RULES, POLICIES AND PROCEDURES

of the

King County Disability Retirement Board

for the

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

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PREAMBLE

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

SCOPE

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

EFFECT OF RULES AND REGULATIONS

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

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

PART 1: DEFINITIONS

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

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

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

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

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

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

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

PART 2: THE BOARD

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

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

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

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

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

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

PART 3: GENERAL PROVISIONS OF BOARD MEETINGS

MEETING PROCEDURES:

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

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

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

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

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

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

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

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

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

D. The record of a hearing shall include:

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

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

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

G. The Disability Board may:

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

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

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

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

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

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

PART 4: PROCESSING APPLICATIONS AND CLAIMS GENERALLY

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

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

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

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

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

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

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

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

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

4.3 Appeal Procedure.

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

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

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

PART 5: DISABILITY LEAVE AND RETIREMENT

General Procedures

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PART 6: OBLIGATIONS OF MEMBERS WHILE ON LEAVE

6.1 Authorization to Return to Active Service from Disability.

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

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

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

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

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

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

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

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

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

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

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

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

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

PART 7: MEMBERS ON DISABILITY RETIREMENT LEAVE

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

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

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

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

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

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

PART 8: MEDICAL EXPENSE CLAIMS, PROCEDURES AND GENERAL PROVISIONS

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

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

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

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

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

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

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

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

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

8.8 Medicare Benefits.

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

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

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

8.9 Offset for Third Party Payments and Subrogation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PART 9: REIMBURSEMENT OF CLAIMS FOR MEDICAL TREATMENT/ PROCEDURES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Significant history.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9.9 Dental Benefits.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

J. **Specialized Surgeries:**

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

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

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

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

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

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

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

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

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

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

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

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

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

10.2 Chronology of Amendments/Revisions of Board Rules.

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

	Human Services (www.LongTermCare.gov)"
Sept 7, 2012	Rule 9.8A,1,e Condition for Approval of Payment for Hearing Aids: *"Maximum cost not exceed $3,000 per hearing aid or $6,000 per pair"*
May 26, 2010	Rule 8.2 Submission of Medical Expense Claims" *"…is sent to the Employer/Board for…"*
	Rule 4.1 Submission of Claims, additional language: *"Applications and Claims required to be submitted to the Board shall comply with the Following criteria:"*
Jan 1, 2009	Rule 9.7A Eyeglass Lenses and Frames: *"$500.00 maximum per Single set…"*
	Rule 9.7B Second Pair *"…shall not exceed $300.00 per single set…"*
	Rule 9.7C Contact Lenses *"…not to exceed $250.00 maximum during any 12-month…"*
Jan 31, 2007	Rule 9.10-E, "Home/Health Care Services", amended to replace: "physician" with "licensed/certified health care provider". Stipulation care would only be allowed following an accident or illness deleted
Sept 27, 2006	Rule 9.10-K, "Specialized Surgeries" amended to expand benefits under eye surgery to include corneal laser surgery, laser treatment and lens implants
	Rule 9.7-D, "Vision Benefits". Replacement pair of glasses, frames, or contacts made available for both retired as well as active-duty
	Rule 9.7 A-C, "Vision Benefits", amended to increase benefits for glasses, frames or a second pair up from $295 to $350
	Rule 9.5-B(4), "Mental Health Services", approved increase in maximum provider fee allowable for psychotherapy
Feb 22, 2006	Rule 9.8,-A, "Hearing Aids" amended to eliminate need for prior approval by the Board if all conditions of the rule are met
Nov 30, 2005	Rules 2.2 and 2.3 amended, 2.4 deleted. Board Clerk to maintain election procedures and hold Fire and Law elections in alternate years
	Reference to "two-year term" omitted

Apr 28, 2004	Rule 9.5-A (1), "Mental Health Services" amended to allow exceptions for providers who could furnish evidence of capability
Sept 24, 2003	Rule 6.3 enacted to set penalties for missed IMEs
Nov 26, 2002	Rule 9.9, "Dental Benefits" amended to limit benefits to $3,000 in any calendar year
Aug 28, 2002	Merged Rules 9.10 (G) and (H) into 9.10 (G), "Long Term Care Facilities" to make requirements the same for adult family homes, boarding homes and nursing homes
Apr 24, 2002	Revised Rule 9.9, "Dental Benefits" to cover all services except cosmetic
	Revised Rule 9.5-B, "Mental Health Services" to change "certified" mental health counselor to "licensed" and add out-of-state stipulation
Mar 27, 2002	Revised Rule 9.10-J to eliminate requirement for review of claims for approval of Viagra. Second paragraph deleted
Apr 4, 2001	Revised Rule 9.5-B(4), "Conditions for Approval of Mental Health Service", to increase maximum rate allowed and add subsection "e", "advanced registered nurse practitioners"
Dec 20, 2000	Revised Rule 9.10-J, "Sexual Dysfunction & Infertility", to eliminate restriction on dosage allowed
Oct 25, 2000	Revised Rule 9.10-E, "Home/Health Care Services", to improve criteria for approval of in-home care to include paraprofessionals and set maximum cost of daily care, and require new Form #10.
	New Form #10 approved for claims for home health care
	Rule 9.10-H, "Nursing Home/Hospital Extended Care Facility", revised to require treatment plan when placement in nursing home/extended care facility exceeds six months
	Form #9 revised to include assisted living care facilities
	Rule 9.10-L (a), "Refractive Keratotomy Surgery (RK)", deleted
Mar 22, 2000	Revised Rule 9.7, "Vision Benefits" to set $295 maximum for frames and lenses once every 12 months; second pair of computer glasses allowed

Feb 23, 2000	Amended Rule 9.8-A, "Hearing Aids", to increase maximum allowed to $2,500/aid or $5,000/pair every five years; examination by otolaryngologist and evaluation by an audiologist required; maintenance and battery replacement allowed
Feb 24, 1999	Amended Rule 9.7-B, "Vision Benefits", to increase maximum allowed for frames to $95/24 months
	Amended Rule 9.10-J, "Sexual Dysfunction and Infertility" to impose maximum for Viagra of 75% of cost not to exceed 15 doses
Nov 23, 1998	AmendedRule9.10-J, "Sexual Dysfunction/Impotence/ Infertility" to allow consideration of Viagra as reimbursable. Amended Rule 9.10 A, "Acupuncture/Acupressure", to include massage therapy
Oct 30, 1998	Amended Rule 9.5-B, "Mental Health Services", to include "certified mental health counselor" payable at $80/50-minute session
Dec 17, 1996	Amended Rule 8.8, "Medicare Benefits" to define rights to apply for reimbursement of Medicare/Medigap insurance premiums
Nov 26, 1996	Amended Rule 9.5 B, "Mental Health Services" to add item #4 to designate maximum rate allowable for psychotherapy
May 29, 1996	Amended Rule 9.5, "Mental Health Services" to require submission of updated treatment plans every six (6) to (10) sessions
Jun 27, 1995	Amended Rule 9.9, "Dental Benefits", and amended Rule 8.3, "Inquiry Prior to Incurring Treatment Services"
Dec 14, 1993	Amended Parts 8 and 9; added Section 9.10, "Additional Medical Services and Supplies"
Sept 29, 1992	Revised Rule 9.7, "Vision Benefits"
Jul 28, 1992	Revised Rule 9.7, "Vision Benefits"
Mar 31, 1992	Revised Rule 6.1 A and B; repealed Section 6.1.C
	Revised Rule 6.6 and 6.7. Added new section 6.8
Aug 16, 1990	Revised Rule 6.1; added new Section C

Apr 19, 1990	Revised Rule 9.7
Apr 18, 1989	Revised Board Rules/Policies effective April, 1989
	Repealed July 1, 1981 Board Rules/Policies
Jan 16, 1985	Amended Part 8.6, alcoholism/drug treatment
Dec 12, 1983	Revised eyeglass policy, Part 8.3
Mar 3, 1982	Amended Part 3.2
Jul 1, 1981	Adoption of revised Board Rules and Policies
Oct 1970	Original formation of King County Board Policies