Improving Integrity and Accountability in the Workers’ Compensation System

2016 Annual Report to the Legislature

December 2016
Table of Contents

Executive Summary .............................................................................................................. 1
Introduction ........................................................................................................................... 5
Worker Fraud Investigations ................................................................................................. 6
  Overview ............................................................................................................................ 6
  Detection ............................................................................................................................ 6
  Criminal and civil cases ..................................................................................................... 6
Employer Fraud Investigations .............................................................................................. 9
  Overview ............................................................................................................................ 9
  Detection ............................................................................................................................ 9
  Criminal and civil cases ..................................................................................................... 12
Provider Fraud Investigations ............................................................................................... 13
  Overview ............................................................................................................................ 13
  Detection ............................................................................................................................ 13
  Criminal and civil cases ..................................................................................................... 14
  Data sharing ......................................................................................................................... 15
Collections ............................................................................................................................ 17
Education and Outreach ....................................................................................................... 19
Initiatives ................................................................................................................................ 21
Conclusion ............................................................................................................................ 23
  How to report fraud .............................................................................................................. 23
Figures
  Figure 1: Fraud prevention, detection and enforcement FTEs .............................................. 3
  Figure 2: L&I investigations, FY 2016 ................................................................................ 7
  Figure 3: Geographic distribution of completed worker fraud investigations, FY 2016 ...... 7
  Figure 4: Unregistered employer audits, FY 2010-2016 .................................................... 10
  Figure 5: Premium Assessments, FY 2016 ........................................................................ 10
  Figure 6: Geographic location of employer audits, FY 2016 ............................................. 11
  Figure 7: Types of health care provider fraud ................................................................... 13
  Figure 8: Delinquent premiums collected, FY 2010-2016 ............................................... 17
  Figure 9: Distribution of delinquent money collected, FY 2016 ....................................... 18
  Figure 10: New employer reviews, by industry, FY 2016 .................................................. 19
Glossary of Terms .................................................................................................................. 24
Executive Summary

The Department of Labor & Industries (L&I) provides information and services to help employers, workers and health care providers understand and comply with the requirements of the Washington workers’ compensation system. Despite considerable efforts to prevent violations and make it easy to do business with L&I, the department uncovers fraud each year. Most violations do not qualify as fraud – actions involving intentional deception intended to secure unfair or unlawful gain. Nevertheless, fraudulent business practices, injured worker claims and inappropriate medical billing cost the state millions of dollars each year.

L&I is committed to cracking down on dishonest behaviors. The purpose of L&I’s workers’ compensation fraud prevention efforts is to preserve the integrity of the workers’ compensation fund. This is done to ensure money is available to pay for injured worker benefits and to help reduce premium costs for both workers and employers. The department uses discovery tools, interagency partnerships and public tips to find, detect and deter fraud.

This annual report summarizes L&I’s efforts to find and eliminate deliberate fraud in the workers’ compensation system. As requested in state law (RCW 43.22.331), the report includes actual and estimated cost savings resulting from these activities where possible. It also describes L&I’s efforts to provide targeted education and assistance to employers. It does not describe the results of L&I’s investigations into employer practices regarding payment of minimum wage, overtime and other pay requirements, or meal and rest breaks.

In fiscal year (FY) 2016, L&I continued to ensure that employers, workers and providers realize that committing fraud can have serious consequences. The following are some of the department’s key actions.

Worker fraud

Worker fraud generally involves someone collecting workers’ compensation benefits to which they’re not legally entitled. Worker fraud involves any individual who obtains benefits through deliberate misrepresentation.

In FY 2016, L&I completed 93 worker investigations of fraudulently claimed benefits, amounting to over $1.5 million.

Employer fraud

Employer fraud occurs when an employer knowingly misclassifies employees in lower-cost rate classes, underreports worker hours or fails to pay required premiums.

It is important to note that not all unpaid workers’ compensation premiums identified through employer audits were the result of deliberate fraud; however, L&I is not always able to identify and separate figures in this publication that represent intentional fraud. In FY 2016, L&I received nearly 4,000 employer fraud leads. The resulting reviews and audits led to more than $25 million in assessments.
In FY 2016, L&I prevented and reduced employer fraud in the following ways:

- Audited more than 3,600 employers, of which 824 were unregistered employers
- Through employer audits, identified a total of nearly $25,500* in workers’ compensation premiums owed. Improved audit selection enabled the department to focus on employers most likely to owe premiums, which resulted in finding that 81 percent of audited employers owed debts to L&I
- Collected $173.3 million in delinquent employer premiums*
- Completed eight employer fraud investigations
- Reviewed nearly 4,000 public works contracts worth $4.9 billion to ensure workers’ compensation premiums were paid

*These dollar amounts include collections due to both fraud and standard collection practices.

**Provider fraud**

Health care provider fraud is any scheme to obtain payment from L&I fraudulently -- for example, billing for more than 24 hours in a day, or billing a 15-minute appointment as a full hour.

In FY 2016, L&I addressed provider fraud by identifying over $5.6 million in health care provider overpayments, of which more than $956,400 was identified as potential fraud.

**Collections**

L&I’s Collections Program gets involved when employers, workers or providers are delinquent in paying money they owe to L&I. The program tracks down debtors and collects what’s owed – whether it’s workers’ compensation premiums, overpayments to providers or injured workers, or penalties. The program also collects and distributes unpaid wages owed to workers. In FY 2016, L&I collected a total of $191.3 million in delinquent money. Of this, $173.3 million came from employer premiums.

**Resources for fraud prevention, detection and enforcement**

Figure 1 shows the number of Full-Time Equivalent (FTE) positions in L&I dedicated to preventing and detecting fraud and enforcing fraud-related laws and rules.
As shown in Figure 1, in FY 2016 L&I employed 293.5 FTEs in detecting, investigating and taking enforcement action against workers’ compensation fraud. For every dollar spent on these efforts, L&I returned $11.45. This is $2.52 more than was returned in 2015, due to increased collections and decreased operating costs. (Note: Return on investment compares operating costs to the money recovered, money collected and expenses avoided during the year. Operating costs include salaries, benefits and capital outlays.)

L&I also offers extensive training programs, direct customer service, and awareness campaigns that promote compliance and prevent fraud by making sure customers understand and follow the rules.

Fraud drives up costs in the workers’ compensation system. L&I continues to implement new and innovative ways to identify and prevent fraud. The agency’s labor and business stakeholders, as well as the legislature, will remain valued partners in these efforts.

**Education and outreach**

Helping businesses reduce reporting mistakes and understand the laws and rules they must follow allows L&I to focus its investigation and enforcement activities on businesses that intentionally undermine the system.

In FY 2016, L&I offered a wide array of programs and services with this goal in mind, including:

- New employer reviews (instructional-only audits to help employers with reporting and recordkeeping)
- Contractor training days
- Agricultural Business Day (training for small agricultural businesses about how to comply with laws)
- Introduction to L&I workshops
- Provider outreach to help health care providers understand L&I’s billing and documentation requirements

Source: L&I Data
Initiatives
FY 2016
In last year’s report, L&I identified five objectives and initiatives for 2016 related to deterring, detecting and prosecuting workers’ compensation fraud. Two of those initiatives – developing and implementing a Stop Work Order process and establishing a “Workers’ Comp Coverage Determinations Unit” – have been completed. Two initiatives are still pending or ongoing, and one has been restructured. The status of each project is given in the Initiatives section of this report (page 21).

FY 2017
In FY 2017, L&I will continue pursuing workers’ compensation fraud in the following ways:

- Develop and enhance relationships with key partner groups to improve overall effectiveness of workers’ compensation claim investigations
- Explore developing data analytics to select high probability case leads for worker fraud investigations
Introduction

Workers’ compensation fraud comes in three forms: employers who fail to pay their workers’ compensation premiums, employees who make false injury and disability claims and health care providers who bill dishonestly.

Cheating the workers’ compensation system is not a victimless crime. Both employers and workers pay insurance premiums into the system – and they all pay the price if costs are unnecessarily high due to fraud.

Impact to honest employers

Employers that don’t comply with business regulations and laws have lower costs, giving them an unfair advantage over other businesses. By not paying for workers’ compensation or other taxes, licenses and wages required by law, these employers are able to charge less. This raises costs for legitimate businesses because there are fewer businesses to cover the full costs of the system.

Impact to workers and the public

Higher premium rates resulting from fraud cut into workers’ wages, lower business profits and increase prices for consumer goods and services. Taxpayers are unduly burdened as workers are misclassified or left without employer-provided workers’ compensation benefits.

The Department of Labor & Industries’ (L&I’s) first priority is to prevent deliberate fraud by offering access to services, information and training that help employers, providers and workers comply with requirements. But the department also protects the public’s interests through an integrated array of programs focused on deterring, detecting and prosecuting fraud and ensuring compliance in the workers’ compensation system.

This report begins by describing worker fraud and how L&I targets, detects and prosecutes it. Later chapters describe these same efforts when fraud is committed by employers and medical providers. Subsequent chapters discuss how L&I collects past-due debt, averts fraud through education and outreach and implements innovative programs and tools.
Worker Fraud Investigations

OVERVIEW

Worker fraud generally involves someone collecting workers’ compensation benefits to which they’re not legally entitled. Worker fraud involves any individual who obtains benefits through deliberate misrepresentation.

Fraud investigations may result in workers having to repay benefits and, in some cases, face criminal convictions. Investigations do more than identify debts owed to L&I; they also help avoid unnecessary expenses. When an investigation determines someone is not entitled to workers’ compensation benefits, L&I stops paying benefits to the worker. L&I estimates that over $2.3 million in future workers’ compensation costs were avoided through these efforts during Fiscal Year (FY) 2016.

DETECTION

L&I uses a variety of sources and tools for detecting fraud. Employees search databases using discovery software, and share data with other state agencies. They also review tips from the public and share them among internal programs. These can often lead to in-depth audits and investigations.

The Detection, Training and Outreach (DTO) Injured Worker Unit is responsible for identifying and preventing fraud and abuse within the injured worker claim system to ensure compliance with the Industrial Insurance Claims Act. This unit is the first to receive and evaluate calls and tips from the public. Unit staff reviews individual claims and assesses the potential for fraud by analyzing multi-agency, cross-matched resources and data.

The public reaches the unit through a dedicated phone line and an online fraud reporting form. In FY 2016, the unit received and reviewed more than 800 public tips regarding potential worker fraud. Based on these tips and other sources, the unit reviewed and evaluated over 12,500 claims and initiated more than 470 investigations in FY 2016.

In FY 2016, the Investigations Program completed *72 fraud investigations -- a direct result of DTO referrals. Of these 72 investigations, 30 resulted in penalties for willful misrepresentation. Overpayments and penalties for FY 2016 totaled over $500,000.

*Referrals made from the DTO program are a subset of the total number of referrals Investigations receives.

CRIMINAL AND CIVIL CASES

In FY 2016, investigators referred 11 worker fraud cases to the Office of the Attorney General and local prosecutors. Of these, five resulted in criminal charges.
L&I receives tips from many different internal and external sources about potential workers’ compensation fraud and abuse. If an initial review suggests there may be inconsistencies, staff refers the tip to the Investigations Program. Fraud adjudicators gather evidence and, when appropriate, issue Administrative Fraud Orders (AFOs) to recover money paid on fraudulent benefits. In FY 2016, investigators issued 55 worker fraud AFOs totaling more than $1.1 million.

L&I investigators conduct the following types of investigations:

- **Activity**: Activity checks investigate the current level of a worker’s activities to see if he or she is still injured or exceeding the documented medical condition. This type of investigation seeks to determine if the injured worker is still unable to work.

- **Validity**: Validity checks examine the facts surrounding a claim for benefits – for example, whether an injury is the result of a work-related accident.

- **Fraud due to worker misrepresentation**: These investigations result when a worker receives benefits, such as wage-replacement funds and medical treatment, by intentionally misrepresenting themselves to their attending physician and L&I in order to continue receiving benefits they would otherwise not be entitled to. An example is a person working under the table while continuing to receiving benefits – usually wage-replacement funds.

- **Claim reopening**: Although infrequent, these investigations are conducted to ensure that there have been no intervening incidents, such as traffic accidents or other insurance claims for the same type of injury, between the time the claim was closed and the request for reopening of the claim.

- **Other**: Other investigations can result from requests by claim managers who need information to manage a claim. Examples include retrieving medical records or checking to see if an individual is in jail.

Figure 2 shows the types of worker fraud investigations L&I conducts, and the number conducted in FY 2016. The most common are activity investigations that verify whether an injured worker is still unable to work.

**Figure 2: L&I investigations, FY 2016**

<table>
<thead>
<tr>
<th>Type of referral</th>
<th>Number of referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity</td>
<td>2,141</td>
</tr>
<tr>
<td>Other</td>
<td>924</td>
</tr>
<tr>
<td>Validity</td>
<td>641</td>
</tr>
<tr>
<td>Fraud</td>
<td>144</td>
</tr>
<tr>
<td>Claim reopening</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>3,859</td>
</tr>
</tbody>
</table>

Source: L&I Investigations
In Figure 3, completed worker fraud investigations are shown by geographic area. Clearly, most investigations take place in higher population areas, particularly in the Puget Sound area.

**Figure 3: Geographic distribution of completed worker fraud investigations, FY 2016**

Source: L&I Investigations
Employer Fraud Investigations

OVERVIEW

Employer fraud occurs when an employer knowingly misclassifies employees in lower-cost rate classes, underreports worker hours or fails to pay required premiums. Employer fraud cases are investigated by both auditors and investigative staff. Some examples of employer fraud include:

- Operating a business without the proper license
- Paying workers in cash with no payroll records
- Intentionally underreporting workers
- Treating workers as independent contractors (failing to cover workers with industrial insurance)

Employers that commit fraud can incur large assessments and penalties and may be criminally prosecuted.

In FY 2016, the Investigations Program received seven employer fraud referrals. These investigations focus on improper or illegal actions by the employer, such as failing or refusing to pay workers’ compensation premiums or misreporting worker hours or classifications. Though the number of these cases is relatively low, these cases require the highest investment of time due to their complexity.

DETECTION

Eleven years ago, fewer than half of employers audited were found to owe premiums to L&I. Since then, L&I has improved its detection and targeting capabilities, resulting in increased detection of employers who owe premiums, as well as fewer compliant employers being audited.

To identify businesses most likely to owe premiums, L&I uses tips from the public, shares data and information with other agencies and interested parties, and makes use of available data to send audit resources to the right businesses. Improved detection methods ensure L&I targets and actively pursues the employers most likely to commit fraud, which also saves time and trouble for employers who follow the rules. In FY 2016, L&I received nearly 4,000 employer fraud leads. The resulting reviews and audits led to more than $25 million in assessments.

Of the more than 3,600 employer audits completed in FY 2016, 81 percent owed money to L&I. L&I assessed $25 million in premiums found through these audits. Since 2010, the number of audits of unregistered businesses has increased by 23 percent, as shown in Figure 4. During that time, the amount of premiums assessed has increased each year until FY 2016, and is now leveling out. As shown in Figure 5, about 36 percent of the assessments involved unregistered employers.
Audits are an important tool to ensure employers report their worker hours correctly and pay appropriate workers’ compensation premiums. L&I has a standard audit process that involves checking business records and conducting interviews to determine if fraud is occurring. Auditors may verify the number of workers reported and that all hours are reported in the correct risk class.
Field audits are employer audits conducted by auditors located in field offices throughout Washington. After completing an audit, L&I performs a closing conference with the employer. This typically is a phone conversation, but may be an in-person meeting. In the closing conference, auditors supply educational materials and explain how to improve record-keeping. This post-audit conference is an important part of the process and is required on every audit. It provides employers with an opportunity to better understand the reporting process. It’s also a chance to answer employer questions, which helps prevent recurring problems.

Figure 6 shows the geographic location of employer audits conducted statewide in FY 2016. As with completed worker fraud investigations, most audits take place in higher population areas.

**Figure 6: Geographic location of employer audits, FY 2016**

Source: L&I Field Audit
Public works contracts
L&I reviews every public works project worth more than $35,000 to determine whether appropriate workers’ compensation premiums were paid. On these projects, the final five percent of payments is withheld until certain tax payments are verified. This ensures that contractors follow the law and pay taxes, including any workers’ compensation premiums owed to L&I. While this process withholding contract payments is also used to pay any wages owing, that information is not included in this workers’ compensation-focused report.

In FY 2016, L&I reviewed nearly 4,000 public works contracts, valued at nearly $4.9 billion. L&I found $345,000 in debt owed for work on public projects during the year.

If, while reviewing a public works project, L&I discovers a contractor owes workers’ compensation premiums for other types of projects, the department may pursue those debts as well. In FY 2016, L&I recovered nearly $1.3 million in debt discovered through public works contract reviews, with most of it found prior to FY 2016.

L&I also works with contractors to resolve unintentional reporting discrepancies. If there is a problem, contractors can voluntarily amend their company’s workers’ compensation reports and make the required payments. However, not all cases are resolved voluntarily; a small number require an audit. In FY 2016, more than 26,900 firms were reviewed; 55 of those were audited, and 99 percent of those audits revealed debt owed to L&I.

CRIMINAL AND CIVIL CASES

Criminal cases
While rare, a criminal case may be filed against an employer for the most egregious actions. Vital support for these cases comes from two full-time assistant attorney generals who help develop cases of employer workers’ compensation abuse for criminal prosecution.

In FY 2016, L&I forwarded two referrals of employer fraud to the Attorney General’s Office. Two cases were charged criminally.

Civil cases
Civil misrepresentation penalties occur when employers intentionally misclassify or underreport employees for workers’ compensation insurance. In FY 2016, L&I assessed 44 misrepresentation penalties, totaling nearly $2.7 million. This was in addition to workers’ compensation premiums owed.
Provider Fraud Investigations

OVERVIEW

Medical professionals serve the public to make a difference in the health and well-being of the community in which they provide services. Most ensure the needs of the patient are met with integrity and honesty; however, some provider fraud does occur.

Health care provider fraud is any scheme to obtain payment from L&I that was not earned. L&I has one employee dedicated to examining records for inconsistent billing patterns and reviewing leads from the public. Examples include billing for more than 24 hours in a day, and “upcoding” (for example, billing a 15-minute appointment as one hour).

Figure 7 shows eight common types of health care provider fraud, in no particular order.

**Figure 7: Types of health care provider fraud**

<table>
<thead>
<tr>
<th>Common Health Care Provider Fraud Schemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Billing for services not rendered</td>
</tr>
<tr>
<td>2. Billing for a non-covered service as a covered service</td>
</tr>
<tr>
<td>3. Misrepresenting location of service (billing for treatment services while in a separate physical location)</td>
</tr>
<tr>
<td>4. Misrepresenting provider of service</td>
</tr>
<tr>
<td>5. Incorrect reporting of diagnosis or procedures (includes unbundling)</td>
</tr>
<tr>
<td>6. Overutilization of services</td>
</tr>
<tr>
<td>7. Corruption (kickbacks and bribery)</td>
</tr>
<tr>
<td>8. False or unnecessary issuance of prescription drugs</td>
</tr>
</tbody>
</table>

Source: L&I Investigations

DETECTION

L&I receives referrals that help detect provider fraud from both internal and external sources, including: injured workers, other medical providers, other agencies, claim managers and staff responsible for paying medical bills.

In FY 2016, L&I’s one-person detection unit served as the sole statewide resource dedicated to detecting improper billing and fraud by medical providers. The employee reviewed 264 providers, identified more than $1.5 million in estimated improper payments, and referred 36 suspected fraud cases to provider fraud investigators for a closer look.
CRIMINAL AND CIVIL CASES

Criminal cases

Provider investigations
Criminal provider investigations are typically complex and labor-intensive. In FY 2016, L&I referred one case to prosecutors for potential criminal charges. No charges were filed.

Civil cases
Civil cases rely on lower evidentiary standards and are more common than criminal cases. In workers’ compensation, L&I focused on private sector rehabilitation services, provider credentialing and improper billing.

Private Sector Rehabilitation Services
The role of Private Sector Rehabilitation Services (PSRS) is to ensure that Washington’s injured workers get high quality vocational rehabilitation services that comply with applicable state laws and regulations, and L&I policies. PSRS does this by monitoring and auditing how providers deliver their services, what the services consist of and how they are billed.

In FY 2016, PSRS completed 46 vocational provider reviews and assessed more than $36,400 in penalties or recoupment.

In FY 2016, PSRS established the Re-Imagine Vocational Audit (RIVA) project. This project aims to create an audit program that supports vocational providers who are in compliance, while effectively addressing those who are not in compliance. The project goals include:

- Using data to identify non-compliance and trends
- Adapting an escalation strategy approach to audit
- Providing effective enforcement options
- Communicating clear expectations to vocational providers through education, consultation and outreach
- Ensuring investigation processes are easily understood and consistent but also credible and transparent

Stakeholders meet via an advisory committee to share and review ideas, information and proposals for change. An internal work group will design the future state program and address gaps and alternative approaches, including the complaint process, use of data, the audit process and methods for identifying activities that support education, consultation and outreach.

Provider credentialing and compliance
The Provider Credentialing and Compliance (PCC) Unit audits medical billing for services paid for by the state workers’ compensation fund. The purpose of the audits is to notify providers of applicable laws, regulations and L&I policies that affect the billing and reimbursement of services provided to injured workers. The audits also enforce compliance with L&I’s medical aid rules and
fee schedules. In FY 2016, the program completed 56 medical provider reviews and assessed nearly $335,000 for improper billing.

Provider investigations
In FY 2016, the program identified more than $956,000 in financial loss from improper billing. Staff issued five orders and notices of violations, with penalties and interest totaling nearly $364,000. These efforts helped to avoid an estimated $5.67 million in costs.

DATA SHARING
In addition to L&I staff detection efforts, sharing and cross-matching L&I data with data from other agencies and organizations helps catch inconsistent reporting or duplicated claims that may indicate fraud. Here are some ways L&I is using data-sharing in its fraud-fighting efforts:

Cross-agency collaboration – referral exchange
L&I shares information with the Department of Revenue (DOR) and Employment Security Department (ESD). When any of the agencies finds businesses or individuals that may need to be investigated, they send referrals or share and cross-check data. In FY 2016, the three agencies exchanged almost 94,000 pieces of data through electronic data transfers.

Cross-agency collaboration – data cross-match
L&I and the Washington State Department of Corrections (DOC) have an interagency data sharing agreement. DOC cross-matches reports of injured workers confined in Washington state prisons. L&I reviewed a total of 351 DOC claims in FY 2016. Of these, 17 were investigated.

Cross-agency data sharing – Internal Revenue Service
After an extensive cost-benefit study, L&I decided to discontinue an agreement with the Internal Revenue Service (IRS) to access Federal Taxpayer Information (FTI). This decision was based on several factors, including return on investment of staff time to maintain the high level of security required by the IRS, and the usefulness of the data due to its age. In addition, analysis showed no significant increase in debit assessments in audits where FTI was used, compared to audit assessments where no IRS data was used. Ultimately, the return on investment from using the IRS data did not warrant the resources needed to support the IRS-focused systems.

Coordinated Enforcement Pilot Project
The Coordinated Enforcement Pilot Project (CEPP) is a focused effort to collaborate and coordinate with the Attorney General’s Office (AGO), other L&I divisions, and regional offices across the state to identify and take significant actions against the worst violators of all laws that L&I enforces. The goal of the pilot is 25 significant civil or criminal actions by 2020 against entities that violate multiple laws administered by L&I.

This project has three components: detection, enforcement and communication. This agencywide effort will focus on a comprehensive enterprise approach to improve the identification of bad actors, decrease the number of bad actions, and increase public awareness that L&I targets bad actions. The
CEPP aims to leverage and replicate L&I’s existing best practices and foster new kinds of partnerships among L&I’s divisions and regional field staff. It may also include a partnership with the AGO when appropriate.
L&I’s Collections Program gets involved when employers, workers or providers are delinquent in paying money owed to L&I. The program tracks down debtors and collects what’s owed – whether it’s workers’ compensation premiums, overpayments to providers or injured workers, or penalties. While the program is also responsible for collecting other types of debt on behalf of other L&I programs, only workers’ compensation-related collections are addressed for purposes of this report.

Figure 8 shows collections for delinquent workers’ compensation premiums over the past five fiscal years. Collections may fluctuate based on a combination of factors, including the economy.

**Figure 8: Delinquent premiums collected, FY 2010-2016**
Figure 9 shows the sources of the collected money. Employer premiums account for the vast majority of collections, more than $173 million in FY 2016.

**Figure 9: Distribution of delinquent money collected, FY 2016**

- Employer Premiums - $173.3 Million
- Injured Worker Overpayments - $5.4 Million
- *Other Debts* - $11.2 Million
- Unpaid Wages - $1.3 Million

Source: L&I Collections

* “Other debts” includes unpaid penalties, safety and health citations, Right-to-Know billings and Retrospective Rating Program billings.
Education and Outreach

L&I wants to help employers, workers and medical providers be proactive in their approach to workers’ compensation, and avoid making mistakes that are costly for them and the workers’ compensation system – and that can potentially lead to fraud. Helping businesses reduce reporting mistakes and understand the laws and rules they must follow makes it easier for them to do business with L&I, and allows L&I to focus investigation and enforcement activities on businesses that intentionally undermine the system. The department offers a wide array of programs and services with this goal in mind.

New employer reviews
Starting a new business can be daunting, and opening a workers’ compensation account is an important task that is often overlooked or confusing. To help business owners, L&I offers new employer reviews in the form of instructional audits. These are available to businesses that have been operating for at least six months. They are designed to teach new businesses about reporting and recordkeeping without the threat of penalties or fines. The program establishes a relationship between the new employer and L&I, connecting individual employers with designated points of contact. Employers can ask L&I questions and learn the requirements specific to their industries. Ultimately, this avoids long-term misreporting and expensive mistakes.

Figure 10 shows the percentage of new employer reviews for each of the target industries. The construction industry accounts for the highest percentage of new employer reviews, mainly because this industry is among the first to rebound when the economy improves.

**Figure 10: New employer reviews, by industry, FY 2016**

<table>
<thead>
<tr>
<th>Industry</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction</td>
<td>63%</td>
</tr>
<tr>
<td>Janitorial</td>
<td>9%</td>
</tr>
<tr>
<td>Retail/wholesale</td>
<td>5%</td>
</tr>
<tr>
<td>Restaurants</td>
<td>4%</td>
</tr>
<tr>
<td>Service &amp; repair</td>
<td>5%</td>
</tr>
<tr>
<td>Property management</td>
<td>6%</td>
</tr>
<tr>
<td>Trucking</td>
<td>2%</td>
</tr>
<tr>
<td>Delivery</td>
<td>4%</td>
</tr>
<tr>
<td>Real estate</td>
<td>2%</td>
</tr>
</tbody>
</table>

Source: L&I Field Audit

Contractor training
Construction is big business in Washington. L&I invests considerable effort in helping businesses understand their legal obligations. L&I educates contractors on almost every aspect of their business and provides an introduction to L&I during Contractor Training Days. At these events, which are highly rated by participants, attendees can learn how to properly report and pay workers’ compensation insurance, keep a safe workplace, market their business, write an effective contract and
more. L&I makes it easy for contractors to register, with online step-by-step instructions and explanations of laws and rules. In FY 2016, over 1,000 contractors were trained at eight events statewide.

**Workers’ Compensation Coverage Determination**

The Workers’ Compensation Coverage Determination Unit was created in response to a request from the employer community for the ability to determine coverage for workers’ compensation insurance without having an assessment. This unit allows an employer or business to get assistance from L&I by submitting a written request for guidance on workers’ compensation issues or on whether an independent contractor would be considered a covered worker in certain circumstances. The unit makes it easier to do business with L&I by combining the education of individual employers into one program, both benefitting the employers and providing consistency in the education provided. In addition, it helps bring businesses into compliance before any reporting errors are found during an audit.

**Agriculture Business Day**

Partnering with several other state agencies and colleges, L&I held its third Agriculture Business Day in November 2015. More than 68 small agricultural businesses in Washington were trained about labor contractor rules, break and meal periods, workers’ compensation insurance, taxes, safety of minor workers and much more.

**Provider outreach**

L&I offers workshops and other assistance to help providers understand the department’s billing and documentation requirements and the Medical Provider Network for injured workers. Step-by-step instructions and examples are provided, such as when to send a corrected claim or when to adjust a bill. Outreach staff provides hands-on demonstrations of how to use L&I resources and, most important, allows providers to ask questions about their specific billing needs. In addition, L&I provides an online outlet for provider questions at ProviderFeedback@LNI.WA.GOV.

**Introduction to L&I workshop**

L&I offers all new employers an “Employer’s Introduction to L&I” workshop. These are held across the state and were attended by more than 470 new businesses in FY 2016.
L&I identified five objectives and initiatives for FY 2016. Here is a summary of their status:

<table>
<thead>
<tr>
<th>Objective</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop and implement an improved Stop Work Order process.</td>
<td>Completed</td>
</tr>
<tr>
<td>Request funding for a Special Investigations Unit (SIU) to investigate and develop cases for criminal prosecution relating to workers’ compensation, wage and hour laws, safety and health violations, construction compliance and prevailing wage laws.</td>
<td>Not funded in FY 2015. Initiative was restructured as the “Coordinated Enforcement Pilot Project,” discussed on page 17</td>
</tr>
<tr>
<td>Implement an agencywide effort to analyze current compliance efforts, including fraud, wage enforcement and safety; to analyze effectiveness of current escalation strategies and deterrents; and to employ strategic data analysis, identify trends and develop customized solutions.</td>
<td>Ongoing – Strategic Data Analysis occurring in each program with compliance responsibility</td>
</tr>
<tr>
<td>Enhance L&amp;I’s ability to enforce consequences for egregious intentional violators by reviewing processes and eliminating gaps in pursuing criminal prosecutions.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Establish a “Workers’ Comp Coverage Determinations Unit” to assist customers with workers’ compensation premiums and classification and compliance concerns.</td>
<td>Completed</td>
</tr>
</tbody>
</table>
The Department of Labor & Industries will continue to aggressively pursue fraud and abuse in the workers’ compensation system. The department will employ the following strategies in FY 2017:

- Continue developing enterprise systems and solutions to improve results in addressing intentional violators through the “Results L&I” initiative. Doing so will ensure a consistent agencywide approach to compliance that is effective in both finding and deterring bad actors.

- Launch the “Escalating Enforcement: Employer Premiums” project, a tool to help L&I staff provide the right information, assistance and consequences to employers at the right time so that employers pay the premiums they owe. It ensures that the agency response is appropriate to the action, and that there is a consistent application of consequences.

- Further implement Coordinated Enforcement.
Conclusion

Fighting fraud remains a priority at L&I. The department is undertaking a range of initiatives – including increased innovation, regulatory actions and collective resources – to bolster the fight against fraud while producing measurable results. Continued Lean\(^1\) process improvements increase results for customers and make more efficient use of agency resources. Moving forward, L&I remains engaged with stakeholders to develop new methods for combating the underground economy in the construction industry.

Return on investment

In FY 2016, L&I employed about 293.5 FTEs to detect, investigate and take enforcement action against workers’ compensation errors and fraud. For every dollar spent on these efforts, L&I returned $11.45. In other words, it costs about 9 cents to collect a dollar of debt. (Note: Return on investment compares the division’s operating costs to the money recovered, money collected and expenses avoided during the year. Operating costs include salaries, benefits and capital outlays.)

The department also supports extensive training programs and direct customer service and awareness campaigns aimed at preventing fraud by making sure customers know the rules. The employees doing this work are in addition to the approximate 293.5 FTEs cited above.

ANYONE CAN REPORT FRAUD; HERE’S HOW

Anyone can help stop workers’ compensation fraud by reporting situations that may be fraudulent, and by telling others how to report:

- Fraud Hotline: 888-811-5974
- Fraud Website: [www.Fraud.Lni.wa.gov](http://www.Fraud.Lni.wa.gov)

Employers can help state government detect workers’ compensation and unemployment insurance fraud by workers. Report newly hired workers at [www.dshs.wa.gov/newhire](http://www.dshs.wa.gov/newhire). The information will be shared with L&I and the Employment Security Department to ensure employed workers aren’t claiming benefits they’re not entitled to receive.

Contact information

For more information about this report, please contact:

- Elizabeth Smith, Assistant Director, L&I Fraud Prevention and Labor Standards
  360-902-5933
- Tami Dahlgren, Communication Consultant, L&I Communication Services
  360-902-6654

\(^1\) Lean is a business philosophy used, along with methods and tools, to create and deliver the most value from the customer’s perspective while consuming the fewest resources.
Glossary of Terms

- **Assessment** – A dollar amount identified as owed and payable to L&I, including premiums, overpaid benefits, penalties and interest.
- **Audit** – An official review of accounts and legally required business records.
- **Benefit** – The medical coverage and/or wage replacement received by an injured worker.
- **Cost avoidance** – The amount of benefits that would have been paid to a claimant found to have committed fraud. Costs recouped from inappropriate medical billing are not usually included in this term.
- **Employer** – Any person or business engaged in work in Washington covered by the state’s Industrial Insurance Act and employing or contracting with one or more workers.
- **Fiscal year** – Washington state government defines a fiscal year as the period from July 1 through June 30. For purposes of this report, all years displayed are fiscal years.
- **Fraud** – A willful misrepresentation of facts for profit or to gain unfair advantage.
- **Lead/tip** – Potential fraud reported to Labor & Industries for investigation.
- **Premium** – Amount to be paid by employers and employees for workers’ compensation coverage.
- **Provider** – Any person or legal entity providing any kind of services for treating an industrially injured worker.
- **Referral** – A verified lead that is forwarded for an investigation, audit or other action.
- **Underground economy** – Businesses or individuals who fail to either record, report or register a significant part of their business activities with the proper authorities as required by law.
- **Worker** – An individual hired to work for compensation who, through employment, is covered under workers’ compensation laws.
- **Workers’ compensation/industrial insurance** – A form of no-fault insurance providing medical benefits and wage replacement to workers injured on the job.