COUNTY OF WHITMAN
LAW ENFORCEMENT OFFICERS' AND FIRE FIGHTERS' (LEOFF)
LEOFF I BOARD
POLICIES AND PROCEDURES

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Preamble

The purpose of these policies and procedures is to establish general operating procedures and reduce to writing the administrative policies of the LEOFF I Board. The Board recognizes that conditions may exist or come into existence, which are not properly encompassed by these policies and procedures. In such cases, the Board reserves the right to take whatever action is necessary to properly deal with the situation, such actions to be consistent with applicable statutes, insofar as found by the Board to be applicable.

Purpose

These policies and procedures are adopted pursuant to and under the authority of Section 1, Chapter 294 Laws of 1981, RCW Chapter 41.26.115 and to provide a basis for uniform administration of disability retirement matters. These rules must be followed by each disability board (as provided in WAC 415-105-020).

Effect of Policies and Procedures

All uniformed personnel and retired members covered by the aforementioned chapters shall be subject to the policies and procedures contained herein, to the extent consistent with applicable state statutory provisions, and shall at all time follow the procedures contained herein. In the event any policy or procedure as prescribed to a particular member, shall be held to be contrary to state law, such member shall not be relieved of any other requirement contained herein, and any such findings, shall not relieve the member from the responsibility to comply with all other policies and procedures contained herein. A member's failure to follow these procedures may subject such member to the loss of benefits otherwise due under the acts.

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LEOFF I BOARD POLICIES AND PROCEDURES

COUNTY OF WHITMAN
LEOFF I Board Policies and Procedures

SECTION I – THE BOARD

1.01 Membership

The Board shall consist of five (5) members (RCW 41.26.110), as follows:

A. One member of the legislative body of the county to be appointed by the county legislative body; and,
B. One member of a city or town legislative body located within the county which does not contain a city disability board to be chosen by a majority of the mayors of such cities and towns within the county which does not contain a city disability board; and,
C. One active fire fighter or retired fire fighter employed by or retired from an employer within the county to be elected by the fire fighters employed 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 and who are subject to the jurisdiction of that Board; and,
D. One law enforcement officer or retired law enforcement officer employed by or retired from an employer within the county 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 and who are subject to the jurisdiction of that Board; and,
E. One member from the public at large who resides within the county but does not reside within a city in which a city disability board is established, to be appointed by the other four members designated in this subsection; and,
F. However, in counties with a population less than sixty thousand, the members of the disability board appointed by a majority of the mayors of the cities and towns within the county that do not contain a city disability board must be a resident of one of the cities and towns but need not be a member of a city of town legislative body. Only those active or retired fire fighters and law enforcement officers who are subject to the jurisdiction of the board have the right to elect under this section. All fire fighters and law enforcement officers 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 are eligible for election. All members appointed or elected pursuant to this subsection shall serve for two-year terms. If there are no fire fighters under the jurisdiction of the board eligible to vote, a second eligible employee representative shall be elected by the law enforcement officers eligible to vote. If there are no law enforcement officers under the jurisdiction of the board eligible to vote, a second eligible representative shall be elected by the fire fighters eligible to vote.

1.02 Terms

Each of the elected members shall serve a two (2) year term. All terms expire on December 31st.

1.03 Vacancy

In the event a vacancy occurs in the membership, a successor will be elected or appointed in the same manner as the original election or appointment and shall serve the remaining unexpired term.

1.04 Meeting

The Board shall meet monthly on the fourth (4th) Tuesday of each month at 10:00 a.m. with the Board's annual meeting being held in January; provided if the fourth (4th) Tuesday falls on a municipal holiday, the Board shall hold its meeting on the next working day at the regular time. If necessary, special meetings may be called by the Chairperson or a majority vote of the Board. Copies of material relevant to the agenda items shall be prepared and distributed prior to each meeting. Notice of meetings shall be given to the press pursuant to RCW 42.30.060; provided, hearings and decisions on quasi-judicial matter, including consideration of applications for disability retirements, shall be at closed meetings unless the applicant requests an open hearing in writing.

1.05 Elections

At the first (1st) meeting of each year, the members shall elect from among the members, a member to serve as Chairperson, Vice-Chairperson and Secretary.

A. The election of a LEOFF firefighter representative shall be by secret ballot of all active and retired LEOFF firefighter personnel subject to the jurisdiction of the Board and shall be held during the month of December of every even numbered year. The election of the LEOFF law enforcement officer representative shall be by secret ballot of all active and retired LEOFF law enforcement personnel subject to the jurisdiction of the Board and shall be held in December of every odd numbered year. The name of the elected LEOFF law enforcement officer and firefighter member 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, or as soon thereafter as the successor is elected.

B. Election procedure for election by secret ballot shall be as follows:
    1. In October of each year, the Secretary to the LEOFF I Board shall prepare and mail forms for nomination of law enforcement or firefighter representative to each active and retired law enforcement or firefighter personnel at their last address of record. Any active or retired member, either LEOFF I or LEOFF II wishing to run for representative must nominate themselves on the form provided by the Secretary. Only those nominating themselves will be placed on the election ballot. The time between the mailing out of the nomination forms until the deadline for receipt by the Secretary will in no case be less than seven (7) but no more than ten (10) business days as determined by the Chairperson.
    2. After the November meeting and upon receipt of nominations, the Secretary shall prepare ballot packages containing:
        a) Ballot,
        b) Self-addressed pre-stamped envelope for returning the ballot,
        c) A letter sized envelope with no markings on it in which the marked ballot is to be enclosed, and
        d) An information sheet explaining who is running for the position and the deadline date by which the Secretary shall have to receive all ballots.
    3. The time between the mailing out of the ballot packets until the deadline for receipt by the Secretary will in no case be less than seven (7) but no more than ten (10) business days as determined by the Chairperson.
    4. All returned ballots must be received by the Secretary through the U.S. mail and must be postmarked by midnight of the deadline date.

5. The Secretary shall be custodian of all returned ballots and shall keep them in a safe place and assure that they remain unopened until authorized.
6. The Chairperson and Secretary shall open the ballots. The results will be announced after the 3-day protest period by the Chairperson and a certification of election results will be sent to the respective department for posting.
7. In the event there are three (3) or more individuals running for representative and one of the individuals does not receive a simple majority of those voting, a run-off election shall be scheduled between the two individuals receiving the highest vote totals utilizing the same process per this section.
8. All ballots shall be retained by the Secretary for one (1) year. After the one-year period, the Secretary shall prepare the ballots for destruction as authorized by the State of Washington General Records Retention Schedule & Destruction Authorization.
9. Any discrepancies regarding the election process shall be submitted in writing to the Secretary of the LEOFF Board within three (3) calendar days following the deadline date.
10. Candidates-elect shall take office at the regularly scheduled meeting in January.
11. In the event that there is only one person nominated for law enforcement or fire fighter representative, balloting will not be required and the individual will be considered elected.

1.06 Absence of Members

In the case of absence or inability of the Chairperson to act, the Vice-Chairperson shall perform the duties and exercise the powers of the Chairperson. Each Board member is expected to notify the Chairperson or the Secretary prior to a scheduled meeting if that member will not be able to attend that meeting. Such notice will serve to establish such absence as excused. All attendance at meetings shall be recorded in the minutes of the meeting. An excused absence shall be construed as illness, work or vacation. Three (3) unexcused absences in a period of one (1) year may be cause for review and possible removal from the Board by a majority vote of the Board.

1.07 Voting

Each member shall have one (1) vote, which must be cast by that member. If any person(s) on the Board concludes that he/she has a conflict of interest or an appearance of fairness problem with respect to a matter pending before the Board so that he/she cannot discharge his/her duties, he/she shall disqualify him/herself from participating in the deliberations and the decision-making process with respect to the matter.

1.08 Board Powers

The Board shall have the powers granted by the state legislature or necessarily implied from such grant of powers in Chapters 41.16, 41.18, 41.20 and 41.26, Revised Code of Washington, as those chapters now exist or may hereafter be amended and per Washington Administrative Code 415-105.

1.09 Jurisdiction of Members

Any member who is on disability leave is under the jurisdiction of the LEOFF I Board for all matters pertaining to his/her disability and shall not engage in any activity which is contrary to the directives for the member's or the LEOFF I Board's physician or which might be detrimental to his/her return to active service. The Board has the authority (and it may be at any time, in any case) cause an investigation to be made of the activities of any active member or any member retired for disability to determine whether his/her disability continues to exist, and may request the Whitman County Sheriff's Office or any other agency to make such investigation, subject to any special instructions or conditions related to the member and his/her condition and/or activities.

1.10 Quorum

A quorum is a simple majority and shall have the authority to conduct all business of the Board.

1.11 Board Officers

A. The elective officers of the board shall consist of a Chairperson, Vice-Chairperson and Secretary.
B. Nomination and election of officers shall be made at the regular meeting in January of each year.
C. The elective officers shall take office at the regular meeting in January and shall serve for a term of two (2) years.
D. Board members shall serve a two-year term.
E. In the event of a vacancy, a successor shall be appointed or elected in the same manner as with an original appointment or election to serve the remainder of the unexpired term or to begin a new term.
F. Duties of Officers:
    1. Chairperson - The Chairperson shall preside at all meetings and public and/or disability hearings of the LEOFF I Board and call special meetings. The Chairperson shall have the privilege of discussing all matters before the Board except where to do so would constitute a conflict of interest. He/she 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 LEOFF I Board. During the period of time between regular Board meetings, he/she shall also have the authority to tentatively approve applications for disability leave; provided, that all the required paperwork is in order, such approval being subject to ratification by a majority of the Board members at the next regular Board meeting.
    2. Vice-Chairperson - The Vice-Chairperson shall assume the duties and powers of the Chairperson in his/her absence. If the Chairperson and the Vice-Chairperson are both absent, the LEOFF I Board members may elect a temporary Chairperson by a majority vote of those present at a regular, adjourned or special meeting, who shall assume the duties and powers of the Chairperson and Vice-Chairperson during their absence.
    3. Secretary - The Secretary shall keep the minutes of all regular, adjourned and special meetings of the LEOFF I Board; such minutes shall be approved by the Board and copies shall be distributed to all members of the Board, Police and Fire Chiefs and the Board physician. The Secretary shall give notice of all regular and special meetings to the board members and post all notices of adjournment or continuance of meetings and public and/or disability hearings; shall prepare the agenda of regular and special meetings; shall serve proper

and legal notice of all public and/or disability hearings; and shall draft and sign routine correspondence of the Board, and process the LEOFF I Board approved claims for payment according to the policies and procedures established by the Whitman County Auditor's Office or City Clerk's Office. The Secretary shall maintain a file of all rules, findings, orders, recommendations and all other official records of the LEOFF I Board.

1.12 Clerk of the Board

The LEOFF I Board may appoint a Clerk of the Board to handle the day-to-day business for the Board and perform all duties of Secretary in the Secretary's absence.

1.13 Agenda and Order of Business

An agenda shall be prepared by the Secretary and distributed to the members prior to each regular monthly meeting. "Robert's Rules of Order" shall guide the Board where these policies or State law does not otherwise govern the proceedings. 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.

1.14 Minutes

The Secretary shall take and prepare the official minutes of the Whitman County LEOFF I Board containing the actions of the Board and a summary account of the proceedings. A record of the Board members present and absent shall be entered and a recording of action authorized by the Board. The minutes shall be signed by the Secretary and the Chairperson and placed on record after approval by the Board. Copies shall be distributed to all members of the Board and those persons of record who have requested such copies to the Secretary.

1.15 Delegation of Authority to Secretary

The County of Whitman LEOFF I Board delegates to the Secretary of the Board the authority to instigate investigative activities, including 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.

SECTION II - DEFINITIONS

2.01 In Line of Duty

"In line of duty" means injury, sickness or illness in consequence or as a result of the performance of the applicant's duties.

2.02 Disabled or Disability

"Disabled" or "disability" means the existence of a physical or psychological condition which renders the member unable to discharge with average efficiency the duty of the grade or rank to which the member belongs, or the position in which the member is serving. Provided, that no member shall be entitled to a disability retirement allowance if there is an available position to which one of such grade or rank is normally assigned and the duties of which the member can perform.

2.03 Disability Leave Period

Disability leave period is a period six months or any portion thereof during which a member is on leave at an allowance equal to the members' full salary at the time he/she began his/her period of disability leave and prior to the commencement of any disability retirement (as provided in RCW 41.26.030(19) and (AGO 1978-8).

2.04 Board Physician

Unless otherwise directed by the LEOFF I Board in specific instances, the LEOFF I Board utilizes the services of Palouse Medical to request the services of a duly licensed and practicing physician. No disability retirement shall be approved by the Board without prior examination of the claimant by the Board physician or a separate specialist of his/her selection, on or near the expiration of the disability leave period. The Board physician shall render such other medical service as may be requested by the Board. (As provided in WAC 415-105-030 (1)). In order to carry out the duties of this position, each physician appointed or approved by the Board is required to be knowledgeable concerning the duties, functions and general demands required of the employee being examined. The LEOFF I Board shall furnish to the examining physician the job and/or position description of the applicant (As provided in WAC 415-105-030 (2)). Re-examination of any member on disability retirement shall be conducted by a Board appointed or approved physician. (As provided in WAC 415-105-030(3)).

2.05 Legal Counsel

The Whitman County Prosecutor is to be the legal counsel of the Board, provided, that, if otherwise authorized, the Board may, in lieu thereof, employ as legal counsel an attorney admitted to practice in this state. Each legal counsel shall provide written opinions, when required by the Board, touching the subject the Board may be required to act upon. The legal counsel, upon request of the Board, shall review all applications for disability retirement and prepare a summary and recommendation based upon all the evidence in the applicant's file and submits it to the Board for review prior to the Board entering its order granting or denying a disability retirement allowance.

2.06 Minimum Medical and Health Standards

The minimum medical and health standards previously promulgated by the State Retirement Board for entry or re-entry into the LEOFF system membership were provided only to safeguard the fiscal integrity of the pension system and are not the applicable standards for any other purpose. (As provided in WAC 415-105-040(3)). This includes eligibility for disability leave or retirement benefits.

2.07 Conditional Return

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

SECTION III – DISABILITY LEAVE

3.01 Application

No member shall receive disability leave benefits unless he/she has completed and signed an application for disability leave and it has been filed with his/her representative. In order to be considered at the regular or special meeting of the Board, applications must be received by the LEOFF I Board Secretary by the first Tuesday prior to the regular or specially scheduled Board meeting. Also, applications must be accompanied by a report from two (2) health care providers attesting to the existence of a disabling condition.

3.02 Burden of Proof

The burden of proving the existence of a disabling condition, and whether or not the condition was incurred in the line of duty, shall be upon the applicant. (As provided in WAC 415-105-040 (2)). The degree of persuasion is by a preponderance of the evidence. To satisfy the preponderance of evidence standard, the LEOFF I Board must be persuaded that the propositions asserted by the applicant are more probably true than not true.

3.03 Duty Related Leave

Any member who requests disability leave because of a duty-related disability shall submit an incident report showing the cause of disability. If there is no incident report, the member will be responsible for submitting evidence at the LEOFF I Board meeting immediately following his/her disability request to show that the injury or illness was duty related. If the Board finds the evidence insufficient for making their decision, they may grant disability leave showing cause as "unspecified" and arrive at a decision on duty-relatedness at a later date. In the event the Board finds that insufficient information is available to make a determination, the matter may be continued to the next regular Board meeting or be set for consideration at a special meeting. The Board shall also advise the member of the additional information needed, and of the member's obligation to provide additional information and the deadline date by which such information must be provided. (As provided in WAC 415-105-040 (5)).

3.04 Disability Leave Allowance

Disability leave allowance is not granted for any specific amount of time. Such leave may not exceed six (6) consecutive months. During this time, the member is to receive an allowance equal to his/her full monthly salary commencing on the first day of such leave (per AGO No 78-8), or the applicable portion thereof, from his/her employer.

3.05 Placement on Disability Leave

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 member is unfit for duty, such member shall be granted disability leave, unless such leave is waived pursuant to RCW 41.21.120 (4). In considering such application, the Board shall consider the duties of the position, and any other evidence that is relevant. (As provided in WAC 415-105-040(1)). All law enforcement officers and firefighters who qualify for disability leave are encouraged to use department sick leave, if available, until the Whitman County LEOFF I Board meets at it's regularly or specially scheduled meeting and has reviewed and approved the application for disability leave.

3.06 Recuperation and Place of Recuperation

It is the intent of the Board to assure that a member, while on disability leave, shall do all in his/her power to recuperate from such disability and shall do nothing, which reasonably appears, would prolong the leave or inhibit recovery from such disability. In case the LEOFF I Board should want to contact the member about matters concerning his/her disability leave, the member's place of recuperation will be assumed to be his/her home, a hospital or health care facility where confined. The Board may, as a condition to authorizing a place of recuperation at a great distance from Whitman County, require that the member be responsible for any travel expenses necessary to comply with an order of the Board.

3.07 Treatments

During the period of leave, the Board shall have the authority to inquire of any examining health care provider 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.

3.08 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 to return to service at the earliest possible time the applicant believes he/she is fit for duty (see Section III, 3.14, "Return to Duty"). The LEOFF I Board is authorized to tentatively return an employee on disability leave to work upon receipt of clearances from the treating health care providers; provided, that all required paperwork is in order. Should there be any discrepancies or concerns about the required paperwork, the Chairperson may call a special Board meeting to expedite the employee's return to work. In the event the Board finds that a member has not actively sought authorization to return to active service immediately upon cessation of disability, the Board shall have the authority to require the report of the Board-appointed physician to determine his/her ability to return to duty and thereafter to determine whether or not the member's disability leave allowance shall be continued.

3.09 Health Care Provider's Report

Current medical reports are required each month from all treating and/or attending health care providers. They must be received by Tuesday prior to the next regular Board meeting. Failure to submit reports will be cause for the Board to recommend withholding of disability benefits.

3.10 Health Care Provider's List

Each application shall be accompanied by a list identifying by name any health care provider who has been contacted within the last six (6) months for the illness or injury for which disability has been claimed. (As provided in WAC 415-105-040(4)).

3.11 Appearance of Member

The Board shall be authorized to demand the appearance of the member and to request the appearance of such other persons, as it deems appropriate. (As provided in WAC 415-105-040 (6)).

3.12 Medical Reports

It shall be incumbent upon each member obtaining medical evaluations to be used in conjunction with such disability leave and subsequent evaluations, to advise each and every examining health care provider; that such evaluation is being conducted at the direction of the Board; that any reports relating thereto are for the benefit of the Board; that the doctor/patient privilege may not be invoked with respect thereto; and that the health care provider may be called upon by the Board to testify as to his/her findings. (As provided in WAC 415-105-040(6) Part 2 of 2). Medical evaluation reports relating to specific members shall not be distributed to the public or media and in the event specific requests are made for such reports pursuant to Chapter 42.17 RCW (Public Disclosure Law) the designated official shall determine whether or not such document is exempt from disclosure and if not, whether a court injunction should be sought to enjoin such distribution pursuant to RCW Chapter 42.17.

3.13 Examination by the Board Physician

The Board may, in all cases, have the member examined at any time by the Board physician or designate. Refusal to submit to such examination may mean forfeiture of rights to benefits.

3.14 Return to Duty

When a member returns from a disability leave, it shall be the member's responsibility to submit to the LEOFF I Board Secretary a written request to return to work, together with appropriate documentation from the attending health care providers treating the disabling condition, authorizing the member's return to work. Upon receipt of the member's request to return to work, the LEOFF I Board Secretary shall forward a copy of the request and the documentation to the Department Head. The LEOFF I Board shall then take appropriate action on the request.

3.15 Conditional Return to Duty

In the event the medical and any other relevant evidence is inconclusive, the Board may specify in written order a reasonable trial service period to determine the member's fitness for duty. The reasonable length of such conditional return to service shall be supported by medical evidence. 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 trial period of service, the member is found to be disabled. (As provided in WAC 415-105-050(2)).

SECTION IV – DISABILITY RETIREMENT

4.01 Examination for Disability Retirement

Applicants for disability retirement shall be examined by the Board physician during the fifth (5th) or sixth (6th) month of disability leave, or sooner as the Board may require, in order to determine the member's eligibility for disability retirement, with the following exceptions: a) if the Board physician assures the Board that the applicant's condition has not and will not be corrected before the end of the sixth (6th) month; or b) if the applicant establishes that the disabling condition will be in existence for a period of at least six (6) months and he/she voluntarily waives disability leave. No applicant will be granted a disability retirement allowance unless conditions imposed by this sub-section are met. (As provided in WAC 415-105-050([1)).

4.02 Granting Disability Retirement

If the evidence shows to the satisfaction of the Board that the member is physically and/or psychologically disabled from further performance of duty and that the disability has been continuous from the date of commencement of disability leave for a period of six (6) months, the Board shall enter its written decision and order, accompanied by appropriate findings of fact and conclusions of law in compliance with RCW 41.26.120. Such written decision and order with supporting documentation shall thereafter be forwarded to the Director, Department of Retirement Systems for review. In the event a regular meeting of the Board precedes by no more than forty (40) days the date at which the full six (6) months will conclude and the evidence is clear that the disability can be expected to continue through the full six (6) month period, the Board may make a finding of six (6) months continuance disability prior to the actual conclusion of the six month period, so as to eliminate unnecessary delay of receipt of retirement benefits. (As provided in WAC 415-105-060(1)).

In order to receive a disability retirement allowance, the applicant will be required to prove that he/she is physically and/or psychologically disabled to such an extent that he/she is unable to discharge with average efficiency the duty of the position held at the time of discontinuance of service: "Provided, that no member shall be entitled to a disability retirement allowance if the appropriate authority advises that there is an available position for which the member is qualified and to which one of such grade or rank is normally assigned and the Board determines that the member is capable of discharging, with average efficiency, the duties of the position." (As provided in WAC 415-105-060(2)).

4.03 Execution

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

A. Findings of fact supported by evidence in the record supporting the granting or denying of the disability retirement allowance. When a disability retirement is granted, findings of fact shall include:
    1. Whether or not the disability was incurred in the line of duty;
    2. Whether or not the disability was incurred in other employment;
    3. Dates encompassing disability leave and/or dates relating to authorized trial basis return to duty; and, in the case of return to duty on a trial basis, the factual basis for such decision;
    4. Dates encompassing waiver of disability leave, if applicable; and that the applicant established that such disability will be in existence for a period of six (6) months.
    5. As required by the Department of Retirement Systems, if the Board relies on the testimony of the treating health care provider(s) over that of the Board physician, a finding stating that fact.

B. Conclusions of law in accordance with law on the basis of facts in the case.

C. Decision and order. (As provided in WAC 415-105-070 below).
    1. Appropriate findings of fact supported by credible evidence sufficient to sustain the decision; and
    2. Conclusions of law.
        a) When a disability retirement allowance is granted, the decision and order and all supporting documentation must be sent to the Director of the Department of Retirement Systems.
            1) The accompanying findings of fact shall include at least the following:
                (a) The applicant's length of service with the employer and the position held at discontinuance of service;
                (b) The names of the examining health care providers and the dates of the examination;
                (c) The nature of the disability;
                (d) Whether or not the disability was incurred in the line of duty;
                (e) Whether or not the disability was incurred in other employment;
                (f) Dates encompassing disability leave;
                (g) Dates related to authorized return to duty on a trial basis and the factual basis for the decision; and

(h) Dates encompassing waiver of disability leave, if applicable, and that applicant established that the disability would be continuous for at least six months.

2) The supporting documentation shall include a copy of at least the following:
   (a) The application for disability benefits showing the applicant's current mailing address;
   (b) The job description accurately reflecting the duties of the position the applicant held at discontinuance of service;
   (c) Employer statement(s), if any, relevant to the applicant's position and/or fitness for duty;
   (d) All medical and other evidence considered by the Board; and,
   (e) The minutes and/or transcript of all meetings at which the applicant's disability status was considered.

4.04 Re-examination and Return to Duty

In the event a member is placed on disability retirement, the Board shall determine whether or not the member is so disabled that no possibility exists for return to duty or that there is no possibility that rehabilitation could restore the member to fitness for duty. Further, the Board may at any point subsequent to retirement make such a determination. A copy of all such determinations shall be sent to the Department of Retirement Systems. Unless the Board has made such a finding, the Board's representative shall order a re-examination at six (6) month intervals and advise the Board of the results thereof with a copy to the Department of Retirement Systems: provided, that such re-examination need not be conducted on a member over 49.5 years of age. Each member who is under 49.5 years of age and placed on disability retirement is subject to periodic review, unless the Findings of Fact state there is no chance of rehabilitation. The periodic review includes a medical examination and completion of the Board's re-evaluation questionnaire every six months to determine whether disability retirement should be continued.

In the event the retired member is residing at a location more than one hundred (100) miles from his/her former place of employment, the member may be authorized to be examined by a health care provider in his/her immediate area, provided, however, such health care provider shall first be approved by the Board and prior to such evaluation the examining health care provider shall be appraised of the basis upon which the examination is to be conducted and the issues to be addressed in the health care provider's evaluation report (As provided in WAC 415-105-090(1)). Health insurance providers may cover fees charged for medical evaluation report letters for required reexamination of disability retirees under the age of 49.5 years. 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.

4.05 Discontinuation of a Retirement Allowance, Notice of

In the event such evaluation discloses fitness to perform duties of the rank or position held by the member at the time of disability retirement, the member shall be entitled to a hearing before the Board, and further consideration of the matter. Such notice of hearing shall comply with the Administrative Procedures Act, RCW Chapter 34.05. (As provided in WAC 415-105-090(2)).

The member shall be notified of the Board's action to discontinue or cancel his/her retirement allowance by mail, and the notification shall contain notice of the time, place and that the hearing will be to determine whether the member continues to be disabled. The hearing provided by RCW 41.26.140 (2) is to be held, unless the retiree waives such hearing, prior to actual cancellation of a disability retirement allowance. (As provided in WAC 415-105-090(3)).
The retirement allowance of any member who fails to submit to medical examination as provided herein shall be discontinued and in the event such refusal continues for one (1) year, his/her retirement allowance shall be canceled. Failure of the member to affirmatively respond to the request for re-examination shall be deemed a continuing refusal. (As provided in WAC 415-105-090(4)).

SECTION V – HEARING PROCEDURES

5.01 Procedures

Whenever the Board holds a hearing pursuant to these rules or RCW 41.26, the following rules shall govern the general conduct of such hearing and shall not be inconsistent with RCW 34.05.

5.02 Subpoenas

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

A. The Board may issue a subpoena on its own motion or upon the request of any party. The issuance and service of a subpoena may be obtained upon the filing of an affidavit therefore, which:
    1. States the name and address of the proposed witness; and,
    2. Specifies the nature of the evidence sought and the materiality thereof to the issues involved; and,
    3. States that the witness has the desired evidence in his/her possession or under his/her control. The Board may refuse to issue a subpoena when the affidavit is defective or incomplete in any particular. The Board's Secretary is authorized to sign the subpoena for the Chairperson.
B. If an individual fails to obey a subpoena without lawful excuse or refuses to testify when requested concerning any matter under examination or investigation at the hearing or fails without lawful excuse to produce material evidence in his/her possession or under his/her control as required by any subpoena issued by the Board and served upon such person, 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 or to produce material evidence.
C. Any subpoena issued by the Board shall be served in the manner provided for any civil suit according to the Washington Court Rules.
D. Witnesses subpoenaed to attend such a hearing shall be paid the same fees and allowances, and in the same manner and under the same conditions, as provided for witnesses in the courts of this State by RCW 2.40 and RCW 5.56.010, as now or hereafter amended: Provided, that the Board shall have the power to fix the allowance for meals and lodging in like manner as is provided in RCW 5.56.010, as now or hereafter amended, as to courts. Such fees and allowances, and the cost of producing records required to be produced by its subpoena, shall be paid by the Board, or by the party requesting the issuance of the subpoena.

5.03 General Procedure for Conduct of Hearings

A. Submission of Briefs - The member applying for retirement may submit a brief of evidence in support of his/her application. The brief must be submitted to the Board's Secretary three (3) working days prior to the hearing.

B. Record - A record of the entire proceeding shall be made by tape record process. Such tape recording shall be preserved for a period of two (2) years by the Board's Secretary. The cost of any reproduction of the tape shall be paid by the requesting party unless requested by the Board.

C. Continuance - The Board may grant a continuance for good cause. Good cause is to be determined by the Board.

D. Oaths/Certification - In any proceeding under the Board's rules, any member of the Board may administer oaths and affirmations and may certify official acts.

E. Reasonable Dispatch - The Board and its members shall proceed with reasonable dispatch to conduct any matter before it.

F. Rules of Evidence - Hearings need not be conducted according to the technical rules relating to evidence and witness.

G. Oral Evidence - Oral evidence shall be taken only on oath or affirmation.

H. Hearsay Evidence - Hearsay evidence may be used for the purpose of supplementing or explaining any direct evidence, but shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions in courts of competent jurisdiction in this state.

I. Admissibility of Evidence - Any relevant evidence shall be admitted if it is the type of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rules which might make improper the admission of such evidence over the objection in civil court action in a court of competent jurisdiction in this state.

J. Exclusive Evidence - Irrelevant and unduly repetitious evidence may be excluded by the Board.

K. Rights of the Applicant Member - The member applying for retirement shall have these rights, among others:

1. Call and examine witnesses on any matters relevant to the issues presented in the hearing;
2. Introduce documentary and physical evidence;
3. Cross examine witnesses on any matter relevant to the issues of the hearing;
4. Impeach any witness regardless of who called him/her to testify;
5. Rebut the evidence against him/her; and,
6. To represent him/herself or to be represented by legal counsel.

L. Presentation of Testimony

1. Order of Presentation of Testimony - the applicant member, who bears the burden of proof, shall present his/her evidence first. Then other witnesses may testify as directed by the Board. After any witness concludes his/her testimony, the Board may direct questions to the witness.
2. Closing Statement - After presentation of all testimony and evidence, the applicant member or his/her representative shall be allowed to make a summarizing statement. The Board may impose a reasonable time limit on such statement, but a minimum of fifteen (15) minutes shall be allowed.

M. Official Notice

1. What May Be Noticed - In reaching a decision, official notice may be taken either before or after submission of the case for decision, of any fact, which may be judicially noticed by the courts of this state or of official records of the Board or departments and ordinances of the county/city or rules and regulations of the Board.
2. Applicant Member to Be Notified - The applicant member, if present at the hearing, shall be informed of the matters to be noticed by the Board, and these matters shall be noted in the record, referred to therein, or appended thereto.
3. Opportunity to Refute - Any applicant member or his/her representative, if present at the hearing, shall be given reasonable opportunity, upon request, to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such reputation to be determined by the Board.

SECTION VI - APPEAL

6.01 Denial or Cancellation

If the Board denies a disability leave or disability retirement or cancels a previously granted disability leave or retirement, the applicant shall be immediately notified and advised of the right of appeal of such decision or order to the Director of the Department of Retirement Systems, pursuant to RCW 41.26.200. Such notification shall be made in writing and served by personal service or mail. Provided, that written notice need not be given if applicant or his/her duly authorized representative is in attendance at the meeting or hearing and is advised of the decision and of the right of appeal (As provided in WAC 415-105-080).

6.02 Procedure for Reconsideration of Board Decision

Any party aggrieved by a decision of the Board may request the Board to reconsider its action by filing a written request with the Board's Secretary for **reconsideration within thirty (30) days of the decision of the Board.** The request for reconsideration shall set forth a concise statement of the facts or errors upon which the request for reconsideration is based. The Board may direct that a copy of the request for reconsideration be mailed to other interested parties at least three (3) days prior to any Board meeting to consider the request. The Board may grant or deny such request for reconsideration at its discretion.

SECTION VII - FALSIFICATION

7.01 Record or Statement Falsification

All applications and other documents filed in conjunction with disability leave or disability retirement must be accurate and truthful. RCW 41.26.300 provides as follows: "Any employer, member or beneficiary who shall knowingly make false statements or falsify or permit to be falsified any record or records of the retirement system, shall be guilty of a felony".

SECTION VIII – MEDICAL SERVICES

All claims for medical expense reimbursement must comply with Sections 8 and 9 of this policy. Members are advised to consult first with their health insurance providers or their employer/personnel officer to learn what is or is not covered in existing health insurance BEFORE incurring treatment services. Elective medical procedures, surgery and/or appliances/supplies may not be covered by the health insurance provided by the employer or authorized by the board.

8.01 Medical Services Provided

Whenever any active member, member on disability leave, member retired for service or disability which requires medical services, such services shall be paid for by the employer, subject to approval by the LEOFF I Board.

A. Only those medical services, which are deemed necessary, shall be approved unless the Board finds the condition which has caused the need for such medical service was caused or brought on by **dissipation or abuse.** Determinations of **dissipation or abuse** and the necessity of such medical services shall be determined by the Board after considering the medical evaluation of the Board's medical advisor together with any other relevant evidence.
B. Applications to the Board for medical services shall be approved by the Board prior to receipt of services except in extraordinary circumstances.
C. Medical services payable shall be reduced by any amount received or eligible to be received under Workers' Compensation, Medicare, insurance provided by another employer, other pension plan, or other similar sources.
D. In the event any such alternative source of payment is available, it shall be incumbent upon the requesting member to apprise the Board of such source, if known to the member, and failure to do so may result in the loss of medical benefits.
E. It shall be the policy of the Board to seek repayment from other sources. NOTE: Medical services payable by insurance provided by an employer pursuant to RCW 41.26.150 shall not be subject to approval by the Board.

8.02 Medical Services - General Guidelines

A. Where deemed necessary, the LEOFF I Board may approve payment for any medical services, which constitute preventative as opposed to curative services. Preventative services are those meant to prevent future occurrence of an illness, injury or disabling condition, as opposed to curative services meant to restore health, cure or correct an existing condition.
B. The Board will not consider any service of a cosmetic nature or which is beyond that reasonably necessary to correct the condition complained of to be a necessary medical service.
C. In the event the member has obtained medical services without obtaining prior approval of the Board, the Board may authorize payment upon filing of such claim by the applicant.
D. Dental expenses will not be considered necessary medical services except in those circumstances where they are incurred by a member who sustains an accidental injury to his/her teeth and commenced treatment within ninety (90) days after the accident, unless said treatment can be justified by the way of curing or correcting an existing health problem (See Also Section 8.03 B-2-g).

E. The Board will authorize the payment of the expense of an eye exam by a licensed optometrist or ophthalmologist according to the limits set forth in Sections 8.03 B-2-k and 9.02 of this policy.
F. The Board may presume that each individual who has attained age sixty-five (65) is eligible for Medicare and will not authorize payment for necessary medical services, where such expenses are met by Medicare pursuant to RCW 41.26.150. Where the expense of necessary medical services exceeds that which is paid by Medicare, the Board may authorize the payment of the excess.
G. The Board will not pay for non-Medicare provider care if services are available from a Medicare contracted provider.
H. Members possessing insurance benefits covering the expense 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 that are not paid by the insurer. The Board will designate those services where this procedure will not be followed.
I. Upon making payment for authorized medical services, the employer shall be subrogated to all rights of the member against any third party who may be held liable for the member's injuries or for the payment of the costs of medical services in connection with a member's sickness or disability. Such subrogation shall be to the extent necessary to recover payments made by the employer.
J. Any reimbursement received by a member that was expended by the county/city on behalf of a LEOFF I member will be returned to the county/city.

8.03 Medical Services Defined

Medical services for persons who establish membership in the retirement system on or before September 30, 1977, shall include the following as minimum services to be provided. Reasonable charges for these services shall be paid in accordance with RCW 41.26.150 and (the entire section as provided in RCW 41.26.030(22)).

A. Hospital expenses are the charges made by a hospital, in its own behalf, for:
    1. Board and room not to exceed semi-private room rate unless private room is required by the attending health care provider due to the condition of the patient.
    2. Necessary hospital services, other than board and room, furnished by the hospital.
B. Other medical expenses. The following charges are considered "other medical expenses", provided that they have not been considered as "hospital expenses".
    1. The fees of the following:
        a) A physician or surgeon licensed under the provisions of RCW Chapter 18.71;
        b) An osteopath physician and surgeon licensed under the provisions of RCW Chapter 18.57;
        c) A chiropractor licensed under the provisions of RCW Chapter 18.25; and,
        d) The charges of a registered graduate nurse other than a nurse who ordinarily resides in the member's home, or is a member of the family of either the member or the member's spouse.
    2. The charges for the following medical services and supplies:
        a) Drugs and medicines upon a physician's prescription;
        b) Diagnostic x-ray and laboratory examinations;
        c) X-ray, radium, and radioactive isotopes therapy;

d) Anesthesia and oxygen;
e) Rental of iron lung and other durable medical and surgical equipment;
e) Artificial limbs and eyes, and casts, splints, and trusses;
f) Professional ambulance service when used to transport the member to or from a hospital when injured by an accident or stricken by a disease;
g) Dental charges incurred by a member who sustains an accidental injury to his or her teeth and who commences treatment by a legally licensed dentist within ninety (90) days after the accident;
h) Nursing home confinement or hospital care extended facility;
i) Physical therapy by a registered physical therapist;
j) Blood transfusions, including the cost of blood and blood plasma not replaced by voluntary donors; and,
k) An optometrist licensed under the provisions of RCW Chapter 18.53 or an ophthalmologist licensed under RCW Chapter 18.71.

SECTION IX – MEDICAL CLAIMS

9.01 Medical Claim Procedures

The Board will approve payment of claims for all medical services and supplies defined in RCW 41.26.030(22) under the conditions set forth in RCW 41.26.150 and this policy. Claim 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:
    1. 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 of health;
    2. Consistent with standards of good medical practice within the organized medical community;
    3. Offered in the most appropriate setting, supply or service which can be safely provided;
    4. Not primarily for the convenience of the member, his/her physician, or other provider.
    5. The charges are reasonable and considered to be usual and customary unless a provision in this policy provides for reimbursement of a lesser amount.
    6. If the member belongs to a pre-paid health plan, he/she could not have obtained reasonably equivalent services at no additional charge through such plan. The Board will decide which services are reasonably equivalent.
    7. 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.
C. 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.
D. Obtain prior LEOFF I Board approval for any necessary medical expense not covered by insurance, Medicare or other similar sources. All medical expenses incurred and claimed for reimbursement by the member will be submitted through Medicare, if eligible and the member's health insurance provider(s) BEFORE the claim is sent to the Board for approval. The medical expense claim submitted for

reimbursement is to be that portion NOT covered by Medicare, if eligible, and existing health insurance provider(s).

1. The Board may presume that each individual who has attained the age of sixty-five (65) is eligible for Medicare and will not authorize payment for necessary medical services where such expenses are met by Medicare, pursuant to RCW 41.26.150. It is each member's responsibility to obtain Medicare insurance whether or not the employer pays the premiums. Pursuant to RCW 41.26.150(5) Medicare premiums supplementing other medical insurance coverage are authorized for reimbursement upon receipt of Form SSA-1099, Social Security Benefit Statement, showing annual Medicare premiums paid for individual members.
2. Members are advised to consult their employer or personnel office regarding eligibility for Medicare health insurance coverage, Parts A, B and D. Where the expense of necessary medical services exceeds that which is paid by Medicare, the Board will consider the payment of any remaining balance that may exist after coordination of benefits with health insurance providers.
3. All LEOFF I members eligible for Medicare coverage must enroll immediately upon becoming eligible.
4. Members may apply to their Governing Board (i.e. County Commissioners or City Clerks) for reimbursement of Medicare premium payments by submitting documentation from Medicare listing the member's name and premium amount. After Board review and authorization, such documentation will be forwarded to the paying agent for that entity for payment.
5. Each member shall be responsible for notifying his/her Board of Medicare premium increases to ensure proper reimbursement.
6. Members will not be reimbursed for any permanent penalties accruing as a result of late enrollment.
7. Claim reimbursement shall be reduced by amounts payable by Medicare if the member declines medical coverage.

E. Member shall process all medical expenses through the appropriate insurance carriers. Members are advised to consult first with their health insurance providers or their employer/personnel officer to learn what is or is not covered in existing health insurance BEFORE incurring treatment services. Elective medical procedures, surgery and/or appliances/supplies may not be covered by the health insurance provided by the employer or authorized by the LEOFF I Board.

F. All LEOFF I members must annually submit a Member Insurance Coverage form to the LEOFF I Board Secretary.

G. If the medical expense is not covered by insurance, a claim can be submitted in advance to the LEOFF I Board for payment consideration. The burden is upon the claimant to establish the necessity of a provided medical service and the reasonableness of the service charge in order for the Board to consider the claim for payment.

H. Member shall complete a Claim for Payment form and attach all explanation of benefits insurance documentation forms showing the amount paid and/or rejected and any health care provider documentation necessary to support the claim.

I. Submit the claim with the above information to the members employer/employer retired from by the third Tuesday of the month. Any claims submitted after that date will be held until the next regular or special LEOFF I Board meeting.

J. If the Board approves the claim for payment, the claim will be processed according to established city/county department policies and procedures.

K. Claims that do not have complete documentation shall be tabled until the next LEOFF I Board meeting or until the required documentation is provided, therefore it is crucial to submit the required paperwork. Only those services deemed medically necessary shall be approved, unless the Board finds the condition that causes the need for such medical service was caused or brought on by dissipation or abuse. Determinations of **dissipation or abuse** and the necessity of such medical services shall be determined

by the Board after considering the medical evaluation of the Board's medical advisor together with any other relevant evidence.

L. All claims, except prescription claims, shall be submitted to the LEOFF I Board within ninety (90) days of the treatment date. Failure to comply may result in rejection of the claim.

M. Prescription drug claims shall be submitted to the LEOFF I Board within twelve (12) months from the date of purchase. This policy shall apply to all prescription drug claims purchased on or after January 1, 2004.

N. All medical expenses/co-pays are the member's initial responsibility to pay. Claims for necessary medical services submitted to the Board shall be reimbursed to the member in the amount approved by the Board.

O. Upon making payment for authorized medical services, the employer shall be surrogated to all rights of the member against any third party who may be held liable for the member's injuries or for the payment of the costs of medical services in connection with a member's sickness or disability. Such subrogation shall be to the extent necessary to recover payments made by the employer.

9.02 Vision

A. Vision Examinations

1. Active/Retired LEOFF I Members

Eye examinations for active/retired LEOFF I members is to be charged to the county/city's medical insurance provider in effect at that time. Any remaining balance will be paid up to a maximum of $75.00/per year.

B. Laser Vision Correction

1. Any non-life threatening medical procedures requires pre-approval by the LEOFF I Board. The member is required to submit a statement to the Board from the retiree's health care provider indicating the procedure/treatment is medically necessary. Laser surgery for cosmetic purposes is not an approved expenditure.

C. Cataract Surgery

1. Any non-life threatening medical procedures requires pre-approval by the LEOFF I Board. The member is required to submit a statement to the Board from the retiree's health care provider indicating the procedure/treatment is medically necessary.

D. Frames/Lenses

1. All allowance of $500 for frames, lenses, contacts, tinting, bifocals, trifocals, etc. per two (2) year period less any amount paid for by insurance coverage of the member.

9.03 Hearing Aids

The LEOFF I Board will consider requests for hearing aid(s) in advance. Pre-approval required with 2 bids; a maximum of $1,600 paid for 1-aid and a maximum of $3,200 paid for 2-aids during a 5-year period. Hearing aids prescribed due to injury, disease or other unusual circumstances will be considered on a case-by-case basis for exception to this policy. The Board may authorize the cost of necessary repairs, however, routine maintenance and batteries shall be the member's responsibility.

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

A. The Whitman County LEOFF I Board will provide reimbursement for the reasonable expenses incurred by a LEOFF I member needing the services of a skilled nursing facility within 100 miles of member's residence. Expenses that shall be reimbursed may include:

B. Under RCW 41.26.030(22)(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.

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

D. 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.

E. 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.

9.05 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. Applications for prior approval of long-term custodial care services/placement will be considered on a case-by-case basis.

9.06 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 expenses of the average cost for such care within a 100-mile radius of the member's residence.

9.07 Home Health Care

A. The Whitman 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.

1. Before any home health care charges may be reimbursed, the Board must be provided with a "Medical Request for Home Health Care" form completed by the member's attending health care provider. The health care provider 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). This form may be obtained from the LEOFF I Board

Secretary. 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.

2. 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 existing Long-Term Care insurance policy.
3. All charges must be submitted to the appropriate insurance carriers, Medicare and other available long-term care insurance before submission to the Board.
4. The Board shall only reimburse for services rendered. The Board will not make advance payment of any charges.
5. 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.
6. 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.
7. Requests for reimbursement shall be made on a Medical Expense Claim form. 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.
8. 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.

9.08 Hospice Care

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

1. Member is admitted to a DSHS-certified or Medicare-approved program;
2. Care provided is part of a written plan of continuous care, prescribed and periodically reviewed by a physician;
3. If eligible for Medicare, member has applied for or is receiving both Part A and Part B of Medicare coverage, whether paid for by the employer or the member.

9.09 Continuous Treatment/Services

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

9.10 Chiropractic Treatment/Services

Claims for chiropractic services are subject to the provisions set forth in Section 9.09.

1. Treatment Plan Required for Continuous Treatment. The Board requires an evaluation and treatment plan for more than three (3) chiropractic visits for the same injury/illness/condition.
2. Submission of Treatment Plan. The service provider is required to submit an initial individualized treatment plan, which was prepared within one (1) month of commencement of treatment or upon request of the Board. Reports of the progress of the member in the treatment program are to be submitted by the therapist at least once every six (6) months if treatment continues for six (6) months or more. If the member will be in treatment for more than six (6) months, a new (second) treatment plan must be submitted within seven (7) months of the initial commencement of treatment. The Board will review the progress reports and treatment plans to determine whether charges for such treatment should continue to be approved for payment.
3. Components of the Treatment Plan. A treatment plan is required as an individualized program to meet the unique treatment requirements of the member. The treatment plan shall include, but not be limited to the following:
    a. Current medical diagnosis;
    b. Significant history;
    c. Description of treatment or therapy (treatment modality, frequency, length of treatment sessions, estimation of duration, approximate recovery time, criteria used to indicate progress, and names and activities of other professionals who participate in the treatment);
    d. Description how the condition being treated affects the member's ability to perform required regular day-to-day duties of the job and/or tasks of daily living with average or better efficiency.
4. Member Compliance to Submit Claims. Nothing in this section relieves the member from complying with the requirements of Section 9.01 in that claims must be submitted within ninety (90) days of the treatment date.

9.11 Mental Health/Psychological Treatment/Services

Claims for mental health service, including psychological counseling services are subject to provisions set forth in Section 9.09 and the following conditions:

1. Treatment Plan Required for Continuous Treatment. The Board requires an evaluation and treatment plan for more than two (2) mental health visits for the same condition/disability.
2. Conditions for Approval of Mental Health Service. Payments for mental health services provided to a member during a continuous twelve (12) month period will be approved only under the following conditions.
    a. The mental health services are provided by a psychiatrist, a licensed psychologist, or a Master's level clinical social worker who is certified by the National Registry of Health Care Providers in Clinical Social Work or the 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.

b. The member's physician or department administrative officer has recommended such services. (Exception: The member may seek consultation with a mental health specialist, as defined in item "#a" above, without administrative recommendation or a physician's referral for two (2) sessions. If treatment is to be continuous, submission of a treatment plan, prepared by the service provider, is required within the first month of treatment. (Refer to Section 9.06.)

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

d. One fifty (50) minute unit of psychotherapy is payable at the following maximum rate:

(1) Psychiatrist----------$135.00
(2) Psychologist----------$110.00
(3) Clinical Social Worker---------- $ 90.00
(4) Certified Mental Health Counselor---------- $ 90.00
(5) Advanced Registered Nurse Practitioner--------- $110.00

3. Components of the Treatment Plan. A treatment plan is required as an individualized program to meet the unique treatment requirements of the member. The treatment plan shall include, but not be limited to the following:
   a. Current medical diagnosis (DSM III-R 5-digit diagnostic code plus other axes involved and any relationship to the condition);
   b. Significant history;
   c. Prescribed medication (dosage, frequency, side effects, estimated length of treatment);
   d. Description of treatment or therapy (treatment modality, frequency, length of treatment sessions, estimation of duration, approximate recovery time, criteria used to indicate progress, and names and activities of other professionals who participate in the treatment);
   e. Description how the condition being treated affects the member's ability to perform required regular day-to-day duties of the job or tasks of daily living with average or better efficiency.
4. Member Compliance to Submit Claims. Nothing in this section relieves the member from complying with the requirements of Section 9.01 in that claims must be submitted within ninety (90) days of the treatment date.

9.12 Substance Abuse Treatment/Services

Claims for outpatient or inpatient treatment for substance abuse are subject to the provisions set forth in Section 9.09. The Board will approve member's cost of treatment for substance abuse (alcohol or drug abuse) provided the following conditions are met:

1. The service provider is state-approved per Chapter 248-26 W.A.C.
2. Total charges do not exceed a maximum cost of $6,000;
3. The member's physician, personnel officer or commanding officer:
   a. Recommends such treatment; and,
   b. Provides a written state.

4. The recommended treatment is prescribed by the member's physician and reviewed by the Board physician prior to approval of reimbursement by the Board;
5. The service provider submits to the Board a written treatment plan, prepared within five (5) business days of the member's admission to such program. The plan shall include a recommendation of the required length of time the member remains in the program/facility. The plan must be submitted with the member's claim for payment of such medical services. The plan will be used by the Board in determining whether the conditions set forth in Section 9.09 are met for these services.
6. Nothing in this Section relieves a member from complying with the requirement in Section 9.01 that all claims for reimbursement shall be submitted within ninety (90) days of the treatment date.
7. Subject to the dollar limitation set forth above, the member remains in the program for the recommended length of time and the service provider submits written confirmation to the Board. If the member leaves the program against medical advice, or before the recommended length of treatment, the Board may approve payment of only a pro-rata portion of the reasonable costs of such program based on the time the member spent in the program.
8. The limitation on allowable costs shall apply to all costs of treatment of substance abuse, including those for hospital, physician and nurse services, medication and supplies allowable under RCW 41.26.030(22)(a), (b) and this policy.
9. For members applying for payment for repeated treatment, a full written case review by a Board-selected specialist or a certified alcohol/substance abuse evaluation service will be obtained and reviewed by the Board before approving additional treatment or payment of member's claim.
10. Repeat patients are expected to pay for the new treatment and evaluation themselves unless the employer or insurance provides payment for additional substance abuse treatment programs;
11. After a period of one (1) year following completion of repeated treatment, the Board may approve reimbursement if;
    a. The member provides the Board with satisfactory evidence that he/she has continued his/her recovery process; and,
    b. The employer approves payment for repeated treatment.

9.13 Acupuncture/Acupressure Treatment/Services and Massage Therapy

Claims for acupuncture/acupressure services are subject to the provisions of Section 9.01. Payments for acupuncture/acupressure provided to a member by an acupuncturist/massage therapist during a continuous six (6) month period will be approved under the following conditions:

1. Services are provided by a certified state licensed acupuncturist (C.A.), including a M.D. or a D.O., as well as other providers awarded a diploma of acupuncture by the National Commission for the Certification of Acupuncturists (NCCA), or a licensed massage therapist.
2. Member/provider first submits a claim for payment to the member' insurer or third party payer, as directed in member's health insurance contract;
3. If treatment is to be continuous, submission of a treatment plan, prepared by the health care provider, is required within the first month of

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

4. Claims for acupuncture/acupressure expenses must be filed with the member's employer within ninety (90) days of the treatment date.

9.14 Physical Therapy

Medical services are allowed whenever performed by a registered physical therapist when prescribed by a physician, provided, that any continuous care in excess of 45-days must be pre-approved by the Board.

9.15 Prosthesis

Claims paid if medically necessary. All requests considered on a case-by-case basis.

9.16 Elective and Non—Emergency Surgery and Procedures

Elective and non-emergent surgical procedures must have pre–approval. For any surgical procedure which is not performed in an emergency basis the members shall:

1. Advise the Board whenever possible, one (1) month in advance, or as circumstances dictates.
2. The Board may elect to require the member to see a Board appointed physician for a second opinion as to the necessity for such surgical procedure.

9.17 Pain Therapy

Pain therapy must be prescribed and pre-approved. Limited pain therapy treatment may be approved for payment as a medical expense when given by a licensed practitioner at a licensed facility. The written order shall state the diagnosed condition for which the treatment is ordered and number of sessions prescribed. Authorization for additional sessions requires substantiation of improvement in applicant's condition. A request for such additional sessions must be accompanied by a written progress report submitted to the Board. This written progress report should include an outline of the nature of the past and proposed treatment program including its length, components, expected prognosis, and estimate of when treatment should be concluded and the condition stabilized. Specific information should be given regarding the degree of improvement and anticipated improvement. Improvement should be reflected in the patient's condition in terms of functional modalities such as range of motion, sitting and standing to tolerance, reduction in medication, etc. The report should address the issue of the justification for continued licensed pain therapy in lieu of more intensive physical therapy or other treatments. If the attending licensed physician or chiropractor issues written orders authorizing additional licensed pain therapy treatments the Board may approve the payment after consideration of the physician's or chiropractor's progress report and written orders.

Pain therapy in places other than the usual and customary business facility will be allowed only upon justification and authorization by the Board.

The Board retains its authority to use its discretion in determining whether recommenced licensed pain therapy should be approved for payment as medical expense under all the facts and circumstances of a given case.

9.18 Podiatry

A. Reasonable expenses not covered by the member's insurance policy for Podiatric care provided by a licensed Podiatrist, or medical doctor may be presented to the employer for approval of payment.

B. Reasonable expenses not covered by the member's insurance policy for orthotic devices and specialized shoes prescribed by a licensed Podiatrist or medical doctor may be presented to the employer for approval of payment.

C. Each case will be considered on an individual basis by the Board. Determinations will be made taking into consideration the severity of the foot problem, the nature of the work performed by the member, and the medical necessity of prescribed devices to aid and/or correct the problem while the member is on the job. The Board may determine to send the member to the Board's Physician, Objective Medical Assessment Center for diagnosis.

D. Approval of payment for specialized shoes to accommodate orthotic devices shall not exceed two pair in a one (1) year period beginning with the claim for the first pair.

E. Invoices must first be submitted to Medicare, other insurances the member is enrolled, then, the member's LEOFF I insurance for payment.

9.19 Weight Loss Program

The Board may consider and/or approve payment for a prescribed weight loss program or surgery monitored by a physician on a one-time-only, case-by-case basis. The Board will consider payment of a claim for the member's pre-approved weight loss program or surgery exclusive of the costs for food supplements/replacements. Claims for reimbursement must be filed with the member's employer/former employer within ninety (90) days of the treatment date as required by Section 9.01.

9.20 Smoking Cessation

The Board will approve reimbursement to members up to a maximum of $250.00, one-time only payment, following successful completion of a smoking cessation program and upon maintenance of program goals for one (1) year. Members are required to submit a description of the smoking cessation program selected and a treatment plan to the Board for prior approval. Claims for reimbursement will be submitted as required in Section 9.01 of this policy.

9.21 Preventative Medical Care

Benefits are provided for the following routine and preventive services performed on an outpatient basis up to a maximum of $350.00 per calendar year:

A. Routine physical exams.

B. Vaccinations/immunizations.

9.22 Medical Claims for Viagra

Approved if prescribed and medically necessary for a condition other than erectile dysfunction (ED).

9.23 Medical Claims for Incontinent Supplies

Approved with physician's letter.

9.24 Rescue Alert Medical Monitor

The Board will review requests for medical necessity and cost savings versus other alternatives.

9.25 Seasonal Affected Disorder Natural Spectrum Light Lamp

The Board will consider the request with documentation from a physician providing proof of the medical necessity and physician's prescription.

9.26 Provider Fees

Policy, administrative, uninsured monthly medical, facility or account fees will be honored by the Board unless an alternate Medicare Provider is available.

9.27 Membership Fees

A one-time group membership fee for discount stores i.e. Costco, Sam's Club is an authorized reimbursement limited up to $60 related to medical care.

9.28 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), members may submit claims for additional medical services subject to the conditions and limitations set forth in this policy and given statutes.

9.29 Medical Claims for Out of Country Services

Out of country claims for prescriptions or dental work if the member received treatment from a physician licensed in another county. Approved for prescriptions, treatment and medically necessary dental work.

9.30 Member Treated Simultaneously For Same Injury/Illness/Condition

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

9.31 Non-Approved Medical Services

A. Sexual dysfunction and infertility;
B. Sterilization;
C. Reverse sterilization;
D. Fitness clubs;
E. Health spas;
F. Exercise and fitness equipment;
G. Food supplements/replacements;
H. Organ transplant surgery – 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 center. If organ transplantation surgery is performed on patient demand, and/or outside the member's medical/hospital coverage or Medicare-certified transplantation center, the Board will not accept or consider for approval any claim for reimbursement or payment;
I. Therapeutic hot tub;
J. Spinal depression therapy;
K. Erection Pumps/Implants;

L. Herbs

9.32 Rejected Claims

The Board shall act upon all claims promptly, **advising the claimant in writing** of any claim that is rejected, together with the reason for rejection.

9.33 Filing Appeal in Cases Involving Claims for Medical Services

Any person feeling aggrieved by any denial of payment of a claim for medical services by the Board shall have the right to request the Board to reconsider its decision and the Board may grant or deny such request at its discretion. A request for reconsideration must be filed with the Board Secretary within thirty (30) days following the denial of the claim by the Board. The Board will set a date and time for reconsideration at which time the member may present such evidence deemed relevant. If the Board sustains the denial of the claim, the member has the right of judicial review.

9.34 Medical Claims for Services Where Insurance Benefits Have Been Expended

In instances where insurance benefits have been exhausted or where treatment is not covered by insurance, the Board may require a written report from the member's health care provider or, at the Board's discretion, be referred to the Board physician requesting information on the diagnosis, prognosis and recommended treatment for the medical problem.

9.35 Medical Claims for Services Where Treatment is Not Covered by Insurance

In instances where insurance does not cover treatment, the member must seek prior authorization by the Board prior to commencing treatment. Failure to do so may cause denial or only partial approval of the medical claim.

9.36 Medical Claims for Board Required Re-examinations (WAC 415-105-090)

Upon receipt of proper documentation for medical claims for Board required re-examinations, the Board shall authorize the Secretary to institute the process to pay the bill to the provider according to established Whitman County Auditor or City policies and procedures.

9.37 Health Care Provider Reports

The costs of reports furnished to the Board will be considered for payment.

Section X – CONFIDENTIALITY

10.01 Health Insurance Portability & Accountability Act (HIPAA)

The LEOFF I Board complies with all HIPAA related rules and regulations pertaining to confidential medical information associated with LEOFF I members.

10.02 Death Certificate

The Board must be notified within ten (10) days of the death of a LEOFF I member. A certified copy of the death certificate must be filed with the LEOFF I Board within sixty (60) days.

Section XI – POLICY REVIEW

11.01 Biennial Review

These policies and procedures shall be reviewed in even years in January to assure that:

A. Provisions herein remain in conformance with Washington Statutory and Administrative Codes.
B. Dollar amounts specified in schedules of benefits reflect current average charges in the local area.
C. Provisions herein reflect current philosophy and intent of the Board.

SECTION XII – SEVERABILITY/SCRIVENER'S ERRORS

12.01 Severability Clause

The LEOFF I Board Policies and Procedures are declared to be separate and severable. The invalidity of any clause, sentence, paragraph, subdivision, section or portion of these policies, or the invalidity of the application thereof to any person a circumstance shall not affect the validity of the remainder of these policies, or the validity of its application to other persons or circumstances.

12.02 Scrivener's Errors

To allow for the correction of scrivener's errors as described below.

A. Scrivener's errors, typographical errors that do not affect the intent or substance of the policy provisions or that cause them to be illogical obviously or apparently due to the error, may be corrected by the Whitman County LEOFF I Board Clerk with approval by the LEOFF I Board. Scrivener's errors are errors of drafting the text of the policy that include inadvertent errors of codification, cross-reference, citation to other sections, the index, table of contents, laws and office administrative manuals, manuals of practice cited by reference in the policy, misspellings, incorrect grammar, punctuation, syntax or ambiguous grammatical structure. Typographical errors are errors of preparation of the text for printing that is typed or set in type that include: inversions of numbers and words, order of words, mispaginated pages, incorrect fonts or styles, inverted, broken or indistinct type characters and upside down typed materials or pages.

SECTION XIII - ADOPTION

13.01 Formal Adoption

Revisions of the Board's policies and procedures shall be adopted no later than the regularly scheduled Board meeting in **MARCH** of the year of review.

DATED THIS 27TH DAY OF JANUARY 2015 AND EFFECTIVE AS JANUARY 1, 2015.

WHITMAN COUNTY LEOFF I BOARD

_____

JENNY JORDAN
FIREFIGHTER REPRESENTATIVE

_____

NORMA BECKER
CITY REPRESENTATIVE

_____

STEVEN R TOMSON
LAW ENFORCEMENT REPRESENTATIVE

_____

MICHAEL LARGENT
COUNTY COMMISSIONER REPRESENTATIVE

_____

LES RUHS
CITIZEN-AT-LARGE REPRESENTATIVE

Section XIV - APPENDIX
Appendix "A" - Board Membership

Jenny Jordan	Firefighter Representative (LEOFF II)	Term Expires 12/31/16
Michael Largent	County Commissioner Representative	Term Expires 12/31/15
Norma Becker	City Representative	Term Expires 12/31/16
Les Ruhs	Citizen at Large Representative	Term Expires 12/31/16
Steven R Tomson	Law Enforcement Representative (LEOFF I)	Term Expires 12/31/15

Appendix "B" - Policy Revisions

July 26, 2005	January 27, 2009	December 18, 2012
February 28, 2006	March 23, 2010	January 28, 2014
March 27, 2007	March 22, 2011	January 27, 2015
March 1, 2008	March 27, 2012	

Appendix "C" - Forms

The LEOFF I Board may revise its forms from time-to-time, as it deems necessary, without going through the policy review process outlined in 11.01.

#1 Employee's Statement
#2 Employer's Statement and Report on Application for Disability Retirement
#3 List of Health Care Providers
#4 Health Care Provider Statement
#5 Health Care Provider Treatment Plan
#6 Medical Expense Claim
#7 Medical Expense Claims Procedures
#8 Employer Statement Regarding Medical Expense Claim
#9 Medical Request for Home Health Care
#10 Approval/Rejection of Claim Form Letter
#11 Response to Request for Medical Payment/Reimbursement (Medicare)
#12 Response to Request for Medical Payment/Reimbursement (Non-Medicare)
#13 Member Insurance Coverages (to be completed annually)
#14-A Nomination Letter –Firefighter Representative
#14-B Nomination Form – Firefighter Representative
#14-C Nomination Certification – Firefighter Representative
#14-D Ballot Form – Firefighter Representative
#14-E Election Certification – Firefighter Representative
#15-A Nomination Letter - Law Enforcement Officer Representative
#15-B Nomination Form – Law Enforcement Officer Representative
#15-C Ballot Form – Law Enforcement Officer Representative
#15-D Election Certification – Law Enforcement Officer Representative
#15-E Nomination Certification – Law Enforcement Officer Representative
#16 Reserved
#17 HIPAA - Response to Access Health Information Record Letter
#18 HIPAA - Revocation of Authorization for Use or Disclosure of Health Care Information-2 Pages
#19-A HIPAA - Request for Corrected/Amended Health Information-Page 1
#19-B HIPAA - Request for Corrected/Amended Health Information-Page 2
#20 HIPAA - Response to Request for Corrected/Amended Health Information
#21 HIPAA - PHI Disclosure Log
#22 HIPAA - Acknowledgement
#23 HIPAA - Sample Grievance Resolution Letter
#24 HIPAA - Confidentiality Statement
#25-A HIPAA - Authorization to Release Private Information-Page 1
#25-B HIPAA - Authorization to Release Private Information-Page 2
#26 HIPAA - Volunteer/Service Provider Confidentiality Statement