Improving Integrity and Accountability in the Workers’ Compensation System

2018 Annual Report to the Legislature

January 2019
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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 Washington’s workers’ compensation system, and works to preserve the integrity of the workers’ compensation fund. The goal is 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 detect and deter fraud in the workers’ compensation system. In the most egregious cases, the department moves to criminal prosecution.

This annual report summarizes L&I’s efforts to find and eliminate deliberate fraud in the workers’ compensation system among workers, employers, and health care providers. 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.

Education and outreach
L&I offered a wide array of programs and services in FY 2018 to help businesses reduce reporting mistakes and understand applicable laws and rules:

- 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

In addition, L&I used Lean principles to create standardized processes for opening new industrial insurance accounts. These processes include emphasis on outreach to businesses via phone and/or e-mail to ensure that the correct premium amounts are being charged and that businesses understand their quarterly reporting requirements to ensure they are in compliance.

Worker fraud
In FY 2018, L&I completed 64 worker investigations of fraudulently claimed workers’ compensation benefits, amounting to over $1.3 million.

Employer fraud
In FY 2018, L&I received close to 3,700 employer fraud leads. The resulting reviews and audits led to nearly $27 million in assessments. L&I conducted the following activities to reduce and prevent employer fraud in FY 2018:

- Audited more than 2,700 employers, of which just over 1,000 were unregistered employers.
Through employer audits, identified a total of nearly $27 million* 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 71 percent of audited employers owed debts to L&I.

- Collected $186.2 million in delinquent employer premiums. *
- Completed two criminal employer fraud investigations.
- Reviewed nearly 4,200 public works contracts worth $4.3 billion to ensure workers’ compensation premiums were paid.

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

**Provider fraud**

In FY 2018, L&I identified nearly $1.2 million in health care provider overpayments, of which more than $726,000 was identified as potential fraud.
Collections
In FY 2018, L&I collected a total of $212.4 million in delinquent money, of which $186.2 million came from employer premiums. Other sources include Accounts Receivable and Collections (ARC) debt collected was $26.2 million which includes Retrospective rating, Washington Industrial Safety and Health Act (WISHA) citations, contractor infractions, Merit-based Incentive Payment System (MIPS), claims overpayments, Wage Payments Act and Third Party.

Return on investment
In FY 2018, L&I employed 255 FTEs in detecting, investigating, and taking enforcement action against workers’ compensation fraud. For every dollar spent on these efforts, L&I returned $9.94. (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.)

Cost savings
Enforcement actions stemming from L&I investigations resulted in cost savings of almost $1,033,000 in FY 2018.

Cost savings due to overpayments discovered and corrected by investigators amounted to $122,000. Additional cost savings from fraud investigations and non-fraud investigations totaled $1,678,000 and $1,418,000, respectively, for a total cost savings directly associated with investigations of $3,219,000.

Initiatives
In previous reports, L&I identified objectives and initiatives for 2017 and 2018 related to deterring, detecting and prosecuting workers’ compensation fraud. As of the writing of this report, 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 on page 19.

In FY 2019, L&I will continue existing efforts to pursue workers’ compensation fraud by:

- Developing and enhancing relationships with key partner groups to improve overall effectiveness of workers’ compensation claim investigations.
- Exploring ways to develop data analytics to select high probability case leads for worker fraud investigations.
- Partnering with other programs and agencies on significant “bad actor” businesses who are severely out of compliance across the varied lines of business.
- Collaborating with other federal, state and private investigation groups to identify provider investigations with common schemes.
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. Fraud drives up costs in the workers’ compensation system. 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 detects and prosecutes it. Later sections describe these same efforts when fraud is committed by employers and medical providers. Subsequent sections 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 any individual collecting workers’ compensation benefits to which they’re not legally entitled, or obtaining 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 $3.2 million in future workers’ compensation costs were avoided through these efforts during fiscal year (FY) 2018.

DETECTION

L&I’s Detection and Tracking Unit (DTU) within the agency’s Investigations program is responsible for identifying and preventing fraud and abuse within the injured worker claim system. The unit uses a variety of resources and tools to detect fraud. Employees review individual claims and assess the potential for fraud by analyzing multi-agency, cross-matched resources and data. They also review tips from the public and share them among internal programs.

In FY 2018, the DTU evaluated a total of over 7,200 individual workers’ compensation claims. As a result of these evaluations, 292 investigations were conducted. Fraud (willful misrepresentation) was found to have occurred in 23 instances during FY2018, amounting to over $500,000 in overpayments and penalties. The evaluations also found non-fraudulent overpayments amounting to over $33,000.

Public tips were the source of nearly 900 of the 7,200 claim reviews done in FY 2018. These nearly 900 claim reviews led to almost 170 investigations.

CRIMINAL AND CIVIL CASES

In FY 2018, investigators referred seven claimant fraud cases to the Office of the Attorney General (ATG) for consideration of prosecution. These cases have yet to be charged and remain in a pending status.

During this reporting period, the ATG filed charges on two cases. These cases were submitted prior to this fiscal year, but charges were brought during FY 2018.

If an initial review of a tip received about potential workers’ compensation fraud suggests inconsistencies, staff refers the tip to L&I’s Investigations program. Fraud adjudicators in this program gather evidence and, when appropriate, issue Administrative Fraud Orders (AFOs) to
recover money paid in fraudulent benefits. In FY 2018, Fraud Adjudicators issued 45 worker fraud AFOs totaling more than $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 if their activities exceed 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 1 shows the types of worker fraud investigations L&I conducts, and the number conducted in FY 2018. Following more than 7,200 claim evaluations, 3,417 investigations were conducted. The most common are activity investigations that verify whether an injured worker is still unable to work.

**Figure 1: L&I investigations, FY 2018**

<table>
<thead>
<tr>
<th>Type of Referral</th>
<th>Number of Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity</td>
<td>1,777</td>
</tr>
<tr>
<td>Other</td>
<td>1,603</td>
</tr>
<tr>
<td>Validity</td>
<td>503</td>
</tr>
<tr>
<td>Fraud</td>
<td>65</td>
</tr>
<tr>
<td>Claim Reopening</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3,417</strong></td>
</tr>
</tbody>
</table>

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 2018, the Investigations program initiated 18 criminal cases. These are special cases where there are allegations of employer misconduct, such as failure to secure industrial insurance for employees, continuing to employ workers after their certificate of coverage was revoked, or violations of other criminal statutes pertaining to employers. Referrals primarily come internally from collections activity, audits, and the Contractor Compliance program. Though the number of these cases is not large, these cases require the highest investment of time due to their complexity.

DETECTION

L&I continues to improve 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 2018, L&I received more than 3,700 employer fraud leads. The resulting reviews and audits led to more than $27 million in assessments.

Of the more than 2,700 employer audits completed in FY 2018, 71 percent owed money to L&I. L&I assessed over $27 million in premiums found through these audits. Since 2010, the number of audits of unregistered businesses has increased by more than 50 percent, as shown in Figure 2. During that time, the amount of premiums assessed increased each year until FY 2016, and is now leveling out. As shown in Figure 3, about 37 percent of the assessments in FY 2018 involved unregistered employers.
Figure 2: Unregistered Employer Audits, FY 2010-2018

Source: L&I Field Audit

Figure 3: Premium Assessments, FY 2018

Source: L&I Field Audit
Field audits
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 includes checking business records, conducting interviews, and verifying the number of workers reported and that all hours are reported in the correct risk class.

Field audits are 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.

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 of withholding contract payments is also used to pay any wages owing, that information is not included in this workers’ compensation-focused report.

In FY 2018, L&I reviewed nearly 4,200 public works contracts, valued at nearly $4.3 billion. L&I found $4.2 million 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.

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 2018, more than 29,870 account reviews were completed; 49 of those have been audited as of the writing of this report.

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 2018, L&I forwarded two referrals of employer fraud to the Attorney General’s Office. Both cases were charged criminally.
Civil cases

Civil misrepresentation penalties occur when employers intentionally misclassify or underreport employees for workers’ compensation insurance. In FY 2018, L&I assessed 28 misrepresentation penalties, totaling over $1 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.

Provider fraud is any scheme to obtain payment from L&I that was not earned. L&I has one employee dedicated to completing a preliminary review to validate referrals. Examples include billing for more than 24 hours in a day, and “upcoding” (for example, billing a 15-minute appointment as one hour).

Figure 4 shows eight common types of provider fraud, in no particular order.

**Figure 4: Types of health care provider fraud**

- Billing for services not rendered
- Billing for a non-covered service as a covered service
- Misrepresenting location of service (billing for treatment services while in a separate physical location)
- Misrepresenting provider of service
- Incorrect reporting of diagnosis or procedures (includes unbundling)
- Overutilization of services
- Corruption (kickbacks and bribery)
- False or unnecessary issuance of prescription drugs

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 2018, there were 300 referrals to L&I about suspected provider fraud.

L&I’s one-person detection unit continues to serve as the sole statewide resource dedicated to detecting improper billing and fraud by medical providers. In FY 2018, after reviewing all 300 providers referred for suspected fraud, this employee identified more than $6.9 million in estimated improper payments and referred 88 providers to provider fraud investigators.
CRIMINAL AND CIVIL CASES

Criminal cases
In FY 2018, L&I referred one medical provider 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 civil cases, L&I focused on private sector rehabilitation services, and improper billing.

Private Sector Rehabilitation Services
The role of Private Sector Rehabilitation Services (PSRS) is to ensure that Washington’s injured workers receive high quality vocational rehabilitation services that comply with applicable state laws and regulations, and the Department of Labor and Industries’ policies. PSRS does this by monitoring and auditing how providers deliver their services, what the services consist of and how providers bill for their services.

In FY 2018, PSRS completed 55 complaint-based investigations. About half of the complaint reviews were resolved with a telephone call to the vocational provider. This success is due to a new audit approach still being implemented, which focuses on education first, with escalation strategies if necessary. No penalties or recoupment were assessed in fiscal year 2018 due to the new approach. However, the program has achieved written agreements with some of the vocational firms involved in the complaints. The agreements are in regard to the vocational firm’s commitment to implementing quality assurance measures in their firms.

Provider quality and compliance
L&I’s Provider Quality and Compliance (PQC) Unit audits medical billing for services paid for by the state workers’ compensation fund. The purpose of the audits is to notify providers of any violations identified regarding applicable laws, regulations, and L&I policies that affect the billing and reimbursement for services provided to injured workers. The audits also enforce compliance with L&I’s medical aid rules and fee schedules. In FY 2018, the program completed a total of 135 medical provider reviews and assessed nearly $2 million for improper billing.

Provider investigations
In FY 2018, L&I issued five orders and notices of violations for fraudulent overpayments, with penalties and interest amounting to nearly $1.2 million of the total $726,000 assessed. These efforts helped avoid an estimated $6.9 million in costs due to fraudulent activity.
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 worker, employer, or provider fraud. Here are some ways L&I is using data-sharing in its fraud-fighting efforts:

**Cross-agency collaboration**

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 2018, the three agencies exchanged over 67,000 pieces of data through electronic data transfers.

In addition to sharing information with DOR and ESD, 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 259 DOC claims in FY 2018. Of these, 14 were investigated.

**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), 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 to take 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. The 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 Office of the Attorney General when appropriate.
Collections

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 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, this report only addresses workers’ compensation-related collections.

Figure 5 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 5: Delinquent premiums collected, FY 2014-2018**

Source: L&I Collections
Figure 6 shows the sources of money collected. Employer premiums account for the vast majority of collections, more than $186.2 million of the total $212.4 million collected in FY 2018.

**Figure 6: Distribution of delinquent money collected, FY 2018**

<table>
<thead>
<tr>
<th>Source: L&amp;I Collections</th>
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<tbody>
<tr>
<td>* “Other debts” includes unpaid penalties, safety and health citations, Right-to-Know billings and Retrospective Rating Program billings.</td>
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</tbody>
</table>
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**

To help business owners, L&I previously offered new employer reviews in the form of instructional audits. Currently, education and outreach is done by contacting employers via phone and/or e-mail when opening a new industrial insurance account. This gives L&I an opportunity to onboard new accounts and ensure they are in compliance. For established accounts that are out of compliance, we provide the opportunity for self-correction, and if that is unsuccessful, we refer them to audit.

**Contractor training**

L&I invests considerable effort in helping all businesses, including construction contractors, understand their legal obligations. The department 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 2018, over 1,300 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.

**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 provide hands-on demonstrations of how to use L&I resources and, most
importantly, allow 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.

**Employers’ Introduction to L&I workshop**

L&I offers employers and/or their representatives an “Employer’s Introduction to L&I” workshop at most of L&I’s regional offices across the state. In the first eight months of 2018, the department offered 26 in-person workshops in English and three in Spanish. In addition, L&I launched a webinar version of this workshop that drew 64 attendees within the same period.

Out of the total 329 workshop attendees, 221 responded to provide valuable evaluation data:

**Marketing efforts:**

- L&I’s website is the top way in which attendees learned about this workshop. L&I anticipates even better marketing effectiveness through an L&I website update designed to improve search optimization. This project is funded in the 2018 Legislative Budget and will launch in July 2019.

**Workshop effectiveness:**

- Attendees’ self-evaluation of their knowledge gain in the good/excellent categories on the four main topics showed:
  - 72% gain in knowledge about Claim Management and Return to Work Partnerships
  - 57% gain in knowledge about Workers’ Compensation
  - 53% gain in knowledge about safety and health requirements
  - 48% gain in knowledge about wage and hour requirements
  - 58% average knowledge gain on all four topics
Future learning interest and use of free resources:

- 159 safety and health consultation requests
- 143 requests for additional Return to Work information or visits to learn more
- 150 requests for general business resources offered
Below is a summary of the status of L&I’s FY 2018 objectives and initiatives:

<table>
<thead>
<tr>
<th>Objective</th>
<th>Status</th>
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<tbody>
<tr>
<td>A Special Investigations Unit (SIU) was created by repurposing other positions 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>This initiative was restructured as the “Coordinated Enforcement Pilot Project,” discussed on page 13</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 analysis of activities and data 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>
</tbody>
</table>
FUTURE INITIATIVES

L&I will continue to aggressively pursue fraud and abuse in the workers’ compensation system. In FY 2019, the department will continue several strategies from FY 2018 and add more collaboration on suspected violations. Goals for 2019 include:

- Transform data collection gathering tools to be incorporated into the Workers’ Compensation replacement system. This will allow for more efficient identification of fraudulent activity.
- Continue to define and develop coordinated enforcement efforts across the enterprise and with other state agencies.
- Continue to expand the use of escalation strategies to other business areas. This will ensure that the agency response is appropriate to the employer’s action, and that there is a consistent application of consequences.
- Continue to implement and support the Special Investigations Unit. This unit focuses on repeat bad actors.
- Collaborate with Employers, RETRO groups, Advocates, Trade Associations and others on how to identify, deter and report suspected violations by Claimants, Businesses and Providers.
Conclusion

Educating employers, medical providers and workers about their rights and responsibilities in the workers’ compensation system is a top priority at L&I. Fighting fraud when education is not enough is also a priority. The department continues to focus on a range of initiatives – including increased innovation, regulatory actions and collective resources – to bolster the fight against fraud while producing measurable results. L&I remains engaged with stakeholders to develop new methods for combating the underground economy in the construction industry.

In FY 2018, L&I employed about 255 FTEs to detect, investigate, and take enforcement action on workers’ compensation errors and fraud. For every dollar spent on these efforts, L&I returned $9.94. In other words, it costs about ten cents to collect a dollar of debt.

**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.
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.