City of Mount Vernon

LEOFF - 1 Disability Board

Rules, Policies, and Procedures

For the

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

Adopted November 1, 2006
Revised March 19, 2014
Changes Effective May 1, 2014
Updated May 15, 2018
Updated October 20, 2021
Updated April 13, 2022
Updated October 19, 2022
Updated March 24, 2024

Contents

City of Mount Vernon LEOFF-I Disability Retirement Board
Rules, Policies and Procedures

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 City of Mount Vernon 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 retired firefighters or law enforcement officers eligible under LEOFF-I covered by **Chapter 41.26 RCW.**

Effect of Rules and Regulations

All retired fire and police personnel of the City of Mount Vernon covered by LEOFF-I shall be subject to the policies and procedures contained herein and applicable state statutory provisions and shall at all times follow the procedures contained herein to avoid possible loss of benefits. In any event any policy or procedure, as applied to a particular member, 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 polices contained herein.

A member's failure to follow these procedures may subject him/her to the loss of benefits otherwise due under RCW 41.26.

The Board reserves the right to amend, modify or deviate from these rules at its discretion. Copies of amendments to the rules shall be mailed to each member at their last registered address and posted online at https://www.mountvernonwa.gov/568/LEOFF-1-Disability-Board. Failure to receive copies of these rules or any amendment thereto shall not be a defense for failure to comply with the required procedures. Each member is expected to be familiar with the Board's processes. Inquiries regarding these rules, any amendments or the Board's procedures may be made in writing, or by email to:

City of Mount Vernon
Human Resources LEOFF I Disability Board
910 Cleveland Avenue
Mount Vernon, WA 98273
mvhr@mountvernonwa.gov

Appeal Procedure

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 filing such an appeal to the State Board.

PART 1 DEFINITIONS

1.1 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 any treatment, services or appliances requiring pre-approval of the Board.

1.2 Member

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

1.3 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(s) and description of how the condition being treated affects the member's ability to perform required duties.

PART 2 THE BOARD

2.1 Membership

The City of Mount Vernon LEOFF-I Disability Board shall consist of five (5) members in accordance with **RCW 41.26.110:**

A. Two members of the City legislative body shall be appointed by the City of Mount Vernon Mayor.

B. One active or retired firefighter employed by, or retired from, the City to be elected by the firefighters employed by, or retired from, the City who are subject to the jurisdiction of the Board.

C. One active or retired law enforcement officer employed by, or retired from, the City to be elected by the law enforcement officers employed by or retired from the City who are subject to the jurisdiction of the Board.

D. One member from the public at large who resides within the City of Mount Vernon to be appointed by the other four members of the Board.

2.2 Term and Vacancy

Board members shall serve a two-year term or until a successor is appointed or elected as set forth in subsection C below:

A. 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.

B. The terms of the firefighter and City Council representatives shall commence at the Boards regular meeting in March in each even numbered year.

C. 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 officers representative, nominations and an election shall be conducted pursuant to a schedule set by the Board.

2.3 Voting

Each Board member shall have one vote that must be cast by that member in person.

2.4 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 procedure on such officers and shall perform such other duties as may be requested by the Board.

2.5 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.

2.6 Quorum

Three members of the Board shall constitute a quorum.

2.7 Powers of the Board

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

2.8 Board Clerk Appointment

The Mayor of the City of Mount Vernon will designate from its Human Resources Department a Clerk of the Board.

2.9 Clerk of the Board Duties

The duties of the Clerk of the Board 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;

C. Provide assistance and information to claimants upon request;

D. Prepare vouchers as required by the Board; sign vouchers for expenditures that have been approved by the Board as recorded in the Board proceedings;

E. Prepare and send all necessary correspondence to the State Department of Retirement Systems, employers and claimants;

F. Prepare annual budget as directed by the Board;

2.10 Election of the Firefighter/Law Enforcement Representative

Only active or retired firefighters or law enforcement officers employed by or retired from the City who are subject to the jurisdiction of the Board have the right to nominate, elect, or be elected as a representative member of the Board under Part 2.1 B and 2.1 C.

2.11 Nomination and Voting

By November 15 of the year before the term expires, an active or retired firefighter or law enforcement officer may submit to the Clerk of the Board 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 member eligible to vote. Each ballot shall be returned to the Clerk in a sealed specially marked envelope provided by the Clerk, no later than December 15th. The ballots shall be opened and counted by the Clerk at the specified time, place, and date and may be witnessed by any interested member. In the event that there is only one nominee, that person shall automatically be the representative.

2.12 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 twice annually; on the third Wednesday of March and October beginning at 5:00 p.m. in an available room of the City of Mount Vernon. The date and time shall be 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

Open Public Meetings Act – All meetings of the Board shall be open to the public unless the Board by majority vote calls an executive session as authorized by RCW 42.30.110.

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 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 42.56**, 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 of 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 Statue **(RCW 42.56).** 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 42.56.120.**

PART 4 MEDICAL EXPENSE CLAIMS PROCEDURES

General: All claims for medical expense reimbursement must comply with Parts 4 and 5 of these rules

4.1 Medical Services

"Medical Services" are defined in **RCW 41.26.030 (20)** to be the minimum services legally required to be furnished or authorized by the Board.

4.2 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 provided and Medicare, if applicable 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 or Medicare. Evidence of insurance benefits allowed and paid must be submitted with the claim.

The submission to the Disability Board should include the following information:

A. Completed Disability Board claim form.

B. Billing invoice issued from the provider, if charge is not covered by insurance.

C. Itemized statement from the service provider indicating any insurance or other payments made to the provider. If the provider bills the insurance carrier directly, it is the member's responsibility to obtain an itemized statement of the member's account from the provider.

D. Insurance carrier's "Explanation of Benefits" (EOB) form.

E. Medicare statement for any claim submitted by a member covered by Medicare.

F. Proof of payment.

Complete documentation must be submitted to the Disability Board before medical claims will be considered. Claims with incomplete documentation will be returned to the LEOFF I member, and will result in delayed processing/payment of claims.

4.3 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 City by the Board Clerk and are available to the member through the Human Resources Department.

4.4 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 list the charges. To do this, each member is responsible for maintaining contact with the City of Mount Vernon about the medical health insurance coverage provided.

4.5 Time of Filing

All claims must be submitted to the Board within 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.

4.6 Injury 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. Members are advised to consult first with their health insurance providers or the City of Mount Vernon 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.

4.7 Board Authorization of Reimbursement for Medical Expenses

The Board considers only the medical necessity of the treatment/ services/ 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 City of Mount Vernon. The City will arrange reimbursement to the member.

4.8 Medicare Benefits

A. 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 4.2 and 4.3.

4.9 Criteria for Authorizing Reimbursement

For each claim, the Board shall determine if the criteria listed in Rule 4.10 and in any other applicable provisions 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.

4.10 General Provisions

The following rules apply to all claims for "medical services and supplies" as described in **RCW 41.26.030(20)** and as authorized under these rules.

A. The Board will allow claims under the provisions set forth in **RCW 41.26.030(20)** and **41.26.150**. Thus, claims for "medical services and supplies" will be approved only if they meet the following conditions:

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

ii. 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;

d. Not primarily for the convenience of the member, his/her physician or other provider.

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

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

v. 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. The fact that the medical services 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 that such services are medically necessary.

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

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

i. **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.

4.11 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(20)**, the Board designates Part 4 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 statues.

4.12 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 2.6.]

PART 5 REIMBURSEMENT OF CLAIMS FOR MEDICAL TREATMENT AND PROCEDURES

5.1 General Rules

The Board will approve payment of claims for all medical services defined in **RCW 41.26.030(20)** under conditions set forth in **RCW 41.26.150** and Part 5 of these rules. Medical services not listed in that section may, at the discretion of the Board be considered for authorization on a case-by-case basis. The Disability Board decides whether medical services are necessary, determines "reasonable" cost and has authority to designate the provider of the services.

5.2 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 4 of these rules.

5.3 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 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 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 the health insurance provider may be submitted to the Board for its consideration. {Ref. Rule 9-3(C)}. Any payment by the Board will be limited to the balance after any insurance reimbursement or other settlement is deducted. However, maximum allowable reimbursement, offset by any other payments, shall not exceed maximum limits established in these policies (ex: vision, dental, chiropractic, etc.).

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

i. 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.

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

iii. 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 and since the reason could bear upon the issue of the medical necessity of such services.

iv. 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 shall 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 required to submit a treatment plan for the Board's review prior to the approval of payment for services over and above the designated contract maximum. Any payment by the Board will be limited to the balance after any insurance reimbursement or other settlement is deducted. However, maximum allowable reimbursement, offset by any other payments, shall not exceed maximum limits established in these policies (ex: vision, dental, chiropractic, etc.).

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 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, 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, 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.

5.4 Chiropractic Treatment or Services

Claims for Chiropractic services are subject to the provisions set forth in Rule 5.3 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 condition.

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 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 (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 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 shall include, but not be limited to, the following:

i. Current medical diagnosis;

i. Significant history;

ii. 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;

iii. 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;

iv. 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 4.4 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 5.3.

5.5 Mental Health Services

Claims for mental health service, including psychological counseling services, are subject to provisions set forth in Rule 5.3 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 will be approved only under the following conditions:

i. The mental health services that are provided by a psychiatrist, a licensed psychologist or a Master's Level Clinical Social Worker who is 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.

ii. The Member's physician, the City's EAP or the 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 5.2 and 5.3.

iii. 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.

iv. 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 Practitioner:	$110.00

v. 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 need not be limited to the following:

i. 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;

ii. Significant history;

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

iv. 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;

v. 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 4.7 and 5.3.

5.6 Substance Abuse Services

Claims for outpatient treatment for substance abuse are subject to the provisions set forth in Rule 5.3. The Board will approve a member's costs 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:

i. Recommends such treatment; and
ii. 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 4.10(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 must submit written conformation of that 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** and Board Rule 4.10.

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, will be obtained and reviewed by the Board before approving additional treatment or payment of the member's claim.

i. 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.

ii. 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 4.7 and 5.3.

5.7 Vision Benefits: (updated April 13, 2022)

Members covered by the Medicare Advantage Plan, shall seek payment from the Medicare Advantage Plan prior to any additional reimbursement under this section.

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 new prescription in accordance with the following schedule:

A. **Eyeglass Lenses and Frames:** $500.00 maximum per set of frames and lenses not more than once every twelve (12) consecutive months. Lenses covered include single vision, bifocal, or trifocal lenses, progressive,

scratch-resistant coating, anti-reflective and rimless mounting. Frames must be of average quality and serviceability unless other frames are prescribed.

B. **Contact Lenses:** $100.00 per lens not to exceed $200.00 maximum during any twelve (12) month period including disposable contact lenses.

C. **Replacement:** Claims for a replacement pair of eyeglass frames and/or lenses or contacts will be allowed if proof of damage is provided to the Board with the request for replacement. Only one replacement pair per year, due to accidental damage, will be allowed, not to exceed the amount allowable above.

D. **Optional Features:** No reimbursement will be made for over sizing, tinting, coloring, photo sun, or other options, special requests, not part of the above schedule, may be presented to the Board by the member along with proper documentation that the item is medically necessary.

E. **Additional Spare Pair:** No reimbursement will be made for a spare pair of eyeglasses or contact lenses.

F. **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 4.10(A)(3).

G. **Applied Offset:** Any payment by the employer will be applied to the net balance after any insurance reimbursement or other settlement is deducted.

H. **Member Compliance to Submit Claims:** Nothing in this rule relieves the member from complying with the requirements of Rule 4.2 and 5.3.

5.8 Medical Equipment and Supplies: (updated April 13, 2022)

In addition to the rental of durable equipment, as provided for in **RCW 41.26.030(20),** the Board will consider for approval, claims for 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.

The Board may approve hearing aids if prescribed by a physician or a licensed hearing aid examiner/audiologist. Charges will be limited to treatment necessary to achieve functional correction. Members should seek pre-approval by the Board prior to the purchase of hearing aids. The Board retains the sole right to determine whether or not to pay for services if the service has not been brought to the Board for prior approval.

When seeking pre-approval:

i. **Conditions for Pre-Approval of Hearing Aid Purchases:**
Members must submit written quotes to the Board from at least two companies that provide hearing aids, **unless** the member wants to purchase hearing aids from Costco, which can be done without a second quote. **Human Resource Staff can authorize the Costco hearing aid purchase without taking the request to the LEOFF 1 Board.**

Writen quotes must include:

- Medical examination by an otolaryngologist to rule out any treatable ear conditions:
- A statement by the evaluating audiologist, as well as a copy of the audiological evaluation, must be included in the application as proof the member's hearing loss is progressive, permanent and/or not likely to improve with other treatment (e.g. medication, surgery, etc.);

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

a. Reasonable charges or fees for services of licensed physician otolaryngologist or state certified audiologist for examination will be allowed.
b. The maximum amounts allowable will be the cost of a 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.

If there is a Costco within 25 miles of the LEOFF member's residence, one of the two quotes must be from Costco. Costco membership is not required for a hearing aid quote. The quotes must be for the least expensive hearing aids that:

- will meet the requirements recommended by the physician, audiologist or licensed hearing aid provider
- fit the member properly
- must have a two-year warranty

If the member does not have a Costco membership, the Board will reimburse the LEOFF member for the cost of the membership fee for the warranty period. The Board will review hearing aid prices annually to ensure that members are receiving quality hearing aids at the best market rate.

When more than one quote is submitted, member preference will not be one of the deciding factors in the Board's decision on which of the two quotes to approve. The final decision will be at the discretion of the Board.

Hearing aids must have a two-year warranty. Reimbursement will be made for hearing aids batteries and for ordinary and necessary repair not due to carelessness on the part of the member.

iii. **Replacement of Hearing Aids:** The Board will consider approval of payment of a member's replacement hearing aid expenses not more frequently than every 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 under the following conditions:

a. The member must provide the Board with documentation of the medical necessity for the replacement; and

b. The loss or damage is duty related or due to an accident

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

v. **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 medical expense forms).

vi. **Member Compliance to Submit Claims:** Nothing in this rule relieves the member from complying with the requirements of Rule 4.7 and 5.3.

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 the 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.

5.9 Dental Benefits

A. Dental Benefits: Effective June 1, 2018, dental related expenses up to an annual amount of $1000 will be covered. Dental expenses above this amount will be the responsibility of the member. The plan period runs from January 1 of each calendar year to December 31st of the same year.

i. The dental expenses incurred by a member, as may be found by the Board to be medically necessary, will be covered up to a maximum of $1000.00 per year. Active LEOFF I members will be covered by the City's Dental Plan and will not be allowed to seek additional reimbursement under this section unless reimbursement is for reasons under section vi or vii below.

ii. 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.

iii. Dental expenses incurred by a member for teeth whitening will not be approved.

iv. 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 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.

v. Mouth Guards that are found to be a medical or dental necessity will be covered up to a maximum of $600.00 annually. The $600 is in addition to the $1,000 annual dental benefit. In order for mouthguards to be considered for reimbursement the member must provide documentation from the member's medical or dental provider as to the necessity of the mouth guard.

vi. 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 pre-approval of any procedure under consideration to correct this condition. Such request for pre-approval will be considered on an individual case-by-case basis. **Member**

Compliance to Submit Claims: Nothing in this rule relieves the member from complying with the requirements of Rule 4.2 and 5.3.

5.10 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 case-by-case basis.

A. Acupuncture and/or Massage Therapy: Claims for acupuncture services and/or massage therapy are subject to the provision set forth in Rule 5.3. Payments for acupuncture and/or massage therapy provided to a member by an acupuncturist and/or a massage therapist during a continuous six (6) month period will be approved if the following requirements are met:

i. The services have been prescribed by a licensed physician

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

iii. The 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 Acupuncturist (N.C.C.A.) or a licensed massage therapist, provides the services;

iv. The member or provider first submits a claim for payment to the member's insurance provider;

v. 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 to the Board for pre-approval as required by Rule 5.3;

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

B. Birth Control Procedures, Devices and Supplies:

i. Vasectomies, tubal ligations, and other surgical procedures for the purpose of birth control are not consider medically necessary;

ii. 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;

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

iv. 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 Re-constructive Surgery:

i. **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.

ii. **Re-constructive Surgery:** Surgery required as the result of accidental injury or incidental to a 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 an individual case-by-case basis.

D. Exercise and Physical Fitness Program: 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 are considered elective on the part of the member and not medically necessary.

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

F. Nursing Home, Assisted Living and Home Health Care Services: (updated April 13, 2022)

If confined to his/her home following an accident or illness, a member is eligible for home health visits for intermittent skilled nursing care. 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.

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.

i. Services are prescribed by a physician or advanced registered nurse practioner;

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

iii. If services or placement 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;

iv. Services are to be provided by a professional licensed and/or certified by the state or professional credentialing agency or services of a Medicare participating home health agency. The facility must have obtained and remained current on Adult Family, Boarding Home, or Nursing Home license from the State of Washington;

v. If the facility is located outside of 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;

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

vii. The provider or member’s claims for payment will be submitted directly to the member’s insurance, third party payor or employer;

viii. The daily costs meet the up-to-date rate set by Genworth for median level care for Home Health Aide Home Health Care, and median level Private Room Nursing Home Care.

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

x. Items for entertainment purposes such as, but not limited to, internet broadband services, televisions, cable hook-ups, and telephone charges are not reimbursable expenses.

"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." **RCW** 41.26.030.
Three criteria must be met to be eligible to provide home care:

- Home care services by a Registered Nurse (RN), or otherwise defined by Genworth.
- Not reside in the member's home.
- Not be a member of the family of either the member or the member's spouse.

The Board may require a Registered Nurse Certification to Provide Home Care form to be completed.

The above policy is reviewed by the Disability Board and updated as Genworth rates are updated.

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

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

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

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

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

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

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

iii. Procedures are limited to nationally recognized licensed facilities.

I. Prescription Drugs: The Board will approve payment of claims for medications prescribed by a physician under the conditions set forth in

RCW 41.26.150. The board will not accept or consider for approval any request for reimbursement for over the counter medications obtained without a prescription.

Services, supplies, and procedures for reproductive and sexual disorders and defects are considered to be elective and not medically necessary.

J. 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.

K. Specialized Surgeries:

i. **Eye Surgery:**

a. **Refractive Keratotomy Surgery (RK):** The Board considers refractive keratotomy surgery (RK) to correct myopia and/or astigmatism to be elective surgery, not a necessary medical service. Request for pre-approval if this procedure will be denied.

Claims for payment or reimbursement for RK surgery will be returned with a request to provide medical evidence why glasses or contact lenses are not a more viable and less costly alternative.

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

ii. **Other Surgeries:** From time to time, the Board may add rules or other specialized surgeries and techniques, as may be required.

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 basis, considered on an individual case-by-case basis.

The Board will consider payment of the claim for the member's pre-approved weight loss program, exclusive of the costs of food supplements.

M. Member Compliance to Submit Claims: Nothing in this rule relieves the member from complying with the requirements of Rule 4.2 and 5.3

5.11 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: 1) newly discovered information/material for the member making the application and claim which could not with reasonable diligence have been discovered or produced at the time of the hearing; or 2) irregularity in the proceedings of the Board, or 3) that there is no evidence or reasonable inference from the evidence to justify the Board's decision or that it is contrary to law;

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, the Board may rule on the request for reconsideration, or may schedule an additional hearing if the Board believes a new hearing is warranted.

PART 6 REVIEW OF BOARD RULES, AMENDMENTS AND REVISIONS

6.1 Periodic Review

These local Board rules, policies, and procedures shall be accordingly reviewed and revised periodically or as often as necessary, subject to the recommendation of the State Retirement Systems usually provided annually, to assure that:

A. **Conformance with State Law:** Provisions 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.

Members 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.

6.2 Chronology of Amendments/Revisions of Board Rules

Adopted/Effective Date	Policy Revisions/Amendments
November 1, 2006	Adopted
May 1, 2014	
May 15, 2018	
October 20, 2021	➢ Effect of Rules and Regulations ➢ Definitions, Section 1.2 ➢ 2.2 Term and Vacancy ➢ Part 8 Medical Claim and Procedures Update ➢ 9.7 Vision Benefits
April 13, 2022	➢ 9.7 Vision ➢ 9.8 Hearing Aids ➢ 9.10 Nursing Home, Assisted Living and Home Health Care Services
October 18, 2022	➢ Removal of language pertaining to disability.
March 20, 2024	➢ 5.9(A)(v) Add language regarding mouthguards