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POLICY 295**

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CLALLAM COUNTY DISABILITY BOARD

.1 INTRODUCTION

The following document is the complete Rules and Regulations of the Clallam County Disability Board adopted by the Disability Board and revised according to established procedure.

1.1 Purpose

To establish rules and procedures and administrative policies regarding the conduct of business of the Clallam County Disability Board (Disability Board) in order to ensure compliance with the provisions of RCW 41.26, the Law Enforcement Officers and Firefighters Retirement System Act.

1.2 Applicability

Any local agency within Clallam County, that employs full-time, regularly compensated, Law Enforcement Officers and/or Firefighters who are LEOFF 1 members, fall under the jurisdiction of the Clallam County Disability Board. All LEOFF 1 members actively employed in a LEOFF 1 eligible position, on disability leave from that position, or retired from a LEOFF 1 position within a local agency, either by service or disability, are subject to this policy.

1.3 Distribution

Copies of these rules and any amendments hereto shall be provided by the Clerk of the Disability Board to each agency subject to the jurisdiction of the Disability Board. This policy is also available on the County's internet site. Copies may be obtained subject to the County's Public Records Disclosure Policy.

.2 DEFINITIONS

"Accidental injury to teeth" is defined as damages to teeth or dental appliances from an occurrence of a sudden and tangible happening of a traumatic nature producing an immediate response. An accidental injury does not include teeth broken, damaged, or caused by an act of normal chewing or biting unless caused by foreign object, or by the neglect of dental hygiene.

"Discontinuance of Service" is the date the member discontinues service with the employing agency (is removed from payroll). A member is considered still in service when using accrued sick leave, vacation, or other accrued leave.

"Long Term Care" means nursing home care, in home nursing assistance, assisted living facilities, and adult family homes, determined to be medically necessary.

“Medically Necessary/Medical Necessity” means treatments, services or supplies that must be ordered by a physician or other covered, qualified provider and commonly and customarily recognized by the physician's profession as appropriate to treat the patient's diagnosed injury or sickness (as specified by authoritative medical or scientific literature). It does not include maintenance or supportive treatments or services or those that are educational, experimental or primarily for medical or other research. The fact that any treatments, services or supplies are furnished, prescribed or approved by a physician or other qualified provider does not in itself mean it is medically necessary (i.e., it may be cosmetic or elective). A medical treatment, service, supply, or setting may be medically necessary in part only.

.3 SELECTION/ELECTION OF DISABILITY BOARD

3.1 Membership

The membership of the Disability Board shall be as follows:

- a. One member from the Board of Clallam County Commissions selected by the Board of Commissioners.
- b. One member of a city or town legislative body located within the County, which city or town does not contain a City Disability Board. The member may be the mayor or another member of the city council, appointed by the mayor.
- c. One member from fire service agencies subject to the jurisdiction of the County Disability Board and elected by the firefighters who are subject to the jurisdiction of the County Disability Board.
- d. One law enforcement officer from law enforcement agencies subject to the jurisdiction of the County Disability Board and elected by the law enforcement officers who are subject to the jurisdiction of the County Disability Board.
- e. One member from the public-at-large who resides within the county but does not reside within a city in which a City Disability Board is established. The member is selected by the other four members described above.

Each elected member, and the public-at-large member, shall serve a two-year term; the county and city legislative members shall also serve a two-year term.

3.2 Selection of Law Enforcement Officers and Firefighters Members

Two months prior to the end of a term, the Clerk of the Disability Board shall request nominations from each LEOFF 1 member. Both LEOFF 1 and LEOFF 2 members (active or retired) may apply.

Within one week following receipt of the nominations, the Clerk shall construct and issue ballots to all LEOFF 1 members. The ballots shall be returned by the voting deadline. Any ballots received after the deadline will be disqualified.

The Clerk, before a witness, shall count the votes. The member receiving the highest number of votes shall be the new member. In the case of a tie, lots shall be drawn.

If only one person is nominated for a position, there is no need to conduct an election.

3.3 Selection of City and County Member

Prior to the regular January meeting, the Clerk shall notify the mayors of all cities and towns subject to the jurisdiction of the Disability Board and the Chair of the Clallam County Board of Commissioners of the need to select a successor member to the Disability Board. The mayors and the chair shall then select members to act as their respective representatives by serving on the Disability Board.

3.4 Selection of Public At Large Member

Two months prior to the end of the term the Clerk shall advertise the opening of the public-at-large position on the Disability Board, and applications shall be taken from any citizen meeting the criteria as described under Membership. The applications shall be reviewed by the Disability Board and a member from the public-at-large will be selected by the other four Disability Board members at a special meeting to be held one month prior to the beginning of the new term of the member.

3.5 Vacancies

Positions vacated by Disability Board members shall be filled for the remainder of the term according to the described selection process. A replacement for the appointed member shall finish the remainder of the vacating member's term at which time the above-described selection process shall be utilized and a new member selected.

3.6 Disability Board Officers

The Disability Board shall elect from its members a vice-chair, annually, at its regular January meeting. After completing the term of vice-chair, the vice-chair shall serve as the chair during the next calendar year. The chair shall preside over all meetings of the Disability Board and call special meetings as needed. The chair shall sign all documents requiring the signature of the Disability Board and his/her signature as chair of the Disability Board shall be as legal and binding as if all members had affixed their names.

The vice-chair shall perform the duties of the chair during the absence of the chair.

3.7 Clerk of the Disability Board

The Human Resources Department of Clallam County shall designate from among its employees a Clerk to the Disability Board. The duties of the clerk shall include but are not limited to:

- a. Notify Disability Board members of dates, times, and locations of meetings
- b. Prepare agendas and other necessary materials for meetings
- c. Distribute agenda, previous meeting minutes, and packets containing other pertinent material to each Disability Board member prior to the meeting
- d. Take minutes of Disability Board meetings
- e. Inform claimants, upon request, of necessary forms and documents necessary to submit claims
- f. Provide claimants with necessary forms
- g. Insure that all benefits under insurance or other health care plans available to the claimant are paid prior to payments made by the Disability Board
- h. Arrange appointments with physicians and other medical personnel when required by the Disability Board and notify claimant of such appointments
- i. Prepare annual budget
- j. Prepare vouchers for payment of claims and other expenses
- k. Sign vouchers for expenditures that have been approved by the Disability Board as recorded in the Disability Board proceedings
- l. Prepare and distribute correspondence as necessary to Disability Board members, claimants, employers, and the State Retirement System
- m. Notify claimant's employer when claim or other action is on the agenda for Disability Board discussion
- n. Maintain inventory and order supplies
- o. Develop, prescribe, and maintain forms necessary to document claims

3.8 Compensation

Members shall receive no compensation for their service on the Disability Board, but shall be reimbursed for travel expenses incidental to such service. Such reimbursement shall be in accordance with County policy.

3.9 Disability Board Doctor

A duly licensed and practicing physician or physicians in the State of Washington shall be appointed by the Disability Board. No disability retirement shall be approved by the Disability Board without prior examination of the claimant by the Disability Board doctor or a specialist of the Board doctor's selection, on or near the expiration of the disability leave period except as provided by RCW. The Disability Board doctor shall render such other medical service as may be requested by the Disability Board. Payment for

examinations by the Disability Board doctor shall be made by the jurisdiction responsible for the member being examined.

In order to carry out the duties of this position, each physician appointed or approved by the Disability Board is required to be knowledgeable concerning the duties, functions, and general demands required of the employee being examined. The Disability Board shall furnish to the examining physician the job description of the applicant.

Re-examination of any member on disability retirement shall be conducted by a Disability Board appointed or approved physician.

.4 MEETINGS

Regular meetings shall be quarterly, on the third Tuesday of months January, April, July, and October and shall begin at 9 a.m. The location of the meetings shall be set by the Clerk of the Disability Board.

Special meetings may be called by the Chair giving such notice thereof as required by RCW 42.30.060 (no less than 24 hours written notice to all members of the Disability Board, local media, the member involved and his/her employer). The Disability Board will consider at special meetings only those matters set forth in the notice of special meeting.

Meetings shall be open to the public. The chair will typically call for an executive session to discuss claims requests.

4.1 Quorum

Three members of the Disability Board constitute a quorum. A quorum must be present to take Disability Board action.

4.2 Agenda

The Clerk of the Disability Board shall prepare an agenda each month for all regular, quarterly and special meetings. Such agenda shall include an item for approval of minutes of prior meetings. The agenda shall be sent by the second Friday of each month to the Disability Board members and to the employers of all claimants on the agenda.

4.3 Minutes

Minutes of all meetings of the Disability Board shall be kept by the Clerk of the Disability Board in accordance with State Law.

4.4 Executive Sessions

The Chair may call an executive session in accordance with the State Open Public Meetings Act.

5 MEMBER RESPONSIBILITIES

5.1 Medicare Enrollment Required

Members are required to enroll in Medicare Part A, if eligible. All members are required to enroll in Medicare Part B, when eligible, the premiums for which will be reimbursed by the Disability Board. In the event that the member declines such insurance, the payments for medical services approved by the Disability Board shall be reduced by an amount equivalent to that which would have been paid by the other source according to RCW 41.26.150.

5.2 Member Required to Submit Claims to Other Sources

It is the responsibility of the member to ensure that all benefits payable under another insurance plan or by another source are claimed prior to submission to the Disability Board. The Disability Board will not authorize payment of claims until assurance that all sources have paid available benefits is proved to the Clerk of the Disability Board. The Disability Board will not reimburse a member for expenses previously paid or approved to be paid by insurance or any other source of re-imburement. The Disability Board will not submit claims to, or coordinate claims with other payment sources.

5.3 Failure to Apply for Coverage and/or Submit Claims to Other Sources

If the member does not apply for coverage under the sources identified above if otherwise eligible shall not be deemed a refusal of payment of benefits thereby enabling collection of charges under the provisions of this section in accordance with RCW 41.26.150. Failure of the member to submit claims to other eligible sources shall render the claim incomplete.

5.4 Member Responsible to Make Payment to Provider(s)

Unless otherwise authorized, the Disability Board does not make payments directly to service providers. It is the responsibility of the member to pay providers charges and to submit proper claims for reimbursement. The Disability Board does not reimburse late charges to providers.

5.5 Member Responsible to Repay Amounts Later Received from Other Sources

Any payment received from another source on a previously submitted claim shall be immediately reported to the Disability Board and the member shall reimburse that amount for which the claim would otherwise have been reduced had the payment been received prior to reimbursement by the Disability Board.

5.6 Member Responsible to Properly Submit Claims

Members are required to submit claims:

- a. On properly completed forms required by the Disability Board.
- b. With documentation required by the Disability Board.
- c. Only for those services eligible for reimbursement under this policy.

5.7 Member Responsible to Obtain Pre-Approval

When pre-approval is required pursuant to this policy and as required under any insurance policy covering the member, members are responsible to properly complete required pre-authorization forms, submit such forms, and receive approval of the Disability Board prior to incurring expenses. Failure to obtain pre-approval when required may result in denial of reimbursement.

6 FILING OF APPLICATIONS AND CLAIMS/CLAIMS PROCEDURES

6.1 Forms and Documentation

Applications for disability leave or retirement or medical claims shall be submitted on forms prescribed by the Disability Board Clerk. Forms may be obtained from the Clerk or on the County's internet site. Required documentation including information from the health care provider which describes the services, explains the medical necessity for such service, a billing statement which lists charges, and evidence of insurance payment must accompany all claims. Original receipts and invoices will be accepted for reimbursement. The Disability Board Clerk, at his/her discretion, may accept copies, faxes, or other forms of documentation.

6.2 Deadline for Filing Applications and Claims

The Disability Board shall consider all applications, claims, and other submitted business each month, provided all necessary materials are submitted to the Clerk no later than close of business, the first of each month. At the discretion of the Clerk, late items may be added to the agenda.

Medical claims must be filed with the Clerk of the Disability Board within one year of the date when medical services were rendered or medical supplies purchased. For purposes of benefit allowances as described herein, claims shall be based upon date of service not date of submission of the claim. Claims submitted after the filing deadline will be denied and returned to the member, unless the Disability Board finds the existence of exigent circumstances that prevented timely filing.

6.3 Reimbursement Paid After Insurance or Other Source

All medical expenses incurred and claimed for reimbursement by the member will be submitted through the member's health insurance provider(s), including Medicare, prior to acceptance and consideration by the Disability Board. Reimbursement shall be made, up to established limits, only for that portion of eligible costs not paid by health insurance provider(s) or other sources including but not limited to:

- a. Workers' Compensation
- b. Social Security
- c. Medicare – Part A and Part B
- d. Insurance provided by another employer
- e. Pension Plan other than LEOFF 1
- f. Insurance provided by spouse's employer if no additional cost is required
- e. Any other insurance plan or similar source

6.4 Payment to be made to Member

When reimbursement for a medical expense is authorized, payment of the claim will be made by the member's employer to the member. It shall be member responsibility to pay the provider.

6.5 Claims Procedures

Claims shall be filed with the Clerk of the Disability Board on the Medical Claim Form(s) provided by the Disability Board. Claims submitted with incomplete information as required on the form shall be returned to the member for completion.

The member shall certify the claim as being true and correct, that the member has paid or is liable for payment of all amounts claimed, and that all monies payable from another source have been collected.

The evidence of medical expenses shall be attached to the claim form. Evidence shall be provided with Explanation of Benefits forms from all other insurance sources (such as Medicare and/or an insurance company such as Teamsters, Regence Blue Shield, Blue Cross, AWC, or any other such insurance provider) or, when there is no other insurance

coverage available, an itemized statement from the medical provider such as hospital, physician, lab, etc.

Prescriptions not payable by insurance must be evidenced by either the original RX receipt or an itemized statement from the pharmacy that includes the date of purchase and the name and RX number of the prescription.

6.6 Consideration of Claims by the Disability Board

Claims for reimbursement of medical expenses shall be considered by the Disability Board on each month's Agenda after the Disability Board Clerk determines that the claim is complete and contains required documentation. When considering approval of the claim the Disability Board shall consider:

- a. Is the claim for a covered expense as detailed in section 7 of this policy? Claims for medical expenses that are not covered may be considered at the discretion of the Disability Board.
- b. Is the expense medically necessary and prescribed according to the requirements of this policy? The Disability Board may examine the entire claim, or any portion thereof.
- c. Are the charges reasonable and/or within the maximums allowed by this policy?
- d. Was the expense caused by abuse and/or dissipation?
- e. Has the expense been paid or is it approved to be paid or reimbursed by another third party? Medical expenses reimbursed by another source, including but not limited to insurance (whether member's or spouses, supplemental, elective, or any other), private party other than the member, settlement or judgment, etc. are not eligible for reimbursement.

Claims will automatically be approved on each monthly agenda by Board Members unless a Board Member notifies the Board Clerk that they object to payment of a claim by the 20th of that month. In which case, the claim will be postponed for payment until reviewed by the Board at their next scheduled quarterly meeting.

6.7 Expenses Caused by Abuse or Dissipation-Denial and Remedy

The Disability Board may deny claims when, in their determination, expenses were caused by abuse and/or dissipation. Such abuse includes, but is not limited to, failure of the member to follow a treatment plan prescribed by a practitioner, or; abuse of drugs and/or alcohol, including prescription drugs. When the Disability Board determines that abuse/dissipation is the cause of medical expenses, the Board may require the member to undergo evaluation and/or examination by a physician of the Disability Board's choosing and to complete a recovery and/or treatment plan prior to approving further medical claims.

6.8 Appearance of Member may be Required

When considering any claim for medical expenses, disability leave, or disability retirement, the Disability Board shall be authorized to demand the appearance of the member and to request the appearance of any other persons as it deems appropriate.

6.7 ELIGIBLE MEDICAL EXPENSES/MEDICAL SERVICES

7.1 Reimbursable Medical Services

Medical services are defined in RCW 41.26.030 (22) as the minimum services legally required to be furnished or authorized by the Disability Board. Whenever any active or retired member subject to the jurisdiction of the Disability Board and who is covered under the provisions of RCW 41.26.150, sick or disabled, not caused by dissipation or abuse, of which the Disability Board shall be judge, is confined in any hospital or in his/her home, and whether or not so confined, requires medical services, the employer shall reimburse reasonable charges for the active or retired employee (excluding spouses or survivors) for those necessary medical services listed below, which are not payable from some other source as provided in section 6.7 of this policy.

- a. Hospital Expenses - Room and board not to exceed semi-private room rate unless a private room is required by the attending physician due to the condition of the patient. Other necessary hospital services furnished by the hospital except non-essential personal items.
- b. Professional Medical Expenses Including Fees of:
 - Physician or surgeon licensed under the provisions of RCW 18.71.
 - Osteopath licensed under the provisions of RCW 18.57.
- c. An optometrist licensed under the provisions of RCW 18.53.
- d. A Chiropractor licensed according to the provisions of RCW 18.25.
- e. 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. Continuous care beyond 45 days must be approved in advance by the Disability Board or with written approval by the attending physician. Reimbursement for qualified nursing care provided by member's relatives will be evaluated on a case-by-case basis.
- f. A psychiatrist or psychologist licensed under the provisions of RCW 18.83.

At Disability Board discretion an evaluation from the attending practitioner may be required to determine the appropriateness of such services or the length of services. Practitioners licensed in other states or countries are also eligible for reimbursement.

7.2 Other Reimbursable Medical Services

- a. Drugs and medicines prescribed by a physician. The name and RX number (if available) of the drug, and the date of purchase must be provided. Quantities of

- Viagra or other drugs for the same purpose are limited to six (6) doses per month.
- b. Medical supplies ordered or prescribed by a physician.
 - c. Vaccinations.
 - d. Diagnostic, x-ray, and laboratory services.
 - e. X-ray, radium, and radioactive isotopes therapy.
 - f. Anesthesia and oxygen.
 - g. Purchase or rental of durable medical/surgical equipment, apparatus, supplies, appliances, and orthotics. Covered items are:
 - Able to stand repeated use (except certain consumable medical supplies).
 - Primarily and customarily used to serve a medical purpose, but generally not useful to a person in the absence of illness or injury.
 - Ordered and/or prescribed by a physician for the patient's exclusive use such as oxygen and rental equipment for its administration, surgical dressings, casts, splints, braces, trusses and crutches, pacemakers, blood glucose monitors and (up to the purchase price) hospital beds, wheelchairs and respirators.
 - Durable medical equipment does not include modifications to vehicles or residences, exercise equipment, ergonomic chairs or hot tubs.
 - The Disability Board may require lease or rental purchase of any equipment as well as requiring price quotes prior to the purchase of equipment.
 - h. Professional ambulance service when medically necessary and used to transport the member to or from a hospital or other medical facility. Other transportation expenses will be considered only if such transportation is to a medical facility more than 200 miles from the member's home, is found to be medically necessary, and is pre-approved by the Disability Board.
 - i. Dental Care:
 - Eligible Services – The following dental services are eligible for reimbursement. Additional services or frequency of services are eligible only if found to be medically necessary on an individual basis.
 - Charges incurred by a member who sustains an accidental injury to teeth or dentures and who commences treatment by a legally licensed physician, dentist, or dental surgeon within 90 days of the accident.
 - One (1) dental cleaning and fluoride treatment per calendar year.
 - One (1) general dental checkup per calendar year, to include x-rays.
 - Up to an additional \$1,500 every two calendar years for routine dental and periodontal work including but not limited to filling of cavities, root canals, crowns, bridges, caps, dentures, tooth extraction, etc. (gold work is not eligible unless determined to be medically necessary). The two year period is considered to begin on 1 January of each even numbered year, effective January 1, 2010.

- Non-Eligible Services
 - Orthodontic services unless documented, through medical/dental examination, that there is a direct relationship to an identifiable physical/medical disorder requiring necessary medical treatment. In this case, pre-approval is required.
 - Teeth whitening.
 - Cosmetic dental services unless determined to be medically necessary and pre-approved by the Disability Board.
- j. Long term care in accordance with section 7.5 of this policy.
- k. Physical and massage therapy by a licensed physical or massage therapist when prescribed by a physician. A physician's treatment plan must be submitted for continuous care in excess of 45 days.
- l. Blood transfusions including the cost of blood and plasma not replaced by voluntary donors.
- m. Services to correct or improve vision performed or prescribed by an optometrist or ophthalmologist as described below:
 - Correcting lenses, glasses, or contacts to a maximum of \$500 every 2 years. Additional reimbursement for breakage or loss will be reviewed on a case by case basis. The 2-year period is considered to begin on 1 January of each even numbered year.
 - Refractive or laser surgery to improve eyesight, determined by an ophthalmologist to be medically necessary.
 - One eye exam per calendar year shall be paid in full.
- n. Treatment and/or surgery for other eye disorders including but not limited to glaucoma, cataracts, macular degeneration, tear ducts, etc.
- o. Birth control procedures and prescriptions when attending physician provides written evidence such procedures and/or prescriptions are medically necessary for the member's health. Reversals of birth control procedures are not covered.
- p. Hearing examinations. Hearing aides prescribed by a physician or certified hearing specialist to the following maximums:
 - \$1,600 per ear within a 36-month period for basic amplifier hearing aid.
 - \$2,600 per ear for digitally programmable analog hearing aids within a 5-year period.
 - \$2,800 per ear for programmable digital hearing aids within a 5-year period.
 - Batteries and repair as necessary.
 - The Disability Board may replace broken and un-repairable hearing aids as necessary.
- q. Chemical dependency treatment if prescribed by a physician, psychiatrist, or licensed psychologist, confirmed by the Disability Board physician. Pre-approval by the Disability Board is required. One course of treatment shall not exceed a maximum of \$6,000. Requires written confirmation that member successfully completed program. The Disability Board reserves the right to determine the appropriateness of out-of-state treatment when there is medical evidence to

- show that a service provider in the State of Washington can render the prescribed treatment.
- r. Acupuncture, naturopathic care, and/or non-Rx treatment such as herbal care when approved by a licensed physician and determined to be medically necessary.
 - s. Part B Medicare supplement.

Other medical services not listed in this section as approved by the Disability Board. Limitations on maximum allowances for services provided under this section shall be reviewed and, if necessary, adjusted at least bi-annually.

7.3 Additional Examination may be Required

The Disability Board may require, at its discretion, additional examinations necessary to gather additional information, clarify medically necessary services, or for any other purpose in regards to any claim. Examination may be by the Disability Board physician or other practitioner as determined by the Disability Board. Payment for any such examination shall be made by the jurisdiction responsible for the member.

7.4 Pre-Approval Required for Certain Expenses

Members must obtain pre-approval for certain expenses. When pre-approval is required, requests shall be made on form(s) prescribed by the Disability Board. Services/expenses requiring pre-approval are:

- a. Purchase of durable equipment expected to cost over \$1,000.
- b. Long term care, except that, if a member is assigned to long term medical care on short notice (i.e. for recovery from a surgical procedure upon release from the hospital) the member will apply for pre-approval as soon as possible after admission.
- c. Hospice Care, unless immediate and unanticipated.

7.5 Long Term Medical Care

Requests for long-term care shall be submitted on forms prescribed by the Disability Board. They shall include a detailed report of diagnosis, medical history, prognosis for recovery, and treatment /care services that are medically necessary.

For assisted living, reimbursement shall be for a studio, if available. For nursing home care, reimbursement shall be for a semi-private room, if available. Additional costs for room upgrades are the responsibility of the member. Excess charges beyond those included in the base rate that are non-medical in nature will not be reimbursed unless certified as medically necessary by a physician.

The latest annual Genworth Cost of Care Survey of either assisted living costs or nursing and home care costs as appropriate shall be used to determine maximum reimbursement. Maximum reimbursement shall be 120 percent of the survey average for the area in which the member resides. Genworth assisted living averages are considered to be for level 2 care. The survey average will be reduced by 12 percent for members receiving level 1 care. The survey average will be increased by 23 percent for members receiving level 3 care.

The Disability Board shall obtain additional examination by the Disability Board appointed physician for any long-term care where the expected recovery time exceeds 6 months. Payment for such examination shall be made by the jurisdiction responsible for the member. Recertification of medical necessity may be required every 6 months.

In home care or assisted living is considered to be preferable to nursing home care when appropriate. However, the level of care will normally be determined by the attending physician.

The facility must have obtained and remain current on Adult Family, Boarding Home, or Nursing Home license from the State of Washington. If the facility is located outside the State of Washington, it shall be the responsibility of the member to provide documentary evidence that the facility is licensed in the state or country where the facility is located and that the licensing requirements are similar, equal to or greater than those required by the State of Washington.

Detailed itemized statements or billings must be submitted for reimbursement. Payment by other insurance coverage, including Medicare and private nursing home insurance, are primary to this benefit.

7.6 Hospice Care

Benefits will be provided for hospice care for a terminally ill member under the following conditions:

- a. Member is admitted to a DSHS-certified, Medicare-approved, or other approved program.
- b. Care provided is part of a written plan of continuous care, prescribed and periodically reviewed by a physician.

.8 DISABILITY LEAVE

Any member who is not able to work due to a disabling injury or illness may receive disability leave in accordance with the following conditions.

8.1 Application

Application for disability leave shall be made on form(s) prescribed by the Disability Board. The application is not considered complete unless properly completed and accompanied by required documentation. Documentation shall include, as a minimum, a detailed report, completed by the primary physician treating the illness or injury, of diagnosis, medical history, the duties that the member cannot perform, prognosis for recovery, and expected date the member can return to duty. Each application shall also be accompanied by a list identifying, by name, any physician who has been contacted within the last 6 months for the illness or injury for which a disability is claimed.

8.2 Consideration

Following receipt of a completed application for disability leave, the Disability Board shall review all relevant information pertaining to the question of the applicant's fitness for duty. If, in the opinion of the majority of the Disability Board, the evidence supports the proposition that the member is unfit for duty, such member shall be granted disability leave unless such leave is waived pursuant to RCW 41.26.120 (4). In considering the application, the Disability Board shall consider the duties of the position and any other evidence that is relevant. The Disability Board may grant leave, at its discretion, retroactively to the date of discontinuance of service.

8.3 Burden of Proof

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

8.4 Standards

Department of Retirement System standards for entry or re-entry into LEOFF system membership were provided only to safeguard the fiscal integrity of the pension system and are not the applicable standards for any other purpose.

8.5 Additional Examination May be Required

The Disability Board may specify, by written order, that a member will submit to additional medical evaluations deemed necessary to evidence fitness for duty. The Disability Board may also require medical evaluations when such member requests return authorization from a disability leave. It is the member's obligation to provide additional information by the deadline given when such information is requested to be provided.

8.6 Doctor-Patient Privilege

According to RCW 41.26.115 and WAC 415-105-030 it shall be incumbent upon each member obtaining medical evaluations to be used in connection with such disability leave and subsequent evaluations to advise each and every examining physician that such evaluation is being conducted at the direction of the Disability Board, that any reports relating thereto are for the benefit of the Disability Board, that the doctor-patient privilege may not be invoked with respect thereto, and that the physician may be called upon by the Disability Board to testify as to his/her findings.

8.7 Temporary Approval

The Disability Board shall appoint a designee from its members to temporarily approve requests for disability leave, subject to subsequent ratification by the Disability Board at the next scheduled Disability Board meeting. The LEOFF 1 member requesting the leave must provide all required forms and necessary information to the Clerk of the Disability Board (or any Disability Board member if the Clerk is not available) including the effective date and reason for disability leave.

When the Clerk has been provided the required information, she shall then contact the designated Disability Board member for temporary approval. If the designated member is not available, the Clerk shall contact any other member of the Disability Board for such approval. Upon review of the application and accompanying documentation by the Disability Board at the next scheduled meeting, the temporary approval shall be ratified or denied.

8.8 Notification of Decision

Following approval or denial of a disability leave application by the Disability Board, the Clerk shall notify the applicant and the employer in writing of such action.

8.9 Authorization to Return to Duty

It is the responsibility of the member to return to duty as soon as possible. Return to duty shall be authorized by the attending physician on form(s) established by the Disability Board. Return to duty may be temporarily authorized by the Clerk of the Disability Board and ratified at the next regular meeting of the Disability Board if proper documentation is submitted between regular meetings.

8.10 Conditional Return to Duty

If the Disability Board finds the medical evidence to be inconclusive, the Disability Board may specify in written order, on a case-by-case basis, a reasonable trial work period to determine the member's fitness for active duty. Such a conditional return to service

does not entitle the member to a second 6-month period of disability leave for the same disability if, based upon this period of service, he/she is found to still be disabled.

Any return to work, following an absence of 14 working days or more, without approval of the Disability Board shall be automatically deemed a conditional return for a 2-month period.

8.11 Extending Conditional Return Period

The Disability Board may vote to extend a member's conditional return to work trial period for an additional 30 days if, through supportive medical evidence and supporting information from the member's supervisor it appears that the member is not fully recovered from his disabling condition. In addition, the member must not have discontinued his/her original conditional return-to-work trial period.

8.12 Disability Leave Allowance

Disability leave allowance is not granted for any specific amount of time. Such leave may encompass a period of one day to a maximum of 6 months. During this time the member is to receive an allowance equal to his/her full monthly salary from the employer.

8.13 Recuperation

It is the intent of the Disability Board to assure that a member, while on disability leave, shall do all in his/her power to recuperate from such disability and shall do nothing that would reasonably appear to prolong the leave or inhibit recovery from such disability. Failure to comply with treatment plans or direction of the Disability Board will constitute grounds for cancellation of the disability leave.

Should the Disability Board want to contact the member regarding matters concerning disability leave, the member's place of recuperation will be assumed to be his/her home or a hospital in which the member may be confined. If it is necessary for the member to be at any other place for more than 24 hours, it is the member's responsibility to notify the Clerk (or any Disability Board member if the Clerk is not available) of his/her location. For travel outside the County in excess of 24 hours during a physical related disability, a physician's recommendation may be required, at the discretion of the Disability Board Clerk, prior to such travel.

8.14 Member Responsibilities during Disability Leave

The member shall fulfill all of his/her obligations during disability leave in accordance with the following policies and procedures:

(1) Treatments

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

(2) Medical Reports

The Disability Board, at its discretion, may require written progress reports from the member's physician stating the medical condition of the member and an anticipated date of return to duty

(3) Return to Duty

It shall be the responsibility of each member granted disability leave to seek authorization to return to active service at the earliest possible time the member believes he/she is fit for duty. In the event the Disability Board finds that a member has not actively sought authorization to return to active service immediately upon cessation of disability, the Disability Board may retroactively cancel the member's disability allowance for the period in question.

(4) Jurisdiction

Any member on disability leave is under the jurisdiction of the Disability Board for all matters pertaining to his/her disability, and shall not engage in any activity which is contrary to the directives of the member's doctor or Disability Board physician or that might be detrimental to his/her return to active duty. The Disability Board has authority to, and may at any time in any case, request an investigation to be made of the activities of any active member on disability leave or any member retired due to a disability to determine whether the disability continues to exist, and may request such investigation as may be appropriate.

.9 DISABILITY RETIREMENT

Members who have a disability that is determined to continue for more than 6 months may apply for disability retirement.

9.1 Application

Application for disability retirement shall be made on form(s) prescribed by the Disability Board. The application is not considered complete unless properly completed and accompanied by required documentation. Documentation shall include, as a minimum, a detailed report, completed by the primary physician treating the illness or injury, of diagnosis, medical history, the duties that the member cannot perform, prognosis for recovery, and whether the member is expected to be able to return to duty, and if so, on what date. Each application shall also be accompanied by a list identifying, by name, any physician who had been contacted within the last 6 months for the illness or injury for which a disability is claimed.

The completed application form shall be accompanied by the Physician's Report, the Supervisor's Report, and any other evidence that the member wishes the Disability Board to consider including the duty/non-duty relationship to the disability retirement.

9.2 Examination

Members applying for disability retirement shall be examined during the 5th or 6th month of disability leave in order to determine their eligibility for disability retirement, with the following exceptions:

- a. The Disability Board doctor assures the Disability Board that the member's condition has not and will not be corrected before the end of the 6th month.
- b. The applicant establishes that the disabling condition will be in existence for a period of at least 6 months and he/she voluntarily waives disability leave. No member will be granted disability retirement allowance unless the conditions imposed by this subsection are met.

9.3 Conditional Return/Trial Service Period

If the Disability Board finds the medical evidence to be inconclusive, the Disability Board may specify in written order, a reasonable trial work period to determine the member's fitness for duty. Such a conditional return to service does not entitle the member to a second 6-month disability leave for the same disability if, based upon this period of service, the member is found to still be disabled.

9.4 Granting Disability Retirement

If the evidence shows to the satisfaction of the Disability Board that the member is physically or mentally disabled from further performance of duty and that the disability has been continuous from the date of commencement of disability leave for a period of 6 months, the Disability Board shall enter its written decision and order accompanied by appropriate findings of fact and conclusions of law in compliance with RCW 41.26.120. Such written decision and order with supporting documentation shall thereafter be forwarded to the State Department of Retirement Systems.

9.5 Duty/Non-Duty Status

As part of the consideration of any application for disability retirement, the Disability Board must determine whether the retirement request is duty related or non-duty related.

9.6 Early Retirement

In the event a regular meeting of the Disability Board precedes the date at which the full 6 months will conclude by no more than 40 days and the evidence is clear that the disability is expected to continue through the full 6-month period, the Disability Board may make a finding of 6 months continuous disability prior to the actual conclusion of the 6-month period, so as to eliminate unnecessary delay of receipt of retirement benefits.

9.7 Standard/Burden of Proof

In order to qualify to receive a disability retirement allowance, the member shall be required to prove that he/she is physically or mentally disabled to such extent that he/she is unable to discharge with average efficiency the duties of the position held at the time of discontinuance of service.

No member shall be entitled to a disability retirement allowance if the appropriate authority advises that there is a position available for which the member is qualified and to which one of such grade or rank is normally assigned if the Disability Board determines that the member is capable of discharging, with average efficiency, the duties of that position. These provisions do not apply to disability leave status.

9.8 Contents of Decision

Every order of the Disability Board granting or denying a disability retirement allowance shall contain the following information presented in clear and concise terms:

- a. Findings of Fact supported by evidence in the record supporting the granting or denying of the disability retirement allowance. When a disability retirement is granted, the Findings of Fact shall include:
 - (1) Duty/Non-Duty status of disability.
 - (2) Whether disability was incurred in other employment.
 - (3) Dates encompassing disability leave and/or dates relating to an authorized trial return to duty; and, in the case of a trial return, the factual basis for the decision.
 - (4) Dates encompassing waiver of disability leave, if applicable; and evidence that disability will exist for 6-month period.
- b. Conclusions of law that are drawn in accordance with the law as related to the facts in the case.
- c. Disposition

9.9 Notification of Decision

A copy of the decision shall be mailed or served to the applicant, the employer, and the Department of Retirement Systems.

If the Disability Board denies the disability retirement or cancels a previously granted disability retirement, the applicant shall be notified immediately and advised of the right to appeal the decision or order to the Director of the Department of Retirement Systems, pursuant to RCW 41.26.200. Such notification shall be in writing and served by personal service or mail; or provided, that written notice need not be given if the member or his/her duly authorized representative is in attendance at the meeting or hearing and is advised of the decision and right of appeal.

9.10 Post Retirement Re-Examination

In the event a member is placed on disability retirement, the Disability Board shall determine whether or not the member is so disabled that no possibility exists for return to duty or that there is no possibility that rehabilitation could restore the member to fitness for duty. Further, the Disability Board may, at any point subsequent to retirement, make such a determination. A copy of such determinations shall be sent to the Department of Retirement Systems.

Any re-examination under this section shall include an evaluation of treatment available that may be employed to rehabilitate the member. Based upon such evaluation, the

Disability Board may direct the member to participate in a reasonable rehabilitation program.

(1) Re-Examination Evaluation

The Clerk shall require each member under 49.5 years of age placed on disability retirement, and not determined to be permanently so disabled, to complete a Re-Examination Evaluation Form approximately every 6 months. The responses shall be provided to the Disability Board doctor who shall advise the Disability Board as to whether re-examination might be beneficial. If the Disability Board determines that a re-examination should be conducted, it shall so be ordered.

(2) Re-Examination of Members Residing 100 Miles Away

If a member ordered to be re-examined is residing at a location more than 100 miles from his former place of employment, the member may be authorized to be examined by a physician in his/her immediate area provided, however, that the physician shall first be approved by the Disability Board and that prior to the examination the physician shall be informed as to the basis on which the examination is to be conducted and the issues to be addressed in the physician's evaluation report.

(3) Failure to Respond

Failure to affirmatively respond to the request for re-examination shall be deemed a continued refusal. The retirement allowance of any member who fails to submit to medical re-examination as provided for in this subsection shall be discontinued. In the event that such refusal continues for one year, the member's disability retirement allowance shall be canceled.

9.11 Re-Entry from Retirement

In the event that re-examination discloses fitness to perform duties of the rank held by the member at the time of disability retirement, the member shall be brought before the Disability Board for hearing and further consideration of the matter prior to actual cancellation of the disability retirement allowance unless the retiree waives such hearing. Notice of such proceedings and the hearing shall comply with the requirements of RCW 34.04.

.10 APPEALS

Members aggrieved by any order, determination, or denial of benefits shall have the right to appeal such order, determination, or denial.

10.1 Denial of Disability Leave or Disability Retirement

Any person feeling aggrieved by any order or determination of the Disability Board denying disability leave or disability retirement or canceling a previously granted disability retirement allowance shall have the right to appeal to the State Retirement Board as provided for in RCW 41.26.200, .211, and .221.

10.2 Appeal of Decision on Claim for Medical Services

Any person or employing agency feeling aggrieved by any decision on payment of a claim for medical services by the Disability Board shall have the right to request the Disability Board to reconsider its decision. The request for reconsideration must be filed, in writing, with the Clerk of the Disability Board within 30 days of the date of the decision on the claim by the Disability Board.

The Disability Board may grant or deny the request for reconsideration, at its discretion, after review of the written request for reconsideration.

(1) Reconsideration of Decision

The Disability Board, upon agreement to reconsider a decision on a medical claim, shall set a date and time for a hearing at which time the member and the employing agency may present such evidence deemed relevant to the claim. The Disability Board shall either sustain or reverse its original decision within 15 working days of the hearing and shall support such decision with findings of facts and conclusions.

(2) Acceptance of Service of Judicial Process

The Disability Board Clerk is authorized to accept service of judicial process on behalf of the Disability Board provided that such process does not include any complaint or prayer for money damages against the Disability Board or any individual member thereof.

11. RECORDS

The Disability Board Clerk shall be responsible for maintaining the records of the Disability Board including minutes of regular and special meetings, elections of Disability Board representatives, claims, and evidence submitted for payment, correspondence, and membership lists. Disclosure of Disability Board records is reserved according to the Open Public Records Act and requirements of HIPAA.