

2004 ANNUAL REPORT

Targeting Fraud and Abuse

In Washington State's Workers' Compensation Program



Department of
**LABOR AND
INDUSTRIES**



2004 Annual Fraud Report

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Executive Summary

Fiscal year 2004 was a transitional year at the Department of Labor and Industries for dealing with fraud and abuse in a workers' compensation insurance system that provides coverage to about 1.9 million workers and 160,000 employers. The year built a solid foundation for even more focused efforts in FY 2005, which we will report on quarterly. The first of these reports is being published simultaneous to this one.

In a system that collects premiums and annually pays out over \$1.4 billion in injured-worker benefits, the potential for fraud and abuse is considerable. Deterring fraud is essential if the financial integrity of the State Fund is to be maintained. In FY 2004, we:

- ⦿ Made the detection and elimination of fraud one of the agency's top priorities.
- ⦿ Crafted and supported legislation, which passed, that gave the agency additional staff and new legal authority to combat fraud and abuse.
- ⦿ Began to consolidate our efforts in the Fraud Prevention and Compliance Program, which was established July 1.

The agency's strategy is to take aggressive action against the worst offenders — those who intentionally cheat the workers' compensation system, using them as an example of L&I's efforts to aggressively reduce fraud and abuse. In FY 2004, the agency's fraud and abuse strategy followed a number of courses:

- ⦿ We conducted more validity checks to ensure that workplace-injury claims are legitimate. Our goal is to contact the employer on any time-loss claim that will impact their rates.



HIGHLIGHTS

- ⦿ L&I spent \$10.9 million on fraud prevention and compliance in FY 2004, including expenditures for salaries, benefits and operating expenses. The agency recovered and had cost avoidance of nearly \$98 million, for a return on investment of 9 to 1 (See table on page 2)
- ⦿ Collections on delinquent accounts continued to rise, climbing to \$94 million.

- ◉ We suspended the registration and/or employee certifications of employers who owed premiums and refused to enter into, or ignored, payment agreements.
- ◉ We are continuing to work closely with other government agencies to detect fraud, and with county prosecutors to get convictions in the most egregious cases.
- ◉ We more aggressively identified and collected unpaid premiums in construction. In FY 2004, the tax-recovery effort collected \$4.5 million in previously unreported premiums in construction — a 42 percent increase over baseline. The initiative won the Governor’s Quality and Performance Award.
- ◉ We implemented provisions of ESHB 3188, including changes to Title 51 for prime contractor liability, successorship, personal liability, education outreach, improved provider collection authority and worker and beneficiary fraud definition changes.

This report provides a comprehensive summary of L&I’s workers’ compensation fraud prevention efforts in FY 2004, as required by RCW 42.22.331. Additionally, a separate report covers activities occurring in the first quarter of 2005, after new anti-fraud legislation and funding took effect.

FY 2004 Return on Investment Schedule

Operating Costs	Assessments	Cost avoidance	Recovery/collections	Return on Inv.
\$10.9 Million	\$13.2 Million	\$4 Million	\$93.8 Million	9 to 1

Operating costs: Includes salaries, benefits, expenses and capital outlays.

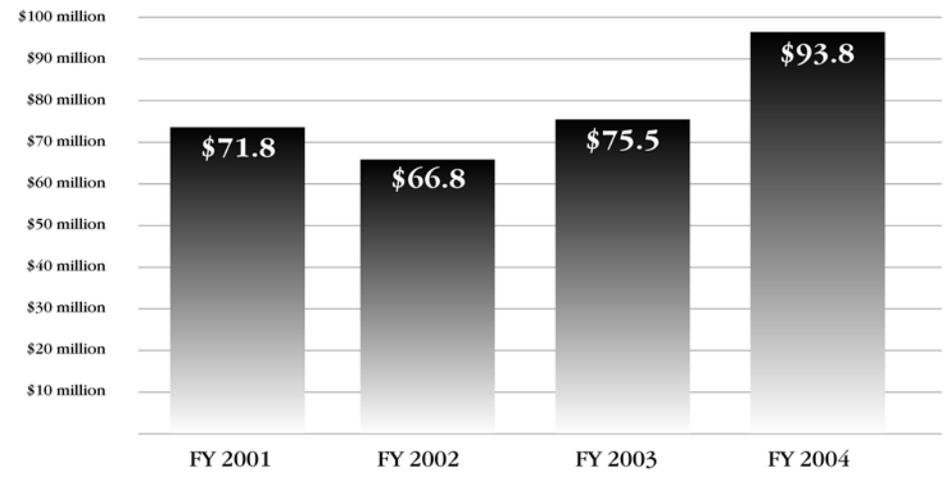
Assessments: Billings for overpayments, improper billings and underreported premiums.

Cost avoidance: Estimates savings from halting improper or illegal provider billings, and the payment of benefits.

Return on investment: A comparison of operating costs to the money that is recovered, collected and avoided during the fiscal year.

Total Collections FY 2001 through FY 2004

(Includes collections of delinquent premiums from employers, and the recovery of improper payments to providers and injured workers)



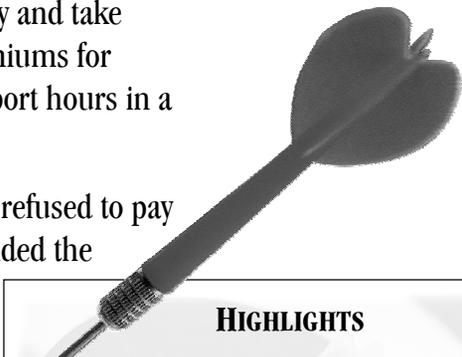
Employer Premium Fraud and Abuse

The financial integrity of the workers' compensation system depends on employers properly reporting hours worked and paying the premiums they owe. Failure to identify and take prompt action against employers who cheat the system results in higher premiums for legitimate employers, and may encourage others to underreport hours, or report hours in a risk class with lower premium rates.

In FY 2004, L&I revoked the certificate of employment of 114 employers who refused to pay the industrial insurance premiums they owed. In addition, the agency suspended the registrations of five construction contractors who owed premiums and failed to enter into, or ignored, payment agreements.

At any given time, there are up to 160,000 State Fund employers. The agency lacks adequate staff to audit all of them, so selecting the right employers and prioritizing audits is crucial to maximizing return on investment. In FY 2004, the agency revamped the employer audit program to more effectively target employers who are most likely to underreport hours worked or report hours in the wrong class. In FY 2004, about 55 percent of the employers audited owed premiums. Through improved targeting, our goal is to increase it to 85 percent by the end of FY 2005.

In FY 2004, the industrial insurance audit program completed 2,822 audits of employers. The table on page 5 demonstrates the agency's effort to verify compliance and identify potential employer fraud and abuse:



HIGHLIGHTS

- ⦿ \$4.5 million collected in previously unreported and unpaid premiums in construction.
- ⦿ Registrations suspended for nonpayment of premiums.
- ⦿ Outreach effort to educate employers on workers' comp.
- ⦿ \$185,000 recovered in three months from data cross-match on public works projects.

***FY 2004 Major Audit Assignment Sources**

Source of referrals/audit assignments	Number of completed assignments	Average premium assessed per assignment	Total assessed (Premiums only)
Computer Targeted Audits	914	\$2,664	\$2,434,554
Underwriter (Acct mgrs)	663	\$3,709	\$2,458,881
Anonymous Public Tips	230	\$3,963	\$911,440
Contractor Registration	184	\$1,622	\$298,426
Revenue Officers	183	\$3,980	\$728,306
Workplace Safety (WISHA)	176	\$1,819	\$320,129
Fraud Line/Internet	157	\$1,863	\$292,463
Other Internal L&I	126	\$1,816	\$228,652
Employment Standards	68	\$3,246	\$220,728
Other External Govt.	43	\$3,142	\$135,114
Firm requested audits	78	N/A	**N/A
Total	2,822	\$2,926	\$8,028,693

*Excludes firm-requested credit audits **Credit audit total refund (\$797,569)

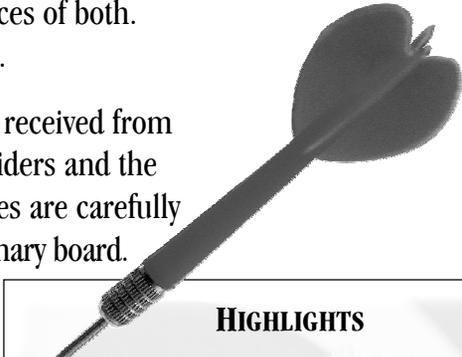
Provider Fraud and Abuse

L&I constantly monitors and reviews the quality of care provided by health-care professionals, the performance of vocational counselors and the billing practices of both. As a result, agency staff identifies the majority of the cases of fraud and abuse.

Provider reviews are generated almost exclusively by referrals and complaints received from internal staff (claim managers, for example), workers, other health-care providers and the public. Investigations and audits that involve integrity and quality-of-care issues are carefully reviewed and coordinated with the Department of Health's professional disciplinary board. Appropriate action is taken based on department findings and disciplinary board actions.

L&I's Provider Fraud Unit is responsible for investigations and referrals that rise to the level of fraud. Where appropriate, investigations and evidence are turned over to local prosecutors. In FY 2004, the unit investigated/ audited 45 new referrals and closed 35 investigations. In one case, L&I investigators worked closely with the U.S. Department of Health and Human Services and the FBI to bring charges against a Seattle therapist who had fraudulently billed the State Fund and the federal government for services that had not been provided.

The provider fraud program identified \$2.3 million in improper billings in FY 2004. If the assessments are upheld, associated penalties would total \$6.9 millions, with claim cost avoidance of about \$704,000 over the next year. Cost avoidance is calculated on a case-by-case basis by reviewing the provider's billing practices and estimating what the expense would be over the next year if the improper billings continued. (See the table on page 7.)



HIGHLIGHTS

- ⊙ Criminal charges filed against a King County physical therapist who overbilled L&I for \$380,000.
- ⊙ Developed improvements in the way we identify poor patient care and conduct peer review of treatment.
- ⊙ An L&I investigation was turned over to the U.S. Attorney, who in August filed charges against a Seattle therapist who overbilled the agency \$400,000.
- ⊙ Worked with the Department of Health to suspend a provider for inadequate care.

In billing cases that did not rise to the level of fraud, providers owe the State Fund about \$1.2 million in receivables as a result of prior-year audits. Although L&I uses collection agencies and other means to recover funds, in the past it has lacked statutory authority to place a lien on a provider's property. That changed in June when ESHB 3188 became law. The statutory authority to place a lien on a provider's property will improve L&I's ability to collect funds it is owed.

FY 2004 Medical and Vocational Provider Investigation/Audits

Type of review	Number reviewed	Assessments	Recoveries
Medical	20	\$1,248,826	\$238,143
Vocational	93	\$80,403	\$57,156
Total	113	\$1,329,229	\$295,299

Medical auditor FTEs during FY 2004 = 1.4 Vocational auditor FTEs during FY 2004 = 3.75

Worker Fraud and Abuse

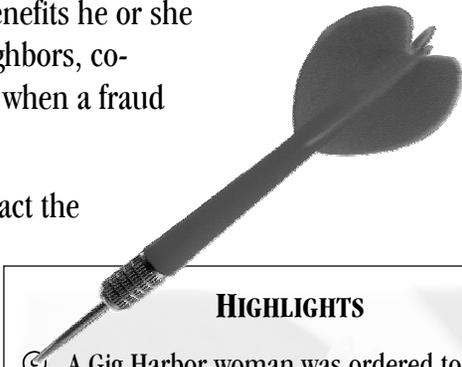
Worker fraud occurs when an employee knowingly applies for and receives benefits he or she is not entitled to. Fraud referrals come from claim managers, employers, neighbors, co-workers and disgruntled spouses. They are investigated and publicized widely when a fraud order is final, when charges are filed and when there is a conviction.

In all claims involving wage-replacement benefits, an attempt is made to contact the employer and ask if the claim is legitimate.

Because workers often don't have the financial resources to repay money that is owed, an emphasis is placed on prevention and the timely closure of claims deemed invalid. Overpayments are assessed against any future payments on any claim.

Our actions include:

- ◉ Conducting validity investigations to assist claims adjudicators in deciding if an injury actually occurred on the job and is allowable. Claims found to be invalid are denied and the cost of the claim ends. In FY 2004, the program conducted 426 validity investigations, up from 314 in 2003.
- ◉ Activity checks to determine whether a claimant's actual activities conform to the reported physical limitations that justify benefits. Investigations can result in earlier claim closure and termination of benefits when claimants are found to be employable. This results in a significant savings to the State Fund. In FY 2004, 2,042 activity checks were conducted, up from 1,772 in 2003.



HIGHLIGHTS

- ◉ A Gig Harbor woman was ordered to repay more than \$46,000 in benefits and penalties after an investigation determined she was collecting workers' compensation benefits while working full time at another job.
- ◉ A Monroe man was ordered to repay more than \$16,000 in benefits and penalties he received while working as a tow-truck driver and auto repairman.
- ◉ Worked with the Federal Office of the Inspector General and other government agencies to convict a Federal Way man of falsifying records to collect workers' compensation and other benefits.

- ⦿ A fraud investigation opens when an activity check reveals that a claimant may be receiving benefits by fraudulent means. Once it is determined that fraud was involved, an administrative fraud order is issued, demanding repayment of benefits plus up to a 50 percent penalty. Criminal charges are sought in the most egregious cases and are pursued through county prosecutors. Because of staff turnover and vacancies in specific areas, only 170 fraud investigations were conducted in 2004. That is down from 221 in FY 2003. The staffing issues have been resolved and a substantial increase in investigations is anticipated in FY 2005.

For both administrative fraud orders and overpayment orders, the department estimates the costs avoided or the amount of benefits that would have been paid had the information not been discovered and the time-loss benefits terminated. The combined overpayments, penalties and cost avoidance for FY 2004 for worker fraud were \$3.3 million. Collections are significantly less because they are impacted by settlement and plea agreements, and by claimants' inability to repay the debt.

FY 2004 Worker Recovery Actions

Action	Number	Dollars assessed	Cost avoidance
Administrative Fraud Orders	94	\$1.4 million	\$2.2 million
Overpayments	6	\$44,000	0
Other Claim Actions Taken	154	NA	\$1.1 million
Total	254	\$1.5 million	\$3.3 million

In FY 2004, the department changed the way it calculates cost avoidance to include cases where an administrative fraud order or order of overpayment were not issued but where an investigations resulted other appropriate actions on the claim. The investigations on these claims saved the State Fund more than \$1.1 million in future benefit payments.

L&I has expanded the number of government agencies it works with to uncover fraud and abuse. Cross-referencing with the departments of Employment Security, Corrections and Social and Health Services, as well as the Social Security Administration, provides L&I with the information it needs to:

- ⦿ Determine if a worker receiving time-loss benefits has gone back to work without notifying L&I.
- ⦿ Discover if someone is receiving benefits in the name of a deceased person.
- ⦿ Identify persons who are receiving time-loss while incarcerated.

The most egregious cases result in criminal prosecution when deemed appropriate by the county prosecuting attorney in the jurisdiction where the fraud occurred. If that county prosecutor does not take the case and L&I determines there is a reasonable chance for conviction, the agency has the option of working through the Thurston County prosecutor.

Next Year

Most of this report focuses on what L&I did in the fiscal year that ended June 30. With the additional legal authority and funding provided by the Legislature, L&I will continue to aggressively pursue fraud and abuse, using tried and true methods, and taking some innovative new approaches to detecting and eliminating fraud. The progress the agency made in the first quarter of FY 2005 is documented in the first of four quarterly reports that will be sent to the Legislature in January 2005.

Looking ahead, in FY 2005 the agency already has or will:

- ◉ Implement and staff the newly created Fraud Prevention and Compliance Program.
- ◉ Develop and implement rules to more effectively prosecute fraud and collect delinquent premiums.
- ◉ Explore the option of expanding data matching to include DSHS's new-hire registry, which that agency uses to track deadbeat dads who owe child support.
- ◉ Continue to reallocate resources and add staff to more effectively detect and pursue fraud and abuse.
- ◉ Step up efforts to educate the public on types of abuses that exist in the workers' compensation system.
- ◉ Work more closely with employers to spot fraudulent claims.
- ◉ Continue to follow up on reports of fraud with an explanation to the complainant of what the investigation found and what action was taken.
- ◉ Continue to prosecute and publicize significant fraud cases.

- Expand the use of technology to detect fraud.
- Improve L&I's web site with additional information on how to report fraud and how a contractor can check the status of an L&I account.
- Evaluate and adopt new technologies to effectively identify fraud, maximizing the agency's resources by targeting workers, employers and providers who are knowingly cheating the system.
- Increase construction-contractor training in trouble areas (such as independent-contractor hiring and prime-contractor liability) to help contractors understand their premium-reporting responsibilities.

Conclusion

New legal authority and additional funding provided by the Legislature in June 2004, plus restructuring of the organization that combats fraud and abuse, have permanently improved L&I's ability to ensure that workplace-injury claims are legitimate, insurance premiums are paid and provider bills are appropriate for the work that was done. Progress throughout FY 2005 will be documented in four quarterly reports to the Legislature. The first report, covering July, August and September — the first three months of the new fiscal year — is being published simultaneous to this one.

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