. A finding of whether or not the disability was incurred in the line of duty.
D. Such written decision and order with supporting documentation shall thereafter be forwarded to the State Retirement Board for review.

5.9 If a member establishes that the disabling condition is continuous and unrecoverable for the duration of six months leave and longer, the member may voluntarily sign a written waiver of his rights to all or part of the six month disability leave in order to have his disability retirement application acted on at an earlier date than would otherwise be permitted.

5.10 When the Board receives an application for a disability retirement where the applicant voluntarily waives his/her right to disability leave, arrangements shall be made to have the applicant examined as soon as practicable by a physician designated by the Board.

5.11 If an application for disability retirement is denied, the Board shall enter a written decision and order which shall contain findings of fact and conclusions of law. The applicant and employer will be promptly notified of the decision and of the applicant's rights to request for reconsideration to the Board under Rule 4.2, if applicable, or to appeal to the State Retirement Board.

PART 6: OBLIGATIONS OF MEMBERS WHILE ON LEAVE

6.1 Authorization to Return to Active Service from Disability.

A. It shall be incumbent upon all members granted disability leave to seek authorization from their physician and employer to return to active service at the earliest possible time. In the event the Board finds that a member has not sought authorization from his/her physician and employer to return to active service immediately upon cessation of disability, the Board may retroactively cancel the member's disability leave allowance for the period in question.

B. In the event the medical and other relevant evidence is inconclusive, the Board may specify, in a written order, a reasonable period for a trial return to service to determine the member's fitness for active duty. The reasonable length of such a trial period shall be supported by medical evidence. A trial return to service does not entitle a member to a second six-month period of disability leave for the same disability if, based upon this period of service, he/she is then found to be still disabled.

6.2 Member Cooperation in Board Evaluation. While on disability leave, the member shall be obligated to comply with the directives of the Board. Such directives may include, but are not limited to, requests for medical or psychological evaluation or testing; requests for submittal of other relevant reports; and orders to appear before the Board. If the Board finds compliance with such a request was within the control of the member and he failed to comply, it will presume compliance with the request would have shown the member to have recovered. This presumption can be overcome by competent medical evidence provided by the member to the Board.

Each member shall, as a condition precedent to returning to active service or being placed on disability retirement, sign a sworn statement that all information provided to the Board is truthful. Any person knowingly making a false statement to the Board shall be guilty of a felony, pursuant to RCW 41.26.300.

6.3 Missed IME's. A member who is unable to attend an Independent Medical Examination (IME) must contact the Disability Board Clerk prior to 48 hours before the scheduled appointment to cancel and/or reschedule the examination.

A member who fails to provide 48 hours notice that they cannot attend a scheduled IME appointment will be responsible for rescheduling the appointment with the specified physician and paying the charge for the previously missed appointment.

Members must resolve missed appointment charges prior to disability benefits being awarded. Award of disability benefits may also be held in abeyance until the missed charge is resolved with the physician and the make-up appointment is completed.

6.4 Member's Address. If a member in receipt of disability leave allowance moves to a location more than one hundred (100) miles from the location of the Disability Board, any travel expenses incurred to appear before the Board or its designated physician shall be borne by the member. A member shall keep the Board advised of his or her current address.

6.5 Determination of Fitness. Any medical standards designed to set minimum health qualifications before a firefighter or law enforcement officer is hired, issued by the State Department of Retirement Systems or used by an employer, are not the applicable standards for determining eligibility for disability leave or retirement benefits.

6.6 Treatments. During the period of leave, the Board shall have the authority to inquire of any examining physician as to what physical, medical or therapeutic treatments might be employed to rehabilitate the applicant and, based upon such evaluation, to direct the applicant to participate in rehabilitation. If the applicant fails or refuses to submit to such treatments, the Board may terminate the applicant's disability benefits.

6.7 Member to Seek Authorization to Return to Duty. It shall be the responsibility of each member granted disability leave pursuant to RCW 41.26, to seek authorization from his/her physician and employer to return to active service at the earliest possible time the member believes he/she is fit for duty (see Part 6.7--"Return to Duty"). In the event the Board finds that a member has not actively sought authorization from his/her physician and employer to return to active service immediately upon cessation of disability, the Board shall require the member to report to a Board-approved physician to determine the member's ability to return to duty. Thereafter, the Board shall determine whether or not the member's disability leave allowance shall be continued.

6.8 Return to Duty. The original claim form signed by a member will serve as his agreement that, if the member returns to duty for a trial period, any further leave due to the same disability is to be counted as a continuation of the prior leave claim and does not begin a new six-month leave period.

6.9 Trial Return to Duty. If, at the end of the trial return period, the employee is performing his duties with average efficiency, the trial return period will cease. The member or employer will contact the Board at the end of the trial return period. If the member has not been able to perform his duties with average efficiency during the trial return period, the member or employer will notify the Board. The Board will then make its decision on the member's retirement, pursuant to Section 5.

PART 7: MEMBERS ON DISABILITY RETIREMENT LEAVE

7.1 Re-entry from Retirement. In the event a member is placed on retirement, in addition to the findings described in Board Rule 5.8, the Board may determine that the member's disability is continuous and unrecoverable, such that no possibility exists for return to duty or there is no possibility rehabilitation could restore the member to fitness for duty. In the event the Board finds that periodic examination is needed, it shall be incumbent upon the Board to order such reexamination.

In the event the retired member is residing at a location more than 100 miles from his former place of employment, the member may be authorized to be examined by a physician in his immediate area. Such physician shall first be approved by the Board and prior to such evaluation the examining physician shall be apprised by the Board of the basis upon which the examination is to be conducted and the issues to be addressed within his evaluation report. The retirement allowance of any member who fails to submit to medical examination as provided above shall be discontinued or suspended until the required medical information to justify continuation of a retirement allowance is provided by the member. In the event such refusal continues for one (1) year, his retirement allowance shall be canceled. Failure of the member to affirmatively respond to the request for reexamination shall be deemed a continuing refusal.

7.2 Periodic Re-examination of Retiree. Each member placed on disability retirement who is under 49.5 years of age is subject to periodic review, to include a medical examination and completion of the Board's re-evaluation questionnaire, approximately every six months, to determine whether disability retirement should be continued.

7.3 Discontinuation of a Retirement Allowance, Notice of. Where a periodic reexamination determines that retired member may no longer be disabled or the member requests to return to duty, the member shall be notified of the Board's action to discontinue or cancel his retirement allowance by mail. The notification shall

contain notice of the time, place, and nature of a hearing to be held under Board Rules Part 3. The purpose of the hearing will be to determine whether the member continues to be disabled.

7.4 Decision, Findings and Conclusion. Every decision and order revoking a disability retirement shall be in writing or stated in the record and shall be accompanied by findings of fact and conclusions of law. The appellant shall be notified of the decision and order in person, by phone or by first class and/or certified mail.

PART 8: MEDICAL EXPENSE CLAIMS, PROCEDURES AND GENERAL PROVISIONS

GENERAL: All claims for medical expense reimbursement must comply with Parts 8 and 9 of these Rules.

8.1 Medical Services. Medical services are defined in RCW 41.26.030(22) to be the minimum services legally required to be furnished or authorized by the Board. Medical services not listed in that section may, in the discretion of the Board, be considered for authorization on a case-to-case basis.

8.2 Submission of Medical Expense Claims. All medical expenses incurred and claimed for reimbursement by the member will be submitted through the member's health insurance provider before the claim is sent to the Employer/Board for approval. The medical expenses claim submitted for reimbursement is to be that portion not covered by the existing health insurance provider.

8.3 Inquiry Prior to Incurring Treatment Services. Some medical procedures require Board approval prior to incurring medical treatment. It is the member's responsibility to submit all pre-approval documents and/or treatment plans to the Board. In addition, members are advised to consult first with their health insurance providers or their employer/personnel officer to learn what is or is not covered in existing health insurance BEFORE incurring treatment services. Elective medical procedures, surgery and/or appliances/supplies may not be covered by the health insurance provided by the employer or authorized by the Board.

8.4 Board Authorization of Reimbursement for Medical Expenses. The Board considers only the medical necessity of the treatment/service/equipment prescribed and the reasonableness of the charges. After the Board reviews and authorizes reimbursement of a medical expense, payment of the claim is to be made by the member's employer. The employer or fiscal officer will arrange payment to the

provider or reimbursement to the member if proof of payment by the member is provided with the claim.

8.5 Member's Responsibility to Prepare Claims. Members must support claims for reimbursement for medical/diagnostic services with information from the health care provider which describes the service, explains the medical necessity for such service and includes a billing statement which lists charges. To do this, each member is responsible for maintaining contact with the employer about the medical/health insurance coverage provided by the employer.

8.6 Forms. Claims for payment of medical services shall be submitted on forms provided by the Board together with any supporting information. These forms, along with instructions for making claims for medical expense reimbursement, are provided to the employer by the Board office and are available to the member from the employer's designated personnel/administrative assistants.

8.7 Time for Filing. All claims should be submitted to the member's employer within six (6) months of the member's receipt of the original billing. Claims submitted after this time may be paid by the jurisdiction as appropriate or can be sent to the Board for determination. No claim will be allowed before the expenses are actually incurred, except as specifically authorized in these Rules.

8.8 Medicare Benefits.

A. Members are advised to contact the Social Security Administration regarding eligibility for Medicare health insurance coverage Parts A and B. If eligible for Medicare coverage, it is each member's responsibility to obtain this insurance for medical expenses. Claims will first be reduced by any portion eligible to be covered by Medicare or other health insurance available to members. (See Rule 8.9.) Members are cautioned that, if eligible for Medicare coverage and fail to obtain this coverage, neither the employer nor the Board is obligated to

authorize payment for medical expenses which would otherwise have been covered under Medicare. RCW 41.26.150 (2).

B. If the employer does not pay for Medicare premiums, members may seek reimbursement for Medicare Part B premiums, as well as premiums for medical insurance that supplements Medicare, by submitting a claim to the Board for consideration of reimbursement. (See Rules 8.4, 8.5, 8.6, and 8.7.) RCW 41.18.060, and RCW 41.20.120.

8.9 Offset for Third Party Payments and Subrogation.

A. Payment of claims shall be reduced by any amount received or eligible to be received under Workmen's Compensation, Social Security, Medicare, insurance provided by another employer or spouse's employer, pension plan, or other similar source in accordance with RCW 41.26.150(2).

Members possessing insurance benefits covering the expenses of necessary medical services, which would otherwise be the obligation of the employer, shall first present the claim to the appropriate insurance carrier and, only thereafter, make claim to the Board for those costs which are not paid by the insurer.

B. Employers shall have the subrogation rights described in RCW 41.26.150(3). The employer may provide for the payment of approved medical claims by insurance, self-funded medical benefit plan, enrollment of the member in an HMO (Health Maintenance Organization) or PPO (Preferred Provider Organization), or any other method offered by the employer.

8.10 Criteria for Authorizing Reimbursement. For each claim, the Board shall determine if the criteria listed in Rule 8.11, and in any applicable provision of these Rules, are met. If there is a doubt as to the reasonableness of a medical service charge, the burden is on the claimant to establish reasonableness.

8.11 General Provisions. The following rules apply to all claims for medical services and supplies as defined in RCW 41.26.030(22) and as authorized under these Rules.

A. The Board will allow claims under the conditions set forth in RCW 41.26.030(22) and RCW 41.26.150. Thus, claims for medical services and supplies will be approved only if they meet the following conditions:

1. The sickness or disability for which services are rendered was not brought on by dissipation or abuse.
2. The services and/or supplies are medically necessary, viz.:
    a. Essential to, consistent with, and provided for by the diagnosis or the direct care and treatment of an illness, accidental injury or condition harmful to or threatening the member's life or health;
    b. Consistent with standards of good medical practice within the organized medical community;
    c. Offered in the most appropriate setting, supply or service which can be safely provided;
    d. Not primarily for the convenience of the member, his/her physician, or other provider.
3. The charges are reasonable and considered to be usual and customary unless a provision in these Rules provides for reimbursement of a lesser amount.
4. If the member belongs to a pre-paid health plan, he/she could not have obtained reasonably equivalent services at no additional charge through such plan. The Board will decide which services are reasonably equivalent.
5. If the member is being treated by more than one physician or specialist, the member must advise the Board of the primary physician/specialist and such collateral/supplemental treatment must be described in the treatment plan.

B. The fact that the medical service or supplies were furnished, prescribed or approved by the member's physician or other provider does not, in itself, assure that the Board will determine such services as medically necessary.

C. The member's employer shall provide the Board with any supporting information to assist the Board in determining whether the criteria set forth in these Rules are met. Such information may include reasons why the claim should be denied or limitations of a member's coverage by a third party payor.

D. The Board will not approve claims for interest on delinquent accounts or charges for missed appointments.

E. Reimbursement of Costs of Reports Furnished to the Board. The Board will receive and review for approval members' claims for costs of furnishing reports to the Board under the following conditions:

1. Progress Reports. As part of Board-approved payment for medical services, the Board requires a treatment plan and at least one (1) progress report from the service provider if treatment is continuous for six (6) months or more. The Board will not approve payment of separate charges for these reports as they are considered to be part of the approved treatment plan and are to be included in charges for individual treatment appointments or office visits.
2. Evaluations and Treatment Plans. Reports to the Board which provide information needed to consider continuation of member's disability retirement leave or to approve plan for treatment of member's claimed disability/illness while on disability leave, should not be billed as a separate charge. The Board considers these reports to be the responsibility of the member as part of the evidence submitted to the Board in support of the member's disability retirement leave application.

(See Rule 6.5.) Further, the Board requires a treatment plan to be prepared and submitted for prior approval if the treatment is continuous for six (6) months or more. (See Rule 9.3.)

3. Reports of Examinations by Board-Designated Physicians. The report of an independent evaluation by a Board-designated physician who examines the member to establish medical grounds for disability retirement eligibility during the fifth or sixth month of disability leave shall be paid by the Board. (See Rule 5.6.)
4. Periodic Medical Examination Reviews for Disability Retirees under Age 49.5. Fees charged for medical evaluation report letters for required re-examination of disability retirees under the age of 49.5 years may be covered by health insurance providers. The Board will consider authorizing payment for fees charged for medical reports toward fulfillment of the periodic medical examination review which have been shown to have first been submitted to the member's health insurance provider. The Board will cover the amount of the billing not reimbursed by or rejected by the health insurance provider.

8.12 Additional Medical Services. Pursuant to the authority granted to the Board under RCW 41.26.150(1) to designate medical services payable by the employer in addition to those listed in RCW 41.26.030(22), the Board designates Part 9 herein to be additional medical services for which members may submit claims, subject to the conditions and limitations set forth in these Rules and given statutes.

8.13 Quorum of the Board. A quorum of the Board may approve payment of members' claims at other than regular Board meetings. [Refer to Part 2, Rule 2.2 (B).]

PART 9: REIMBURSEMENT OF CLAIMS FOR MEDICAL TREATMENT/ PROCEDURES

9.1 General Rule. The Board will approve payment of claims for all medical services defined in RCW 41.26.030(22) under the conditions set forth in RCW 41.26.150 and Part 8 of these Rules.

9.2 Emergency Treatment. Charges for emergency services and treatment not covered by the member's insurance provider will be approved in cases of sudden, acute medical emergencies or accidental injuries, provided claims are processed as required in Part 8 of these Rules.

9.3 Continuous Treatment/Services. Treatment or services requiring continuous, consecutive and frequent treatment for mental health/psychological counseling, substance abuse treatment and chiropractic treatment are subject to provisions set forth herein. Evaluations and treatment plans, including estimate of duration and frequency of treatment, must be submitted for review and prior approval by the Board before the member undertakes treatment. Claims for reimbursement of the cost of continuous treatment undertaken at member's own volition without prior Board approval will be considered at the Board's discretion and may not be approved.

A. **Members Covered by Health Insurance Provider.** When the member is covered by a health insurance provider, the member is required to submit claims to their health insurance provider for payment. Certain health insurance providers, such as King County Medical, Blue Shield or Blue Cross, pay for medical services up to a specified amount, subject to the contract entitlement. Once medical service costs exceed the member's contract year entitlement, the portion of the claim not covered or rejected by health insurance may be submitted to the Board for its consideration [Ref. Rule 9.3 (C)].

B. **Members Covered by a (Non-Self-Funded) Group Plan Health Provider.** When the member is covered by a comprehensive group health insurance provider, such as Group Health or Pacific Medical, the member is required to first seek medical services from those health insurance providers since they are known to have medical staff/specialists available.

1. If this group plan health insurance provider's physicians certify that specific medical services are unable to be provided through their facilities, the member should seek a referral through the health insurance provider's physician to a physician/specialist outside of that group plan health facility.
2. When there is a referral, such group plan health insurance provider is required to pay up to an aggregate maximum dollar amount per contract year for specific services.
3. If a physician of a group plan health insurance provider refuses to make such a referral, the reasons for the refusal should be reported in writing to the Board by the member or the physician since the reasons could bear upon the issue of the medical necessity of such services.
4. If such a referral is not provided with the claim, the Board will consider such services provided outside the member's group plan health facility as elective on the part of the member and may deny such claim.

C. **Medical Expenses Exceeding Contract-Year Entitlement of a Given Health Insurance Plan.** In the event the cost of specific medical services will exceed the aggregate contract year entitlement provided by a health insurance provider, the member may be asked to submit a treatment plan for the Board's review prior to approval of payment for services over and above the designated contract maximum.

D. **Medical Treatment/Services Found Unreasonable.** If continuous treatment or charges thereof are found to be unreasonable or excessive, the Board may require the member to undergo specific medical examination and provide a medical evaluation from a physician or specialist. If a member fails to undergo such an examination, the Board will construe such services as elective on the part of the member and will deny such claim.

E. **More Than One Physician for Same Injury/Illness/Condition.** If the member is being treated simultaneously for the same injury/illness/condition by a physician or specialist in addition to his primary care physician, the member must advise the Board of his/her primary physician/specialist and provide the Board with the treatment plan which describes the supplemental and/or additional medical service. In addition, the Board may require a statement from the primary physician describing reasons for referral to other physicians/specialists.

9.4 Chiropractic Treatment/Services. Claims for chiropractic services are subject to the provisions set forth in Rule 9.3 and the following conditions:

A. **Treatment Plan Required for Continuous Treatment.** The Board requires an evaluation and treatment plan for more than two (2) chiropractic visits for the same injury/illness/condition.

B. **Submission of Treatment Plan.** The service provider is required to submit an initial individualized treatment plan which was prepared within one (1) month of commencement of treatment or upon request of the Board. Reports of the progress of the member in the treatment program are to be submitted by the therapist at least once every six (6) months if treatment continues for six months or more. If the member will be in treatment for more than six (6) months, a new

(second) treatment plan must be submitted within seven (7) months of the initial commencement of treatment. The Board will review the progress reports and treatment plans to determine whether charges for such treatment should continue to be approved for payment.

C. **Components of the Treatment Plan.** A treatment plan is required as an individualized program to meet the unique treatment requirements of the member. The treatment plan shall include, but not be limited to, the following:

1. Current medical diagnosis;
2. significant history;
3. description of treatment or therapy (treatment modality, frequency, length of treatment sessions, estimation of duration, approximate recovery time, criteria used to indicate progress, and names and activities of other professionals who participate in the treatment);
4. description how the condition being treated affects the member's ability to perform required regular day-to-day duties of the job and/or tasks of daily living with average or better efficiency.

D. **Member Compliance to Submit Claims.** Nothing in this Rule relieves the member from complying with the requirements of Rule 8.7 in that claims must be submitted within six (6) months of the member's receipt of the original billing from the provider and of Rule 9.3.

9.5 Mental Health Services. Claims for mental health service, including psychological counseling services, are subject to provisions set forth in Rule 9.3, and the following conditions:

A. **Treatment Plan Required for Continuous Treatment.** The Board requires an evaluation and treatment plan for more than two (2) mental health visits for the same condition/disability.

B. **Conditions for Approval of Mental Health Service.** Payments for mental health services provided to a member during a continuous 12-month period will be approved only under the following conditions:

1. The mental health services are provided by a psychiatrist, a licensed psychologist, a Master's level clinical social worker who is certified by the National Registry of Health Care Providers in Clinical Social Work or the N.A.S.W. (National Association of Social Workers), or a licensed mental health counselor who is licensed by the Department of Health in the State of Washington, or by any other state whose certification requirements are, at a minimum, equivalent to the certification requirements set forth by Washington State. It shall be the sole responsibility of the member seeking treatment to provide the necessary documentation to the Board establishing the treating provider's licensing and/or certification credentials.

   The Board may choose to make an exception to any of the qualification provisions in this paragraph in the case of a mental health provider who is able to provide evidence of education, credentials and work experience satisfying the spirit of this paragraph.

2. The member's physician or department administrative officer has recommended such services. (Exception: The member may seek consultation with a mental health specialist, as defined in item "#1" above, without administrative recommendation or a physician's referral for two (2) sessions. If treatment is to be continuous, submission of a treatment plan, prepared by the service provider, is required within the first month of treatment. (Refer to Rules 9.2 and 9.3.)

3. The service provider submits an initial individualized treatment plan which was prepared within one (1) month of commencement of treatment or upon request of the Board. Updated treatment plans are to be submitted by the person providing treatment once every six (6) to ten (10) sessions in order for the Board to determine whether charges for such treatment should continue to be approved for payment.

4. One 50-minute unit of psychotherapy is payable at the following maximum rate:

a. Psychiatrist:	$150.00
b. Psychologist:	$125.00
c. Clinical social worker:	$110.00
d. Certified mental health counselor:	$110.00
e. Advanced registered nurse practitioners	$125.00

C. **Components of the Treatment Plan.** A treatment plan is required as an individualized program to meet the unique treatment requirements of the member. The treatment plan shall include, but not be limited to, the following:

A. Current medical diagnosis (DSM-IV 5-digit diagnostic code plus other axes involved and any relationship to the condition).

B. Significant history.

C. Prescribed medication (dosage, frequency, side effects, estimated length of treatment).

D. Description of treatment or therapy (treatment modality, frequency, length of treatment sessions, estimation of duration, approximate recovery time, criteria used to indicate progress, and names and activities of other professionals who participate in the treatment).

E. Description how the condition being treated affects the member's ability to perform required regular day-to-day duties of the job or tasks of daily living with average or better efficiency.

D. **Member Compliance to Submit Claims.** Nothing in this rule relieves the member from complying with the requirements of Rule 8.7 in that claims must be submitted within six (6) months of the member's receipt of the original billing from the provider and of Rule 9.3.

9.6 Substance Abuse Services. Claims for outpatient or inpatient treatment for substance abuse are subject to the provisions set forth in Rule 9.3. The Board will approve member's cost of treatment for substance abuse (alcohol or drug abuse) provided the following conditions are met:

A. The service provider is state-approved per Chapter 248-26 WAC.

B. Total charges do not exceed a maximum cost of $6,000.

C. The member's physician, personnel officer or commanding officer:
   1. Recommends such treatment; and
   2. Provides a written statement.

D. The recommended treatment is prescribed by the member's physician and reviewed by the Board physician prior to approval of reimbursement by the Board.

E. The service provider submits to the Board a written treatment plan which was prepared within five (5) business days of the member's admission to such program. The plan shall include a recommendation of the required length of time the member remains in the program/facility. The plan will be used by the Board in determining whether the conditions set forth in Rule 8.11(A) are met for these services. The plan must be submitted with the member's claim for payment of such medical services.

F. Nothing in this Rule relieves a member from complying with the requirement in Rule 8.7 that all claims for reimbursement shall be submitted within six (6) months of the member's receipt of the original billing.

G. Subject to the dollar limitation set forth above, the member remains in the program for the recommended length of time and the service provider submits written confirmation to the Board. If the member leaves the program against medical advice, or before the recommended length of treatment, the Board may approve payment of only a pro rata portion of the reasonable costs of such program based on the time the member spent in the program.

H. The limitation on allowable costs shall apply to all costs of treatment of substance abuse, including those for hospital, physician and nurse services, medication and supplies allowable under RCW 41.26.030(22)(a), (b) and Board Rule 8.11.

I. For members applying for payment for repeated treatment, a full written case review by a Board-selected specialist or a certified alcohol/substance abuse evaluation service, will be obtained and reviewed by the Board before approving additional treatment or payment of member's claim.

    1. Repeat patients are expected to pay for the new treatment and evaluation themselves unless the employer or insurance provides payment for additional substance abuse treatment programs;
    2. After a period of one (1) year following completion of repeated treatment, the Board may approve reimbursement if:
        a. The member provides the Board with satisfactory evidence that he/she has continued his/her recovery process; and
        b. The employer approves payment for repeated treatment.

9.7 Vision Benefits. Payments for eyeglasses and contact lenses, plus the reasonable costs of necessary eye examination services of a licensed ophthalmologist or

optometrist, will be approved pursuant to the authority granted to the Board under RCW 41.26.150, if eyeglasses are prescribed by an ophthalmologist or optometrist.

The Board will approve payment for one pair of eyeglasses or contact lenses, at the member's option or as prescribed, to correct vision when required for a new prescription in accordance with the following schedule:

A. **Eyeglass Lenses and Frames.** $500 maximum per single set of frames and pair of lenses not more than once every twelve (12) consecutive months. Lenses covered include single vision, bifocal, or trifocal lenses. Frames must be of average quality and serviceability unless other frames are prescribed.
B. **Second Pair.** A second pair of monofocal (i.e., computer) glasses shall be approved only if prescribed by an ophthalmologist or licensed optometrist. The maximum cost of the second pair shall not exceed $350 per single set of frames and pair of lenses not more than once in twenty-four (24) consecutive months.
C. **Contact Lenses.** $100 per lens not to exceed $250 maximum during any 12-month period including disposable contact lenses.
D. **Replacement.** Claims for a replacement pair of eyeglass frames and/or lenses or contacts will be allowed. Only one replacement pair per year, due to accidental damage, will be allowed, not to exceed the amount allowable above.
E. **Additional/Spare Pair.** No reimbursement will be made for a spare pair of glasses or contact lenses.
F. **Maximum Allowable Amount.** The maximum amount allowed for reimbursement by the Board will represent an average charge for vision services considered usual and customary within the applicable geographical area. Refer to Rule 8.11(3).
G. **Applied Offset.** Any payment by the employer will be limited to the net balance after any insurance reimbursement or other settlement is deducted. Refer to Rule 8.9.

9.8 Medical Equipment and Supplies. In addition to the rental of durable equipment provided for in RCW 41.26.030(22)(b)(iii)(E), the Board will consider for approval claims for purchase of durable medical equipment and supplies under the following conditions:

A. **Hearing Aids.** Payment for hearing aid purchase will be allowed without prior Board approval if the claim meets all of the following conditions and includes all documentation required herein. Equipment charges that exceed these Board-mandated limits may require submission of the claim for Board review with additional medical information or additional cost estimates required.

1. **Conditions for Approval of Payment for Hearing Aids:**
    a. Medical evaluation by an otolaryngologist to rule out any treatable ear conditions.
    b. Hearing evaluation by a state-certified audiologist to include an audiogram and recommendations regarding the type of hearing aid(s).
    c. Fitting of hearing aid(s) only by a state-certified audiologist.
    d. Statement by the evaluating audiologist, as well as a copy of the audiological evaluation (e.g., audiogram), must be included in the claim as proof the hearing loss is progressive, permanent and/or not likely to improve with other treatment (e.g., medication, surgery, etc.).
    e. Maximum cost not to exceed $3,000 per hearing aid or $6,000 per pair during any five-year period based on equipment of average quality and serviceability. Any difference between the amount allowed by the Board and the cost of the hearing aid purchased shall be the responsibility of the member.
    f. The cost must also include at least a 2-year warranty on the hearing aids.

2. **Hearing Aid Maintenance and/or Repair:**
   a. Payment is allowed at reasonable cost for regular maintenance beyond the 2-year warranty, as well as expense for batteries, on submission of expense claim forms by the member to the LEOFF-I employer.
   b. Members requesting payment for repair of hearing aid(s) from their LEOFF-I employer must provide the employer with appropriate claim forms and a written explanation of why the devices are no longer serviceable.
3. **Replacement of Hearing Aids:** Replacement costs need to be submitted to the Board as a claim for approval, and will be made on a case-by-case basis. Replacement expenses will be approved under the following conditions:
   a. Replacement occurs not more than once every five years.
   b. If replacement occurs more frequently, proof must be provided that the need is duty-related or medically necessary.
   c. Amounts allowed will be the reasonable cost of a hearing aid of average quality and serviceability.
   d. Examination fees will be allowed if provided by a licensed otolaryngologist or state-certified audiologist.
   e. Any payment of the employer will be limited to the net balance after any insurance reimbursement of other settlement is deducted.
   f. Any difference between the amount allowed by the Board and the cost of the hearing aid(s) shall be the responsibility of the member.
4. **Member Compliance to Submit Claims.** Nothing in this rule relieves the member from complying with the requirement of Rule 8.7 in that claims must be submitted within six (6) months of the member's receipt of the original billing from the provider, and of Rule 9.3.

B. **Purchase of Durable Medical Equipment and Supplies.** The Board must receive and review a request for pre-approval to purchase durable medical equipment and/or supplies. This will include purchase of wheelchairs, special equipment, medical or surgical equipment, orthotics, etc., which are prescribed by a physician as medically necessary for treatment of member's illness or disability.

These items are in addition to those considered necessary medical services and supplies under RCW 41.26.030(22) (iii).

Members and employers are advised that fees and charges for purchase/rental of such durable medical equipment and supplies (or percentage thereof) may be covered by health insurance providers. Therefore, members must first submit claims for payment to health insurance before sending them to the Board.

C. **Other.** The Board will not approve any claims for equipment or supplies which have a non-medical use or function.

9.9 Dental Benefits.

A. All dental-related expenses up to an annual amount of $3,000 will be covered. Dental expenses above this amount will be the responsibility of the member. The plan period runs from January 1st of each calendar year to December 31st of the same year.
B. This plan does not include cosmetic dental procedures.
C. No payments will be authorized without proof that the member has first submitted the claim for payment to the member's outside dental insurance.
D. Cosmetic dental procedures that are determined to be medically necessary by a dentist, orthodontist, or oral surgeon will be decided on by the Board on a case-by-case basis. Except in the case of a medical emergency, payment for cosmetic procedures will not be authorized without first obtaining prior approval by the Board.

E. Member Compliance to Submit Claims. Nothing in this rule relieves the member from complying with the requirement of Rule 8.7 in that claims must be submitted within six (6) months of the member's receipt of the original billing from the provider, and of Rule 9.3.

F. Approval of dental benefits must comply with Rule 8.3, "Inquiry Prior to Incurring Treatment Services".

9.10 Additional Medical Services and Supplies. The following services may be considered by the Board as additional medical services and approved for payment subject to the requirements set forth in Part 8 of these Rules and the following listed conditions. Claims will be considered on an individual basis.

A. **Acupuncture/Acupressure and/or Massage Therapy.** Claims for acupuncture/ acupressure services and/or massage therapy are subject to the provisions set forth in Rule 9.3. Payments for acupuncture/acupressure and/or massage therapy provided to a member by an acupuncturist and/or massage therapist during a continuous six (6) month period will be approved under the following conditions:

1. Services have been prescribed by a licensed physician.
2. Services are provided by a certified acupuncturist (C.A.), including an M.D. or a D.O., as well as other providers awarded a diploma of acupuncture by the National Commission for the Certification of Acupuncturists (N.C.C.A.), or a licensed massage therapist.
3. Member/provider first submits a claim for payment to the member's insurer or third party payor, as directed in member's health insurance contract.
4. If treatment is to be continuous (more than two (2) visits for the same illness or condition) an evaluation and proposed treatment plan must be

submitted by the prescribing physician to the Board for pre-approval as required by Rule 9.3.

5. Claims for acupuncture/acupressure and/or massage therapy expenses must be filed with member's employer within six (6) months of the member's receipt of the original billing as required by Rule 8.7.

B. **Birth Control Procedures, Devices and Supplies.**

1. Vasectomies, tubal ligations, and other surgical procedures for purposes of birth control are not considered medically necessary.
2. If procedure is medically necessary for the health of the member, application for pre-approval must be submitted to the Board, along with the physician's statement attesting to the medical necessity. The Board will consider such applications on a case-by-case basis.

a. The member or the member's provider must first submit a claim for payment of such medically necessary, pre-approved procedures to member's insurer or third party payor, as directed in member's health insurance contract.

b. Claims for payment of the difference between the cost of pre-approved services and the amount covered by insurance must be filed with member's employer within six (6) months of the member's receipt of the original billing as required by Rule 8.7.

3. Claims for payment of devices and/or supplies used for birth control are not considered to be necessary medical expenses and will not be approved by the Board.

C. **Cosmetic Surgery/Reconstructive Surgery.**

1. **Cosmetic Surgery:** Surgery to improve appearance or to correct physical defects, such as a pre-existing or congenital condition, is defined as

"cosmetic surgery". Applications for cosmetic surgery will not be approved. Claims for reimbursement or payment of claims for cosmetic surgery will not be approved.

2. **Reconstructive Surgery:** Surgery required as the result of accidental injury or incidental to/following disease of an involved body part and which is necessary to improve or correct the function of the involved body part, will be considered on a case-by-case basis.

D. **Exercise and Physical Fitness Programs.** The Board, as do the employers, encourages and supports physical fitness for members and is aware of its importance in prevention of injuries and disease. However, physical fitness is considered the responsibility of the individual member.

Members enrolling in exercise programs, physical fitness clubs and/or health spas are advised the Board considers these programs as elective on the part of the member and not medically necessary.

E. **Home/Health Care Services.** If confined to his/her home following an accident or illness, a member is eligible for home health visits for intermittent skilled nursing care under the following conditions:

1. Services are prescribed by a physician.
2. Services are part of a written treatment plan prepared by the physician and periodically reviewed by a physician. The Board will consider non-medical charges if deemed necessary by the health care provider.
3. If care exceeds six months, the Board may require submission of a new treatment plan, or may require member to be examined by a Board-appointed physician.

4. Services are provided by a professional or paraprofessional licensed and/or certified by the state or professional credentialing agency, or services of a Medicare-participating home health agency.
5. Services of an informal caregiver, who ordinarily resides in the member's home or is a member of the family of either the member or the member's spouse, and who provides unpaid assistance to a spouse, relative or other claimant, are not eligible for approval of reimbursement.
6. If eligible for Medicare, member has applied for or is receiving both Part A and Part B of Medicare coverage, whether paid for by the employer or the member.
7. Unless otherwise approved by the Board, the maximum cost allowed shall not exceed the average daily cost of nursing home care in the county where provided, as determined by the U.S. Department of Health and Human Services (www.LongTermCare.gov).
8. Request for reimbursement shall be made by completion of all forms required for consideration of a medical claim and include claim Form #10. All medical documentation required from the prescribing physician and the home health care provider or providing agency, necessary to support the claim, must be attached.

F. **Hospice Care.** Benefits will be provided for hospice care for a terminally ill member under the following conditions:
   1. Member is admitted to a DSHS-certified or Medicare-approved program;
   2. Care provided is part of a written plan of continuous care, prescribed and periodically reviewed by a physician;
   3. If eligible for Medicare, member has applied for or is receiving both Part A and Part B of Medicare coverage, whether paid for by the employer or the member.

G. **Long-Term Care Facilities.** Adult Family Home, Boarding Home, Nursing Home: Confinement in any of the above-entitled facilities is to be provided as a minimum required service. The Board will review and consider for approval of placement and payment of charges for care in any of these facilities under the following conditions:

1. Placement is prescribed by a physician or advanced registered nurse practitioner.
2. The facility must have obtained and remained current on Adult Family, Boarding Home, or Nursing Home license from the State of Washington.
3. If the facility is located outside the State of Washington, it shall be the responsibility of the member to provide documentary evidence that the facility is licensed in the state or country where the facility is located and that the licensing requirements are similar, equal to, or greater than those required by the State of Washington.
4. If placement exceeds six (6) months, the Board shall require a treatment plan from the facility.
5. If placement exceeds six (6) months, the Board shall require an updated progress report from a treating physician not less than every six (6) months.
6. If eligible for Medicare, member has applied for, or is receiving, both Part A and Part B of Medicare coverage, whether paid for by the employer or member.
7. The provider's/member's claims for payment will be submitted directly to member's insurance/third party payor or employer.
8. Application for prior approval of long-term care services/placement will be considered on a case-by-case basis.

H. **Organ Transplants.** The Board will not accept requests for pre-approval of organ transplantation surgery. Members are advised to process all such applications through their physicians to their health insurance providers and Medicare-certified transplant centers.

If organ transplantation surgery is performed on patient demand, and/or outside the member's medical/hospital coverage or Medicare-certified transplantation center, the Board will not accept or consider for approval any claim for reimbursement or payment. (See Rule 8.3)

I. **Smoking Cessation.** The Board will approve reimbursement to members of a maximum of $250.00, one time only, following successful completion of a smoking cessation program and upon maintenance of program goals for one (1) year.

Members are requested to submit a description of the smoking cessation program selected and a treatment plan to the Board for prior approval.

Claims for reimbursement will be submitted as required in Part 8 of these Rules.

J. **Specialized Surgeries:**

1. **Eye Surgery.** Eye surgeries, to include standard corneal surgery or lens implants, will be eligible for coverage if determined to be medically necessary by the provider and meet all criteria specified herein. Routine refractive surgery for non-surgically induced conditions or presbyopia is not eligible for coverage. Pre-approval must be obtained before entering into treatment.

   Members are advised to review the following eligibility criteria with their physicians prior to submission of a claim to the Board.

   a. **Corneal Laser Surgery (Medical Condition):**

a. A specific corneal disorder must be diagnosed with ICD-9 code specified.
b. Medical necessity and failure of standard non-laser treatment must be documented.

b. **Laser Treatment (Refractive Conditions):** Necessity must be proven by documentation of the following conditions:
   a. Induced refractive error following previous eye surgery; or
   b. Intolerance of contact lens or spectacles.

c. **Lens Implants:** Only standard monofocal lens implants will be approved. Specialty multifocal lens implants are excluded from coverage.

2. **Other Surgeries.** From time to time, the Board may add Rules for other specialized surgeries and techniques, as need arises.

L. **Weight Loss Programs.** The Board may approve payment for a weight loss program that is prescribed, approved and monitored by a physician, on a one-time-only basis, considered case-by-case.

The Board will consider payment of the claim for the member's pre-approved weight loss program, exclusive of costs of food supplements/replacements. Claims for reimbursement must be filed with member's employer within six (6) months of the member's receipt of the original billing as required by Rule 8.7.

PART 10: REVIEW OF BOARD RULES: AMENDMENTS, REVISIONS PER STATE RETIREMENT SYSTEMS.

10.1 Periodic Review. These local Board rules and regulations shall be accordingly reviewed and revised, periodically or as often as necessary, subject to the recommendations of the State Retirement Systems usually provided in their annual pension seminar, to assure that:

A. Provisions herein remain to conform with Washington statutory and administrative codes.
B. Dollar amounts specified in schedule of benefits reflect current and reasonable average charges in the local area.
C. Provisions herein reflect current philosophy and intent of the Boards.

Member claims are subject to the last revised rulings adopted and exceptions will not be made. Any newly revised rulings and statutes supersedes previous policies and makes obsolete any prior existing rule or statute therefore claims may not be made to apply to obsolete policies.

10.2 Chronology of Amendments/Revisions of Board Rules.

Adopted/ Effective Date	Policy Revisions/Amendments
Dec 31, 2014	Removed Rule 9.10 (I), Sexual Dysfunction and Infertility": ~~I. Sexual Dysfunction and Infertility. Some services and prescriptions for sexual dysfunction are determined to be reimbursable. However, the Board reserves the right to judge each case on its own merits, considering such factors as medical necessity, frequency of use, organic diagnosis by a physician, and cost. Services, supplies and some procedures for reproductive disorders and defects are considered to be elective and not medically necessary.~~
Nov 26, 2014	Rule 9.7B Second Pair *"…shall not exceed $350.00 per single set…".* Board reviewed previous rulings and decided to increase limit to $350.
	Amended Rule 9.5-B (1), "Mental Health Services" to allow exceptions for providers who "provide evidence of *education, credentials and work experience".* Previous rule asked for "evidence of capability" but did not define capability.
	Rule 8.7 Time for Filing: *"All claims ~~must~~ should be submitted to the member's employer within six (6) months of the member's receipt of the original billing. Claims submitted after this time may be paid by the jurisdiction as appropriate or can be sent to the Board for determination. ~~will only be approved by the Board if it is submitted late due to circumstances not within the control of the member.~~ No claim will be allowed before the expenses are actually incurred, except as specifically authorized in these Rules."*
	Amended Rule 9.10.E.2 Home/Health Care Services: 2. Services are part of a written treatment plan prepared by the physician and periodically reviewed by a physician. *The Board will consider non-medical charges if deemed necessary by the health care provider.*
Feb 26, 2014	Rule 9.10.E.7 Home/Health Care Services: *"Unless otherwise approved by the Board… as determined by the U.S. Department of Health and*

	Human Services (www.LongTermCare.gov)"

Sept 7, 2012	Rule 9.8A,1,e Condition for Approval of Payment for Hearing Aids: *"Maximum cost not exceed $3,000 per hearing aid or $6,000 per pair"*

May 26, 2010	Rule 8.2 Submission of Medical Expense Claims" *"…is sent to the Employer/Board for…"*
	Rule 4.1 Submission of Claims, additional language: *"Applications and Claims required to be submitted to the Board shall comply with the Following criteria:"*

Jan 1, 2009	Rule 9.7A Eyeglass Lenses and Frames: *"$500.00 maximum per Single set…"*
	Rule 9.7B Second Pair *"…shall not exceed $300.00 per single set…"*
	Rule 9.7C Contact Lenses *"…not to exceed $250.00 maximum during any 12-month…"*

Jan 31, 2007	Rule 9.10-E, "Home/Health Care Services", amended to replace: "physician" with "licensed/certified health care provider". Stipulation care would only be allowed following an accident or illness deleted

Sept 27, 2006	Rule 9.10-K, "Specialized Surgeries" amended to expand benefits under eye surgery to include corneal laser surgery, laser treatment and lens implants
	Rule 9.7-D, "Vision Benefits". Replacement pair of glasses, frames, or contacts made available for both retired as well as active-duty
	Rule 9.7 A-C, "Vision Benefits", amended to increase benefits for glasses, frames or a second pair up from $295 to $350
	Rule 9.5-B(4), "Mental Health Services", approved increase in maximum provider fee allowable for psychotherapy

Feb 22, 2006	Rule 9.8,-A, "Hearing Aids" amended to eliminate need for prior approval by the Board if all conditions of the rule are met

Nov 30, 2005	Rules 2.2 and 2.3 amended, 2.4 deleted. Board Clerk to maintain election procedures and hold Fire and Law elections in alternate years
	Reference to "two-year term" omitted

Apr 28, 2004	Rule 9.5-A (1), "Mental Health Services" amended to allow exceptions for providers who could furnish evidence of capability
Sept 24, 2003	Rule 6.3 enacted to set penalties for missed IMEs
Nov 26, 2002	Rule 9.9, "Dental Benefits" amended to limit benefits to $3,000 in any calendar year
Aug 28, 2002	Merged Rules 9.10 (G) and (H) into 9.10 (G), "Long Term Care Facilities" to make requirements the same for adult family homes, boarding homes and nursing homes
Apr 24, 2002	Revised Rule 9.9, "Dental Benefits" to cover all services except cosmetic
	Revised Rule 9.5-B, "Mental Health Services" to change "certified" mental health counselor to "licensed" and add out-of-state stipulation
Mar 27, 2002	Revised Rule 9.10-J to eliminate requirement for review of claims for approval of Viagra. Second paragraph deleted
Apr 4, 2001	Revised Rule 9.5-B(4), "Conditions for Approval of Mental Health Service", to increase maximum rate allowed and add subsection "e", "advanced registered nurse practitioners"
Dec 20, 2000	Revised Rule 9.10-J, "Sexual Dysfunction & Infertility", to eliminate restriction on dosage allowed
Oct 25, 2000	Revised Rule 9.10-E, "Home/Health Care Services", to improve criteria for approval of in-home care to include paraprofessionals and set maximum cost of daily care, and require new Form #10.
	New Form #10 approved for claims for home health care
	Rule 9.10-H, "Nursing Home/Hospital Extended Care Facility", revised to require treatment plan when placement in nursing home/extended care facility exceeds six months
	Form #9 revised to include assisted living care facilities
	Rule 9.10-L (a), "Refractive Keratotomy Surgery (RK)", deleted
Mar 22, 2000	Revised Rule 9.7, "Vision Benefits" to set $295 maximum for frames and lenses once every 12 months; second pair of computer glasses allowed

Feb 23, 2000	Amended Rule 9.8-A, "Hearing Aids", to increase maximum allowed to $2,500/aid or $5,000/pair every five years; examination by otolaryngologist and evaluation by an audiologist required; maintenance and battery replacement allowed
Feb 24, 1999	Amended Rule 9.7-B, "Vision Benefits", to increase maximum allowed for frames to $95/24 months
	Amended Rule 9.10-J, "Sexual Dysfunction and Infertility" to impose maximum for Viagra of 75% of cost not to exceed 15 doses
Nov 23, 1998	AmendedRule9.10-J, "Sexual Dysfunction/Impotence/ Infertility" to allow consideration of Viagra as reimbursable. Amended Rule 9.10 A, "Acupuncture/Acupressure", to include massage therapy
Oct 30, 1998	Amended Rule 9.5-B, "Mental Health Services", to include "certified mental health counselor" payable at $80/50-minute session
Dec 17, 1996	Amended Rule 8.8, "Medicare Benefits" to define rights to apply for reimbursement of Medicare/Medigap insurance premiums
Nov 26, 1996	Amended Rule 9.5 B, "Mental Health Services" to add item #4 to designate maximum rate allowable for psychotherapy
May 29, 1996	Amended Rule 9.5, "Mental Health Services" to require submission of updated treatment plans every six (6) to (10) sessions
Jun 27, 1995	Amended Rule 9.9, "Dental Benefits", and amended Rule 8.3, "Inquiry Prior to Incurring Treatment Services"
Dec 14, 1993	Amended Parts 8 and 9; added Section 9.10, "Additional Medical Services and Supplies"
Sept 29, 1992	Revised Rule 9.7, "Vision Benefits"
Jul 28, 1992	Revised Rule 9.7, "Vision Benefits"
Mar 31, 1992	Revised Rule 6.1 A and B; repealed Section 6.1.C
	Revised Rule 6.6 and 6.7. Added new section 6.8
Aug 16, 1990	Revised Rule 6.1; added new Section C

Apr 19, 1990	Revised Rule 9.7
Apr 18, 1989	Revised Board Rules/Policies effective April, 1989
	Repealed July 1, 1981 Board Rules/Policies
Jan 16, 1985	Amended Part 8.6, alcoholism/drug treatment
Dec 12, 1983	Revised eyeglass policy, Part 8.3
Mar 3, 1982	Amended Part 3.2
Jul 1, 1981	Adoption of revised Board Rules and Policies
Oct 1970	Original formation of King County Board Policies

CITY OF OLYMPIA
LEOFF DISABILITY BOARD

POLICIES AND PROCEDURES

I. GENERAL

A. Purpose

The policies and procedures contained herein are promulgated for the purpose of:

1. Apprising employees of the City of Olympia covered by LEOFF of the benefits provided under Chapter 41.26 RCW, and the means by which such benefits may be obtained.

2. Serving the public interest by regulating the payments of benefits.

3. Informing both local LEOFF members and the general public of the procedures under which the Disability Board operates so as to provide consistency and uniformity in dealing with individual member's claims.

B. Scope

These policies and procedures shall be applicable to all employees covered by Chapter 41.26 RCW, whether firefighter or police officer, unless otherwise specifically provided herein.

C. Effect of Policies and Procedures

All uniformed personnel of the City of Olympia covered by LEOFF shall be subject to the policies and procedures contained herein to the extent consistent with applicable state statutory provisions and shall at all times follow the procedures contained herein to avoid possible loss of benefits. In the event any policy or procedure as applied to the particular member shall be held to be contrary to state law, such member shall not be relieved of any other requirement contained herein and any such finding shall not relieve the member from the responsibility to comply with all other procedures and policies contained herein.

A member's failure to follow these procedures may, at the discretion of the Disability Board, subject him/her to the loss of benefits otherwise due under the LEOFF Act.

D. Promulgation of Policies and Procedures

Upon adoption of these rules, each member of the respective departments shall be provided a copy of such rules. It shall be the responsibility of the Board Secretary to document each member's receipt of such rules so as to obviate any future possibility of a member alleging that he/she was unfamiliar with the requirements contained herein and lost benefits as a result thereof. It is the responsibility of the LEOFF Disability Board to provide all LEOFF 1 members with a copy of the Disability Board Policies and Procedures upon completion of any changes and/or ensuing updates formally adopted by the LEOFF 1 Disability Board.

E. Appeal Procedure

Any member feeling aggrieved by an order of the LEOFF Disability Board, which is within the jurisdiction of the State Retirement Board, shall comply with the provisions of RCW 41.26.200 in perfecting such an appeal to the State Board.

II. MEETING PROCEDURES

A. Membership - Disability Board

Pursuant to RCW 41.26.110 (a), the LEOFF Disability Board shall be composed of the Mayor or his/her designee, who shall be a member of the City Council, another member of the City Council appointed by the Mayor, one active or retired firefighter to be elected by the firefighters employed by or retired from the City, one active or retired law enforcement officer to be elected by the law enforcement officers employed by or retired from the City, and one member from the public at large who resides within the City to be appointed by the other four members designated herein. Retired members who are subject to the jurisdiction of the Board have both the right to elect and the right to be elected under this section. The Human Resources Director or his/her designee shall appoint the Secretary to the LEOFF Board. All members, duly appointed, shall be voting members and, if present, shall participate in the actions taken by the Board unless disqualified by a concurrence of a majority of the members present due to conflict of interest. Only the Mayor may send, in his/her stead, a representative to participate in Board actions who shall be a member of the City Council. A majority of the members of said Board shall constitute a quorum and have power to transact business.

B. Regular Meetings

The LEOFF Disability Board shall hold a regular monthly meeting on the second Monday of each month at 5:30 p.m., in the Executive Conference Room at City Hall. In the event such Monday is a City holiday, such meeting shall be held on the third Monday of the month. The LEOFF Disability Board shall elect one Board member to serve as Chairperson and one Board member to serve as Vice-chairperson at the January Board meeting of each year. The Vice-chairperson shall serve as Chair in the absence of the elected Chairperson. In the absence of the Chairperson and Vice-chairperson, the Board member present who is the most senior in tenure to the Board shall serve as Chair.

The Board Secretary shall keep the official record of the deliberation of the Board meetings, and prepare all findings and conclusions and other orders connected therewith for entry or submission to the State Retirement Board. In the event an interested party requests a stenographer to be present at a meeting to record the proceeding, such request must be made in writing, along with proper assurances that the cost thereof will be paid by the requesting party, no less than five (5) working days prior to the meeting in question. If a party wants a verbatim transcription of the tape recording made of a previous meeting, he/she must give similar written notice within ten (10) working days of the desired date for delivery of the transcript. In either case, the requesting party shall underwrite the costs involved.

III. PROCEDURES TO RECEIVE BENEFITS

A. Relationship between Sick Leave and Disability Leave

No member shall be absent or laid-off from duty due to sickness, injury or other disability, except when authorized by the applicable provisions of these policies and procedures. Disability leave benefits granted pursuant to RCW 41.26.120 shall be controlled by these provisions unless specifically provided otherwise herein.

B. Disability Leave

All applications for disability leave shall be submitted to the Board Secretary of the LEOFF Disability Board and shall bear the date the application was received by the Board Secretary. No application for disability leave shall be accepted by the Board Secretary unless it is accompanied by at least one physician's report substantiating the nature of the illness and confirming that the applicant is unfit for duty. In addition, an evaluation may be required by a physician designated by the Disability Board.

Such application, with appropriate documentation, shall thereafter be forwarded to the Disability Board for consideration.

C. Date of Commencement of Disability

In general, the Board may set the date of commencement of the disability retroactively to the date a proper application is made or prior to said application if the member is reasonably unable to immediately apply as a result of the disability but makes application as soon thereafter as he/she is able. In the event the member has seen or otherwise communicated with a physician and such physician has verbally advised that the member lay-off from duty, but has been unable to provide the written documentation described above, the Board Secretary shall accept the member's application attaching thereto a statement of the applicant documenting this circumstance and the Board may thereafter declare such disability leave to be retroactive to the date of submittal or lay-off if such physician's report is subsequently received within five (5) working days of the Board Secretary's acceptance of the application.

D. Obligations of Member While on Disability Leave

1. Return to Active Service

It shall be incumbent upon all employees granted disability leave pursuant to RCW 41.26 to seek authorization to return to work at the earliest possible time he/she believes he/she is fit for duty. In the event the Board finds that a member has not actively sought authorization to return to active service immediately upon cessation of disability, the Board shall have the authority to retroactively set the date of return to service and cancel the member's disability pay for the period in question.

2. Member Cooperation in Board Evaluation

While on disability leave, the member shall be obliged, upon possible penalty of loss of benefits, to comply with all lawful directives of the Board. Such directives may include, but are not limited to, requests for medical and psychological evaluation, medically supervised departmental evaluation reports and testing requests, or submittal of other relevant reports and orders to appear before the Board. In the event a member fails to comply with such requests, the Board shall make a finding as to whether compliance was within the control of the member, and upon an affirmative finding, may discontinue the members' disability benefit as deemed appropriate. Such a discontinuance of disability benefit shall not be deemed a termination of disability leave, but rather a suspension of benefits and shall be counted as a portion of the six (6) months disability period for the purpose of fixing the date of commencement of disability retirement. Upon the reinstatement of disability leave, it shall be presumed that the disability was continuous for the period of suspension, unless the member returned to active service during such suspension of benefits, which shall terminate the disability leave period upon such return.

3. Activities of Member while on Disability Leave

Any member desiring to engage in any employment while on disability retirement or leave shall so notify the Disability Board Secretary prior to commencement of said employment and describe the nature and duration of same. The Board shall examine

the nature of the outside activity and may request a medical opinion as to any detrimental effects it may have on the member's rehabilitation.
Refusal to discontinue activity deemed detrimental to rehabilitation may result in suspension or cessation of benefits. In addition thereto, no member shall engage in any activity or travel while on disability leave which is contrary to the directives of his physician or the Disability Board physician, or would otherwise be detrimental to his return to active service.

4. Obligation to Comply with Rehabilitation Directives

During the period of disability, the Disability Board shall have the authority to inquire of any examining physician as to what physical, medical or therapeutic treatments might be employed to rehabilitate the applicant and based upon such evaluation may order the applicant to participate in rehabilitation. Failure to comply with such order may be cause to suspend disability leave benefits as provided above.

5. Certification of Compliance

Each member shall, as a condition precedent to returning to active service or being placed on disability retirement, sign a sworn statement assuring compliance with all medical instructions or advice contained herein and a falsification of such statement shall be deemed a violation of RCW 41.26.300 which provides as follows:

"RCW 41.26.300 Falsification--Penalty. Any employer, member or beneficiary who shall knowingly make false statements or shall falsify, or permit to be falsified, any record or records of the retirement system in an attempt to defraud the retirement systems, shall be guilty of a felony."

E. Findings of the Disability Board

Procedure Generally:
At its regular meeting next following the Board Secretary's receipt of an application for disability leave, the Board shall review all relevant information pertaining to the question of the member's fitness for duty, and if, in the opinion of the majority of the Board members present, the evidence supports the proposition that the member is unfit for duty, such members shall be granted disability leave and separated from active service effective upon acceptance of the application by the Board Secretary. In considering such application, the Board shall consider the nature of the possible work assignments, within the applicant's civil service rank, the evaluation of the Board physician and any other evidence the Board deems appropriate. In the event the Board finds that insufficient information is available to make a determination, the matter shall be continued to the next regular Board meeting or be set for consideration at a special meeting. In the event the Board finds it has insufficient information to make a determination, the Board Secretary shall be advised of exactly what additional information is requested and the Secretary shall notify the applicant by certified letter or by personal service of his/her obligation to provide additional information and the deadline date by which such information must be provided. The Board shall be authorized to demand the appearance of the member, his/her supervisors or their superiors and such medical experts as the Board deems appropriate. It shall be incumbent upon each member obtaining medical services in connection with applications for disability leave and subsequent evaluations to advise each and every examining physician that such evaluation is being conducted at the direction of the Disability Board, that any reports relating thereto are for the benefit of the Disability Board, that the doctor/patient privilege may not be invoked with respect thereto, and that the physician may be called upon by the Board to testify as to his/her findings.

F. Findings that Disability was Line of Duty Incurred

In the event an applicant for disability leave alleges that the disability was incurred while in the line of duty, he/she shall prepare an affidavit for attachment to the application for disability leave describing with particularity the duty situation which caused the disability. Further, in such instances, the physician in his/her evaluation report shall state his/her opinion as to whether the disability was incurred or caused while the applicant was in the line of duty as alleged by the applicant.

It shall be the responsibility of the applicant to demonstrate, by a preponderance of the evidence, that the disability was incurred while in the line of duty. In the event the applicant is unable to provide such evidence, the disability shall be deemed to be non-duty incurred. For the purposes of this determination, it shall not be sufficient that the applicant demonstrate that the disability was work related or that the disabling condition commenced while the applicant was on duty, if the cause was other than externally incurred physical injury.

G. Return to Duty

No member shall return to active service from disability leave unless authorized to do so by action of the Disability Board. In the event the physician fixes the duration of the disability at the time of initial evaluation, the member may, at the discretion of the Board, return to active service pursuant to that authorization and no further medical approval shall be required. A member may be authorized by the Chief upon a physician's report to return to work prior to the meeting at which the Board authorizes the return to work and the Board shall fix the date of return to active service retroactively to the date of actual return to service by the member. If the Board does not authorize the return to work at such meeting, the disability shall be deemed continuous from before the member's return to work. In cases where questions remain as to the qualification of the member to return to service, the Board may stipulate that the return is on a trial basis for a period of 90 days with the Board reserving the right to extend an additional 90 day trial period; total trial basis not to exceed six (6) months. In that case, if the member must go back on disability leave, such original disability leave shall be considered continuous through the trial return period and a new six month disability leave period shall not commence upon the second application of said leave.

H. Granting Disability Retirement

If the evidence shows to the satisfaction of the Board that the member is physically or mentally disabled from further performance of duty and that the disability has been continuous from the date of commencement of disability leave for a period of six months, the Board shall enter its written decision and order, accompanied by appropriate findings of fact and conclusions in compliance with RCW 41.26.120. Such written decision and order with supporting documentation shall thereafter be forwarded to the State Retirement Board for review. In the event a regular meeting of the Disability Board precedes, by a reasonable time, the date at which the full six months would conclude and the evidence is clear that the disability can be expected to continue through the full six month period, the Board may make a finding of a six month continuous disability prior to the actual conclusion of the six month period, so as to obviate the possibility of the member receiving no allowance for an intervening period.

I. Re-entry from Retirement

In the event a member is placed on retirement, in addition to the findings described in Sections 5 and 6 above, the Board shall determine whether or not the member is so irretrievably and permanently disabled that no possibility exists for return to duty or that a possibility of rehabilitation could restore the member to fitness for duty. In making such determination, the Board shall take into account the proximity of the member's age to 50 years of age. In the event the Board finds that reexaminations would serve the public interest, it shall be incumbent upon the Board Secretary to order such reexamination and advise the Board of the results thereof. In the event the retired member is residing at a location more than 100 miles from Olympia, the member shall be authorized to be examined by a physician in his/her immediate area, provided, however, such physician shall be first approved by the Disability Board's medical advisor and prior to such evaluation the examining physician shall be apprised of the basis upon which the examination is to be conducted and the issues to be addressed within his evaluative report.

In the event such evaluation discloses fitness to perform any normal duty of the rank held by the member at the time of disability leave, the member shall be brought before the Disability Board for hearing and further consideration of the matter at which meeting the Chief or his designate shall also attend. Such member shall receive notice of such hearing which shall comply with the Administrative Procedures Act (RCW 34.05).

The retirement allowance of any member who fails to submit to medical examination as provided above shall be discontinued and in the event such refusal continues for one (1) year, his/her retirement allowance shall be cancelled (pursuant to RCW 41.26.140). Failure of the member to affirmatively respond to the request for reexamination shall be deemed a continuing refusal.

J. Medical Services

Whenever any active member or member retired for service or disability, requires medical services, such services shall be paid for by the City, if approved by the Disability Board. Only those medical services which are deemed necessary shall be paid for, provided the condition which has caused the need for such medical services was not caused or brought on by dissipation or abuse, and the necessity of such medical services shall be determined by the Board based upon the medical evaluation of the medical advisor and other relevant information. [RCW 41.26.150 (1), (2)]

All active and retired members shall be covered by a City-purchased insurance plan for group hospitalization and medical aid. It is a member’s responsibility to choose a City-purchased insurance plan and apply for coverage. The Board designates the insurance plan that a member joins to be the designated provider of medical services for that active or retired member. In addition, those medical services available under the chosen plan shall be the medical services authorized by the Board. [RCW 41.26.150(4)]

In the event an active or retired member fails to be covered by a City-purchased plan or incurs expenses for medical services not covered by a City-purchased insurance plan, the Board may refuse to pay for those medical services unless the Board has approved payment in advance of treatment. [RCW 41.26.110 (3)]

The Board shall be responsible for copayments and deductibles under city-purchased insurance plans by an active or retired member. [RCW 41.26.110 (3)]
The City does not usually pay claims for medical services that arise because an active or retired member either fails to be covered by a City-purchased insurance plan or obtains medical services not covered by a City-purchased insurance plan. The Board can make exceptions to this policy in special circumstances if payment for such medical services is approved by the Board in advance of treatment.
[RCW 41.26.110 (3)]

Medical services payable as a LEOFF benefit shall be reduced by any amount received or eligible to be received under worker's compensation, social security, including public welfare, insurance or pension plan, or other similar source. In the event any such alternative source of payment is available, it shall be incumbent upon the requesting member to apprise the Board of such source and failure to do so may result in a revocation of medical benefits and be deemed a violation of RCW 41.26.150. It shall be the policy of the Board to pay only the difference in benefits rather than pay the full amount and seek repayment from the other source, unless the affected member shows to the satisfaction of the Board that he/she has demanded payment of such benefits expeditiously, and that the Board's failure to make such advance repayment would cause unreasonable hardship to the member. [RCW 41.26.150 (2) and (3)]

When a member becomes eligible for Medicare Part B (at age 65 or earlier due to a disability), the member **is required** to enroll in Medicare Part B the month prior, during, or after the member becomes 65. Premiums for Medicare Part B which are paid by the member will be reimbursed by the Disability Board. [RCW 41.26.150 (5)]

All requests for payment/reimbursement of medical services must be submitted to the City for payment within one year of services rendered. Requests not submitted to the City within the required one-year time period will become the responsibility of the LEOFF I employee/retired employee. The Board may, in its discretion, waive this requirement, if the employee/retired employee can demonstrate a delay in timely submission due to circumstances beyond his/her control. [RCW 41.26.110 (3)]

All requests submitted to the Board for payment of services or equipment shall be accompanied by a completed Application for Payment of Services Requiring Board Approval and Health Care Provider's Statement of Member's Current Condition. These forms are available from the Board Secretary. *(Added November 24, 1997.)* [RCW 41.26.110 (3)]

K. Counseling Services

Members are authorized to counseling services from a State of Washington licensed psychologist, psychiatrist or counselor for up to six visits per year without prior board approval. All visits after the initial six visits shall be approved by the board prior to the visit.

All regular treatment programs and marital counseling shall be approved by the Board before treatment.

L. Chiropractic Services

Whenever any active member or member retired for service or disability requires chiropractic services, such services shall be paid for by the City to a maximum number of 20 visits per calendar year.

When treatment exceeds 20 visits per year, the Board may require an evaluation of the affected member's chiropractic condition and prognosis, or a plan for continued chiropractic care, or a second chiropractic opinion of continued care by a Board appointed chiropractor, or a combination of any of the above.

A member should contact the Board or Board Secretary as soon as it is known that chiropractic treatments may exceed the 20 visit limit in order to allow timely Board action and preclude any hardship on the member.

M. Vision Care Services

Each LEOFF I active/retired employee is entitled to the services of a participating physician or a participating optometrist for an examination of the eyes once each calendar year. Please check with Regence BlueShield or Group Health Cooperative to determine the participating physician or optometrist.

In addition to the services of the participating physician or participating optometrist, LEOFF I retired employees are entitled to a reimbursement toward the cost of necessary lenses and frames or contact lenses, as shown in the Schedule of Vision Care Benefits. Reimbursements will be made toward the cost of lenses only once in each two (2) calendar years for each LEOFF I retired employee. (See Schedule of Vision Care Benefits – Page 12)

N. Long Term Care

Any request for long-term nursing assistance shall be submitted to the LEOFF Disability Board for approval.

Charges for services associated with long term care must be substantiated by a physician's report of medical necessity. Medical necessity will normally be proven by the absence of two ADL's (Activities of Daily Living) or the presence of senile dementia. The Disability Board has the right to request additional examinations by the Board's doctor in order to obtain needed information regarding any request for payment for services. [RCW 41.26.150, 1(a)] Recertification of medical necessity may be required every six months.

In-home care or assisted living is considered to be preferable to nursing home care when appropriate. However, the level of care will normally be determined by the attending physician.

After initial Board approval of a request, the maximum monthly benefit amount shall be based upon the average of the cost of three nursing facilities or services in the Thurston County area for 24 hour-a-day care in a semi-private room as private pay rates. The Board will determine the three nursing facilities or services that will be used to average the cost.

The Board will further determine the costs of needed health care in a long term care facility based on the type and level of care medically necessary as prescribed by the member's personal licensed medical provider and permanent residence of the member. [RCW 41.26.030 (22) (b) ii and iii I]

Only those services provided by bonded and licensed providers will be considered for approval.

Itemized statements or billings shall be submitted with the reimbursement request.

Payment by other insurance coverage, including Medicare and private nursing home insurance, are primary to this benefit. [RCW 41.26.150 (1), (2) and (4)]

In-home services not covered are those of a custodial or housekeeping nature such as house cleaning, laundry services, cooking, recreational companionship, and other homemaker tasks.

O. Hearing Aids

The Board may approve hearing aids if prescribed by a physician. Pre-approval by the Board is required prior to purchase. Charges will be limited to those necessary to achieve functional correction. When seeking pre-approval, members must submit to the Board quotes from at least two licensed audiologists. The member must also have a current hearing test, exam and referral from a physician. Hearing aids must have a three-year warranty. Reimbursement will be made for ordinary and necessary repair not due to carelessness on the part of the member, and for hearing aid batteries.

P. Preventative Care - ***(Effective 1/1/02)***

1. Routine Annual Physical Examination

   Routine annual physical examinations are authorized for members. Expenses for such examination and associated tests shall be limited to $350 per year. In no event shall routine physical examinations be scheduled less than twelve months apart.

2. Vaccinations and immunizations

   Members are authorized one annual flu vaccination. All other vaccinations shall be authorized when prescribed by a physician.

3. Colonoscopy Examination (Effective 7/1/09)

   Board will consider payment for Colonoscopy Exams when the following conditions are met and appropriate documents are submitted by the member:

   a) Member must be age 50 and is medically recommended by his personal physician to undergo such examination.

   b) Member must submit copy of a written prescription of the recommended examination from his personal physician.

c) Member must submit a copy of the Explanation of Benefits received from the medical insurance carrier indicating denial of benefits/coverage of medical services.

d) Member must submit a completed LEOFF Board Request for Payment of Medical Services for review and consideration for approval of payment.

4. Bone Density - DEXAscan Examination (Effective 7/1/09)

Bone density (DEXAscan) exam is authorized only when medically recommended by personal medical provider of members who are 70 years and older. Expenses for such medically recommended examination shall be limited to $350 every two years.

In the event a member is covered by a health care plan paid for by the City of Olympia/MEDICARE which may provide benefits coverage for any of the examinations above, the member shall use that plan benefit before applying for compensation under this rule. Payment or reimbursement will be made upon approval of the Board.

Q. <u>Dental Benefits</u> ***(Effective 1/1/07)***

LEOFF 1 retirees who are actively employed and have dental coverage through their current employer or can acquire group dental coverage through their spouses' dental plans, have the option to remain with their group dental plan. The City will pay or reimburse the premium for the member's coverage up to $48.00 per month. Members who select this option will not be allowed to seek reimbursement from the City for any dental care.

All expenses directly associated with the dental provisions under this policy will be **<u>paid only on a reimbursement basis</u>** to the member receiving those services. Members are required to pay for the dental services specified under this policy and must submit a receipt and description of the covered services for reimbursement. Any other dental services not specified under the provisions of this policy will **<u>require advance</u>** LEOFF Disability Board approval, and expenses will be subject to the plan limitations, unless the procedure is determined to be medically necessary, as prescribed by a medical doctor.

1) Dental Provision

$600 annually to be applied directly towards preventative care that will include one annual cleaning and x-ray; restorative, that will include fillings, crown; tooth extraction, periodontal (treatment of tissues supporting the teeth), pulpal and root canal treatment.

2) Denture Provision

Member is required to submit two quotes from dentist/licensed denturists. Dentures (full/partial) will be reimbursed at 50% of lowest quote. LEOFF Disability Board approval **<u>must be obtained prior</u>** to receiving services.

SCHEDULE OF VISION CARE BENEFITS

(Revised and effective 7/1/09)

1. All expenses in excess of those listed below will become the responsibility of the LEOFF I member.

2. This coverage is limited to the LEOFF I member only. An itemized statement of expenses will be submitted to the City of Olympia for payment.

3. LEOFF I members are authorized to one (1) benefit every two (2) years.

4. Tints, photochromatics, lens care equipment, polarization, etc, are not covered options.

5. Allowed expenses: Type of Lenses and Frame

Type of Lenses and Frame	
Single Vision	$40.50 (each lens)
Bifocal	$59.00 (each lens)
Trifocal	$75.00 (each lens)
Progressive	$90.00 (each lens)
Contacts	$100.00 (each lens)
Frame	$132.00

N. Long Term Care

A physician's report of medical necessity must substantiate that the member requires long-term nursing assistance (either at home or in a nursing home).

The Board has the right to ask that its own Dr. examine the member to verify the medical reasons for long-term assistance. [RCW 41.26.150, 1(a)] The Board can ask its Dr. to recertify the medical reasons every six months.

If medically possible, the Board wants to pay for in-home or assisted living care rather than nursing home care.

The Board reviews in-home or assisted living costs periodically to make sure those costs are less than nursing-home care.

If the Board approves nursing-home care, it will pay either $290/day or the amount the Panorama Rehabilitation and Convalescent Care Center in Lacey, Washington charges for 24 hour-a-day nursing home care in a semi-private room, whichever is greater.

The Board may also look at where the member lives and the type of care needed in deciding what it will pay for nursing-home costs. [RCW 41.26.030 (22) (b) ii and iii I]

The Board will only pay for services from licensed and bonded care givers.

The Board will only pay when the member follows the rules in the policies and procedures manual.

If the member needs help at home, the Board won't pay for services of a custodial or housekeeping nature such as house cleaning, laundry services, cooking, recreational companionship, and other homemaker tasks.

The Board will follow State law when paying for long term care.

Dental Care Policy

LEOFF I retirees who **are actively employed** and have dental coverage through their current employer or can acquire group dental coverage through their spouses' dental plans, have the option to remain with their group dental plan. The City will pay or reimburse the premium for the member's coverage up to $50.00 per month. Members who select this option will not be allowed to seek reimbursement from the City for any dental care.

LEOFF I retirees **who are not actively employed** can purchase their own dental plan. The City will reimburse the premium for the member's coverage up to $600.00 per year ($50.00 per month). If the cost of the dental plan selected by the member is less than $600.00 per year, the member will be reimbursed for additional dental bills up to a maximum total reimbursement of the difference between the cost of the dental insurance and $600.00. If the member seeks additional dental reimbursement above $600.00 per year, the member must submit the additional costs and medical necessity information to the Board before undergoing the procedure. The Board has the sole discretion on additional dental cost reimbursements.

Hearing Aid Procedure

The Board may approve hearing aids if prescribed by a physician or a licensed hearing aid examiner. **Pre-approval by the Board is required prior to purchase**. Charges will be limited to those necessary to achieve functional correction. When seeking pre-approval:

1. Members must submit written quotes to the Board from at least two companies that provide hearing aids. If there is a Costco within 25 miles of the LEOFF member's residence, one of the quotes must be from Costco. The quotes must be for the least expensive hearing aids that:
    a. Will meet the requirements set out by physician, audiologist or licensed hearing aid provider
    b. Fit the member properly
2. If the LEOFF Board decides to select a quote from a company that has a membership fee, the Board will reimburse the LEOFF member for the cost of the membership fee for the warranty period.

3. The final decision will be at the discretion of the board.

Hearing aids must have a three-year warranty. Reimbursement will be made for ordinary and necessary repair not due to carelessness on the part of the member, and for hearing aid batteries.