



Fraud Prevention and Compliance

First Quarter, Fiscal Year 2010

Workers' Compensation Fraud Report

Statistics at a Glance

Number of cases referred to prosecution	6
Number of Administrative (civil) Fraud Orders Issued	17
Number of Employer Audits completed	1,544
All Dollars Collected and Avoided	\$ 37,777,495

Prevention Highlights

Key Components of Fraud Prevention and Compliance Program:

- Creating an informed public that helps identify noncompliant employers.
- Helping those who use the workers' compensation system to follow the law.
- Building public awareness of compliance actions taken.

Outreach Opportunities in the 1st Quarter

In the 1st quarter of FY 2010, Fraud Prevention employees spoke at the Contractor Training days, the AGC, Society of Enrolled Agents, Self Insured Employers, TPA's, farm worker camps in Yakima, Pasco, Parker, and Bickelton, Realtors Consumer and Business Affairs Committee and with Legislative staff members and the Underground Economy Task Force.

Contract Retainage Release

The agency obtained authority to collect unpaid premiums from retainage held on public works contracts in recent legislation. The Detection and Tracking Unit began a review process for contracts completed after September 30, 2009. Legislature approved two new Auditors to review the requests for retainage release submitted by public entities. We are comparing information from affidavits and quarterly reports to spot reporting errors and outstanding premium debt. We are also speaking with contractors to resolve problems and referring contractors to field audit and collections when necessary. Already, several instances have shown incorrect reporting and illustrate the potential to promote compliance with this new tool.

Compliance Highlights

This quarter the Detection and Tracking unit received 2,611 referrals resulting in 1,939 referrals to Employer Audit, Claims Investigations and other areas within the agency.

Injured Worker

A 41 year old Puyallup man who reopened a minor back injury claim due to a worsening without a new injury was issued a willful misrepresentation order for more than \$548,000.00. Five investigations found that he was able to mountain climb, go four wheeling and hang-gliding, but according to his physicians, he was unable to return to work as a carpenter. However, the last investigation revealed that he willfully withheld the fact that prior to his reopening, he suffered a severe fall while working at self-employment with no insurance and no L&I coverage which was determined by expert medical evidence to be the cause of his worsening back condition.

The four back surgeries, years of vocational services, medical treatment, time-loss benefits and the entire reopening were denied under the willful misrepresentation order. Criminal charges are pending and an investigation is ongoing into whether the attending physician was involved in this deception.

Employer

The Bankruptcy unit was able to collect over \$800K with just one single payment. This particular firm is a large corporation from Georgia that provides plant maintenance for nuclear power plants across the U.S. The firm came to the bankruptcy unit with a history of late filing and late paying.

After many attempts, the Revenue Agent (Brenda Cothary) was finally able to contact the individual responsible for tax reporting. She obtained the reports and payments to bring the account into compliance and provided them with information about electronic filing. Once they were able to successfully sign up for electronic reporting they paid the account in full. The firm has been keeping their account in good standing which helped them from facing dismissal for non compliance and are still actively in Bankruptcy proceedings.

Provider

Administrative fraud action was taken against an Idaho Hearing Aid Fitter and Dispenser. The provider received fraudulent payments for hearing aids and related services by falsifying invoices, billing the department for payments not covered by the department, and for failing to refund money to the department for hearing aids that were returned. The provider was assessed \$39,000.00; \$19,000 for the department's loss and \$20,000.00 in penalties. Per the order of agreement the provider surrendered his provider number and ability to provide services to injured workers.

Program Administration

L&I spent \$4,471,431 on salaries, benefits, and other expenses for the Fraud Prevention and Compliance program. L&I recovered \$ 34,636,395 in delinquent premiums from employers and improper payments to providers and workers. Also, estimated avoided costs totaled \$1,343,728 (improper future benefits stopped by investigations).

Results: 8.0 to 1 return on investment – a cost of .12 cents for each dollar collected.

More Fraud Prevention Figures

These represent dollars collected from fraudulent activity due to misrepresentation, overpayments to workers, providers, and employers owing delinquent premiums.

Worker

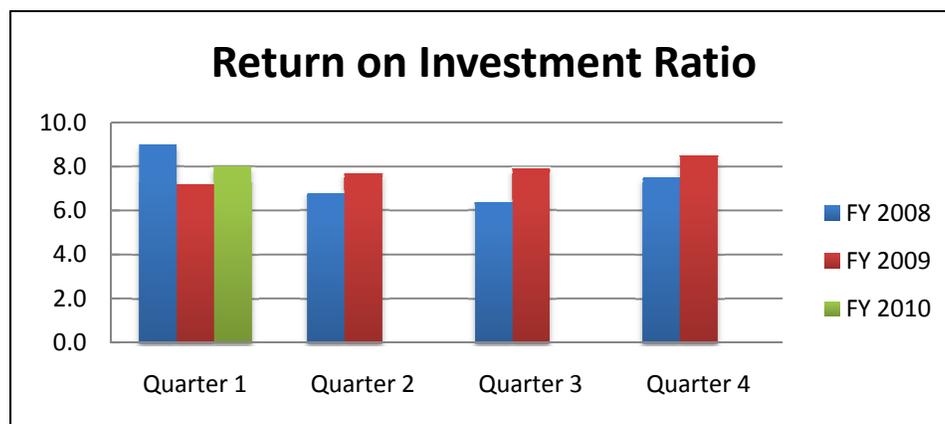
Assessments	\$ 877,002
Cost avoidance	\$ 1,307,522

Employer

Assessments	\$ 7,858,950
Collections	\$ 32,838,056

Provider

Cost avoidance	\$ 36,206
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Need more information?

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