LEOFF I

RULES, POLICIES AND PROCEDURES

of the

KLICKITAT COUNTY
DISABILITY RETIREMENT BOARD

of the

STATE OF WASHINGTON
LAW ENFORCEMENT OFFICERS' AND
FIRE FIGHTERS' RETIREMENT SYSTEM

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Klickitat County LEOFF-I Disability Retirement Board

RULES, POLICIES AND PROCEDURES

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SECTION I

GENERAL

1.1 **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 existence which are not encompassed by these rules and regulations. In such cases, the Board reserves the right to take whatever action is necessary consistent with applicable statutes and State regulations.

1.2 **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.

1.3 **Agencies Served**: Any local agency within Klickitat County with full time regularly compensated and/or retired LEOFF I act members who are not employed in a city with a disability board and who were hired prior to October 1, 1977 shall fall under the jurisdiction of the Board. The following agencies are served by the Board:

Klickitat County Sheriff's Office
Goldendale Police Department
Bingen Police Department
White Salmon Police Department

1.4 **Distribution**: Copies of these rules and any amendments hereto shall be provided by the Clerk of the Board to each agency subject to the jurisdiction of this board.

SECTION II

THE BOARD/MEMBERSHIP

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 **Composition of the Board**: The composition of the Klickitat County LEOFF Disability Board shall be as provided by RCW 41.26.110(b).

2.3 **Membership/Five Members**:

One (1) member shall be elected from the County legislative body. Said member to be selected by the County legislative body.

One (1) member shall be chosen by a majority of the mayors of the cities and towns within the county that do not contain a city disability board. In counties with a population less than sixty thousand, the member appointed by the majority of the mayors must be a resident of one of the cities and towns but need not be a member of a city or town legislative body.

One (1) law enforcement officer or retired law enforcement officer employed by or retired from an employer within the county who are not employed by or retired from a city in which a disability board is established. Retired members who are subject to the jurisdiction of this board have both the right to elect and the right to be elected to this board.

One (1) eligible law enforcement representative shall be elected when there are no fire fighters under the jurisdiction of the board eligible to vote pursuant to 2005 legislation and amendment to RCW 41.26.110 (1) (b). This position is to be elected by the law enforcement officers employed in or retired from an employer within the county who are not employed by or retired from a city in which a disability board is established. Retired members who are subject to the jurisdiction of this board have both the right to elect and the right to be elected by this board.

One (1) member from the public-at-large who resides within the county but does not reside within a city in which a city disability board is established. Said member to be appointed by the other four members heretofore designated in this section.

A) **Term and Vacancy**: Board members shall serve a two-year term. 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 as provided by RCW 41.26.110(b).

B) **Quorum:** Three (3) members of the board shall constitute a quorum. Each member shall have one vote which must be cast by that member in person or by proxy vote in emergency situations when a quorum is not possible.

C) **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 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.

2.4 **Election of Chair**. The members of the Board shall elect a Chair to serve a one-year term at their first meeting in January 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.

2.5 **Board Clerk, Appointment Of**: The Board Chair shall at their first meeting in January appoint a person to serve as the Board Clerk, who shall be subject to confirmation by the Board. The duties of the Clerk include:

1) Prepare the agenda for each meeting;
2) Provide notice of all special meetings;
3) Keep an attendance record of the members of the Board for all meetings;
4) Take minutes of all Board meetings;
5) Distribute previous meeting draft minutes for members review prior to the next regularly scheduled meeting;
6) Inform members, upon request, of forms and documents necessary to make an application for disability leave/retirement;
7) Ensure that all benefits under insurance or health care plans provided by employer are obtained prior to payment by the LEOFF Disability Board;
8) Notify members of evaluation and/or re-evaluation appointments when required by the LEOFF Disability Board;

9) Prepare annual budget;

10) Prepare and send all necessary correspondence to the State Retirement Board, employers, and members; and

The Board may delegate to its clerk, from time to time, the authority to undertake an investigation of matters before the Board. These matters include, but are not limited to, areas of disability leave, pensions, medical expenses, and activities collateral to them.

2.6 Elections:

A) **Law Enforcement Officer Member(s)**: The law enforcement officer member(s) of the Board shall be nominated and elected in accordance with RCW 41.26.110 (b) and procedures as established by the Klickitat County LEOFF Disability Board.

1) Prior to October 1st the Clerk will submit a request for solicitation of interest from all law enforcement officers who are employed by or retired from an employer within the county for potential interest in serving on the board as the law enforcement representative(s). No later than November 15th, the Clerk will distribute ballots forms containing the names of the top four nominees to each eligible law enforcement officer, active and retired, who are subject to the jurisdiction of the board (LEOFF I) and who are eligible to elect the law enforcement representative(s). No later than December 1st each eligible law enforcement officer, active and retired, eligible to elect the law enforcement representative(s) may submit their sealed ballot to the Clerk containing two (2) nominee(s). The election shall be by secret ballot with all sealed ballots to be returned to the Clerk postmarked no later than December 1st. Any ballots received which are postmarked after December 1st will not be counted. The name(s) of the two law enforcement officer member(s) receiving a majority of the votes shall be noted in the minutes of the next regular meeting of the Board subsequent to the election, along with the term for which elected. Each member will hold office for a period of two (2) years.

B) **City and County Members**: The County and City members of the Board shall be appointed in accordance with procedures established by the respective councils and commission. Prior to December 1st, the Clerk will notify the mayors of all cities and towns subject to the Board's jurisdiction and the Chairman of the Board of County Commissioners for Klickitat County of the need to select a successor member. The name of the Mayor, ~~or~~ Councilman or Resident appointed by the Mayors of the three

cities, and the County Commissioner appointee shall be forwarded to the Klickitat County LEOFF Disability Board during the month of December and shall be noted in the minutes of the next regular meeting of the Board.

C) **Citizen-At-Large Member:** The law enforcement officer representatives, City representative, and County Commissioner representative shall elect a citizen-at-large to the Board. The name of the elected citizen shall be noted in the minutes of the next regular Board meeting.

2.7 **Expenses**: Members shall receive no compensation for their service upon the Board but the members shall be reimbursed by their respective county or city for all expenses incidental to such service as to the amount authorized by law**.**

SECTION III

GENERAL PROVISIONS OF BOARD MEETINGS

3.1 **Regular Meetings**: Regular meetings shall be held quarterly on the second Thursday of the months of January, April, July, and October at 9:00 AM in the Klickitat County Commissioner's conference room, 205 S. Columbus, Room 101, Goldendale, Washington 98620. In the event that the regularly scheduled meeting falls on a holiday, such meeting shall be held on the Thursday next following; Provided, if no matters over which the Board has jurisdiction are pending in the week prior to the Board's regular meeting, the Chairman may cancel said regular meeting.

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.

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

3.2 **Special Meetings**: Special meetings may be called by the Chair giving such notice thereof as is required by RCW 42.30.060. All special meetings shall be open to the public.

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

A) Only as required by RCW 42.17, 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, the member's permission must be obtained before release of the information.

C) A copy of a record of proceedings, minutes, agenda, Board action, disability records (with member's written 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.

3.4 **Delegation of Authority**: The LEOFF-1 Disability Board delegates to the Secretary of the Board the authority to instigate investigative activities, including the gathering, collating and presenting facts regarding matters within the scope of the Board's authority. These matters include, but are not limited to, areas of disability leave, pensions, medical expenses and activities collateral to them.

The LEOFF-1 Disability Board also delegates to the Secretary the authority to authorize payment of routine medical, vision, and prescription drug expenses when these expenses are approved by the Chair and Vice-Chair. A special meeting shall be called with a quorum of the Board present to consider any medical expenses that may be in question.

SECTION IV

HEARINGS

4.1 **Purpose**: Hearings by the Board shall be open to the public and may be conducted by a quorum of the Board. All parties at a hearing may, at their own expense, select representatives of their choosing. Any fees or expenses of any kind for the appearance of a witness shall be assumed by the requesting party.

4.2 **Testimony under Oath**: The testimony of any witness shall be under oath.

4.3 **Official Record**: The Board shall prepare and keep an official record of the hearing which shall include testimony recorded manually or be mechanical device, and all other evidence including but not limited to the pleadings, exhibits, and other records and documents offered and made a part of the record by the Board. Documentary evidence may be received in the form of copies or excerpts, or by incorporation by reference.

No factual information or evidence other than the official record shall be considered by the Board in the determination of the case.

4.4 **Hearings Informal**: All hearings shall be informal and the Board may admit and give probative effect to evidence which possesses probative value commonly accepted by reasonably prudent men in the conduct of their affairs. The Board shall give effect to the rules of privilege recognized by law and it may exclude incompetent, irrelevant, immaterial, and unduly repetitious evidence. The Board need not follow formal rules of evidence.

4.5 **Decisions**: A quorum of the Board may render a decision, and decisions of the Board on hearings shall be final and binding unless otherwise provided by the pension legislation pursuant to which the hearing is being conducted. Board members who are to participate in the making of a decision but who were not present at the reception of evidence shall review, consider, and familiarize themselves with the record of the hearing. Decisions and orders arising from hearings shall be in writing, and shall be accompanied by findings of fact and conclusions of law, which shall also be in writing.

SECTION V

MEDICAL SERVICES/EXPENSES

5.1 **Purpose**: The purpose of this rule is to establish uniform methods for the administration of necessary medical service benefits to eligible active and retired members.

5.2 **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.

5.3 **Medical Expenses**: When the member is covered by a health insurance provider, the member is required to submit claims to their health insurance provider for payment. Certain health insurance providers pay for medical services up to a specified amount, subject to the contract entitlement. Once medical service costs exceed the member's contract year entitlement, the portion of the claim not covered or rejected by health insurance may be submitted to the Board for its consideration.

A) 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.

B) Vasectomies, tubal ligations, and other surgical procedures for purposes of birth control are not considered medically necessary.

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 Board for approval. The medical expenses claim submitted for reimbursement is to be that portion *not* covered by the existing health insurance provider(s).

All claims for reimbursement must be made within one (1) year of the treatment or service date. Claims not meeting this requirement will not be paid.

5.4 **Prescription Drugs**: LEOFF members are required to utilize mail order prescription drug services when available and provided as part of their applicable health insurance plans. Any member failing to do so will have their reimbursement reduced by whatever amount would have been covered through the prescription drug service.

(Example: If the mail order prescription drug plan allows a member to fill a 90 day prescription at the cost of two co-payments reimbursement to a member failing to utilize the plan will only be reimbursed for two co-payments for that claim.)

A) All claims must be accompanied by the original receipts.

B) All claims for reimbursement of prescription drugs must be made within one (1) year of the service date. Claims not meeting this requirement will not be paid.

5.5 **Inquiry Prior to Incurring Treatment Services**. 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 for services. Elective medical procedures, surgery and/or appliances/supplies may not be covered by the health insurance provided by the employer or authorized by the Board.

5.6 **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 first seek medical services from those health insurance providers since they are known to have medical staff/specialists available.

A) 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 the group plan health facility.

B) 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.

C) 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.

D) 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.

5.7 **Medicare Benefits**. If eligible for Medicare coverage, it is each member's responsibility to obtain this insurance whether or not the employer pays the premiums. Members are advised to consult their employer or personnel office regarding eligibility for Medicare health insurance coverage, Parts A and B. If the employer does not pay for Medicare premiums, members are urged to pay their own premiums for this coverage because claims for medical expenses 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 eligible for Medicare coverage and do not obtain this coverage, neither the employer or the Board is obligated to authorize payment for medical expenses which would otherwise have been covered by Medicare. RCW 41.26.150 (2).

5.8 **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.

5.9 **Criteria for Authorizing Reimbursement:**

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 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.

SECTION VI

PROCESSING OF CLAIMS

6.1 **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 this, each member is responsible for maintaining contact with the employer about the medical/health insurance coverage provided by the employer.

6.2. **Submission of Claims**: All applications and claims shall be submitted to the Board Clerk who will review them for accuracy before forwarding the completed claims to the Chairman and Vice Chairman or the full Board for review and approval.

A) and placed on the next available agenda when applicable.

6.3 **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.

6.4 **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 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 Clerk 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.

6.5 **Criteria**. For each claim, the Board shall determine if the criteria listed in paragraph A of Subpart 6.6 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 upon the claimant to establish reasonableness.

6.6 **General Provisions.** The following rules apply to all claims for medical services, 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 41.26.150 and RCW 41.26.030(22). Thus, claims for medical services 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 medical services are necessary.

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.

SECTION VII

APPEAL PROCEDURE

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

Decisions of a Disability Board which can be appealed to the Department of Retirement Systems are: denial and/or cancellation of disability leave; denial of disability retirement; cancellation of a previously granted disability retirement allowance, and a determination by the Disability Board that a retiree's disability has not ceased following the retiree's application for determination under RCW 41.26.135(1).

7.2 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 Klickitat County Superior Court within the appropriate time frame.

7.3 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.

SECTION VIII

DISABILITY LEAVE AND RETIREMENT

8.1 **Retirement for Disability**: Retirement of a law enforcement officer or firefighter for disability shall be as provided by RCW 41.26.

Although applications filed with a disability board are sometimes designated as applications for disability leave, they are at all times applications for disability retirement (AGO 1975 No. 84).

8.2 **Applications for Disability Leave/Retirement**: All applications for disability leave and/or retirement shall be submitted to the Clerk of the Board and shall bear the date the application was executed, as well as the date the application was received by the Board.

No application shall be accepted by the Board unless it is accompanied by a physician's report substantiating the nature of the illness, injury, and/or disability and confirming that the applicant is unfit for duty. Such report should be made by the treating physician.

An application, with appropriate documentation, shall be forwarded to the Board for consideration at their next regularly scheduled meeting. The Board may require such additional medical reports, including an independent medical examination by a **board physician**, as it may require to determine the disability of the applicant.

Any application deemed incomplete by the Board shall be returned to the applicant for completion. All applications and other documents filed in connection with the disability retirement or disability must be accurate and truthful. In this regard, RCW 41.26.300 provides:

> "Any employer, member or beneficiary who shall knowingly make false statements or shall falsify or permit to be falsified any record or records of the retirement system in an attempt to defraud the retirement system, shall be guilty of a felony."

8.3 **Employer's Statement and Report on Application for Disability Leave/Retirement**: The applicant's employer shall complete an Employer's Statement and Report on Application

for Disability Retirement as soon as the employer has been made aware that the applicant has submitted his or her application for disability retirement.

Employer will also submit a copy of employee's current job description/duties with the Employer's Statement and Report on Application for Disability Retirement.

8.4 **Status Pending Action on Application**: An applicant may, with the permission of his or her employer, remain on leave until the Klickitat County LEOFF Disability Board has met at its regularly scheduled meeting and has acted upon an application for disability leave.

8.5 **Consideration**: Following receipt of an application for disability benefits, the Board shall review all relevant information pertaining to the question of the applicant's fitness for duty, and if, in the opinion of the majority of the Board, the evidence supports the proposition that the applicant is unfit for duty, such applicant shall be granted disability leave, unless such leave is waived pursuant to RCW 41.26.120(4). In considering such application, the Board shall consider the duties of the position, and any other evidence that is relevant;

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 the line of duty, shall be upon the applicant."

C) Each application shall be accompanied by a list identifying by name any physician who has been contacted within the last six (6) months for the illness or injury for which disability is claimed.

8.6 **Appearance before the Board**: The Board shall be authorized to demand the appearance of the applicant and to request the appearance of such other person(s) as it deems appropriate.

A) **Doctor-Patient Privilege**: It shall be incumbent upon each applicant obtaining medical evaluations to be used in connection with such disability leave and subsequent valuations, to advise each and every examining physician of the following:

1) The evaluation is being conducted at the direction of the Board;

2) That any reports relating thereto are for the benefit of the Board;

3) That the doctor-patient privilege may not be invoked with respect, thereto; and

4) That the physician may be called upon by the Board to testify as to his findings.

8.7 **Conditional Return to Duty**: In the event the medical evidence is inconclusive, the Board may specify in written order a reasonable trial work period to determine the member's fitness for active duty. Such a conditional return to service does not entitle the member to a second six (6) month period of disability leave for the same disability if, based upon this period of service, he or she is then found to be still disabled. Unless the member has received Board authorization to return to work, any return to work following an absence of fourteen (14) working days or more shall be automatically deemed a conditional return for a two (2) month period.

8.8 **Decision and Order:** 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 as provided in RCW 41.26.120(4) and .125(4).

4) Conclusions of law on the basis of the facts in the case.

5) A finding of whether or not the disability was incurred in the line of duty.

B) Such written decision and order with supporting documentation shall thereafter be forwarded to the State Retirement Board for review.

8.9 **Denial of Application/Appeal:** 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, if applicable, or to appeal to the State Retirement Board. (See Section VII-Appeal Procedure).

8.10 **Disability Leave Allowance**: Disability leave allowance is not granted for any specific amount of time. Such leave may encompass a period of from one (1) hour to a maximum of six (6) months. During this time, the member is to receive an allowance equal to the member's full monthly salary from his/her employer.

SECTION IX

OBLIGATIONS OF MEMBERS WHILE ON LEAVE

9.1 **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 of 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.

9.2 **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.

9.3 **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.

9.4 **Determination of Fitness**. Any medical standards designed to set minimum health qualifications before a 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.

9.5 **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.

9.6 **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 his/she is fit for duty. In the event the Board finds that a member has not actively sought authorization for his/her physician and employer to return to active service immediately upon cessation if disability, the Board shall require the member to report to the 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.

9.7 **Return to Duty**. The original claim form signed by a member shall 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.

9.8 **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 ad 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.

SECTION X

MEMBERS ON DISABILITY RETIREMENT LEAVE

10.1 **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.

10.2 **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.

10.3 **Notice of Discontinuation of a Retirement Allowance**. 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 the purpose of which shall be to determine whether the member continues to be disabled.

10.4 **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.

SECTION XI

VISION BENEFITS

11.1 Payment 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 prescribed by an ophthalmologist or optometrist. Contact lenses are considered as eyeglass lenses for the purposes of this policy. Frames must be of average quality and serviceability unless other frames are prescribed.

The Board will approve payment for eyeglasses prescribed to correct vision when required for a new prescription, in accordance with the following schedule, which may be revised from time:

A) **Eye Exam**: 100% of usual and reasonable charges of examination services of a licensed ophthalmologist or optometrist will be considered not more than once every twelve (12) consecutive months.

B) **Eyeglass Lenses/Contacts**: 100% of usual and reasonable charges, not more than once every twelve (12) consecutive months for single-vision, bifocal, trifocal or lenticular lenses.

C) **Eyeglass Frames**: $120.00 maximum during any 24-month period.

D) **Replacement**. Claims for a replacement pair of eyeglass frames and/or lenses will be allowed if proof of damage is provided and shown to have incurred in the performance of a member's regular duties. Only one replacement pair per year, due to accidental damage, will be allowed, not to exceed the amount allowable above.

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

SECTION XII

HEARING AIDS/DEVICES:

12.1 **Hearing Aids**: Prior approval must be obtained from the Board before the member purchases a hearing aid device. All requests must be considered on an individual basis.

A) **Conditions for Pre-Approval of Hearing Aid Purchase**: Applications for pre approval for purchase of hearing aid(s) must meet the following conditions:

1) Examination by a physician or hearing specialist documenting the medical necessity for hearing aid(s);

2) Results of audiological evaluations (e.g., audiogram);

3) Report stating the member's hearing loss is progressive, permanent and/or not likely to improve with other treatment (e.g., medication, surgery, etc.);

4) A maximum cost estimate not to exceed $2,200.00 per hearing aid or $4,400.00 per pair during any 48-month period, based on equipment of average quality and serviceability;

5) The Board may ask for additional medical information to determine medical necessity of equipment charges which exceed the Board approved limits. Also, the Board may request the member obtain additional cost estimates of the equipment charges that exceed the Board-approved limits.

B) **Replacement of Hearing Aids**: The Board will consider approval of payment of member's replacement hearing aid expenses not more frequently than once every 48 months under the following conditions:

1) Member must provide the Board with documentation of the medical necessity for replacement.

2) Replacement of hearing aids(s) will be approved if the loss or damage is duty-related or due to an accident.

C) **Repair of Hearing Aids**: Members requesting payment for repair of hearing aid(s) must document why the devices are no longer serviceable. (Exception: Payment will be approved for costs of regular maintenance and batteries at reasonable cost.)

D) **Schedule of Limits of Approval of Payment**:

1) Reasonable charges/fees for services of licensed physician or licensed audiologist for examination will be allowed.

2) Invoices or billing for payment for hearing aid(s) must first be submitted to the member's health insurance. The member shall also be required to file a claim for hearing loss with the Department of Labor and Industries if the loss was job related. The Board will then consider approval of the balance not covered by insurance or third party payor.

3) Any payment by the employer will be limited to the net balance after any insurance reimbursement or other settlement is deducted including Labor and Industries payments for approved claims.

4) The maximum amounts allowable will be the cost of a hearing aid of average quality and serviceability. Any difference between the amount allowed by the Board and the cost of the hearing aid purchased by the member shall be the responsibility of the member.

(Revised 07/19/2011)

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SECTION XIII

MEDICAL EQUIPMENT AND SUPPLIES

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

A) **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 (leg braces, etc), 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 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 provider before sending them to the Board.

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

SECTION XIV

DENTAL BENEFITS

14.1 Dental Benefits:

A) Dental expenses will be approved if incurred by a member who sustains an accidental injury to his or her teeth and commenced treatment within 90 days after the accident, or said treatment can be justified by way of curing or correcting an existing health problem.

B) An accidental injury does not include teeth broken, damaged or caused by the act of normal chewing or biting, or by the neglect of dental hygiene.

C) Orthodontic work will not be approved unless member can document, through medical/dental examination, that there is a direct relationship to an identifiable physical/medical disorder requiring medical treatment. In this case, member must submit application for Board pre-approval of any procedure under consideration to correct the condition. Such requests for pre-approval will be considered on an individual basis.

Orthodontic work, strictly for cosmetic purposes, is not considered to be medically necessary.

SECTION XV

CHIROPRACTIC SERVICES

15.1 **Chiropractic**: Prior Board approval is required for all chiropractic visits beyond 12 per calendar year.

A) A maximum charge of $45.00 will be allowed per visit.

B) All chiropractic expenses incurred and claimed for reimbursement by the member shall be submitted through the member's health insurance provider *before* the claim is sent to the Board for approval. The chiropractic expense claims submitted for reimbursement are to be that portion *not* covered by the existing health insurance provider(s).

C) All claims for chiropractic services must be made within one (1) year of the treatment or service date. Claims not meeting this requirement will be denied.

SECTION XVI

MASSAGE THERAPY

16.1 **Message Therapy**: Massage therapy may be reimbursed on a case-by-case basis subject to the following conditions.

A) Board approval is required prior to treatment.

B) Treatment must be specific to a medical condition.

C) Member must have a referral from a licensed physician.

D) Treatment must be performed by a licensed physical therapist or a certified/licensed massage therapist.

E) All billings must first be submitted to the member's primary medical coverage.

Section XVII

Long-term Care/Nursing Home/Hospital/Extended Care Facility

17.1 The Klickitat County LEOFF I Board will provide reimbursement for the reasonable medical expenses incurred by a LEOFF I member needing the services of a skilled nursing facility within 100 miles of the incorporated areas of Klickitat County. Expenses that shall be reimbursed may include:

A) Under R.C.W. 41.26.030(19)(iii)(l), confinement in a nursing home or stay in a hospital/extended care facility is to be provided to members as a minimum required service.

B) The Board will review and consider for approval of placement and payment of charges for long-term care/nursing home/hospital extended care services which are defined as "extended care" under the following conditions:

1) Placement is prescribed by a physician;

2) If placement exceeds six (6) months, the Board shall require a treatment plan;

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 member;

4) Nursing home care is not to exceed the daily benefit for nursing care under the County's existing long term care insurance.

5) The provider's/member's claims for payment will be submitted directly to member's insurance/third party payor or employer.

C) Non-medical charges, including but not limited to hair care, personal toiletries and sundries, bed holds, and recreational events organized by the skilled nursing facility shall not be reimbursed.

D) All charges must be submitted to the appropriate insurance carriers, Medicare, Medicaid or other available long-term care insurance before submission to the

Board. The Board will reduce the amount of reimbursement for skilled nursing facility care by the amount a LEOFF I member receives from these other sources.

17.2 **Long-Term Custodial Care:** Long-term custodial care is care given mainly to assist with activities of daily living: walking, bathing, dressing, eating, etc. Most insurance companies and/or HMO's do not pay for them. These "custodial care" services are also excluded from payment under Medicare. Requests for prior approval of long-term custodial care services/placement will be considered on a case-by-case basis.

17.3 **Day Care/Nursing Home Care:** Adult Day Care Treatment and Nursing Home Care for members must receive prior approval of the Board. The Board will only approve such funds, when combined with insurance or other sources that do not exceed the reasonable medical expenses of the average cost for such care within a 100-mile radius of the incorporated areas of Klickitat County.

17.4 **Home Health Care:** Home Health Care for members must receive prior approval of the Board. The Klickitat County LEOFF I Board may provide reimbursement for reasonable expenses incurred by a LEOFF I member needing the services of home health care. It is the intent of this policy to reduce the amount paid for skilled nursing facility care.

A) The members attending health care provider must submit a request to the Board on behalf of the member which shall state the medical necessity and the estimated length of time during which home health care will be required and the type of care required (medical, daily living, and/or other). The attending health care provider must provide to the Board a description of work to be performed by the home health care provider. This description is to be as detailed as possible. The question of medical necessity for home health care may be subject to annual or more frequent review by the Board, at the Board's discretion.

B) Home health care services must be prescribed by the member's physician and must be provided by a professional/paraprofessional licensed and/or state certified provider.

C) The total amount allowed shall not exceed the current Board allowed rate for home health care or skilled nursing home care as provided for under the County's Long-Term Care insurance policy.

D) In-home services not covered are those of a custodial or housekeeping nature such as house cleaning, laundry services, cooking, recreational companionship, or other homemaker tasks.

E) All charges must be submitted to the appropriate insurance carriers, Medicare and other available long-term care insurance before submission to the Board.

F) The Board shall only reimburse for services rendered. The Board will not make advance payment of any charges.

G) The Board reserves the right to have an independent assessment agency evaluate the member's home health care needs. The Board also reserves the right to approve or deny home health care reimbursement based upon the findings of the independent assessment agency.

H) The Board will not reimburse for home health care provided by an individual who ordinarily resides in the member's home or is a member of the family of either the member or the member's spouse, unless the individual is a licensed home health care provider.

I) All explanations of benefits insurance documentation forms showing the amount paid and/or rejected and any health care provider documentation necessary to support the claim must be attached to all requests for reimbursement.

J) The Board reserves the right, at its sole discretion based on the record before it, to approve or disapprove reimbursement for home health care expenses incurred by a LEOFF I member.

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

A) Member is admitted to a DSHS-certified or Medicare-approved program;

B) Care provided is part of a written plan of continuous care, prescribed and periodically reviewed by a physician;

C) 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.

SECTION XVIII

AMENDMENT AND REVIEW OF POLICY

18.1 **Amendments**: These rules and regulations may be amended, repealed or altered in whole or in part by a majority vote of the total membership of the board.

18.2 **Review:** These rules and regulations shall be reviewed and revised, periodically or as often as necessary, subject to the recommendations of the State Retirement Systems; to assure that:

(a) Provisions herein remain in conformance with Washington statutory and administrative codes.

(b) Provisions herein reflect the current philosophy and intent of this board.

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

Originally adopted: January 10, 1996
Revised Board Rules/Policies effective November 3, 2004
Revised Board Rules/Policies effective September 8, 2005
Revised Board Rules/Polices effective April 13, 2006
Revised Board Rules/Policies effective July 19, 2011 (Section XII-Hearing Aids/Devices).
Revised Board Rules Policies effective July 9, 2015 (Section XVII Long-term Care/Nursing Home/Hospital/Extended Care Facility)

ADOPTED by the Klickitat County Law Enforcement Officers and Fire Fighters Disability Board this 9th day of July 2015.

_____
Jim Sizemore, County Representative

_____
Rick McComas, Law Enforcement Representative

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Ray Thayer, "At-Large" Member

_____
Arletta Parton, City Representative

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Thomas W. Hawes, Law Enforcement Representative