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

2.2 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 <u>Subpoenas</u>: 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. **<u>Components of the Treatment Plan</u>:** 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 $362.00 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
4/19/18	9.10 F.7 Home Health care change in maximum daily cost