

2005 Annual Fraud Report to the Legislature

# Targeting Fraud and Abuse

In Washington State's Workers' Compensation Program



## 2005 Annual Fraud Report to the Legislature

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## Executive Summary

Fiscal Year (FY) 2005 was the first year for the realigned Fraud Prevention and Compliance Program at the Department of Labor and Industries (L&I). The program is designed to emphasize fraud and abuse prevention, and support stability in the workers' compensation system that covers 2.3 million workers and 161,000 employers. During this fiscal year, the department reported quarterly on prevention and compliance efforts. These reports are available online at [www.Fraud.LNI.wa.gov](http://www.Fraud.LNI.wa.gov).

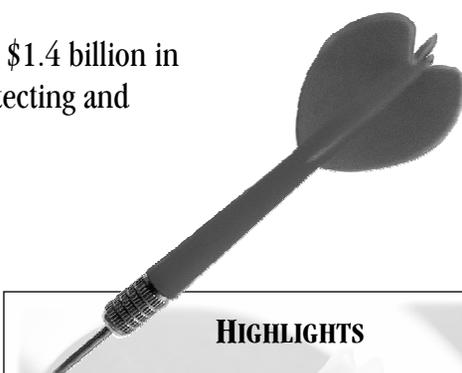
In a workers' compensation system that collects premiums and pays out over \$1.4 billion in injured-worker benefits, the potential for fraud and abuse certainly exists. Detecting and preventing fraud is essential to maintaining the system's financial integrity.

In FY 2005, L&I:

- ◉ Implemented provisions of ESHB 3188, *Concerning liability to the department of labor and industries for premiums, overpayments, and penalties*, which the Legislature passed in 2004.

For example, L&I designed and implemented Internet access for contractors to easily determine the premium status of their subcontractors. The department also conducted outreach workshops to educate contractors on their premium liability.

- ◉ Made it easier for the public to report fraud online. The links on L&I's web site are easier to find and the online reporting forms are shorter and easier to use. A toll-free telephone line continues to be available to report fraud.



**HIGHLIGHTS**

- ◉ Collections on delinquent premium accounts and overpayments continued to rise, topping \$104.9 million in FY 2005, up 12 percent.
- ◉ L&I spent \$13.6 million on fraud prevention and compliance in FY 2005. Collections and cost avoidance totaled close to \$112 million.
- ◉ The return on investment for this fiscal year remained stable during a period of major changes.

- Purchased and prepared to launch new fraud detection software that screens claims based on numerous criteria, looking for irregularities that should prompt additional action by the claim manager or trigger an investigation.

The agency's approach 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 2005, L&I used a number of strategies to find and stop fraud and abuse:

- Conducted 670 validity checks to ensure that workplace-injury claims are legitimate. That is up from 426 in FY 2004.
- Suspended the registration and/or Certificate of Coverage of employers who owed premiums and refused to enter into, or ignored, payment agreements.
- Continued to work closely with other government agencies to detect fraud.
- Referred 23 investigations to county prosecutors for criminal charges, an increase of 8 over 2004.

This report summarizes L&I's workers' compensation fraud prevention efforts in FY 2005, as required by RCW 43.22.331.

### FY 2005 Return on Investment Schedule

Operating costs	Audit assessments	Cost avoidance	Recovery/collections	ROI
\$13.6 Million	\$16.3 Million	\$7 Million	\$104.9 Million	8.2 to 1

**Operating costs:** Includes salaries, benefits, expenses and capital outlays of the Fraud Prevention and Compliance Program.

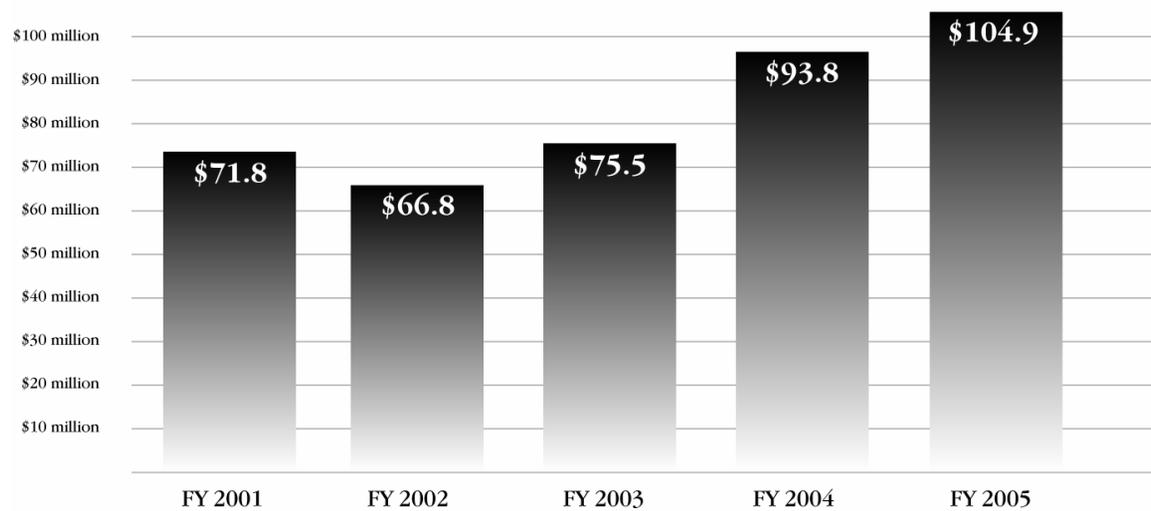
**Audit assessments:** Billings for overpayments to injured workers and/or medical providers, improper billings and underreported premiums.

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

**ROI (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 2005

Includes collections of delinquent premiums, penalties and interest from employers, civil assessments for fraud, assessments for criminal fraud, and the recovery of improper payments to providers and injured workers



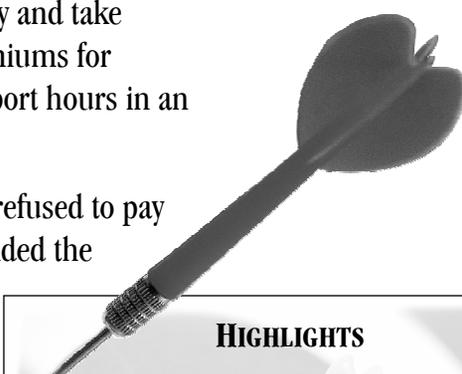
## Employer Premium Fraud and Abuse

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 an improper risk class with lower premium rates.

In FY 2005, L&I revoked the Certificate of Employment of 31 employers who refused to pay the industrial insurance premiums they owed. In addition, the agency suspended the registrations of 65 construction contractors who owed premiums and failed to enter into or ignored payment agreements.

The workers' compensation system covers about 161,000 employers. L&I 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 2005, 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 2005, the audit program completed 3,827 audits of employers, up 36 percent from 2004. The table on page 5 demonstrates the agency's effort to verify compliance and identify potential employer fraud and abuse.



### HIGHLIGHTS

- ⦿ Conducted 3,827 audits of employer accounts, a 36 percent increase over the previous year, resulting in audit assessments of over \$13 million, more than a 60 percent increase over FY 2004.
- ⦿ Revoked the Certificate of Coverage of 31 employers and suspended 65 construction contractors who refused to pay the premiums they owe.
- ⦿ Identified and collected over \$109,000 from an unregistered siding contractor.

### FY 2005 Major Referral Sources for Audit Assessment

<b>Source of referrals/audit assignments</b>	<b>Completed assignments</b>	<b>Average premium assessed per assignment</b>	<b>Total assessed (Premiums only)</b>
Employment Standards	111	\$5,531	\$613,908
Underwriter (account managers)	608	\$5,408	\$3,287,924
Revenue officers	245	\$4,356	\$1,067,290
Selection by L&I's auditors	1,191	\$4,182	\$4,980,700
Other L&I programs	231	\$3,710	\$857,023
Other government agencies	38	\$2,855	\$108,484
Workplace safety (WISHA*)	250	\$2,756	\$689,032
Fraud telephone line/Internet	19	\$2,478	\$47,089
Anonymous public tips	284	\$2,146	\$609,462
Contractor registration	229	\$1,879	\$430,272
Other organizations	26	\$1,622	\$42,167
Computer-targeted audits	215	\$1,558	\$334,970
Fraud detection/tracking program	255	\$1,539	\$392,489

\*WISHA (Washington Industrial Safety and Health Act) is Washington State's workplace safety and health program administered by L&I.

## Provider Fraud and Abuse

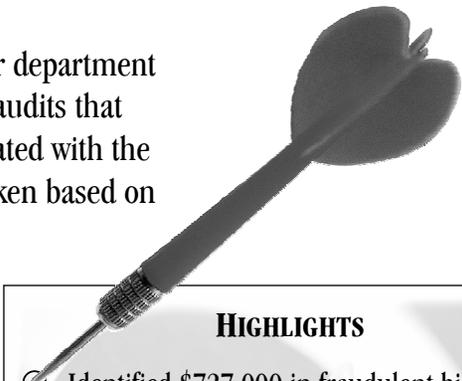
L&I constantly monitors and reviews the quality of care provided by health-care professionals, the performance of vocational counselors and the billing practices of both. As a result, agency staff identifies the majority of the cases of fraud and abuse.

L&I's **Provider Review Section** receives referrals and complaints from other department staff, 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.

### FY 2005 Civil Investigations and Audits of Medical & Vocational Providers

Type of review	Number reviewed	Assessments	Recoveries
Medical	152	\$525,910	\$111,774
Vocational	49	\$62,453	\$51,276
Total	201	\$588,363	\$163,050

In L&I's **Provider Fraud Unit**, staff conducts investigations and audits of providers who are suspected of having committed fraud. When appropriate, L&I turns over investigations and evidence to county or federal prosecutors. Program staff works with local, state and federal agencies, and often collaborates on investigations that involve multiple jurisdictions. In FY 2005, the unit investigated/audited 56 new referrals and closed 35 investigations.



#### HIGHLIGHTS

- ⊙ Identified \$727,000 in fraudulent billings with associated penalties of \$1.8 million. (See table on Page 7.)
- ⊙ L&I's investigation of Peak Performance Physical Therapy Clinic led to the owner's conviction of theft for overcharging the department \$375,000 for treatments not performed. Sentencing is expected in January 2006.
- ⊙ A Southwest Washington physician was barred from treating injured workers after a review of his medical files showed he had over-prescribed opiates and had provided poor quality care.

The **Provider Fraud Unit** identified \$727,000 in fraudulent provider billings in FY 2005. If the assessments are upheld, associated penalties would total \$1.8 million, with claim cost avoidance of about \$283,000 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.

### FY 2005 Provider Fraud Investigations/Audits

Referrals Received	Investigations/ Audits Completed	Improper Billing	Penalties*	Cost Avoidance**
56	35	\$727,000	\$1.8 million	\$283,000

\*Recovery of penalty amounts is contingent on whether or not the initial assessments are upheld.

\*\*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.

## Worker Fraud and Abuse

Worker fraud occurs when an employee knowingly applies for and receives benefits he or she is not entitled to receive. 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.

Emphasis is put on prevention, early detection and the timely closure of claims deemed invalid.

In the area of worker fraud, actions include the following.

- ◉ L&I conducts 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 2005, L&I conducted 670 validity investigations, up from 426 in 2004.
- ◉ L&I conducts activity checks to determine whether a claimant's actual activities conform to the reported physical limitations that justified benefits. Investigations can result in earlier claim closure and termination of benefits when claimants are found to be employable. Activity checks result in significant savings to the workers' compensation system. In FY 2005, L&I conducted 2,044 activity checks.



### 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.
- ◉ L&I worked with other state and federal agencies to convict a man who set up businesses for the sole purpose of filing claims and collecting workers' compensation and other benefits.

- ⦿ L&I opens a fraud investigation 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. Over 220 fraud investigations were completed during FY 2005.
- ⦿ In FY 2005, L&I conducted a total of 3,908 investigations (including the 220 claimant fraud investigations listed above), an increase of 24 percent over the previous year.
- ⦿ 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 2005 for worker fraud were \$9.5 million. Collection of overpayments and penalties is significantly less due to the impact of settlement and plea agreements, and by claimants' inability to repay the debt.

L&I uses a standardized method to determine “cost avoidance,” which is an estimate of the money that would have been spent on a claim if benefits had not been stopped as a result of an investigation.

L&I has increased the number of government agencies it works with to uncover fraud and abuse and expanded computerized cross-match reporting with other agencies' databases. The departments of Employment Security, Corrections and Social and Health Services, as well as the Social Security Administration, provide 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.

## Next Year

This report focuses on what L&I did in the fiscal year that ended June 30, 2005. With the recent legal authority and funding provided by the Legislature in 2004, 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 during FY 2005 is documented in the four quarterly reports that were sent to the Legislature during the fiscal year.

Looking ahead, in FY 2006 the agency already has or will:

- ◉ Continue to reallocate resources and add staff to more effectively detect and pursue fraud/abuse and improve collections.
- ◉ Increase collections by earlier phone contact with employers regarding their failure to file quarterly reports or pay past due amounts.
- ◉ Step up efforts to educate the public on types of abuses that exist in the workers' compensation system.
- ◉ Work closely with employers to ensure that they are promptly notified when a claim is filed so that they can challenge claims that might be fraudulent.
- ◉ 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.
- ◉ 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.
- ◉ Run all open workers' compensation claims through sophisticated tracking software that can detect fraud and other irregularities. This process began in October 2005.

## 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 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 will continue through FY 2006 and beyond.

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