



Washington State Department of  
**Labor & Industries**

*2008 Annual Fraud Report to the Legislature*

## **Targeting Fraud and Abuse**

*In Washington State's Workers'  
Compensation System*



# Executive Summary



The Department of Labor & Industries (L&I) is pleased to submit this 2008 Annual Fraud Report to the Legislature: Targeting Fraud and Abuse in Washington State's Workers' Compensation System.

*Fiscal Year 2008 (July 1, 2007, through June 30, 2008) saw another year of systematic, innovative, and sustained activity to detect and deter fraud and abuse by employers, workers, and health-care providers.*

**FY 2008 Return on Investment:  
\$7.60 for every \$1 spent.**

## Key developments included:

- New legislative enforcement tools and targeted funding increases to help us combat the underground construction economy.
- Extensive enhancements to the new Field Audit (employer) computer system, improving our ability to target audits to employers with problems in their premium-reporting, including potential fraud.
- Continuing increase in referrals from internal L&I programs. In FY 2008, cross-program referrals accounted for 33 percent of all employer referrals and 20 percent of worker referrals.

## Our fraud-fighting activities produced measurable and substantial results:

- Collected \$124.5 million (delinquent employer premiums, audit assessments, overpayments to workers, health-care and vocational providers, and fraud recovery orders).
- Increased the percentage of audits where monies are owed to L&I — to 66 percent compared to 50 percent in FY 2007.
- Assessed \$24,167,707 through employer audits. Of that total, \$6.5 million was assessed against unregistered employers — companies that hired employees but failed to open a workers' compensation account.
- Identified 90 percent more overpayments and questionable billings to medical and vocational providers compared to the previous year.
- Referred 25 cases for criminal prosecution.

In 2008, we continued to **extensively use fraud-fighting capabilities authorized by the Legislature in 2004**. For example, we pursued premiums from 215 companies that closed and then reopened under a new name. These actions were made possible by the changes in the law governing successorship. We also focused on educating prime contractors about their liability for unpaid workers' compensation premiums generated by sub-contractors on their contracts.

# Fighting Fraud

## Fairness and Financial Integrity

Fighting fraud in the workers' compensation is about fairness. By preventing abuse of the workers' compensation system, we help keep the system healthy for the 165,000 employers and 2.4 million workers it covers. Our mission protects the economic vitality of Washington State.

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

- All businesses and workers in an industry pay more if some employers in that industry under pay or don't pay at all.
- Under Washington law, workers injured on the job are guaranteed workers' compensation benefits even if their employers fail to pay premiums. Other businesses in the same "risk class" pick up the added cost.
- Honest contractors struggle under unfair competition. Construction contractors who underreport employee hours and don't pay the full premiums they owe can undercut honest contractors when bidding on a job.
- Workers who scam the system hurt their co-workers as well as their employers. Workers pay about 25 percent of workers' compensation premiums. Their payroll deduction as well as the rates employers pay go up when some workers collect benefits they are not entitled to receive.
- Providers drive up medical costs if they bill for services they didn't provide. Inflated billings increase the rates of an individual employer, which the employer and his/her workers pay, and they increase medical costs overall.

We have heard the concerns of stakeholders who believe more should be done to reduce fraud, and we have acted on their concerns in our planning and budgeting processes. The following pages describe our fraud-fighting efforts and results.

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# Key Developments in FY 2008

## Background

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

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

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

## Key developments from July 1, 2007, through June 30, 2008 (FY 2008)

**Combating the underground economy.** L&I played a key role in the Joint Legislative Task Force on the Underground Economy in Construction. Based on the task force's recommendations, the 2008 Legislature gave us new tools for fighting fraud, the most significant developments since the 2004 session:

- Established penalties for knowingly falsifying information on applications for contractor registration.
- Barred contractors from working on public works projects if they have multiple violations for working as a contractor while being unregistered or for knowingly misreporting their workers' compensation premiums.

- Made it easier to share data between Labor & Industries and the departments of Employment Security and Revenue.
- Increased support from the Attorney General's Office by adding another dedicated attorney to enforce criminal contractor compliance cases.
- Added four premium auditors.
- Doubled the size of the FAIR contractor fraud team, leading to its first permanent staffing in Eastern Washington. This is the team that canvasses for contractors who are ignoring registration and workers' comp laws and gaining an unfair competitive advantage. In addition to conducting regular inspections, this team works nights and weekends.
- Provided funding for a public awareness campaign to "make fraud wrong again." By highlighting how unregistered contractors threaten consumers and honest companies, the campaign will persuade people to report unregistered and underground businesses.
- Continued the Underground Economy Task Force.

**Payoffs from new technology.** Our new computer systems are improving our ability to share and analyze data and distribute and measure our work.

- **Provider billing detection system.** The Fraud Investigations team is now receiving referrals from this new system that analyzes provider billings to identify anomalies that could be a sign of fraud. The system was developed by L&I's Health Services Analysis.
- **Improvements to audits.** During FY 2008 the department completed 658 streamlined employer audits — a mail-in process that saves time for employers involved in single-issue or limited-scope audits — resulting in over \$1 million in assessments. In addition, we have improved our ability to target audits. Compared with 2004, when 50 percent of audited firms resulted in debit audits, the debit audit percentage has risen steadily to 66 percent during the last six months of FY 2008.

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- **Cross-agency collaboration.** As we continue working with other government agencies to uncover fraud and abuse in multiple agencies, we received over 240 referrals during FY 2008. This led to several successful audits, including an audit of an unregistered firm that resulted in an assessment of \$56,000.

In addition, L&I compared worker-related data with Employment Security on over 3,000 claims: 100 claims were referred for investigations and 19 claims were referred to claim managers. As examples of the results of this cross-agency collaboration, L&I issued fraud orders against an Everett worker for \$10,600 and against a Tacoma worker for \$2,300 for collecting workers' compensation wage-replacement benefits while working at other jobs.

**Progress on other new technology.** During the year we advanced two other major projects:

- **Unregistered employers and premium fraud detection system.** We completed the feasibility study for a comprehensive system that will help us detect unregistered employers and premium fraud.
- **Identity resolution software.** We selected the vendor of new profiling software that will help us uncover companies that are defrauding the system by changing identities — for instance, going out of business still owing premiums and then re-opening under a new name. The new software will determine whether multiple records that appear to represent different entities are actually records for the same entity. We expect to be using this software by the end of FY 2009.

### Major results

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

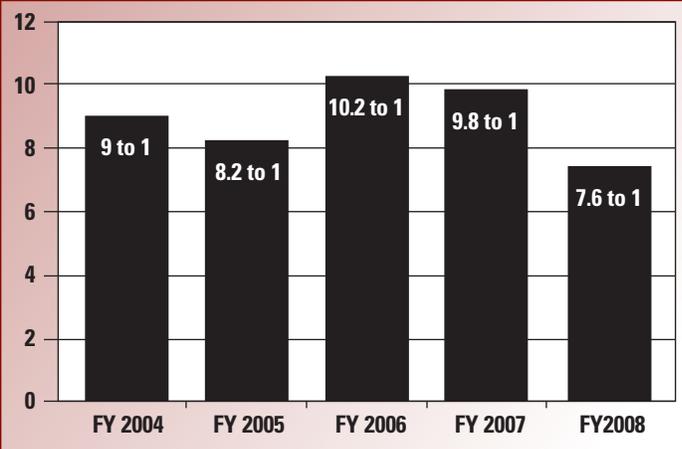
Operating costs include full-time equivalent (FTE) positions, benefits and capital outlays. For FY 2008 the FTEs were 250. This figure includes the Fraud Prevention and Compliance staff — Detection and Tracking Unit, Field (Employer) Audit, Investigations, Collections, Provider Fraud, Significant Cases, Firm Appeals and program administration — and the Provider Review and Vocational Program Audit sections in the Insurance Services Division.

In FY 2008, L&I's Fraud Prevention and Compliance Program brought in about \$8 for every dollar invested, a lower return than in FY 2007. The decline was primarily due to lower collections following a rate holiday, or six-month reduction in workers' compensation premiums, implemented by L&I. With employers reporting lower premiums, delinquent dollars for collection immediately declined by about 25 percent.

To a lesser extent, the lower ROI also reflects a shift in staffing resources: we required significant staffing to test and train on new technology and to train new employees hired in response to turnover. With staffing resources used elsewhere, we completed fewer audits and collected fewer dollars.

**Lower ROI expected for FY 2009.** The effects of the economic downturn were first apparent in Collections in the final

### Return on Investment Ratios



quarter of FY 2008 and are now strongly evident. The number of employers coming into Collections has increased dramatically, while the dollars involved and what they are able to pay has declined. The businesses involved are smaller and, compared to previous years when an employer might have come into collections owing \$1,000, now they might owe \$300. Resolving each of these smaller delinquent accounts requires the same amount of work from L&I staff.

In addition, we will face the same challenges with staffing, especially early in the year when we must use our staffing resources for continuing improvements to our new Field Audit Computer Technology (FACT) system.

# Fraud-fighting Resources at Work

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

The financial integrity of the workers' compensation system depends on **employers** voluntarily and accurately 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.

Worker fraud and abuse occurs when a **worker** knowingly applies for and/or receives benefits he or she is not entitled to receive. Examples are filing a claim when no work-related injury occurred, participating in activities that are inconsistent with the alleged injury, and working for one employer while receiving workers' compensation benefits from another.

Fraud and abuse by **health-care and vocational-services providers** includes inappropriate, costly and sometimes harmful treatments to injured workers, billing for more expensive services than actually provided, billing for treatment not rendered and other questionable billings.

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

## Detection and Tracking Unit

**Purpose: Prevent and detect fraud.**

**Staffing: 10 FTE**

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



- Identifies the valid prospects in the referrals received and sends them to appropriate sections or units, such as Field Audit, Investigations, or Provider Fraud for action.
- Reviews up to 2,000 claims a month (online and paper reports) from cross-matched reports that identify potential fraudulent claims.
- Tracks referral results to identify opportunities for process improvements and provide information for decision-making.
- Operates the fraud telephone hotline and web site (**1-888-811-5974 or [www.fraud.Lni.wa.gov](http://www.fraud.Lni.wa.gov)**).

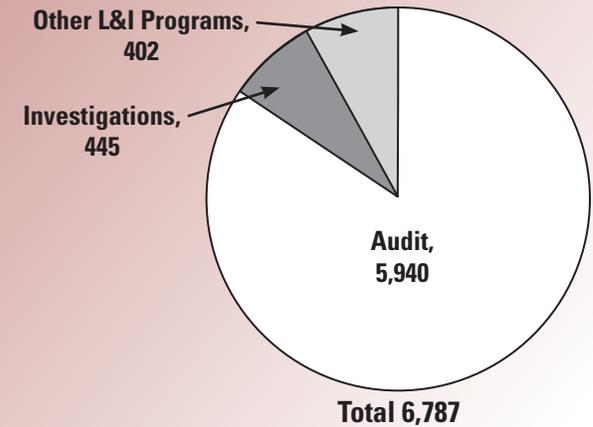
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The DTU also manages the *Verify Workers' Comp Premium Status* online search (<https://fortress.wa.gov/lni/crpsi/>). The system allows users to determine whether a particular business has an active workers' compensation account and is in good standing on their premium payments. Users can sign up to be notified if a business falls out of compliance.

**FAIR Team.** This compliance team (Fraud, Audit, Infraction, and Revenue) focuses on the underground economy, searching for contractors and electricians that ignore registration and licensing laws. During FY 2008 the team issued 126 infractions to unlicensed contractors, and made 146 referrals to L&I revenue agents who collected over \$1.1 million owed to the department. In addition, the team made 322 referrals to the workers' compensation employer audit program resulting in additional collections totaling over \$510,998. Much of their effectiveness is due to close cooperation with other L&I programs.

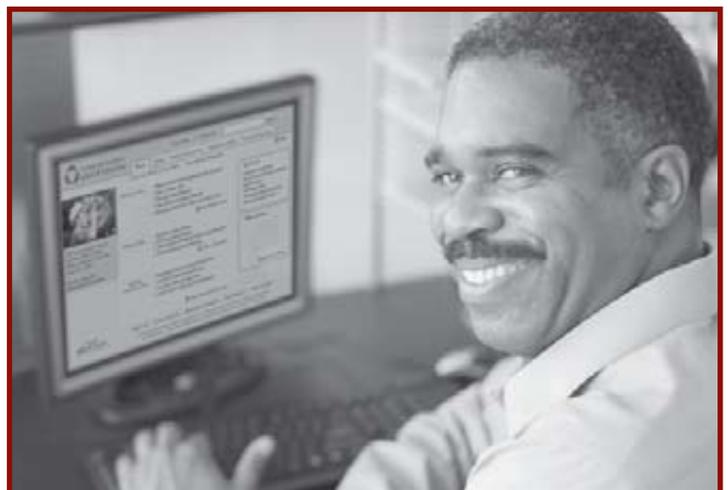
**Outreach and education.** The DTU staff also works to build public awareness of our fraud-fighting activities and conducts training workshops covering prime contractor liability and how to determine whether a subcontractor is an independent contractor or a worker. In FY 2008, the DTU presented 12 workshops.

### Where Referrals Were Assigned



### ► **Fast Fact!**

The *Verify Workers' Comp Premium Status* online search has 70,000 registered users since 2004. Current tracking requests average 125 per day.



## Employer Audit

**Purpose: Identify unpaid employer premiums.**

**Staffing: 71 FTE**

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

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

Process changes and increased staffing have improved our audits, including our ability to target firms that are reporting incorrectly. As a result, even though the number of audits performed fell in FY 2008, the dollars identified increased by more than 20 percent. In 2004, 50 percent of the firms that we audited resulted in debit audits. That audit percentage has risen steadily to 66 percent during the last six months of FY 2008.

One sign of improvement in our processes is the decline in protests as a percentage of completed audits.

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

With future funding, we plan to further upgrade and streamline the auditing system. We have implemented the new auditing system and are continuing to improve and develop efficiencies to the system. We expanded mail-in and phone-in audits, a cost-effective strategy that allows us to interact with more employers using existing staff. Mail-in and phone-in audits are also a convenience to employers.

### FY 2008 Audit Results

Audits: Registered Businesses	Assessments	Audits: Unregistered Businesses*	Assessments	Total Audits	Total Assessments
3,620	\$19,506,967	583	\$4,660,740	4,203	\$24,167,707

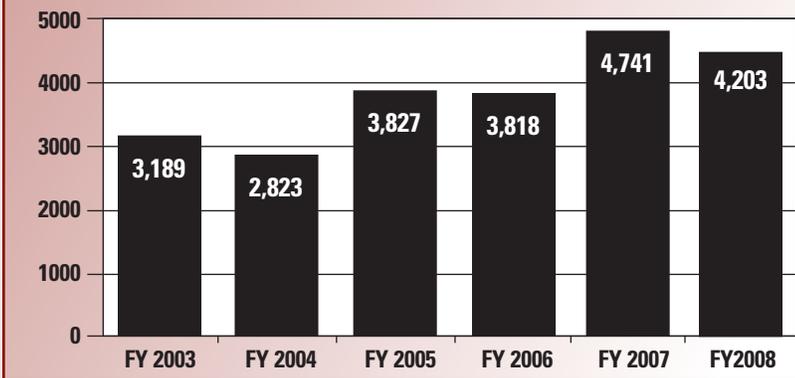
\* An unregistered business is one that hires employees but fails to open a workers’ compensation account.

**▶ Fast Fact!**

Audits benefit all employers by helping to ensure that they pay only their fair share of costs.



### Number of Completed Employer Audits



### Case in Point

A targeted audit of a large Canadian construction firm operating out of Bellevue showed that the firm was misreporting classifications. Based on an audit of six quarters, the firm was assessed a total premium of over \$700,000. The firm immediately paid the premium owed and changed their reporting.

### Challenge hiring and retaining auditors

In July 2001, 57 percent of our auditors had more than 10 years of experience with L&I while 23 percent had less than five years. By comparison, in July 2007, 56 percent had less than 5 years experience and just 24 percent had more than 10 years.

With only 60 auditors and over 168,000 employers, our ability to audit effectively is compromised if we are unable to retain experienced auditors. Auditing skills have been in high demand since Congress passed the Sarbanes-Oxley Act in 2002, designed to protect investors from corporate accounting fraud.

While we experience problems recruiting auditors in some parts of the state, the greater issue is keeping those we hire. We are hiring college graduates, training them, and then watching them leave for higher-paying positions in the private sector or other government positions. Our recruitment and retention may be impacted by the current economic downturn, but it will take time to see the effects.

### Millions of Dollars Assessed through Employer Audits



## Investigations

**Purpose: Stop improper workers' compensation payments to workers.**  
**Staffing: 62 FTE**



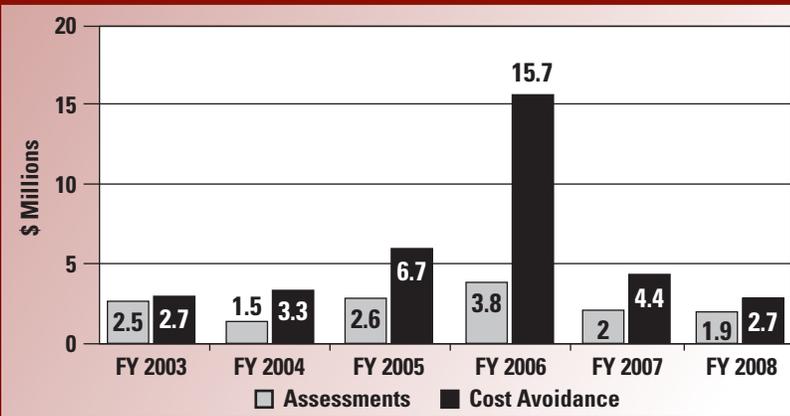
Our Investigations section conducts a variety of investigations to identify improper payments to workers. Detection of abusive or fraudulent claims starts with tips from the public and employers, internal staff such as claim managers, and computer cross matches. When warranted, investigations can lead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

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

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

These activity checks result in significant savings to the workers' compensation system. Using a standardized method to determine avoided costs, we estimate how much would have been spent on a claim if benefits had not stopped as a result of the investigation.

**Millions of Dollars Assessed and Costs Avoided from Investigations**



In FY 2008, compared with the previous two years, L&I's assessments were reduced as well as costs avoided as a result of investigations. Although staff investigated more cases and issued more fraud orders than in the previous two years, the frauds involved fewer dollars.

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

### Case in Point

A Snohomish County man was convicted of willful misrepresentation to get time-loss benefits and the court ordered him repay over \$52,000. The man had filed a lawsuit claiming his girl friend owed him \$36,000 for work as a contractor. As part of the suit he stated under oath when he had performed the contracting work — which was during the same period that he was drawing time-loss benefits. L&I recovered the money it was owed and avoided significant future costs for his time-loss payments.

#### **Fast Fact!**

Avoided costs due to investigations totaled \$2.7 million in FY 2008.

## 2008 Annual Fraud Report to the Legislature

- **Fraud investigations.** When an activity check reveals that a claimant may be receiving benefits fraudulently, we open a fraud investigation. If we determine that fraud was involved, we issue an administrative fraud order (AFO) demanding repayment of benefits plus penalties of 50 percent of the overpayment. These investigations can take several months or longer to complete, depending on the complexity of the case.
- **Out-of-state investigations.** We conduct these investigations if potential fraud involves a person receiving workers' comp benefits who doesn't reside in this state. Out-of-state efforts in FY2008 produced 367 completed investigations and administrative fraud order assessments totaling \$60,047.
- **Other investigations.** Investigators conduct other preliminary inquiries or checks that may lead to a full fraud investigation. For example, we check on persons drawing benefits who may be ineligible if they are incarcerated. Our Pension section may want us to verify that surviving spouses of deceased pensioners are still eligible for benefits and haven't remarried. We investigate cases involving persons who are seeking drugs by presenting themselves as injured workers when they are not.

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

The Investigations program also conducts industrial insurance discrimination and claim suppression investigations. The law protects workers from employer discrimination or retaliation for filing a workers' compensation claim and also allegations that an employer intentionally influenced an injured worker not to file a claim.

### **► Fast Fact!**

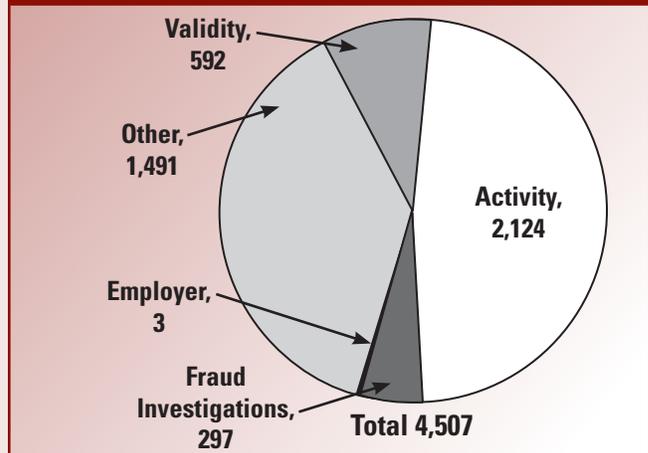
As a result of investigations in FY 2008, L&I issued 181 orders totaling \$1,918,417.

### Computers are key to increasing productivity of investigations

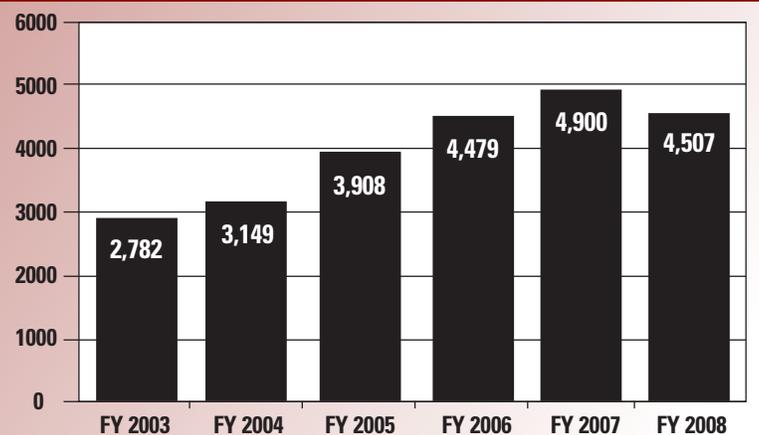
Our Investigations Program currently operates without an electronic case management system. We need to be able to capture case data, review information online, and transfer final reports electronically. LINIIS, the agency's primary and aging mainframe system, has proven inadequate for this purpose. Until new case management technology can be incorporated, Investigations will have limited gains in productivity.

L&I developed a budget request for a case management system that could be used by several programs, but did not move the request forward. When the state's economic climate improves, the agency will reconsider this initiative.

#### FY 2008 Investigations Conducted — by Type



#### Investigations Completed All Types



## Provider Fraud and Abuse

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

Staffing: 17 FTE \*

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



Labor & Industries paid out more than \$537 million for health-care and vocational services in FY 2008. To ensure quality and prevent fraud, we constantly monitor and review the services and

billing practices of health-care providers and vocational counselors. We also receive information about potential fraud from other providers and the public.

In FY 2008, based on new efficiencies and new technology, these units were able to increase their identification of overpayments and questionable billings by over 90 percent compared to the previous year.

Provider overpayments and fraudulent billings may not always be recoverable, but the Fraud Prevention and Compliance Program is increasingly effective at uncovering billing issues earlier, thus preventing ongoing overpayments and possible fraud. +

The **Provider Review and Education Unit** performs quality-of-care reviews and billing audits of health-care providers. The **Vocational Audit Unit** carries out the same responsibilities for vocational-services providers. In FY 2008, these units' audits identified over \$2 million in overpayments to providers. \*

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

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

### FY 2008 Provider Fraud Results

Investigations Conducted	Questionable Billings	Possible Penalties	Costs Avoided
68	\$2,346,150	\$7,024,414	\$633,765

#### **Fast Fact!**

In FY 2008 the L&I units involved with provider reviews and provider fraud identified over \$4 million in overpayments and questionable billings.

#### **Case in Point**

The owner of a Spokane Hearing Aid Company was convicted in Spokane County Superior Court of third-degree theft for billing for services not provided, billing workers and the department for the same hearing aids and billing L&I for new hearing aids which were actually used hearing aids. The owner was sentenced to a one-year suspended sentence and ordered to pay \$60,000 restitution.

### FY 2008 Provider Review Results

Type of Reviews	Completed Reviews	Assessments
Health-care	86	\$1,995,686
Vocational	95	\$78,261
<b>Total</b>	<b>181</b>	<b>\$2,073,947</b>

+ Recoveries or collections for these units are included in the section on Collections.

\* Both the Provider Review and Education Unit and the Vocational Audit Unit are part of L&I's compliance and anti-fraud efforts, but they reside in L&I's Insurance Services Division.

## Collections

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

**Staffing: 81 FTE**



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

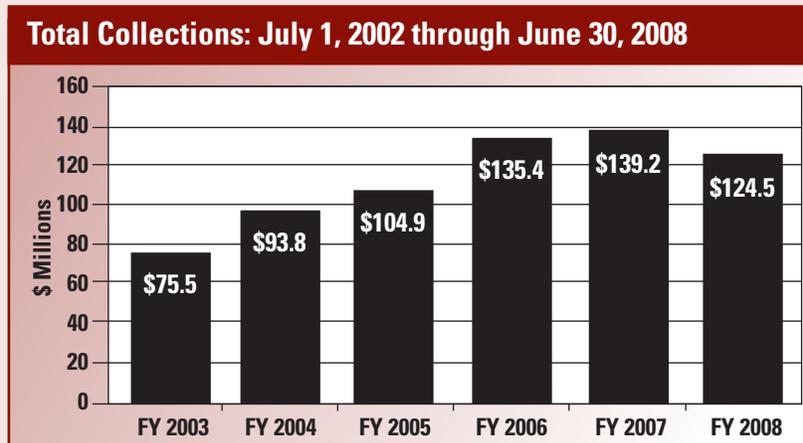
Collections declined in FY 08 due to the temporary reduction in rates, or rate holiday. With lower premiums reported, there were fewer delinquent dollars to collect.

However, our collections of overpayments to injured workers improved by 75–80 percent over the previous year. These gains were made possible through improvements to our processes — we implemented the most efficient and effective strategies developed by our employer-related collections.

Collections has the legal authority to assess penalties and interest and to recover monies through civil action. For example, we can file tax warrants in superior court and seize bank accounts, garnish wages and seize property. In addition, when there are unpaid premiums for work performed by contract, we may pass the debt to the person, firm, or corporation letting the contract.

In FY 2008 we revoked the Certificate of Coverage of 56 employers who refused to enter into or adhere to payment agreements.

This year, Collections began a Plain Talk Project to rewrite our forms and letters to make them easier to understand. We used focus groups to help us revise 25 legal forms, many letters to customers, and other forms used by collectors. We expect to increase collections because our customers will know how to resolve their delinquencies. The new forms will be implemented beginning in the fall of 2008.



## 2008 Annual Fraud Report to the Legislature

### Dollars Collected

Action	What It Means	Amount Collected in FY 2008
<b>Employer</b>		
<b>Premiums collected</b>	Revenue Agents take action to collect unpaid premiums from employers, including delinquent amounts from misrepresentation of payrolls, successorship issues, corporate officer liability, revocations of certificate coverage and prime contractor liability.	<b>\$117,228,228</b>
<b>Health-care and Vocational Providers</b>		
<b>Overpayments collected</b> <i>(fraud and other overpayments)</i>	Provider reviews identify and recover monies paid through inappropriate billings.	<b>\$843,591</b>
<b>Injured Workers</b>		
<b>Overpayments collected</b> <i>(fraud and other overpayments)</i>	Revenue Agents take collection action to recover monies from injured workers who were overpaid and no longer entitled to benefits.	<b>\$6,468,042</b>
<b>Total</b>		<b>\$124,539,861</b>

### Other Results

Action	What It Means	Number of Actions Taken
<b>Contractor registrations suspended</b>	<p>A contractor's registration can be suspended for failing to pay workers' comp premiums. Contractors who continue to work after being suspended are subject to fines under contractor registration laws. Anyone who hires an unregistered contractor can be held responsible for their unpaid workers' compensation premiums.</p> <p>In FY 2008 L&amp;I suspended 111 more registrations than in FY 2007. Much of this effort came from the task force working to combat the underground economy.</p>	<b>297 registrations suspended</b>
<b>Revocations</b>	If efforts to bring an employer into compliance fail, L&I may revoke that employer's Certificate of Coverage. It is a Class C felony to hire employees without that certificate.	<b>56 Certificates of Coverage revoked</b>

## Significant Employer Cases

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

**Staffing: 6 FTE**

Significant Employer Cases (SEC) is a statewide program created to address the most flagrant employer abuses of Industrial Insurance. The program manager coordinates actions across all fraud prevention programs and the Attorney General's Office to successfully resolve cases, including civil and criminal remedies. The efforts of the Significant Employer Cases program resulted in revenue of \$346,087 collected during FY 2008.

This year the Significant Employer Cases program expanded to include an Audit/Investigation team that focuses on specific industries. Targeted industries often have complex issues with Industrial Insurance or with paying wages for vulnerable workers.



The Significant Employer Cases program brings a heightened vigilance and persistence to the pursuit of employer fraud. As an example of the program's impact, the Board of Industrial Insurance Appeals affirmed our findings from a second audit in a major case involving a Lakewood Driving school owner who treated his instructors as independent contractors to avoid workers' compensation premiums.

## Criminal Prosecutions



The SEC program receives vital support from a full-time assistant attorney general (AAG) that develops fraud cases for criminal prosecution. The position was created in 2006.

The attorney works closely with county prosecutors, supporting them in the development of criminal cases or acting as co-counsel, or — when they already have their hands full — prosecuting the cases from the Attorney General's Office.

In FY 2008 the AAG reviewed over 40 cases and referred 25 of them for criminal prosecution. Twenty cases were handled by local prosecutors. Five cases were prosecuted by the Attorney General's office: four were resolved, one through the civil process and three through guilty pleas and sentencing. The AAG also handled six civil cases and provided other important support, including advising on subpoenas, reviewing search warrants and helping obtain them, and training investigators.

The 2008 Legislature assigned another full-time attorney to assist with criminal prosecutions.

### *FY 2008 Cases Referred for Prosecution*

Type	Number
Employer	3
Provider	4
Worker	18
<b>Total</b>	<b>25</b>

### *Case in Point*

Two brothers who owned an excavating company in Clark County were charged with 24 counts of 1st degree theft and 7 counts of employer false reporting/failure to secure payment of compensation for paying employees under the table, failing to pay overtime, and failing to pay prevailing wages when required. After extensive work by the Assistant Attorney General and Significant Employer Cases program, the brothers agreed to pay \$356,000 in unpaid overtime wages and workers' compensation premiums.

# Progress from FY 2007

In the 2007 *Annual Fraud Report to the Legislature*, we identified several specific objectives for Fiscal Year 2008.

Objective	Status
Continue process improvements to increase the quality and timeliness of investigations into potential workers' compensation fraud and abuse.	 <b>Complete</b>
Complete a joint study with Department of Revenue and Employment Security Department on the impact of the underground economy in Washington on state revenue.	 <b>Complete</b>
Investigate possible cases of claim suppression using two new FTEs in the Industrial Insurance Discrimination unit.	 <b>Complete</b>
Complete a feasibility study regarding a computer system for worker fraud investigators to increase efficiencies and provide remote data access.	 <b>Complete</b>
Perfect our use of the new Field Audit Computer Technology (FACT) system and Referral Tracking System (RTS) to identify more cases of employer fraud and abuse.	 <b>Ongoing</b>
Compare additional employer data with the Internal Revenue Service to identify reporting discrepancies.	 <b>Ongoing</b>
Expand our alternative audit unit to increase mail-in and phone-in audits.	 <b>Complete</b>
Participate in a joint legislative task force looking at the underground economy in construction.	 <b>Ongoing</b>
Conduct a feasibility study reviewing employer fraud software and prepare a budget package to implement in the 09-11 biennium.	 <b>Complete</b>
Implement software for reviewing provider billings, based on 2007 feasibility study.	 <b>Complete</b>

## Next Year

### **The Department of Labor & Industries will continue to aggressively pursue fraud and abuse in the workers' compensation system.**

Looking ahead, in FY 2009, the agency already has or will employ the following strategies.

- Respond to the state's economic downturn by changing the way we work with employers in collection, including doubling the length of repayment periods and being more generous about waiving penalties when firms have experienced significant drops in revenue. We are also looking at other options. In the short term these strategies will lower the return on investment for L&I's fraud prevention and compliance program. However, the additional support for employers will be better for the state's future economic health.
- Build on our improvements in worker-related collections in FY 2008 by reassigning staff and triaging cases so that we concentrate on the newest, most promising ones.
- Perfect our use of the new Field Audit Computer Technology (FACT) system and Referral Tracking System (RTS) to identify more cases of employer fraud and abuse.
- Add four new audit FTEs per the Underground Economy Task Force legislation.
- Work with L&I's Employer Services to identify industries with reporting issues and develop a proactive education campaign to help them get into compliance, prior to any audits or enforcement actions.
- Prepare a budget package to implement a comprehensive system to detect unregistered employers and premium fraud in the 2009–2011 biennium.
- Continue our Plain Talk revisions to our collection documents so that our customers will understand their part in resolving their delinquencies with us.
- Continue to participate in the legislative task force looking at the underground economy in construction.

## How to Report Fraud

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

- Fraud reporting hotline at 1-888-811-5974.
- Fraud reporting Web site:  
[www.Fraud.Lni.wa.gov](http://www.Fraud.Lni.wa.gov).



Employers can help detect workers' comp and unemployment insurance fraud by reporting newly hired workers at [www.dshs.wa.gov/newhire/](http://www.dshs.wa.gov/newhire/).

### For more information about this report, please contact:

- Carl Hammersburg, Manager,  
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360-902-5933 or  
hamc235@Lni.wa.gov

*or*

- Barbara Davis,  
L&I Communication Services  
360-902-4216 or  
daba235@Lni.wa.gov

*Other formats for persons with disabilities are available on request.  
Call 1-800-547-8367. TDD users, call 360-902-5797.  
L&I is an equal opportunity employer.*