CITY OF BELLEVUE
LEOFF 1 DISABILITY BOARD
Meeting Minutes

May 5, 2015 Conference Room 1E-118
5:30 p.m. – Administration Bellevue City Hall
6:00 p.m. – Business Meeting

MEMBERS PRESENT: Chairperson Susan Neiman
Boardmember Wayne Bergeron
Boardmember Bryan Reil
Councilmember John Stokes

MEMBER ABSENT: Councilmember Lynne Robinson

OTHERS PRESENT: Paula Dillon, Human Resources
Siona Windsor, City Attorney's Office

MINUTES TAKER: Michelle Cash

I. CALL TO ORDER

The meeting was called to order at 6:05 p.m. by Chair Neiman.

II. ROLL CALL

III. APPROVAL OF MINUTES

Motion by Boardmember Bergeron and second by Councilmember Stokes to approve the April 7, 2015 LEOFF 1 Disability Board meeting minutes as presented.

Boardmember Bergeron corrected page 2, Item IV.A. of the meeting minutes. The proper count for the motion approval was 5-0, rather than 6-0.

At the question, motion carried unanimously (4-0) to approve the April 7, 2015 LEOFF 1 Disability Board meeting minutes as corrected.

IV. CONSIDERATION OF APPLICATIONS FOR DISABILITY ALLOWANCES

A. Applications for Disability Allowances

None.

B. Applications for Disability Allowances Greater than 1 month

Motion by Boardmember Bergeron and second by Boardmember Reil to approve the Applications for Disability Allowances greater than 1 month as presented. Motion carried unanimously (4-0).

V. CONSIDERATION OF MEDICAL CLAIMS

A. Routine Claims

Motion by Boardmember Reil and second by Boardmember Bergeron to approve the Routine Claims as presented. Motion carried unanimously (4-0).

B. Special Claims

Motion by Councilmember Stokes and second by Boardmember Bergeron to approve the Special Claims as presented.

Ms. Dillon explained that Member #71 has pulmonary fibrosis. The Member's physician says that home care is needed during the six hours per day that the Member's family members are away at work. The Member selected Andelcare as the in-home care provider.

At the question, motion carried unanimously (4-0) to approve the Special Claims as presented.

VI. PRE-APPROVED RECURRING LONG-TERM CARE CLAIMS

The pre-approved recurring long-term care claims were reviewed and included in the Board packet.

VII. STAFF REPORT

Ms. Dillon reported that Boardmember Bergeron announced his retirement from the City. His last day will be May 6, 2015. However, Boardmember Bergeron will continue with his position on the LEOFF 1 Disability Board.

VIII. EXECUTIVE SESSION

The Executive Session was postponed until the entire Board can be present for the discussion.

IX. UNFINISHED BUSINESS

A. Out-of-Network Claims

Further out-of-network claim discussions were postponed until the entire Board can be present for the discussion.

X. NEW BUSINESS

None.

XI. ANNOUNCE DATE & TIME OF NEXT MEETING

The next Disability Board meeting will be held on Tuesday, June 2, 2015.

XII. ADJOURNMENT

By general consensus, the meeting was adjourned at 6:21 p.m.

City of Bellevue

Disability Board

Agenda Regular Meeting
City Hall, Conference Room 1E-118

Date: Tuesday, May 5, 2015

Time: 5:30 pm Administrative Meeting
6:00 pm Business Meeting

I. Call to Order

II. Roll Call

III. Approval of Minutes of Regular Meeting, April 7, 2015

IV. Consideration of Applications for Disability Allowances

- **A.** Applications for Disability Allowances
  - 1) Fire Department
- **B.** Applications for Disability Allowances Greater than 1 month
  - 1) Fire Department

V. Consideration of Medical Claims

- **A.** Routine claims
- **B.** Special claims
- **C.** Pre-Approved Recurring Long-Term Care Claims

VI. Staff Reports

VII. Executive Session

VIII. Unfinished Business – Out of Network claims policy discussion

IX. New Business

X. Announce Date & Time of next meeting: Tuesday, June 2, 2015

XI. Adjournment

CITY OF BELLEVUE
LEOFF 1 DISABILITY BOARD
Meeting Minutes

April 7, 2015 Conference Room 1E-118
5:30 p.m. – Administration Bellevue City Hall
6:00 p.m. – Business Meeting

MEMBERS PRESENT: Chairperson Susan Neiman
Boardmember Wayne Bergeron
Boardmember Bryan Reil
Councilmember Lynne Robinson
Councilmember John Stokes

OTHERS PRESENT: Paula Dillon, Human Resources
Siona Windsor, City Attorney's Office

MINUTES TAKER: Michelle Cash, *via recording*

I. CALL TO ORDER

The meeting was called to order at 6:14 p.m. by Chair Neiman.

II. ROLL CALL

III. APPROVAL OF MINUTES

Motion by Boardmember Reil and second by Councilmember Robinson to approve the January 6, 2015 LEOFF 1 Disability Board meeting minutes as presented. Motion carried unanimously (5-0).

Motion by Boardmember Reil and second by Councilmember Robinson to approve the February 3, 2015 LEOFF 1 Disability Board meeting minutes as presented. Motion carried unanimously (5-0).

Motion by Boardmember Reil and second by Councilmember Robinson to approve the March 3, 2015 LEOFF 1 Disability Board meeting minutes as presented. Motion carried unanimously (5-0).

IV. CONSIDERATION OF APPLICATIONS FOR DISABILITY ALLOWANCES

A. Applications for Disability Allowances

Motion by Boardmember Bergeron and second by Boardmember Reil to approve the Applications for Disability Allowances as presented. Motion carried unanimously (6-0).

B. Applications for Disability Allowances Greater than 1 month

Motion by Boardmember Bergeron and second by Councilmember Stokes to approve the Applications for Disability Allowances greater than 1 month as presented. Motion carried unanimously (5-0).

Ms. Dillon noted that Member #44 will be retiring on a service retirement on April 14, 2015.

V. CONSIDERATION OF MEDICAL CLAIMS

A. Routine Claims

Motion by Boardmember Bergeron and second by Boardmember Reil to approve the Routine Claims as presented. Motion carried unanimously (5-0).

B. Special Claims

Motion by Boardmember Bergeron and second by Councilmember Robinson to approve the Special Claims as presented.

Councilmember Robinson explained that the doctor made an error in the diagnosis code for Member #139 and should be contacted to correct the error so the claim can be resubmitted to Premera. The diagnosis code should be jaw pain or facial pain, which insurance does cover, rather than TMJ. Staff will forward this recommendation to the Member.

Ms. Dillon explained that Member #56 submitted massage therapy claims over the four that the Premera plan allows within a calendar year. The Board's policy is that claims must be submitted to the Board within six months of receiving the insurance EOB or, if no EOB is received, within 18 months of incurring the medical expense. The Member's physician who initially approved the treatments is no longer in practice, so the original approval letter is not available. The letter from the member stating the reason the claims were not submitted timely was included in the Board packet. In addition, a letter was included in the Board packet from the Member's current physician recommending continued massage therapy treatment. Since Premera covers four massage therapy claims per calendar year, Councilmember Robinson expressed her concern with the Board covering the additional cost of therapy appointments above and beyond four treatments. Boardmember Bergeron added that the state statute states that claims must be "medically necessary."

Ms. Dillon clarified that Medicare covered some of Member #56's claims but they did not receive all of the bills timely so there were some claims that were not covered. Boardmembers questioned if the massages prescribed by the Member's prior physician were authorized by the Board. The Member had a referral from the prior physician but is unable to obtain a record of this due to medical issues with the prior physician. The current prescription for massage therapy is two times per month.

Councilmember Robinson suggested that the Member submit the claim to Medicare and/or file an appeal with an explanation so the Member can be reimbursed by Medicare.

Ms. Windsor read Item. IV.7.Processing Medical Claims of the Disability Board Policies and Procedures, which states:

> *"…If the insurance carrier(s) do not pay the entire claim, the LEOFF 1 active/retiree member must submit a claim to the Disability Board for the unpaid balance within six months of receipt of the Explanation of Benefits from the insurance company and Medicare, if applicable. If the LEOFF 1 active/retiree member does not receive an Explanation of Benefits from the insurance company or Medicare within a reasonable period of time or if the Board's rules or practices permit a claim to be filed directly with the Disability Board, the claim must be filed with the Board no later than 18 months after incurring the medical expense. Failure to comply with these timelines will result in the Disability Board denying the claim unless extraordinary circumstances outside the control of the member prevents timely submission."*

Ms. Dillon clarified that Member #56's prior physician did not send the Member an invoice for 2013 outstanding charges until July, 2014. Staff received the claim in December, 2014, at which time Ms. Dillon began working with the Member to obtain additional information. Since the Member did not receive the invoice for outstanding charges until July, 2014, Boardmembers decided to use this date to determine the "reasonable period of time." However, they directed staff to caution the Member to monitor medical invoices and dates of service.

At the question, motion carried unanimously (5-0) to defer a decision on Member #139's claim so the Member can resubmit the claim for proper medical coding; and directed staff to remind Member #56 about proper claim submittal timelines/procedures.

VI. PRE-APPROVED RECURRING LONG-TERM CARE CLAIMS

The pre-approved recurring long-term care claims were reviewed and included in the Board packet.

VII. STAFF REPORT

None.

VIII. UNFINISHED BUSINESS

A. Out-of-Network Claims

Ms. Dillon explained that currently the Board's policy manual is silent on the use of out-of-network providers. However, the manual and law both only require the Board to reimburse for "reasonable" necessary medical expenses. Because of some recent changes to the Premera in-network physician listings, the Board has expressed an interest in further clarifying what constitutes reasonable necessary medical expenses. Boardmembers currently consider out-of-network claims on a case-by-case basis.

Ms. Dillon reminded Boardmembers that there has been a barrier in determining "Usual and Customary Rates" because these charges are typically proprietary calculations. Ms. Windsor added that the statute states that reasonable expenses of necessary medical care will be covered. Determining "reasonable" is a challenge.

From 2002-2014, the out-of-network charges totaled approximately $37,000. Ms. Dillon distributed a WSLEA Policy Comparison and noted that most other jurisdictions do not require use of a preferred provider.

Councilmember Robinson noted that there isn't anything currently in the policy to encourage members to make the effort to ensure that their provider is in-network. She called attention to a claim that was submitted in 2014 for over $14,000 where the Member was under the impression that he/she was utilizing an in-network physician when in actuality the physician was out-of-network. Councilmember Robinson requested that the proper phone numbers be listed in large print on Member's medical cards so that they know what numbers to call to determine if a physician is in-network.

Boardmembers discussed the challenges that LEOFF 1 Members face and the aging population of the Members.

Since a reminder was placed in the December, 2014 LEOFF 1 Newsletter to encourage Members to use in-network providers, as an option, Ms. Windsor proposed that Boardmembers monitor the incoming claims and reevaluate the policy in December, 2015. She reviewed Item. IV.3.Payment for Medical Services, which states:

> *"…When a medical service is not covered under the medical plan(s), the service may be submitted to the Disability Board for consideration and approval. Determination of the necessity of services is made after considering relevant evidence provided to the Disability Board by the LEOFF 1 active/retiree member and any other relevant information obtained through the Disability Board Medical Advisor(s)."*

In addition, Ms. Windsor reviewed Item. IV.5.All Other Services or Charges, which states:

> *"…All other services or charges must be submitted for consideration by the Disability Board. Circumstances and conditions may exist or come into existence which are not fully or clearly encompassed by these Policies and Procedures. In such cases, the matter will be considered on a case-by-case basis and the Disability Board will act in keeping with the spirit of statutory authority, and legal and administrative precedent."*

Councilmember Robinson proposed that the Disability Board Policies and Procedures define "reasonable charges" as being an in-network (when possible) charge. Other Boardmembers disagreed with this recommendation.

Ms. Windsor reviewed RCW 41.26.150 subsection 2, which states:

> *"The medical services payable under this section will be reduced by any amount received or eligible to be received by the member under workers' compensation, social security including the changes incorporated under Public Law 89-97, insurance provided by another employer, other pension plan, or any other similar source. Failure to apply for coverage if otherwise eligible under the provisions of Public Law 89-97 shall not be deemed a refusal of payment of benefits thereby enabling collection of charges under the provisions of this chapter."*

She continued with RCW 41.26.150 subsection 4, which states:

> *"Any employer under this chapter, either singly, or jointly with any other such employer or employers through an association thereof as provided for in chapter 48.21 RCW, may provide for all or part of one or more plans of group hospitalization and medical aid insurance to cover any of its employees who are members of the Washington law enforcement officers' and firefighters' retirement system, and/or retired former employees who were, before retirement, members of the retirement system, through contracts with regularly constituted insurance carriers, with health maintenance organizations as defined in chapter 48.46 RCW, or with health care service contractors as defined in chapter 48.44 RCW. Benefits payable under the plan or plans shall be deemed to be amounts received or eligible to be received by the active or retired member under subsection (2) of this section."*

Councilmember Robinson recommended that further discussions be tabled so staff can review the laws and determine if there is a precedent for wanting to encourage Members to use in-network providers.

Ms. Windsor clarified that if a proposed policy change is identified, it would need to be sent to LEOFF 1 members for review and comment. Then, the Board would review the comments and make a final recommendation. Councilmember Robinson requested a list of pros versus cons of making a policy change and a list of next steps. If a policy amendment is made, Ms. Dillon stressed the challenges of determining Usual and Customary Rates.

IX. NEW BUSINESS

None.

X. ANNOUNCE DATE & TIME OF NEXT MEETING

The next Disability Board meeting will be held on Tuesday, May 5, 2015.

XI. ADJOURNMENT

By general consensus, the meeting was adjourned at 7:24 p.m.

Disability Board
Agenda Item No. 7
April 7, 2015

☐ Action
☒ Discussion
☐ Information

Subject: Out of Network Claims

Contact: Paula Dillon – Human Resources

Policy Discussion: Shall the Board amend its October 2014 restated Policies and Procedures Section IV 3 "Payment for Medical Services" by adding the following?

Effective January 1, 2016, if the member chooses to use an out of network provider when an in network provider in the same specialty is available in a reasonable geographic area to the member, the maximum amount that will be covered for any service will be equal to the Usual and Customary Rate (UCR) for that service. Any charges above UCR will be the responsibility of the member.
The Board will consider reimbursing above the UCR for medically necessary charges incurred:

1) out of state or out of PPO service area,
2) because of an emergency situation,
3) when using an in network doctor for a procedure in an in network facility and the facility uses out-of-network health care providers in support of the procedure.
4) As a result of a continuing course of on going treatment for an illness or injury that commenced prior to member notification of this policy.
5) Due to extraordinary circumstances

Background:

Currently, the Board's policy manual is silent on the use of out of network providers. However the manual and law both only require the Board to reimburse for "reasonable" necessary medical expenses. Because of some recent changes to the Premera in network physician listings, the Board has expressed an interest in further clarifying what constitutes reasonable necessary medical expenses.
Section IV 3 provides:

IV. 3. Payment for Medical Services

Most of these necessary medical services are automatically covered under the medical

plan(s) provided by the City of Bellevue to LEOFF I active/retiree members, and therefore do not need to be further approved by the City of Bellevue Disability Board.

The amount of the benefit payment will be reduced by any amounts the member receives or is eligible to receive under Workers' Compensation benefits provided by any employer for the medical condition in question, Medicare, medical insurance provided by another employer, other pension plan, or any other similar source. (RCW41.26.150)

When a medical service is not covered under the medical plan(s), the service may be submitted to the Disability Board for consideration and approval. Determination of the necessity of services is made after considering relevant evidence provided to the Disability Board by the LEOFF I active/retiree member and any other relevant information obtained through the Disability Board Medical Advisor(s).

Suggested Discussion Topics:

1. Should the Board adopt a policy limiting reimbursement for necessary medical services to the usual and customary rates for services?
2. Should the Board adopt the effective date for the policy to be January 1, 2016?
3. How can/should UCR be determined?