2007 Annual Fraud Report to the Legislature

Targeting Fraud and Abuse

In Washington State’s Workers’ Compensation System
Executive Summary

The Department of Labor and Industries (L&I) is pleased to submit this 2007 Annual Fraud Report to the Legislature: Targeting Fraud and Abuse in Washington State’s Workers’ Compensation System.

Fiscal Year 2007 (July 1, 2006, through June 30, 2007) saw another year of systematic, innovative and sustained activity to detect and deter fraud and abuse by employers, workers, and providers of health-care and vocational rehabilitation services. Key developments included:

- More contacts with those who owe us money by using automated telephone software.
- Major progress developing a new Field Audit (Employer) computer system.
- Continuing increase in referrals from internal L&I programs. In FY 2007, cross-program referrals accounted for 43 percent of all employer referrals.
- Hiring a dedicated assistant attorney general to support criminal prosecution of fraud cases.

The results of these activities are measurable and substantial.

For example:

- Assessed $19,883,918 through employer audits. Of that total, $6,588,052 was assessed against unregistered employers – companies that hired employees but failed to open a workers’ compensation account.
- Investigations resulted in a total of $4.4 million in avoided costs for both time-loss compensation and medical billing.
- Collected $139.2 million (delinquent employer premiums, audit assessments, overpayments to workers, health-care and vocational providers, and fraud recovery orders), an increase of $3.8 million over FY 2006 and $34.3 million more than in FY 2005.
- Thirteen cases referred for prosecution (6 employers, 4 providers, 3 workers).

In 2007, we continued to extensively use fraud-fighting capabilities authorized by the Legislature in 2004 and 2005, including:

- Seeking premiums from 120 companies that closed, and then reopened under a new name. These actions were made possible by the changes in the law governing successorship.
- Revoking the Certificate of Coverage of 34 employers who refused to enter into or adhere to payment agreements.
- Educating prime contractors about their liability for unpaid workers’ compensation premiums generated by sub-contractors on their contracts.
Keeping the System Healthy

In Washington State, the Department of Labor and Industries (L&I) administers the state-operated workers’ compensation system. This “State Fund” provides workers with wage-replacement and medical benefits to offset the financial impact of a job-related injury or occupational disease. This no-fault insurance protects employers from lawsuits when work-related injuries and diseases occur. Premiums paid by employers and workers, plus investment earnings, finance the State Fund.

- Fraud prevention and detection is important because cheating the workers’ compensation system is NOT a victimless crime.

- All businesses and workers in an industry pay more if some employers in that industry underpay or don’t pay at all.

- Under Washington law, a worker injured on the job is guaranteed workers’ compensation benefits even if his/her employer failed to pay premiums. Other businesses in the same “risk class” pick up the added cost.

- Honest contractors struggle under unfair competition. A construction contractor who underreports employee hours and doesn’t pay the full premiums he or she owes can undercut honest contractors when bidding on a job.

- Workers who scam the system hurt their co-workers as well as their employers. Workers pay about 25 percent of workers’ compensation premiums. Their payroll deduction as well as the rates employers pay go up when some workers collect benefits they are not entitled to receive.

- Providers inflate medical costs if they bill for services they didn’t provide. Inappropriate billings impact costs in two ways: they affect an individual employer’s rates, which the employer and his/her workers pay, and they increase medical costs overall.

Our mission is to prevent abuse of the workers’ compensation system and protect the economic vitality of Washington State. We have heard the concerns of stakeholders who believe more should be done to reduce the effects of fraud, and we have acted on these concerns in our strategic planning and budgeting processes. The following pages describe our fraud-fighting resources and results.
2007 Annual Fraud Report to the Legislature

Key Developments in FY 2007

Background

In 2004, the Department of Labor and Industries (L&I) established its Fraud Prevention and Compliance Program, bringing together several separate programs, including Audit, Investigations and Collections, to coordinate fraud-fighting efforts.

The new program built on past results. It also strengthened our ability to find and stop fraud by workers, employers and health-care providers. Major changes in FY 2004 and 2005 included:

- Legislation on prime contractor liability, successorship, corporate officer liability, and provider collection authority that significantly improved our ability to go after individuals or companies that owed L&I money.
- Significantly increased staffing.
- Technology improvements.

Key developments from July 1, 2006, through June 30, 2007 (FY 2007)

- Predictive dialer system. This automated telephone software allows us to make early telephone contact with those who owe us money. We use it to educate employers about their industrial insurance reporting requirements as well as to collect accounts receivable. When the system dials someone who answers the phone, the call is transferred to an L&I staff person for action. If the system reaches a messaging system, it leaves a message requesting a return call.

This software increases efficiency and call volume. The result is we collect more money faster.

During FY 2007 the department improved the predictive dialer process and collected an average of $2.9 million per month. (L&I received an additional benefit from this investment by expanding its use beyond collections. For example, the software was used to conduct a prevailing wage survey.)

- Funding for technology. In March 2006, the Legislature authorized funding to replace the inadequate computer system used for employer audits. The new Field Audit Computer Technology (FACT) system and Referral Tracking System (RTS) were implemented in late spring 2007. By streamlining data entry and simplifying retrieval of information, the new system will allow us to do more audits and collect more money. The FACT system will also support alternative auditing methods that are less time-consuming and, therefore, less costly for the employers we audit.

- Innovative audit approaches. During FY 2007 the department completed 810 streamlined employer audits resulting in over $2 million in assessments. Four FTEs were added to the central office Field Audit Unit to perform alternative audits, also referred to as mail-in desk audits, where field assignments are not cost-effective. (We began using the streamlined mail-in audit process in late FY 2006 to save time for employers involved in single-issue or limited-scope audits.)

- Hired a dedicated assistant attorney general (AAG). This position supports local prosecutors or acts as co-counsel on workers’ comp cases involving criminal fraud. When local prosecutors already have their hands full, the dedicated AAG may prosecute criminal cases through the Attorney General’s Office. As a result of this AAG’s work, in FY 2007 a Jefferson County construction contractor was charged with misrepresenting his payroll and operating with a revoked certificate of coverage. He pled guilty to a class “C” felony and was ordered to pay restitution of $100,000.
Investigations, both to confirm entitlements to benefits and identify improper payments to workers. Although 2007 did not produce the major-dollar cases seen in 2006, investigations increased in efficiency, completing 8 percent more investigations than in FY 2006, and in the same period, issuing 199 administrative fraud orders — more than ever before. These orders resulted in over $2 million assessed and over $4.4 million more in avoided costs.

Cross-agency collaboration. We work with other government agencies to uncover fraud and abuse. For instance, in FY 2007 an Employment Security comparison with L&I’s employer reporting resulted in an L&I audit assessment of $718,316, while a Department of Revenue comparison produced an L&I audit assessment of $7,198. This cross-agency collaboration is also productive on worker-related cases. After L&I and Employment Security compared worker-related data on over 3,000 claims, we referred 100 of the claims to our investigators and 19 to claim managers. Fraud orders were issued against an Everett worker for $10,600 and against a Tacoma worker for $2,300 for collecting workers’ compensation wage-replacement benefits while working at other jobs.

Cross-program coordination. As an agency, we are committed to combating fraud and abuse and we have communicated this priority across our 20+ programs. We’ve taken steps to improve coordination across program areas, which led to more and better fraud referrals. In FY 2007, 43 percent of our referrals came from other L&I programs.

Return on investment compares the operating costs of the Fraud Prevention and Compliance Program to the money that is recovered, collected and avoided during the fiscal year.

L&I is bringing in about $10 for every dollar invested and expects that rate of return to continue.

In FY 2007 L&I’s return on investment declined slightly compared to FY 2006. This reflects a shift in staffing resources: significant staffing was required to test and train on new technology and to train new employees hired in response to turnover. Staff completed more investigations in 2007 than in the previous year, but cases were smaller.

The pattern will be similar for FY 2008, especially early in the year. With staffing used to create improvements, fewer audits are completed and fewer dollars collected.

Operating costs include full-time equivalent (FTE) positions, benefits and capital outlays. For FY 2007 the FTEs were 250. This Figure includes the Fraud Prevention and Compliance staff — Detection and Tracking Unit, Field (Employer) Audit, Investigations, Collections, Provider Fraud, Significant Cases, Firm Appeals and Program administration — and Provider Review and Vocational Program Audit sections in the Insurance Services Division.

Return on Investment Ratios

<table>
<thead>
<tr>
<th>Year</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2004</td>
<td>9 to 1</td>
</tr>
<tr>
<td>FY 2005</td>
<td>8.2 to 1</td>
</tr>
<tr>
<td>FY 2006</td>
<td>10.2 to 1</td>
</tr>
<tr>
<td>FY 2007</td>
<td>9.8 to 1</td>
</tr>
</tbody>
</table>

1 The figure of 250 full-time-equivalent positions includes the program manager and an administrative assistant, positions the report does not refer to elsewhere.
Fraud-fighting Resources at Work

Most injured workers, employers and health-care professionals don’t misuse the workers’ compensation system. But some act unethically or illegally for financial gain.

Employer fraud and abuse occurs when employers underreport hours, or report hours in an improper risk class with lower premium rates, or don’t register or pay at all.

Workers who knowingly apply for and/or receive benefits they are not entitled to receive are committing fraud. This includes filing a claim when no work-related injury occurred, participating in activities that are inconsistent with the alleged injury, or working for one employer while receiving workers’ compensation benefits from another.

Health-care and vocational-services providers commit fraud and abuse when they provide inappropriate, costly and sometimes harmful treatments to injured workers, bill for more expensive services than actually provided, or bill for treatment they did not provide.

The Department of Labor and Industries directs fraud-fighting resources to all of these areas.

Detection and Tracking Unit

Purpose: Prevent and detect fraud.
Staffing: 10 FTE

The Detection and Tracking Unit (DTU) uses a variety of tools including technology, cross-agency data sharing and referral screening techniques to identify non-compliance and potentially fraudulent activities. This unit also:

- Identifies the valid prospects in the referrals received and sends them to appropriate sections or units, such as Field Audit, Investigations or Provider Fraud for action.
- Reviews up to 2,000 claims a month (online and paper reports) from cross-matched reports that identify potential fraudulent claims.
- Tracks referral results to identify opportunities for process improvements and provide information for decision-making.
- Operates the fraud telephone hotline and web site (1-888-811-5974 or www.fraud.Lni.wa.gov).
The DTU also manages the **Verify Workers’ Comp Premium Status** online search (https://fortress.wa.gov/lni/crpsi/). The system allows users to find out if a particular business has an active workers’ compensation account and determine whether they are in good standing on their premium payments. Users can sign up to be notified if a business falls out of compliance.

The DTU staff also participates in outreach and education activities to build public awareness of our fraud-fighting activities and conducts training workshops covering prime contractor liability and how to determine whether a subcontractor is an independent contractor or a worker. In FY 2007, the DTU presented 16 workshops to over 300 attendees.

**Compliance Team.** Called the FAIR team, for Fraud, Audit, Infraction, and Revenue, the Compliance Team canvasses the state for contractors and electricians who are ignoring registration and licensing laws and gaining an unfair competitive advantage. In addition to regular inspections, this three-person team works nights and weekends. Originally funded temporarily in 2006, the compliance team was made permanent this year.

As they focused on the underground economy, the FAIR team found 107 unlicensed contractors and made 128 referrals to revenue agents that resulted in over $1 million being collected. The team also uncovers employers that are misreporting: this year the team referred 350 employers to the employer audit program, resulting in over $1 million in assessments and $267,000 collected so far. Much of their effectiveness is due to close cooperation with other L&I programs.

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**Fast Fact!**

The **Verify Workers’ Comp Premium Status** online search has 49,894 registered users since 2004. Current tracking requests average 125 per day.
Employer Audit

**Purpose:** Identify unpaid employer premiums.

**Staffing:** 71 FTE

State Fund employers use quarterly reports to calculate and report the premiums they owe. Their “risk classifications” are based on the type of work performed by their employees and their claims experience. Both factors influence the premiums they pay.

We audit employers’ business records to make sure employers report accurately and pay the premiums they owe. The audit function is a primary tool for determining where abusive or fraudulent behavior is taking place.

Process changes and increased staffing have improved our audits, including our ability to target firms that are reporting incorrectly. As a result, we have increased both the number of audits and dollars assessed over the last two years. In 2004, 50 percent of the firms that we audited resulted in debit audits. That audit percentage has risen steadily to 66 percent during the last six months of FY 2007.

In 2007, as part of L&I’s increasing emphasis on the underground economy, we completed 826 audits of unregistered businesses — a nearly 35 percent increase over 2006.

Our focus now and in the next biennium is to continue to increase both the number and the effectiveness of the audits we perform. To do this, we have developed the Field Audit Computer Technology (FACT) system and the Referral Tracking System (RTS) which were implemented in late spring 2007.

With future funding, we plan to further upgrade and streamline the auditing system, fully replacing antiquated technology. These changes will allow us to focus audit resources on employers and industries where misreporting is most severe. We also plan to expand mail-in and phone-in audits, a cost-effective strategy that allows us to interact with more employers using existing staff. Mail-in and phone-in audits are also a convenience to employers.

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**FY 2007 Audit Results**

<table>
<thead>
<tr>
<th>Audits: Registered Businesses</th>
<th>Assessments</th>
<th>Audits: Unregistered Businesses*</th>
<th>Assessments</th>
<th>Total Audits</th>
<th>Total Assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3,915</td>
<td>$13,299,781</td>
<td>826</td>
<td>$6,588,052</td>
<td>4,741</td>
<td>$19,883,918</td>
</tr>
</tbody>
</table>

* An unregistered business is one that hires employees but fails to open a workers’ compensation account.

**Fast Fact!**

Audits benefit all employers by helping to ensure that they pay only their fair share of costs.
In FY 2007 the total dollars assessed through employer audits declined slightly compared to FY 2006. Through improved targeting, staff increased the number of total audits and the average dollars assessed per audit. However, there were fewer major-dollar cases in 2006 compared to the previous year.

Case in Point

In FY 2007, audits of out-of-state firms operating in Washington State resulted in collections of $79,000 from a Michigan firm and $40,000 from a Memphis firm, among others.
Investigations

Purpose: Stop improper workers’ compensation payments to workers.

Staffing: 60 FTE

Our Investigations section conducts a variety of investigations both to identify entitlements to benefits and to identify improper payments to workers. Detection of abusive or fraudulent claims starts with tips from the public and employers, internal staff such as claim managers, and computer cross-matches. When warranted, investigations can lead to both civil and criminal fraud action. The most common investigations are:

- **Validity investigations.** Investigators assist claim managers in deciding whether the injury or disease was work-related and whether the claim should be allowed or denied. Claims found to be invalid are denied.

- **Activity investigations.** Investigators conduct “activity checks” to determine whether claimants’ activities conform to the reported physical limitations that justified benefits. Investigations can result in claims closing earlier when the claimants are found to be employable. Collection activity may occur to recoup inappropriately paid benefits.

In FY 2007, compared with the previous two years, L&I’s assessments were reduced as well as costs avoided as a result of investigations. Staff investigated more cases and issued more fraud orders than in the previous two years. However the frauds involved fewer dollars.

In 2006, cost avoidance was particularly high due to a few large pension cases, an infrequent occurrence.

In FY 2007, compared with the previous two years, L&I’s assessments were reduced as well as costs avoided as a result of investigations. Staff investigated more cases and issued more fraud orders than in the previous two years. However the frauds involved fewer dollars.

In 2006, cost avoidance was particularly high due to a few large pension cases, an infrequent occurrence.

These activity checks result in significant savings to the workers’ compensation system. Using a standardized method to determine avoided costs, we estimate how much would have been spent on a claim if benefits had not stopped as a result of the investigation.
- **Fraud investigations.** When an activity check reveals that a claimant may be receiving benefits fraudulently, we open a fraud investigation. If we determine that fraud was involved, we issue an administrative fraud order (AFO) demanding repayment of benefits plus penalties of 50 percent of the overpayment. These investigations can take several months or longer to complete, depending on the complexity of the case.

- **Out-of-state investigations.** We conduct these investigations if potential fraud involves a person receiving workers’ comp benefits who doesn’t reside in this state. Out-of-state efforts in FY2007 produced 397 completed investigations and administrative fraud order assessments totaling $327,668.

- **Other investigations.** Investigators conduct other preliminary inquiries or checks that may lead to a full fraud investigation. For example, we check on persons drawing benefits who may be ineligible if they are incarcerated. Our Pension section may want us to verify that surviving spouses of deceased pensioners are still eligible for benefits and haven’t remarried. We investigate cases involving persons who are seeking drugs by presenting themselves as injured workers when they are not.

Miscellaneous investigations also involve requests for assistance from other agencies, business records checks and obtaining documentation, and service notification when claims have been stopped.

![FY 2007 Investigations Conducted, by Type](image)

![Case in Point](image)

An anonymous tip and follow-up investigation confirmed that an Okanogan woman had collected survivor benefits illegally. Three months after she certified that she was unmarried and would not remarry, she married. In each of the following years she certified that she was still unmarried and eligible for survivor benefits. She has been ordered to repay $78,000 in benefits and $39,000 in penalties.

![Investigations Completed All Types](image)

**Fast Fact!**

As a result of investigations in FY 2007, L&I issued 199 orders totaling $2,031,984.
Provider Fraud and Abuse

**Purpose:** Ensure quality services to injured workers and stop improper payments to providers.

**Staffing:** 17 FTE*

Labor and Industries paid out more than $537 million for health-care and vocational services in FY 2007. We constantly monitor and review the quality of care health-care professionals provide to injured workers, the performance of vocational counselors and the billing practices of both. We also receive information from other providers and the public.

The **Health-care Review Unit** performs billing audits and quality-of-care reviews of health-care providers. The **Vocational Audit Unit** carries out the same responsibilities for vocational-services providers. Both units reside in L&I’s Insurance Services Division, but are part of L&I’s Fraud and Abuse Prevention program. Statistics shown below represent a 68 percent increase in assessments over the previous year.

The **Provider Fraud Unit** in the Fraud Prevention and Compliance Program audits and investigates health-care and vocational providers suspected of criminal fraud.

During Fiscal Year 2007 this unit identified over $2.9 million in improper billings, penalties and cost avoidance and referred four cases for criminal prosecution.

### FY 2007 Provider Review Results

<table>
<thead>
<tr>
<th>Type of Reviews</th>
<th>Number</th>
<th>Assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health-care</td>
<td>72</td>
<td>$983,476</td>
</tr>
<tr>
<td>Vocational</td>
<td>120</td>
<td>$103,557</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>192</td>
<td><strong>$1,087,033</strong></td>
</tr>
</tbody>
</table>

### FY 2007 Provider Fraud Results

<table>
<thead>
<tr>
<th>Investigations Conducted</th>
<th>Questionable Billings</th>
<th>Penalties</th>
<th>Costs Avoided</th>
</tr>
</thead>
<tbody>
<tr>
<td>65</td>
<td>$1,214,050</td>
<td>$1,166,993</td>
<td>$504,500</td>
</tr>
</tbody>
</table>

* Staffing
  Health-care Reviews: 6 FTE
  Vocational Audits: 5 FTE
  Provider Fraud: 6 FTE
Collections

Purpose: Collect monies that employers, workers and providers owe the workers’ compensation system.

Staffing: 81 FTE

Monies owed to L&I include delinquent employer premiums; audit assessments; overpayments to workers, and health-care and vocational providers; fraud recovery orders; safety citation penalties; contractor infraction penalties; and other penalties and fees. In this report, we focus on collections pertaining to workers’ compensation.

We have the legal authority to assess penalties and interest and to recover monies through civil action. For example, we can file a tax warrant in the appropriate superior court and take collection actions such as seizing bank accounts, garnishing wages and seizing property. In addition, we may pass the debt of unpaid premiums for work performed by contract to the person, firm or corporation letting the contract.

Since the Fraud Prevention and Compliance program was created in 2004, collections have risen steadily to $139.2 million, an increase of 48 percent over the four-year period. In FY 2007 we continued to refine and improve our processes, implementing efficiencies where possible.
## Dollars Collected

<table>
<thead>
<tr>
<th>Action</th>
<th>What It Means</th>
<th>Amount Collected in FY 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer</td>
<td>Revenue officers take action to collect unpaid premiums from employers, including delinquent amounts from misrepresentation of payrolls, successorship issues, corporate officer liability, revocations of certificate coverage and prime contractor liability.</td>
<td>$133,852,123</td>
</tr>
<tr>
<td><strong>Health-care and Vocational Providers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overpayments collected (fraud and other overpayments)</td>
<td>Provider reviews identify and recover monies paid through inappropriate billings.</td>
<td>$523,989</td>
</tr>
<tr>
<td><strong>Injured Workers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overpayments collected (fraud and other overpayments)</td>
<td>Revenue Officers take collection action to recover monies from injured workers who were overpaid and no longer entitled to benefits.</td>
<td>$4,837,843</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$139,213,955</strong></td>
</tr>
</tbody>
</table>

## Other Results

<table>
<thead>
<tr>
<th>Action</th>
<th>What It Means</th>
<th>Number of Actions Taken</th>
</tr>
</thead>
</table>
| Contractor registrations suspended          | A contractor’s registration can be suspended for failing to pay workers’ compensation premiums. Contractors who continue to work after being suspended are subject to fines under contractor registration laws. Anyone who hires an unregistered contractor can be held responsible for their unpaid workers’ compensation premiums.  

In FY 2007 L&I suspended 73 more registrations than in FY 2006, a 64% increase. Much of this effort came from a task force working to combat the underground economy: the task force issued 107 of these suspensions. | 186 registrations suspended |
| Revocations                                 | If efforts to bring an employer into compliance fail, L&I may revoke that employer’s Certificate of Coverage. It is a Class C felony to hire employees without that certificate. |
|                                             |                                                                                                                                             | 34 Certificates of Coverage revoked |
Significant Employer Cases

**Purpose:** Take action to stop blatant disregard of the law.

**Staffing:** 2 FTE *

The Significant Employer Cases (SEC) manager coordinates action on the most egregious cases of employer misconduct statewide and makes them a high priority for successful resolution. The SEC manager works on the cases with the new assistant attorney general dedicated to fraud cases, with a focus on criminal prosecution.

The SEC manager and the assistant attorney general work closely with local prosecutors on felony cases. When the local prosecutor does not have the time to focus on workers’ comp cases, our attorney may prosecute the case. In many instances, significant employer cases involve years of investigation, coordination, and preparation for prosecution. Having the new dedicated assistant attorney general can shorten the time frame for major cases, by deciding when it’s appropriate to seek search warrants and pursue prosecution and by coordinating the prosecutions. During 2007, the assistant attorney filed three criminal cases from the SEC list, and also coordinated the filing of one additional criminal SEC case.

* Staffing will increase to 6 FTE in FY 2008. A temporary enforcement team focusing on select industries in FY 2007 has been made permanent.

**FY 2007 Cases Referred for Prosecution**

<table>
<thead>
<tr>
<th>Type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer</td>
<td>6</td>
</tr>
<tr>
<td>Provider</td>
<td>4</td>
</tr>
<tr>
<td>Worker</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
</tr>
</tbody>
</table>

**Case in Point**

In Poulsbo the owner of a construction company was charged with engaging in business without a certificate of coverage. In March, he pled guilty to a Class C felony for failure to register and agreed to pay restitution in the amount of $100,000 to L&I.

**Criminal Prosecutions:**

Deter future fraud by seeking criminal prosecutions.

A key element in preventing workers’ compensation fraud is raising awareness of the consequences. For its deterrent effect, L&I publicizes successful prosecutions by sending news releases to newspapers, radio and television stations, and business/trade and labor publications; posting information on the agency’s web site; and referencing criminal cases in speeches and community presentations.

In early FY 2007 the Attorney General’s Office assigned a dedicated attorney to our fraud cases. The attorney worked with local prosecutors to pave the way for their future prosecutions of our cases.
Progress from FY 2006

In the 2006 Annual Fraud Report to the Legislature, we identified several specific objectives for Fiscal Year 2006.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete development of the new Field Audit Computer Technology (FACT) system by June 30, 2007.</td>
<td>✔️ Initial development complete; enhancements ongoing.</td>
</tr>
<tr>
<td>Develop and present training to audit staff at L&amp;I and the departments of Revenue and Employment Security on how to make good audit referrals to other agencies.</td>
<td>✔️ Complete</td>
</tr>
<tr>
<td>Set up more contracts for out-of-state audits. By contracting to obtain audits of out-of-state firms that cannot make their records available to us in Washington State, we can increase the number of out-of-state firms we audit without reducing the number of audits performed in state.</td>
<td>✔️ On hold while staff are needed to implement new audit system (FACT).</td>
</tr>
<tr>
<td>Compare employer data with the Internal Revenue Service to identify where reporting discrepancies may exist.</td>
<td>✔️ Ongoing</td>
</tr>
<tr>
<td>Use the national child support “new hire” register to detect injured workers who have returned to work outside of the state. We currently check the in-state new hire registry.</td>
<td>✔️ In progress: need change in federal law to obtain out-of-state data.</td>
</tr>
<tr>
<td>Contract with an outside billing firm to conduct specialized audits of providers.</td>
<td>✔️ Ongoing. Contracted firm is conducting audits.</td>
</tr>
<tr>
<td>Conduct a feasibility study to determine whether software that detects provider fraud and abuse may be beneficial.</td>
<td>✔️ Complete</td>
</tr>
<tr>
<td>Continue process improvements to increase the quality and timeliness of investigations into potential workers’ compensation fraud and abuse.</td>
<td>✔️ Ongoing</td>
</tr>
</tbody>
</table>
Next Year

The Department of Labor and Industries will continue to aggressively pursue fraud and abuse in the workers’ compensation system.

Looking ahead, in FY 2008, the agency already has or will employ the following strategies.

Worker-related strategies

- Continue process improvements to increase the quality and timeliness of investigations into potential workers’ compensation fraud and abuse.
- Investigate possible cases of claim suppression using two new FTE in the Industrial Insurance Discrimination unit.
- Complete a feasibility study regarding a computer system for worker fraud investigators to increase efficiency and provide remote data access.

Employer-related strategies

- Perfect our use of the new Field Audit Computer Technology (FACT) system and Referral Tracking System (RTS) to identify more cases of employer fraud and abuse.
- A temporary enforcement team that focused on select industries in FY 2007 has now been made permanent. The team is now part of the Significant Employer Cases Unit’s efforts to focus on hot spots of non-compliance.
- Compare additional employer data with the Internal Revenue Service to identify reporting discrepancies.
- Expand our alternative audit unit to increase mail-in and phone-in audits.
- Participate in a joint legislative task force looking at the underground economy in construction.
- Complete a joint study with Department of Revenue and Employment Security Department on the impact of the underground economy in Washington on state revenue.
- Conduct a feasibility study reviewing employer fraud software and prepare a budget package to implement in the 09–11 biennium.

Provider-related strategies

- Implement software for reviewing provider billings, based on 2007 feasibility study.
How to Report Fraud

The people of Washington State can help stop workers’ comp fraud by reporting situations that may be fraudulent and letting others know how to report. These leads will help the Department of Labor and Industries track down and stop workers’ comp fraud.

- Fraud reporting hotline at 1-888-811-5974.
- Fraud reporting web site: www.Fraud.LNI.wa.gov.

Employers can help detect workers’ comp and unemployment insurance fraud by reporting newly hired workers at www.dshs.wa.gov/newhire/.

For more information about this report, please contact:

- Carl Hammersburg, Manager, Fraud Prevention and Compliance Program, 360-902-5933 or hamic235@LNI.wa.gov
- Barbara Davis, L&I Communication Services 360-902-4216 or daba235@lni.wa.gov
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