

# **Rules, Policies, and Procedures**

**City of Oak Harbor LEOFF 1 Disability Board**

**For the**

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

**Adopted June 9, 2016  
Last Amended November 6, 2020**

**City of Oak Harbor  
LEOFF 1 Disability Board  
Rules, Polices, and Procedures**

**Table of Contents**

Preamble .....	4
Scope .....	4
Effect of Rules and Regulations .....	4
<b>PART 1    DEFINITIONS .....</b>	<b>5</b>
1.1    Claim .....	5
1.2    Employee Assistance Program .....	5
1.3    Member .....	5
1.4    Treatment Plan .....	5
<b>PART 2    THE BOARD .....</b>	<b>5</b>
2.1    Membership .....	5
2.2    Term and Vacancy .....	6
2.3    Voting .....	6
2.4    Chair .....	6
2.5    Election of Chair .....	7
2.6    Quorum .....	7
2.7    Powers of the Board .....	7
2.8    Board Secretary Appointment .....	7
2.9    Board Secretary Duties .....	7
2.10   Election of the Firefighter/Law Enforcement Representative .....	8
2.11   Nomination and Voting .....	8
2.12   Conflict of Interest .....	8
<b>PART 3    GENERAL PROVISIONS OF BOARD MEETINGS .....</b>	<b>8</b>
3.1    Time of Meetings .....	8
3.2    Open to Public .....	8
3.3    Examination of Records .....	9
3.4    Oral Proceedings and Transcripts .....	9
3.5    Subpoenas .....	10
<b>PART 4    PROCESSING APPLICATIONS AND CLAIMS .....</b>	<b>11</b>
4.1    Submission of Claims .....	11
4.2    Reconsideration of Board Decisions .....	11
4.3    Board Approved Physician .....	12
4.4    Appeal Procedure .....	12
<b>PART 5    MEDICAL EXPENSE CLAIMS PROCEDURES .....</b>	<b>12</b>
5.1    Medical Services .....	12
5.2    Submission of Medical Expense Claims Over \$750.00 .....	12
5.3    Submission of Medical Expense Claims Under \$750.00 .....	12
5.4    Injury Prior to Incurring Treatment Services .....	13

5.5	Board Authorization of Reimbursement for Medical Expenses.....	13
5.6	Member’s Responsibility to Prepare Claims.....	13
5.7	Forms .....	13
5.8	Time of Filing .....	13
5.9	Medicare Benefits.....	13
5.10	Offset for Third Party Payments and Subrogation .....	14
5.11	Criteria for Authorizing Reimbursement.....	15
5.12	General Provisions .....	15
5.13	Additional Medical Services.....	16
5.14	Quorum of the Board.....	16
<b>PART 6</b>	<b>REIMBURSEMENT OF CLAIMS FOR MEDICAL TREATMENT .....</b>	<b>16</b>
	<b>AND PROCEDURES .....</b>	<b>17</b>
6.1	General Rules .....	17
6.2	Emergency Treatment.....	17
6.3	Continuous Treatment and Services .....	17
6.4	Chiropractic Treatment or Services.....	18
6.5	Mental Health Services.....	19
6.6	Substance Abuse Services.....	21
6.7	Vision Benefits.....	22
6.8	Medical Equipment and Supplies.....	23
6.9	Dental Benefits .....	25
6.10	Additional Medical Services and Supplies.....	26
<b>PART 7</b>	<b>REVIEW OF BOARD RULES, AMENDMENTS AND REVISIONS .....</b>	<b>31</b>
7.1	Periodic Review.....	31

# City of Oak Harbor LEOFF-1 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 Oak Harbor 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 statutes and State regulations.

## Scope

These rules and regulations shall be applicable to all retiree law enforcement officers, eligible under LEOFF-1 covered by **Chapter 41.26 RCW**, unless specifically provided herein. There are no active Law Enforcement LEOFF-1 members, and no active or retired Firefighter LEOFF-1 members within the City of Oak Harbor.

## Effect of Rules and Regulations

All police personnel of City of Oak Harbor covered by LEOFF-1 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 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 polices contained herein.

A member's failure to follow these procedures may subject him/her to the loss of benefits otherwise due under the LEOFF-1 Act.

## Contact for Benefits and Claims

The Association of Washington Cities (AWC) provides the City of Oak Harbor with a group health plan, specifically, for LEOFF-1 members the Regence Medicare Advantage plan and Delta Dental. For any assistance, questions, or to obtain additional benefit or claim information, please contact AWC at **1-800-562-8981** or by email at [benefitinfo@awcnet.org](mailto:benefitinfo@awcnet.org):



## **PART 1      DEFINITIONS**

### **1.1      Claim**

A filed request by a member to the Board for approval of reimbursement of expenses incurred for prescriptions, medical services or treatment; or pre-approval of a medical appliance, or pre-approval of a surgical procedure or successive treatment.

### **1.2      Employee Assistance Program**

“EAP” An EAP program is a confidential, professional counseling service provided by the City of Oak Harbor for members.

### **1.3      Member**

A retired law enforcement officer eligible under LEOFF-1 for benefits provided under **RCW 41.26**.

### **1.4      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 tasks of daily living.

## **PART 2      THE BOARD**

### **2.1      Membership**

The City of Oak Harbor LEOFF-1 Disability Board shall consist of five (5) members in accordance with **RCW 41.26.110(1)(a)**:

- A.**      Two members of the City Council shall be appointed by the City of Oak Harbor 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. If there are either no firefighters or law enforcement officers under the jurisdiction of the board eligible to vote, a second eligible employee representative shall be elected by the law enforcement officers or firefighters eligible to vote.
- 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 Oak Harbor to be appointed by the other four members of the Board.

- E. One alternate or temporary member who resides within the City of Oak Harbor to be appointed by the other five 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. If a Board member is unable to vote or participate due to medical reasons, the Board member may resign at any time for a successor to be appointed or elected.

### A. Law Enforcement Representative Member

The Board Secretary will send election information within two (2) months of the term expiration to all Board Members.

### B. City Council Representative Member

The Board Secretary will communicate with the Mayor within two (2) months of the Councilmember's term expiring. The Mayor will appoint the Councilmember representative on a Regular or Special City Council Meeting Agenda.

### C. Citizen Representative Member

Within two (2) months of the Citizen Member's term expiration, the Board Secretary will communicate with the Board to appoint a new Citizen Member. The appointment will be submitted to council for approval at least within two (2) months after appointment.

### D. Alternate or Temporary Member

To serve in the absence of any regular member or when a vacancy on the board has occurred (OHMC 2.65.010). Within two (2) months of the Alternate or Temporary Member's term expiration, the Board Secretary will communicate with the Board to appoint a new Alternate or Temporary Member. The appointment will be submitted to council for approval at least within two (2) months after appointment.

- E. 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 (1) vote that must be cast by that member. Voting to allow telecommuting and/or voting participation by email, teleconference, or video conference. No voting by proxy is allowed.

## 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 the American Institute of Parliamentarians Standard Code of 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 (3) 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 Secretary**

The Human Resources Director of Oak Harbor shall serve as the LEOFF-1 Board Secretary.

**2.9 Secretary of the Board Duties**

The duties of the Secretary of the Board shall include:

- A. Provide official notice of Board Meetings including Notification of members of meeting and location;
- B. Journal entry of the Board Meeting Minutes, including special and regular meetings; shall keep the minutes of all regular;
- C. Preparation and distribution of agendas for meetings, previous meeting minutes and packets to the Board members five (5) calendar days prior to the meeting;
- D. Provide assistance and information to claimants upon request;
- E. Provide claimants with the necessary forms upon request;
- F. Coordinate the elections of Law Enforcement Representatives and the selection of Member-At-Large to the board;
- G. Ensures that the Board obtains benefits under insurance or health care plans provided by the employer prior to authorization of payment;
- H. Prepares vouchers as required by the Board;

- I. Prepares and sends all necessary correspondence to the State Department of Retirement Systems, employers and claimants;
- J. Signs vouchers for expenditures that have been approved by the Board as recorded in the Board proceedings;
- K. Other tasks as directed by the Board;

#### **2.10 Election of the Law Enforcement Representative**

Only LEOFF-1 members have the right to nominate and elect the Law Enforcement Board Representatives.

#### **2.11 Nomination and Voting**

Within two (2) months of the expiring Law Enforcement Representative terms, retired LEOFF-1 law enforcement officers may submit to the Board Secretary of the Board nominations for the respective representative. If no nominations are received the current elected officer shall serve an additional term. The Board Secretary will prepare and mail or email ballots to each voting member (LEOFF-1 Retirees only) eligible to vote. Each ballot shall be returned to the Board Secretary in person or via email, no later than one (1) month before the term expiration(s). The ballots shall be opened and counted by the Board Secretary and may be witnessed by any interested member if requested in writing and scheduled at least one (1) week in advance. 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 may meet quarterly (January, April, July, October) when medical claims from Members are pending. When a LEOFF-I member submits a claim to the Board Secretary, the Secretary will notify the Chair and Board of the claim(s). Quarterly or Special meetings will be called by the Chair or a majority of the Board of which notice shall be given in accordance with **RCW 42.30.080**. The meeting shall take place in the Mayor's Conference Room located at City Hall, unless otherwise scheduled. The date and time shall be determined in advance by the Board with notice as required by law. Pursuant to **(OHMC) 2.33.020**, the Board will not meet for Regularly Scheduled Meetings, but shall have the authority to set its own meeting times.

#### **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 meetings relating to consideration of specific applications or claims where consideration of the application or claim may include discussion of sensitive personal information relating to the member.

### **3.3 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 Secretary, members may examine their disability file at the Board office during times scheduled by the Board Secretary.
- B.** A person requesting examination of Board records of minutes must submit a written request and arrange with the Board Secretary an appointed time for viewing the materials. Request for examination of Board records must comply with the Public Records Statute (**RCW 42.56 et seq.**). The appropriate redactions and/or exemptions related to a members' privacy rights may be taken pursuant to RCW 42.56.
- 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**.

### **3.4 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 hearing shall include:
  - i.** All pleadings, motions and intermediate rules;
  - ii.** Evidence received or considered;
  - iii.** A statement of matters officially noticed, if any;

- iv. Questions and offers of proof, objections and rulings thereon, if any;
  - v. Proposed finding and exceptions, if any;
  - vi. Any decision, opinion or report by the Disability Board
- E.** Board Secretary shall record all oral proceedings before the Board. Transcription may be furnished to a requesting party upon request to the Board Secretary 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 hearing.
- G.** The Disability Board may:
- i. Administer oaths and affirmations, examine witnesses and receive evidence;
  - ii. Issue subpoenas as provided in Board Rule 3.6;
  - iii. Rule upon offers of proof and receive relevant evidence;
  - iv. Take or allow depositions to be taken for good cause shown at the discretion of the Board;
  - v. Regulate the course of the hearing.

### **3.5 Subpoenas**

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

- A.** The Board may issue a subpoena on its own motion or on request of any party upon the showing of good cause.
- B.** If an individual fails to obey a subpoena, or obeys a subpoena but refuses to testify when requested concerning any matter under examination or investigation at the hearing, the Board may petition the Superior Court of the County where the hearing is being conducted for enforcement of the subpoena. The petition shall be accompanied by a copy of the subpoena and proof of service, and shall set forth in what specific manner the subpoena has not been complied with, and shall ask an order of the court 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 cost 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, except for the claims submitted pursuant to Rule 5.3, shall be submitted to the Board Secretary and shall comply with the following procedures;

- A.**      They shall be made on forms provided by the Board;
- B.**      To be considered in connection with any application or claim, they shall be complete, legible and submitted to the Board Secretary 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;
- C.**      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: 1) newly discovered information material for the member making the application and claim which could not with reasonable diligence have 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 Secretary 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.

### **4.3 Board Approved Physician**

- A.** The Board shall approve a licensed and practicing physician or physicians to conduct all required medical examinations pursuant to WAC 415-105-030;
- B.** The approved physician shall meet all requirements contained in WAC 415-105-030 and conduct all necessary tasks as set forth in RCW 41.26 as applied to LEOFF-1 plan members.

### **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, 211, and 221** in perfecting such an appeal to the State Retirement Systems Director.
- B.** If after the member has exhausted all administrative appeal remedies as set forth in RCW 41.26.200, 211 and 221, the interested member may seek Judicial Review of the final decision of the State Retirement Systems Director with the Island County Superior Court within the appropriate time frames and procedures as governed by chapter 34.05 RCW.

## **PART 5 MEDICAL EXPENSE CLAIMS PROCEDURES**

**General:** All claims for medical expense reimbursement must comply with Parts 5 and 6 of these rules.

### **5.1 Medical Services**

“Medical Services” are defined in **RCW 41.26.030 (19)** to be the minimum services legally required to be furnished or authorized by the Board. 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 Submission of Medical Expense Claims Over \$750.00**

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.

### **5.3 Submission of Medical Expense Claims Under \$750.00**

Any medical claims submitted for reimbursement under \$750.00 will be automatically paid without approval of the Board. These claims must be submitted to the Clerk on the approved form within six (6) months of the medical services received and/or

prescriptions purchased. Evidence of insurance benefits allowed and paid must be submitted with the claim.

#### **5.4 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 Oak Harbor 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.

#### **5.5 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 Oak Harbor. The City will arrange payment to the provider or reimbursement to the member if proof of payment by the member is provided with the claim.

#### **5.6 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 Oak Harbor about the medical health insurance coverage provided.

#### **5.7 Forms**

Claims for payment of medical services and perscriptions 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 Secretary and are available to the member through the HR department.

#### **5.8 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. This process does not apply to Medicare Premium reimbursement requests as set forth in Rule 5.9.

#### **5.9 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 5.10). Members are cautioned that if they are eligible for Medicare coverage and do not obtain this coverage, neither the City of Oak Harbor 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.** The City of Oak Harbor shall reimburse members for Medicare Part B Premiums for the calendar year Standard Premium amount (medicare.gov), and shall reimburse premiums for high income threshold earnings, and shall not reimburse any Medicare late penalties. **RCW 41.20.120; City of Oak Harbor Resolution No. 15-43; amended Resolution No. 17-04.**

Medicare Part B Premium reimbursement requests shall be processed on a quarterly basis by the Board Secretary. Members seeking Medicare Part B Premium reimbursement shall submit a claim on the approved claim form and all supporting documentation within two (2) weeks after the end of the relevant quarter.

Below are the deadlines for submitting quarterly premiums to the Board Secretary:

- i. January – March premiums: submit by second Friday in April
- ii. April – June premiums: submit by second Friday in July
- iii. July – September premiums: submit by second Friday in October
- iv. October – December premiums: submit by second Friday in January

Premium reimbursement requests for the relevant quarter submitted after the dates provided above will not be accepted.

## **5.10 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, including amounts received or eligible to be received under the city's or Board's employee insurance plans, prior to submitting reimbursement requests to the City.

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

- B.** The City of Oak Harbor shall have the subrogation rights described in **RCW 41.26.150(3)**. The City 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 City. In the event an active or retired member fails to be covered by a City-purchased plan or incurs expenses for medical services not covered by a City-purchased insurance plan, the Board may refuse to pay for those medical services unless the Board has approved payment in advance of treatment. [RCW 41.26.110 (3)], unless an emergency exists, proven by documentation provided by the retiree's physician.

### **5.11 Criteria for Authorizing Reimbursement**

For each claim, the Board shall determine if the criteria listed in Rule 5.12 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.

### **5.12 General Provisions**

The following rules apply to all claims for “medical services and supplies” as described in **RCW 41.26.030(19)** and as authorized under these rules.

- A.** The Board will allow claims under the provisions set forth in **RCW 41.26.030(19)** 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.** The member's employer shall provide the Board with any supporting information to assist the Board in determining whether the criteria set forth in these Rules are met. Such information may include reasons why the claim should be denied or limitations of a member's coverage by a third party payor. 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 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.

### **5.13 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(19)**, the Board designates Part 6 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 statutes.

### **5.14 Quorum of the Board**

A quorum of the Board may approve payment of members' claims at other than regular or special board meetings [Refer to Part 2, Rule 2.6.]

## **PART 6 REIMBURSEMENT OF CLAIMS FOR MEDICAL TREATMENT**

## AND PROCEDURES

### 6.1 General Rules

The Board will approve payment of claims for all medical services defined in **RCW 41.26.030(19)** under conditions set forth in **RCW 41.26.150** and Part 5 of these rules.

### 6.2 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 5 of these rules.

### 6.3 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 6-3(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, 5.10 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.

#### **6.4 Chiropractic Treatment or Services**

Claims for Chiropractic services are subject to the provisions set forth in Rule 6.3 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;
  - ii. Significant history;
  - iii. 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;
  - iv. Description how the condition being treated affects the member's ability to perform required regular day to day tasks of daily living with average or better efficiency;
  - v. 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 5.8 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 6.3.

## **6.5 Mental Health Services**

Claims for mental health service, including psychological counseling services, are subject to provisions set forth in Rule 6.3 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 6.2 and 6.3.
- 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 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 5.8 and 6.3.

#### **6.6 Substance Abuse Services**

Claims for outpatient treatment for substance abuse are subject to the provisions set forth in Rule 6.3. 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 5.12A 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 5.12.
- 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 5.8 and 6.3.

## **6.7 Vision Benefits**

Members covered by the City's Vision Insurance, shall seek payment from the Insurance carrier 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:** \$295.00 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. Frames must be of average quality and serviceability unless other frames are prescribed.
- B. **Second Pair:** A second pair of monofocal (i.e. computer) glasses shall be approved only if prescribed by an ophthalmologist or optometrist. The maximum of the second pair shall not exceed \$295.00 per single set of frames and pair of lenses not more than one in twenty-four (24) consecutive months.
- C. **Contact Lenses:** Coverage of contact lenses shall not exceed \$200.00 maximum during any twelve (12) month period. This limit includes any type of contact lens.
- D. **Replacement:** Only one replacement pair per year, due to accidental damage, will be allowed, not to exceed the amount allowable above.
- E. **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.
- F. **Additional Spare Pair:** No reimbursement will be made for a spare pair of eyeglasses or contact lenses.
- G. **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 5.12(A)(iii).
- H. **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 Rules 5.9 and 5.10.
- I. **Member Compliance to Submit Claims:** Nothing in this rule relieves the member from complying with the requirements of Rules 5.8 and 6.3.

## 6.8 Medical Equipment and Supplies

In addition to the rental of durable equipment, as provided for in **RCW 41.26.030(19)**, 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.

- i. **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 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 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.);
  - d. The fitting of hearing aid(s) shall be done only by a state certified audiologist
  - e. A maximum cost estimate not to exceed \$2,600 per hearing aid or \$5,200 per pair during any three year period based on equipment of average quality and serviceability. This cost estimate must also include at least a 2-year warranty on the hearing aids;
- ii. **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
- iii. **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).

- 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. **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. 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 balance 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.
  - d. 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.
- vi. **Member Compliance to Submit Claims:** Nothing in this rule relieves the member from complying with the requirements of Rule 5.8 and 6.3.

**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.

## 6.9 Dental Benefits

**A. Dental Benefits:** Dental expenses are covered by health insurance plan provided by the City. Dental expenses not covered by insurance will be the responsibility of the member, subject to subsection 6.9 A.i below.

- 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 \$3,000.00 per year. LEOFF-1 members will be covered by the City's Dental Plan.
- ii. No dental expenses incurred by a member for dental services or work which is purely cosmetic in nature will not 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. 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.
- vi. If a Member has reached the \$3,000.00 annual dental limit, then the Member may submit the claim for Board Review.
- vii. **Member Compliance to Submit Claims:** Nothing in this rule relieves the member from complying with the requirements of Rule 5.8 and 6.3.

#### **6.10 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 5 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 6.3. 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 6.3;
- 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. Home Health Care Services:** The City provides Long-Term insurance benefits as directed by RCW 42.26.030(19). 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:
- i. Services are prescribed by a physician;
  - ii. Services 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 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 as required by the Long-Term insurance coverage;
  - 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;
  - v. 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;
  - 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 nursing home facility must be a preferred provider with the Long-Term insurance paid by the City. The maximum cost allowed shall not exceed the average daily cost of an assisted living facility in Island County, as determined by the Long-Term Care insurance carrier.
- viii. Comply with any other requirements and conditions set forth by the Long-Term insurance carrier.

**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. Assisted Living 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 of placement and payment of charges for care in any of these facilities under the following conditions:

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. Through the Association of Washington Cities (AWC), the City provides a group long term care insurance plan through UNUM Life Insurance Company of America, group policy # 220603.025. More information is available through AWC: <https://wacities.org/about-us/contact-us> or through the City website: <http://www.oakharbor.org/page.cfm?pageId=1544>. Click [here](#) to review the UNUM Long Term Disability Plan details.

- i. Placement is prescribed by a physician or advanced registered nurse practitioner;
- ii. The facility must have obtained and remained current on Adult Family, Boarding Home, or Nursing Home license from the State of Washington;
- iii. 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;

- iv. If placement exceeds six (6) months, the Board shall require a treatment plan from the treating physician;
- v. 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;
- vi. If eligible for Medicare, the member has applied for or is receiving both Part A and B of Medicare coverage, whether paid for by the employer or 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. Application for prior approval of long-term care services and placement will be considered on a case-by-case basis;
- ix. Personal care items will not be covered unless medically necessary and prescribed by the treating physician and approved by the Board.
- x. After initial Board approval of a request, the maximum monthly benefit for Assisted Living Facilities, Boarding Home or Adult Family Homes shall be based upon the average daily rate of an Assisted Living Facility in Island County. The maximum monthly benefit for a nursing facility will be based on the average daily rate of a nursing facility in Island County for 24 hour-a-day care in a semi-private room. Human Resources will submit a report to the Board every December establishing the average daily rate for the following year.

**I. 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.

**J. Prescription Drugs:** Health Insurance provided by the City covers the cost of prescription drugs. Any expense claims over \$750 under this section not covered by insurance will be reviewed by the board (5.2). 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.

**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 of 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, including the attending physician's recommendation that RK surgery is medically necessary.

- 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 5.8 and 6.3

**PART 7 REVIEW OF BOARD RULES, AMENDMENTS AND REVISIONS**

**7.1 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.

### **Chronology of Amendments/Revisions of Board Rules**

#### **Adopted/Effective Date**

June 9, 2016

#### **Policy Revisions/Amendments**

November 6, 2020  
October 18, 2019  
February 9, 2017

Approved by:

  
Ray Heltsley, Chair