

GRAYS HARBOR COUNTY
LEOFF I DISABILITY BOARD
MEDICAL SERVICES POLICY

(Revised January 2016)

I. Medical Services - Defined

Medical Services for persons who established membership in the retirement system on or before September 30, 1977, shall include the following minimum services to be provided. Reasonable charges for these services shall be paid in accordance with RCW 41.26.150.

- A. Hospital expenses are the charges made by a hospital, in its own behalf, for:
 - (1) Room and board not to exceed semi-private room rate unless a private room is required by the attending physical due to the condition of the patient.
 - (2) Necessary hospital services, other than board and room, furnished by the hospital.
- B. Other medical expenses: Provided that they have not been considered hospital expenses. The fees of the following:
 - (1) A physician or surgeon licensed under the provisions of Chapter 18.51 RCW;
 - (2) An Osteopath licensed under the provisions of Chapter 18.51 RCW;
 - (3) X-ray, radium and radioactive examinations;
 - (4) Anesthesia and oxygen;
 - (5) Rental of iron lung or other durable medical and surgical equipment;
 - (6) Artificial limbs and eyes, casts, splints, and trusses;
 - (7) Professional ambulance service when used to transport the member to and from a hospital when he/she is injured by an accident or stricken by a disease/illness.
 - (8) Physical therapy by a registered physical therapist;
 - (9) Blood transfusions, including the cost of blood and blood plasma not replace by voluntary donors;
 - (10) An optometrist or ophthalmologist licensed under the provisions of chapter 18.53 RCW.
 - (11) Routine, Preventative Medical Examinations by a licensed physician under the provisions of Chapter 18.51 RCW

II. Employer to Pay Medical Expenses Approved by the Board with Exceptions of Insurance Coverage or Abuse and other exclusions *(Revised 11/19/09)*

Whenever any member (active or retired) requires medical services because of sickness or disability not caused by dissipation of abuse, of which the Disability Board shall be the judge, the employer shall pay for the active or retired member the necessary medical expenses not payable from some other source, including:

- (1) The State of Washington Department of Labor and Industries for “workers’ compensation or industrial insurance benefits payable under Title 51 RCW.
- (2) Medicare. Failure to apply for coverage shall not be deemed a refusal of payment of benefits, thereby enabling collections of charges. (RCW 41.26.150(2))
- (3) Insurance provided by another employer, social security or other pension plan.
- (4) Any other similar source.
- (5) Other exclusions:
 - a. Psychotherapy from a MSW (Masters of Social Work)
 - b. Psychiatric treatments for sexual dysfunction.
 - c. Non-emergency air ambulance service.
 - d. Hypnotherapy to stop smoking.
 - e. Vitamins not prescribed by a physician.
 - f. Medical Marijuana or equipment to grow or devices to use. The Board will not approve anything that is a violation of state or federal law.
 - g. Transgender surgeries or medications.
 - h. Any cosmetic surgery not medically necessary.

III. Nursing Home Care

Expenses incurred in a nursing home or extended care facility for reasonable and necessary charges will be approved by the Board within the following guidelines:

- A. Adult Day Care and Nursing Home Care for members must receive prior approval of the Board. The Board will only approve payment for such care where, when combined with insurance or other sources, the cost does not exceed by ten percent (10%) the average cost for such care in the Grays Harbor area.
- B. Payment shall be reduced by any amount which the member received or is eligible to receive from insurance, Medicare, Medicaid or any similar source.
- C. The facility must be state licensed nursing home center or a center as approved by the Board.
- D. Items for entertainment purposes such as a television, cable hookups, and telephone charges are not reimbursable expenses
- E. The Board may require a written treatment plan from the provider or request any additional information as needed.

IV. Long Term Care (In-Home, Assisted Living, Group Home)

(Revised 6/1/2016)

1. Prior approval for In-Home, Assisted Living or Group home is required by the Board.
2. The In-Home, Assisted Living or Group home care must be prescribed by a physician with the Board's Long Term Care form completed outlining the medical necessity of the type of care requested, the specific needs of the member and the ADL's the member is unable to perform.
3. The In-Home, Assisted living or Group home care must be provided through an agency licensed to perform this type of care.
4. Payment will NOT be made to a caregiver residing in the member's home. **Payment will not be approved for a relative of the member.**
5. If the member is eligible for Medicare, the member will apply for both Part A and Part B of Medicare coverage. If the member does not seek Medicare coverage the Board will have the discretion to deny payment for medical services that may have been paid by that coverage.
6. If the member is eligible for benefits through the U.S. Department of Veteran's Affairs, or Tri-Care military benefits, the member will apply for said benefits. If the member does not seek benefits through the U.S. Department of Veteran's Affairs, or Tri-Care military benefits, the Board will have the discretion to deny payment for medical services that may have been paid by that coverage. When/if a member is reimbursed from the U.S. Department of Veteran's Affairs then the member must reimburse the entity (city, county).
7. Payments will be made to the agency providing the In-Home, Assisted Living or Group home care by the member after services are rendered. The Board will not approve advance payments. If an agency providing services requires advance payment, the member must make the advance payment and seek reimbursement from the member's entity (city, county).
8. An itemized cost breakdown from the agency providing the In-Home, Assisted Living or Group home care is required, regardless of whether the member's entity (city, county) is paying the agency directly or reimbursing the member for advance payments to the agency.
9. Services and supplies that are not deemed medically necessary by the physician, such as supplements, hair care, and toiletries are not eligible for payment or reimbursement. Expenses for the normal activities of daily life such as food, clothing and household supplies are not eligible for payment or reimbursement.
10. The Board may request an examination by the Board's physician.
11. The Board requires a physician re-evaluation every six months.
12. Authorization may be withheld by the Board if the costs of the In-Home care, Assisted Living, or Group home care exceeds the average cost of care in a Nursing Home in Grays Harbor County.

Exceptions to this policy may be granted under special circumstances determined by the Board.

Amendment: Each entity (city, county) should have the option to either pay the Provider or Agency directly or the member directly.

V. Hearing Aid

(Revised 11/20/08)

- A. Hearing aid claim will be limited to \$2,500 per aid or \$5,000 per pair per a five-year period.
- B. Hearing tests must be provided to prove medical necessity.
- C. The Board will approve payment for reasonable necessity expenses for hearing aid batteries and repairs not caused by negligence to the member.

VI. Eyewear

(Revised 10/21/10)

- A. It is the policy of the Board to reimburse members for eyeglasses and contact lenses that are prescribed by an optometrist or ophthalmologist as follows
 - (1) One (1) eye examination per twelve-month period less amount payable by insurance.
 - (2) All allowance of \$500 for frames, lenses, contacts, tinting, bifocals, trifocals, etc. per two year period less any amount paid for by insurance coverage of the member.
- B. Individual, special circumstances may be approved by the Board, such as a change in prescription following eye surgery.

VII. Psychiatrist and Psychologist

- A. Counseling will be limited to and under the direction of a licensed psychiatrist or psychologist.
- B. The Board will approve payment as follows:
 - 1. A member is entitled to a maximum of six (6) visits per year without Board review.
 - 2. After six (6) visits, the member must submit an evaluation to the Board including, but not limited to, a diagnosis and prognosis.
 - 3. After six (6) months, the Board physician shall review any report(s) or request additional reports and advise the Board whether there has been sufficient improvement or if a change of treatment may be warranted. The Board will notify the member if its decision regarding future evaluations and/or payments.
- C. Failure to provide evaluations from the psychiatrist or psychologist may result in the Board's rejection of a member's claim for payment.

VIII. Chiropractor

- A. When a member exceeds the number of visits that his/her insurance policy covers, the following criteria will be used to approve or disapprove chiropractic payments.
 - 1. After an initial allowance of 20 visits per calendar year, January through December, the member must submit a written request for additional allowance. The written request should explain why an additional allowance is medically necessity, including a written explanation of the Chiropractor.
 - 2. The Board may send the member to the Board Physician as it deems necessary.

IX. Dental

(Revised 01/2016)

General Dental

- A. Dental charges incurred by a member who sustains an accidental injury to his/her teeth shall be approved.
- B. Dental expenses incurred by a member for teeth whitening will not be approved.
- C. No dental expenses incurred by a member for dental services or work which is purely cosmetic in nature will be approved or paid, except in unusual circumstances, and then only with the prior, written approval of the Board and based upon medical necessity.
- D. Annual dental expenses are limited per the following two categories and a member may have expenses from both categories in the same year.
- E. All costs considered will be after insurance has paid.

Exams, Cleanings, X-rays, Fillings, and Extractions approved up to \$1000 per year

- A. The expense of one (1) general dental check each year will be covered for a member.
- B. No more than two (2) dental cleanings each year will be covered for a member, unless it is determined, at the discretion of the Board, that a more frequent cleaning schedule is a medical necessity in a particular case or for a particular member.
- C. X-rays, fillings & extractions, build-ups, and periodontal work will be approved within the \$1000 yearly allowance.

Dentures, Implants, Bridgework, Crowns

- A. The Board will consider, if submitted for pre-approval, dentures, implants, bridgework and crowns if shown to be medically necessary at 50% of cost up to \$3000 maximum per year.

X. Erectile Dysfunction (ED) Policy

(in effect January 1, 2007)

A. A limit of 8 doses per month or 96 doses per year on a written doctor's prescription, explaining the medical necessity of the E.D. prescription, will be approved.

XI. Policies Regarding Certain Claims

- A. The Board will not approve payment of claims for expenses of members in weight loss programs, physical fitness clubs, health spas, or other programs of this nature unless such treatment is prescribed by a physician as a medical necessity and equivalent treatment could not be obtained at less expense.
- B. Chemical dependency treatment will be approved when prescribed by a licensed physician.

X. Claim Filing Procedures

(Revised 4/2012)

- A. Claims for payment of medical services shall be submitted to employer or entity which retired from after member has made claim to his/her medical provider. The member shall submit itemized billings and explanations of benefits from member's medical insurance carrier.
- B. Claims must be submitted within six (6) months of the date of service or date processed by insurance carrier. Claims submitted after this period of time may not be approved.
- C. Documentation on payments from other sources must be attached. Incomplete information may delay processing of claims.
- D. The claim shall be received by employer/entity at least ten (10) working days prior to the Board meeting for consideration of claim at the meeting.
- E. Members submitting claims for payment of medical treatment are deemed to have waived any doctor/patient privilege with regard to the treatment. On request, the member shall sign a release form to be presented to the physician.
- F. The chairperson or vice-chairperson of the Board may approve, at other than regular Board meetings, payment of claims.
- G. Members are encouraged to use preferred providers with their insurance carrier. If a member closes an out-of-network provider, they are obligated to furnish a letter of explanation as to medical necessity and as to why they didn't choose a preferred provider. The Board will consider approval on a case-by-case basis.
- H. Upon approval of the Board, medical bills will be forwarded to the member's Entity for payment. Members are not required to pay in advance any co-pay or medical bill over \$100.00 before it is submitted to the Board for approval. Entities shall reimburse members within forty-five (45) days after approval of the Board.
- I. When medical treatments are long-term, the Board is entitled to updates on the member's medical status as requested by the Board. Failure to provide that information may lead the Board to revisit any approval of payment.