RULES, POLICIES AND PROCEDURES of the Cowlitz County Disability Retirement Board

for the

State of Washington

Law Enforcement Officers' and

Fire Fighters' Retirement System

Cowlitz County Disability Retirement Board

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1 INTRODUCTION

LEOFF1, as it is today, is no longer available for new participants. This document sets forth the rules and policies under which the Cowlitz County Disability Board will administer sickness and medical benefits to retirees enrolled in LEOFF 1.

As of the writing of this document, there are a total of 35 participants divided into the jurisdictions: Cowlitz County Sheriff's Office (19); City of Kelso (12); Cowlitz 2 Fire & Rescue (1); City of Castle Rock (1); and the City of Woodland (1). These participants are grandfathered in the program for life.

1.1 Operational Structure.

By RCW 41.26.110(1)(a), this program requires a Board to be formed to provide minimum standards and operational guidance to each jurisdiction having extant participants. This Board will be referenced in this document as the Board.

Previous functions of the Board changed significantly when the program was closed to new participants. These changes are reflected in a reduction and simplification of this document.

1.2 Funding.

Each jurisdiction is responsible for managing and financing this program solely for the benefit of its own participants. In other words, there is no pooling of financial resources.

1.3 Jurisdictions.

While the Board sets the overall minimum rules and polices of the program for employers under its jurisdiction, each jurisdiction retains the authority to pay claims over and above the minimum rules set forth hereins. This flexibility may result in different decisions being made for the special circumstances which invariably will arise.

2 EFFECT OF RULES AND REGULATIONS

All fire and police personnel of Cowlitz 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 always follow the procedures contained herein to avoid possible loss of benefits. In the event any policy or procedure as applied to the 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.

3 DEFINITIONS

"Member" means a retired law enforcement officer or firefighter currently enrolled in LEOFF1 for benefits provided under RCW 41.26.

“Payor” means the entity responsible for paying the claims. Typically, this is the employer of record at retirement.

4 THE BOARD

4.1 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.

4.2 Board Members.

The Cowlitz County Disability Board shall consist of five members in accordance with RCW 41.26.110(b): one member shall be from and appointed by the Cowlitz County Commissioners; 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.

4.2.1 Election of Firefighter/Law Enforcement Representative.

Nominations and elections are conducted by the Board Secretary pursuant to the written election procedures approved by the Board. Approved election procedures are to be kept on file by the Board Secretary. The election of the Firefighter and Law Enforcement Representative shall be conducted in alternate years. Law Enforcement Representative will be in the “odd year”, and the Firefighter Representative will be in the “even year”.

4.2.2 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. A term is for two years.

4.2.3 Voting.

Each Board member shall have one vote, which must be cast by that member in person, via telephone or by electronic appearances. Three members of the Board shall constitute a quorum.

4.2.4 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 if 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.

4.2.5 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 Tempore shall assume the duties and powers of the Chair in the Chair's absence.

4.2.6 Appointment of Board Clerk.

The Board Chair shall appoint a person to serve as the Board Secretary who shall be subject to confirmation of the Board.

5 BOARD MEETINGS

5.1 General provisions

5.2 Meetings, Agenda.

The Board shall meet regularly once a quarter, on the last Tuesday of the month at 1:00 p.m. in the Cowlitz County Hall of Justice. If necessary, special meetings may be called by the Chair or a majority of the Board.

5.3 The Board.

The Board may 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.

5.4 Electronic Recording.

No one attending any Board meeting may make electronic recordings of any portion of the meeting without the prior approval of the Board.

5.5 Examination of Records.

Information relating to a member's claim or application shall be released under the following conditions:

1. Only as required by RCW 42.56 with all necessary redactions required by RCW 70.02 or other laws, by court order, or written permission of the member. Upon request to the Board Secretary, members may examine their disability file at the Board office during times scheduled by the Board Secretary.
2. A person requesting examination of Board records, minutes or agendas must submit a written request and arrange with the Board Secretary an appointed time for viewing the materials. Requests for examination must comply with RCW 42.56, the Public Records Act and RCW 70.02, Washington Health Care Information Act. If a request would violate a member's privacy rights, all identifying details in the information must be redacted or the member's permission must be obtained before release of the information.
3. 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.

5.6 Oral Proceedings/Transcripts.

The Board may hold a full hearing on any matter when deemed necessary or on a motion for reconsideration. At such a hearing:

1. Any person testifying before the Board may have his or her attorney present.
2. Opportunity shall be afforded all parties to respond and present relevant evidence and argument on all issues involved.
3. Unless precluded by law, informal disposition may also be made of any contested case by stipulation, agreed settlement, consent order, or default.
4. The record of a hearing shall include:
    a. All pleadings, motions, intermediate rulings
    b. Evidence received or considered
    c. A statement of matters officially noticed, if any

   d. Questions and offers of proof, objections, and ruling thereon, if any
   e. Proposed findings and exceptions, if any; and
   f. Any decision, opinion, or report by the Disability Board.
5. All oral proceedings before the Board may be recorded by a court reporter. A copy of the record, or any part thereof, may 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.
6. Findings of fact shall be based exclusively on the evidence and on matters officially noticed.
7. The Disability Board may:
   a. Administer oaths and affirmations, examine witnesses, and receive evidence.
   b. Issue subpoenas.
   c. Rule upon offers of proof and receipt of relevant evidence.
   d. Take or cause depositions to be taken pursuant to rules promulgated by the Payor.
8. For incurred expenses refer to 1.2. (Each jurisdiction is responsible for managing and financing this program solely for the benefit of its own participants).

5.7 Subpoenas.

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

1. The Board may issue a subpoena on its own motion or on the request of any party. (See Section 3. Below)
2. 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.
3. 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 party requesting the issuance of the subpoena. For incurred expenses refer to 1.2. (Each jurisdiction is responsible for managing and finance this program solely for the benefit of its own participants).

6 PROCESSING APPLICATIONS AND CLAIMS GENERALLY

6.1 Submission of Claims.

Applications and claims are to be submitted to the entity responsible for payment, the member's employer/department, referred herein as Payor.
The Payor acts independently of the Board to honor or disallow claims.
The member or the Payor may request the Board to review any issue or conflict they may have with the other party.

6.2 Reconsideration of Payor Decisions.

The Payor's decision to approve or deny applications or claims may be made without a full hearing solely based on the written information submitted to the Payor. Any person feeling aggrieved by any denial of payment of a claim for medical services shall have the right to request the Board to reconsider the decision and the Board may grant or deny such request for reconsideration, at its discretion.

1. Such a request must be filed in writing within thirty (30) days following the denial of claim by the Payor. The Board Secretary will set a time at the next earliest regular Board meeting or set a Special Board meeting if needed for a hearing.
2. 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 Secretary 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.

6.3 Appeal Procedure

1. Any member aggrieved by an order of the Payor may bring the issue before the local Board.
2. Any member aggrieved by an order of the Board, which is within the jurisdiction of the State Retirement Systems, shall comply with the provisions of RCW 41.26.200 in perfecting such an appeal to the State Retirement Systems director.

3. 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 Cowlitz County Superior Court within the appropriate time frame.

7 MEDICAL EXPENSE CLAIMS, PROCEDURES AND GENERAL PROVISIONS

All claims for medical expense reimbursement must comply with these Rules.

7.1 General Provisions

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

1. The Payor 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:
    a. The sickness or disability for which services are rendered was not brought on by dissipation or abuse.
    b. The services and/or supplies are medically necessary, viz:
        i. 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.
        ii. Consistent with standards of good medical practice within the organized medical community.
        iii. Offered in the most appropriate setting, supply or service which can be safely provided.
        iv. Not primarily for the convenience of the member, his/her physician, or other provider.
    c. The charges are reasonable and considered to be usual and customary unless a provision in these Rules provides for reimbursement of lesser amount. The Payor will decide what is reasonable and customary subject to these rules and by review of the Board.
    d. If the member belongs to a pre-paid health plan and he/she could not have obtained reasonable equivalent services at no additional charge through such plan. The Payor will decide which services are reasonably equivalent.
    e. If the member is being treated by more than one physician or specialist and such collateral/supplemental treatment must be described in the treatment plan.

2. The fact that the medical service or supplies were furnished, prescribed, or approved by the member's physician or other provider does not assure that the Payor will approve such services as medically necessary.
3. The member shall provide the Payor with any supporting information to assist the Payor in determining whether the criteria set forth in these Rules are met. Such information may include reason why the claim should be denied or limitations of a member's coverage by a third-party Payor.

7.2 Criteria for Authorizing Reimbursement

For each claim, the Payor shall determine if the criteria 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.

7.3 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 Payor. Medical services not listed in that section may, in the discretion of the Payor, be considered for authorization on a case-to-case basis.

7.4 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 Payor for approval. The medical expenses claim submitted for reimbursement is to be that portion not covered by the existing health insurance provider.

7.5 Inquiry Prior to Incurring Treatment Services.

Some medical procedures require Payor approval prior to incurring medical treatment. It is the member's responsibility to submit all pre-approval documents and/or treatment plans to the Payor. In addition, members are advised to consult first with their health insurance providers 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 may not be authorized by the Payor.

7.6 Payor Authorization of Reimbursement for Medical Expenses.

The Payor considers only the medical necessity of the treatment/service/equipment prescribed and the reasonableness of the charges. 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.

7.7 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.

7.8 Time for Filing.

All claims should be submitted to the member's Payor within six (6) months of the member's receipt of the original billing. Claims submitted after this time may be paid by the Payor. No claim will be allowed before the expenses are actually incurred, except as specifically authorized in these Rules.

7.9 Medicare Benefits.

1. 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. Members are cautioned that, if they are eligible for Medicare coverage and fail to obtain this coverage, the Payor is not obligated for medical expenses which otherwise would have been covered under Medicare. RCW 41.26.150 (2).
2. 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 Payor for consideration of reimbursement, RCW 41.18.060, and RCW 41.20.120.

7.10 Offset for Third Party Payments and Subrogation.

1. 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.

2. Payors shall have the subrogation rights described in RCW 41.26.150(3). The Payor 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 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 allows each Payor to approve additional medical services for which members submit claims, subject to the conditions and limitations set forth in these Rules and given statutes, and subject to Section 7.1 and Section 7.2.

8.1 REIMBURSEMENT OF CLAIMS FOR MEDICAL TREATMENT/ PROCEDURES

8.1.1 General Rule.

The Payor 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 Rules adopted by the Payor.

8.1.2 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 these Rules.

8.1.3 Continuous Treatment/Services.

Treatment or services requiring continuous, consecutive, and frequent treatment for mental health/psychological counseling, substance abuse treatment, acupuncture, chiropractic and massage treatment are subject to provisions set forth herein. If these treatments are covered by the members Medicare and the Payors Medical Plan, there is no requirement to provide further evaluations and/or treatment plans. If the event exceeds the coverage provided by Medicare and the Payors Medical Plan, then the treatment or services requiring continuous, consecutive, and frequent treatment will need to provide: an evaluations and treatment plan, including estimate of duration and frequency of treatment must be submitted to the Payor for their review. Prior approval by the Payor is needed before the member undertakes the treatment. The Payor will use these Rules, Policies and Procedures to determine if the event will be covered. Claims for

reimbursement of the cost of continuous treatment undertaken at member's own volition, without prior Payor approval, may not be covered.

8.1.4 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. Some health insurance providers pay for medical services only 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 Payor for its consideration.

8.1.5 Members Covered by a (Non-Self-Funded) Group Plan Health Provider.

When the member is covered by a comprehensive group health insurance provider, the member is required to seek medical services first from those health insurance providers because they are known to have medical staff/specialists available.

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.

1. 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.
2. 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 Payor by the member or the physician because the reasons could bear upon the issue of the medical necessity of such services.
3. If such a referral is not provided with the claim, the Payor 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.

8.1.6 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 Payor's review prior to approval of payment for services over and above the designated contract maximum.

8.2 Medical Treatment/Services Found Unreasonable.

8.2.1 Continuous Treatment.

If continuous treatment or charges thereof are found to be unreasonable or excessive, the Payor 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 Payor will construe such services as elective on the part of the member and will deny such claim.

8.2.2 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 Payor of his/her primary physician/specialist and provide the Payor with the treatment plan which describes the supplemental and/or additional medical service. In addition, the Payor may require a statement from the primary physician describing reasons for referral to other physicians/specialists. This section does not restrict any member's right from seeking a second opinion.

8.3 Chiropractic/Massage/Acupuncture Treatment/Services.

Treatment or services requiring continuous, consecutive, and frequent treatment for Chiropractic/Massage/Acupuncture beyond the health insurance providers contract entitlement limits.

Evaluations and treatment plans, including an estimate of duration and frequency of treatment, must be submitted for review and prior approval by the Payor before the member undertakes treatment. Claims for reimbursement for continuous treatment undertaken for Chiropractic/Massage/Acupuncture treatment/services will be at the members own volition without prior Payor approval. If need be, the Board may, at their discretion, not approve these claims.

8.3.1 Submission of Treatment Plan.

Claims for Chiropractic/Massage/Acupuncture treatment/services beyond the health insurance providers contract entitlement limits are required to provide the following treatment plan. The Board requires 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 twelve (12) months if treatment continues for twelve months or more. For continuous services refer to Section 8.1.3. The Payor will review the progress reports and treatment plans to determine whether charges for such treatment should continue to be approved for payment.

8.3.2 Member Compliance to Submit Claims.

Nothing in this Rule relieves the member from complying with the requirement that claims must be submitted within six (6) months of the member's receipt of the original billing from the provider.

8.4 Mental Health/Substance Abuse Services.

Treatment or services requiring continuous, consecutive, and frequent treatment for Mental Health /Substance Abuse (alcohol or drug abuse) services/treatment beyond the health insurance providers pay for medical services up to a specified amount, subject to the contract entitlement are subject to the following provisions.

Evaluations and treatment plans, including an estimate of duration and frequency of treatment, must be submitted for review and prior approval by the Payor before the member undertakes treatment. Claims for reimbursement for continuous treatment undertaken for Mental Health/Substance Abuse Treatment/services will be at the members own volition without prior Payor approval. If need be, the Board may, at their discretion, not approve these claims.

Claims for mental health service, including psychological counseling services, are subject to the following conditions:

8.4.1 Treatment Plan Required for Continuous Treatment.

Claims for Mental Health/Substance Abuse treatment/services beyond the health insurance providers contract entitlement limits are required to provide the following treatment plan. For continuous services refer to Section 8.1.3. The Board requires an evaluation and treatment plan for more treatment/services than the contract entitlement limits are for the same condition/disability.

8.4.2 Conditions for Approval of Mental Health/Substance Abuse Service.

Payments for Mental Health Services/Substance Abuse Service provided to a member during a continuous 12-month period will be approved only under the following conditions:

8.4.2.1 Qualified Mental Health Services.

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 Payor 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.

If treatment is to be continuous, beyond contract entitlement, submission of a treatment plan, prepared by the member's physician must be submitted in a written treatment plan, including: (current medical diagnosis, description of treatment/therapy, the length of time the member needs treatment and a description how the condition being treated affects the member's ability to perform day-to-day task of daily living with average or better efficiency), to the Payor within the first month of treatment. Updated treatment plans are to be submitted by the provider providing treatment once ten (10) sessions to the Payor who will determine whether charges for such treatment should continue to be approved for payment. The member may appeal decisions to the Board.

8.4.2.2 Qualified Substance Abuse Services

The services for substance abuse (alcohol or drug abuse) providing the service provider is state-approved per Chapter 248-26 WAC. The recommended treatment is prescribed by the member's physician and they submit a written treatment plan, including the required length of time the member remains in the program/facility, to the Payor within ten (10) business days of the member's admission to the program.

If the member leaves the program against medical advice, or before the recommended length of treatment, the Payor 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.

For members applying for payment for repeat treatment, a full written case review by a specialist or certified alcohol/substance abuse evaluation service, will be obtained and reviewed by the Board before approving additional treatment or payment of member's claim. **Repeat patients** are expected to pay for the new treatment and evaluation themselves unless the Payor or insurance provides payment for additional substance abuse treatment programs. After a period of one (1) year following completion of repeated treatment, the Payor may approve reimbursement.

8.5 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 Payor will approve reasonable and customary payment (no less than provided policy coverage for current employees) for one pair of eyeglasses or a years' worth of contact lenses once a year at the member's option or as prescribed to correct vision when required for a new prescription.

The following items previously were given prices; the prices have been removed.

1. Eyeglass Lenses and Frames. A 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.
2. Second Pair. A second pair of glasses, for specific applications, such as working on a computer, shall be approved only if prescribed by an ophthalmologist or licensed optometrist. Reimbursement is limited to one single set of frames and pair of lenses in any twenty-four (24) consecutive months.
3. Contact Lenses. A years' worth of contact lenses once every (12) consecutive months.
4. Replacement. Claims for a replacement pair of eyeglass frames and/or lenses or contacts will be allowed. Only one replacement pair per year.
5. Additional/Spare Pair. No reimbursement will be made for a spare pair of glasses or contact lenses.

8.5.1 Eye Surgery/Procedures.

Eye surgeries will be eligible for coverage if determined to be medically necessary by the provider, such as cataract, Lasik, eye injections, laser treatments, etc.

8.6 Medical Equipment and Supplies.

In addition to the rental of durable equipment provided for in RCW 41.26.030(22)(b)(iii)(E), the Payor will consider claims for purchase of durable medical equipment and supplies under the following conditions:

8.6.1 Hearing Aids.

Payment for hearing aid purchase will be allowed without prior Payor approval if the claim meets all the following conditions and includes all documentation required herein.

8.6.1.1 Conditions for Approval of Payment for Hearing Aids:

1. Medical evaluation by an otolaryngologist to rule out any treatable ear conditions.
2. Hearing evaluation by a state-certified audiologist to include an audiogram and recommendations regarding the type of hearing aid(s).
3. 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.).
4. A maximum of one pair of hearing aids will be allowed during any five-year period based as recommended by the state-certified audiologist.
5. The cost must also include at least a 2-year warranty on the hearing aids.

8.6.1.2 Hearing Aid Maintenance and/or Repair:

1. 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 Payor
2. Members requesting payment for repair of hearing aid(s) must provide the Payor with appropriate claim forms and a written explanation of why the devices are no longer serviceable.

8.6.1.3 Replacement of Hearing Aids:

Replacement costs need to be submitted to the Payor as a claim for approval and will be made on a case-by-case basis. Replacement expenses will be approved under the following conditions:

1. Replacement occurs not more than once every five years. If replacement occurs more frequently, proof must be provided that the need is medically necessary.
2. Examination fees will be allowed if provided by a licensed otolaryngologist or state-certified audiologist.
3. Any payment of the Payor will be limited to the net balance after any insurance reimbursement or other settlement is deducted.

8.6.1.4 Member Compliance to Submit Claims.

Nothing in this rule relieves the member from complying with the requirement that claims must be submitted within six (6) months of the member's receipt of the original billing from the provider.

8.6.1.5 Purchase of Durable Medical Equipment and Supplies.

The Payor 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 Payors 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 Payor.

The Payor will not approve any claims for equipment or supplies which have a non-medical use or function.

8.7 Dental Benefits.

Dental-related expenses will be covered subject to the criteria in Section 7.1 and Section 7.2 Dental expenses denied by the Payor will be the responsibility of the member.

The Payor will approve reasonable and customary payment for medically necessary services (no less than provided policy coverage for current employees). “Well care” (as defined by current provided Payor plan) is categorized as “medically necessary services” and consequently are covered by the LEOFF 1 plan.

No payments will be authorized without proof that the member has first submitted the claim for payment to the member's outside dental insurance.

8.7.1 Cosmetic Procedures

Reimbursement for cosmetic dental procedures which are determined to be medically necessary by a dentist, orthodontist, or oral surgeon will be at the discretion of the Payor, 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 Payor.

8.7.2 Member Compliance to Submit Claims.

Nothing in this rule relieves the member from complying with the requirement that claims must be submitted within six (6) months of the member's receipt of the original billing from the provider.

8.8 Additional Medical Services and Supplies.

The following services may be considered by the Payor as additional medical services and approved for payment subject to the following listed conditions. Claims will be considered on an individual basis.

8.9 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.

8.10 Exercise and Physical Fitness Programs.

Physical fitness is considered the responsibility of the individual member and is not reimbursable.

8.11 Home/Health Care Services.

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 Payor will consider non-medical charges if deemed necessary by the health care provider.
3. If care exceeds six months, the Payor may require submission of a new treatment plan or may require member to be examined by a Payor-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.
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 "What is Long-Term Care (LTC) and Who Needs it?".

8.12 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 Payor or the member.

8.13 Long-Term Care Facilities.

Residential placement in a state approved long term care facilities is to be provided as a minimum required service. The Payor will review and consider for approval of charges and payment 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. The provider's/member's claims for payment will be submitted directly to member's insurance/third party Payor.
5. Application for prior approval of long-term care services/placement will be considered on a case-by-case basis.

8.14 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 Payor will not accept or consider for approval any claim for reimbursement or payment.

8.15 Smoking Cessation.

The Payor will approve reimbursement to members of a maximum of beyond the health insurance providers pay for medical services up to a specified amount, subject to the contract entitlement, 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 Payor for prior approval.

8.16 Specialized Surgeries:

8.16.1 Other Surgeries.

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

8.17 Weight Loss Programs.

The Payor may approve payment for a weight loss program that is prescribed, approved, and monitored by a physician, considered case-by-case.

Claims for reimbursement must be filed with member's Payor within six (6) months of the member's receipt of the original billing.

9 REVIEW OF BOARD RULES: AMENDMENTS. REVISIONS PERSTATE RETIREMENT SYSTEMS.

9.1 Periodic Review.

The rules, policies and procedures of Cowlitz County Disability Retirement Board shall be reviewed and revised, periodically, or as often as necessary, to assure that it follows the current RCW’s. Provisions herein, reflect the current Disability Board’s philosophy and intent.

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.

9.2 Chronology of Amendments/Revisions of Board Rules.

Refer to the previous version of this document dated November 1988 for the revision history up to this point.

This Rules, Policies and Procedures of the Cowlitz County Disability Retirement Board was Adopted: June 3, 2021 – This has been a total re-write of the document, with primary focus of transferring payment functionality to the Payor, not the Board.