



**STATE OF WASHINGTON  
OFFICE OF FINANCIAL MANAGEMENT**

STATE HUMAN RESOURCES DIVISION | DIRECTOR'S REVIEW PROGRAM  
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May 15, 2013

TO: Teresa Parsons, SPHR  
Director's Review Program Supervisor

FROM: Kris Brophy, SPHR  
Director's Review Investigator

SUBJECT: Michael Pierce v. Labor and Industries (LNI)  
Allocation Review Request ALLO-12-043

**Director's Determination**

As the Director's designee, I carefully considered all of the documentation in the file, including the exhibits presented during the Director's review process and the verbal comments provided by both parties. Based on my review and analysis of Mr. Pierce's assigned duties and responsibilities, I conclude his position is properly allocated to the Labor and Industries Auditor 5 classification.

**Background**

On May 21, 2012, LNI Human Resources (LNI-HR) received Mr. Pierce's Position Review Request (PRR) form, requesting that his position be reallocated to the Medical Program Specialist 2 classification (Exhibit B-7).

LNI-HR, conducted a position review and by letter dated June 25, 2012, notified Mr. Pierce that his position was properly allocated to the LNI Auditor 5 classification (Exhibit B-5).

On July 20, 2012, the Office of the State Human Resources Director received Mr. Pierce's request for a Director's review of LNI's allocation determination (Exhibit A-1).

On March 27, 2013, I conducted a Director's review telephone conference. Present for the conference were Michael Pierce, Provider Audit Supervisor; Perry Gordon, Council Representative, WFSE; Debbie Yantis, HR Manager, LNI, and Vicki Kamin, Human Resource Consultant, LNI.

During the conference Mr. Pierce submitted an additional exhibit. This information has been added to the record and incorporated as exhibits herein.

### **Rationale for Director's Determination**

The purpose of a position review is to determine which classification best describes the overall duties and responsibilities of a position. A position review is neither a measurement of the volume of work performed, nor an evaluation of the expertise with which that work is performed. A position review is a comparison of the duties and responsibilities of a particular position to the available classification specifications. This review results in a determination of the class that best describes the overall duties and responsibilities of the position. Liddle-Stamper v. Washington State University, PAB Case No. 3722-A2 (1994).

### **Duties and Responsibilities**

Mr. Pierce works within the Provider Fraud Program at LNI.

Mr. Pierce's duties and responsibilities are summarized from the PRR (Exhibit B-3) as follows:

65% **Leads professional staff in the identification, investigation, and forensic audits of fraud and theft for prosecution and/or civil action by state and county prosecutors.**

**Supervises the preparation and processing of civil and provider fraud cases done by Industrial Insurance Provider forensic audits, case preparation, and research and review of cases.** Tasks include:

Supervises the collection and analysis of seized documents, data, and evidence acquired during investigation of fraud cases. Oversees in-depth examinations and review of provider patient files, billings, accounts, and records for injured workers to determine that billings and services rendered are appropriate and justified according to accepted fiscal, healthcare, injured worker care standards and Medical Aid Rule and Fee Schedules.

Provides administrative direction to subordinate staff regarding program operations, projects, and initiatives. Establishes goals and objectives for staff. Uses statistical sampling techniques, research and methodologies to identify, select, analyze and assign cases to Provider Fraud auditors.

Monitors performance of staff assigned to the unit in order to determine training needs. Provides technical assistance regarding interpretation of policies, procedures, program analysis, and monitoring activities. Assesses policy implications and outcomes. Develops plans and policies for review, analysis, and monitoring of health care fraud directed towards the department. Develops and coordinates implementation of program initiatives to contain provider fraud.

Organizes and administers audit review processes performed by subordinate auditors. Supervises coordination of findings from audits and reviews with audit and investigative staff for case progression leading to civil or criminal action. Prepares plans for long term operation of the program. Supervises the resolution of and resolves issues arising from the audits of medical providers.

- 10% **Performs and supervises analytical and consultative activities.** Tasks include: Receives statewide referrals. Staffs and performs comprehensive evaluation and examination of complex issues to verify validity of fraud allegations. Coordinates research, prioritizes, selects and targets providers who have potentially fraudulent billing practices using statistical sampling techniques and methodologies to identify, select and analyze the providers' records and billing practices. Oversees the analysis of Current Procedural Terminology (CPT) billed by providers to determine correct billing of services.
- Coordinates data sent to management and improvement committees to improve payment practices or to stop abusive billing and contain costs. Develops and coordinates reporting procedures to ensure validity of data. Coordinates recommends changes to medical program policies.
- Conducts stake-holding of proposed administrative and procedural regulations for program implementation. Monitors program policies and procedures for adequacy and consistency, including the Medical Aid Rules and Fee Schedules.
- 4% **Provides training.** Tasks include: Analyzes need for positional training for Provider Fraud Program Auditors. Coordinates and provides training to Provider Fraud investigators and auditors, MIPS claim staff, and any providers receiving payments from the Medical Aid Fund regarding policies and procedures relating to forensic audits and investigations. Develops manuals and procedures.
- 4% **Maintains liaison and develops teamwork.** Maintains and oversees liaison and develops teamwork with members of other investigative agencies including the United States Attorney's Medical Fraud Task Force and other state law enforcement, investigative, and regulatory agencies. Coordinates referral of providers to other regulatory agencies for follow up or corrective action.
- 3% **Recommends and orders recovery.** Tasks include: Oversees the recovery of inappropriate or excess provider payments.
- 3% **Negotiates and prepares settlement and/or payment agreements.** Tasks include: Coordinates the activities of auditors when negotiating with providers. Supervises and prepares settlement and/or payment agreements with the assistance of the Assistant Attorney General.
- 3% **Intra-agency consultation.** Tasks include: Consults with administrative, supervisory, and operating personnel to determine and define problem areas with medical and other practitioners providing services to injured workers. Confers with other departmental staff in the development and implementation of program and procedural changes to ensure compliance with departmental requirements, rules and regulations. Participates in decision making process and coordinates implementation of program changes from recommendations developed through project teams or other initiatives. Coordinates and consults with department staff regarding implementation, monitoring, and follow up on program recommendations. Staffs and assigns auditors to sit on committees for process improvement initiatives.

- 3% **Prepares reports.** Tasks include: Supervises and prepares monthly, quarterly, and specialty reports. Compiles technical information and writes analyses, summaries, histories, and reports, in assessment of payment policy quality/effectiveness and areas needing improvement. Authors and issues documents which synthesize data, breaks down problems, and provides education and directives to providers for future changes and used in criminal and civil proceedings.
- 2% **Recommends corrective action.** Tasks include: Recommends corrective action for providers audited/investigated, and monitors corrective action plans where appropriate.
- 2% **Testifies in court and administrative proceedings.** Tasks include: Testifies at criminal and civil court proceedings. Coordinates preparation of staff to testify.
- 1% **Maintains accounts receivable information and data bases.** Tasks include: Responsible for overseeing and maintaining Provider Fraud accounts receivable information regarding restitution or overpayment collection. Maintains and monitors data bases and adapts them to management's needs as required.

Mr. Pierce reports to Mr. Lawrence Yokoyama, Investigations Supervisor. Mr. Yokoyama indicates in Exhibit B-7 that Mr. Pierce's description of his assigned work activities is accurate and complete.

#### Summary of LNI's Reasoning

LNI contends Mr. Pierce's position fits the L&I Auditor 5 class because the primary purpose of his position is to supervise auditors who investigate provider fraud. LNI asserts Mr. Pierce supervises employees who specifically perform auditing work as Provider Fraud Specialists in the Provider Fraud Unit. LNI asserts this includes performing industrial insurance provider audits which includes analyzing medical data preparing cases, and assisting in the prosecution and litigation of provider fraud cases.

LNI asserts Medical Program Specialists work in a different discipline than the L&I Auditor positions and primarily serve as project leads with responsibility for developing medical fee payment policies based on research and analysis in the medical field. LNI asserts that the majority of MPS positions are located in the HSA unit. LNI asserts the HSA has a specific program objective to implement RCW 51.36.080.

LNI asserts Mr. Pierce's duties are not identical to duties performed by MPS positions that work outside but are organizationally aligned to the Health Services Analysis Program (HSA). LNI asserts the other MPS positions which work outside of the HSA provide rules review and legislative analysis consultation to the Office of the Medical Director regarding the affects the quality of care for injured workers. LNI contends Mr. Pierce's position is more narrowly focused on identifying fraud and recouping losses from an accounting rather than medical services perspective.

Based on the assigned duties and responsibilities, L&I contends the L&I Auditor 5 classification best describes the duties assigned to Mr. Pierce's position.

### Summary of Mr. Pierce's Perspective

Mr. Pierce asserts the Provider Fraud auditing program is a medical program, and that the auditing work that he and his staff performs, which includes reviewing medical records, results in cost containment and therefore falls within the scope of the Medical Program Specialist (MPS) series.

Mr. Pierce further asserts his duties are identical to those performed by MPS positions in the Health Services Analysis Program (HSA). Mr. Pierce asserts there are MPS positions which work outside of the HSA program; therefore, LNI's argument that MPS positions must work in the HSA unit is not defensible.

Additionally, Mr. Pierce asserts that fraud prevention is a major cost containment measure and that the provider fraud auditing work he performs is a recognized cost containment strategy (see exhibits F,H, I). Mr. Pierce contends that as a supervisor he leads two forensic auditors in the review and in-depth analysis of medical records, and monitoring of health care cost containment programs, specifically fraud prevention and cost containment. Mr. Pierce asserts he performs cost containment through prevention, through administrative actions, and through the courts by the recovery of losses.

Mr. Pierce further asserts that RCW 51.36.110 provides the authority from which both the HSA and the Provider Fraud program units use to conduct audits and engage in cost containment programs.

Mr. Pierce asserts that he develops, plans, evaluates and promulgates policies to stop provider fraud. He asserts that he provides consultative services to external medical providers and department staff regarding fraud prevention and program administration. Mr. Pierce contends his position serves to educate providers, which is consistent with the MPS 2 class.

In total, Mr. Pierce asserts the Medical Program Specialist 2 classification best fits the overall level of work and responsibility assigned to his position.

### Comparison of Duties to Class Specifications

When comparing the assignment of work and level of responsibility to the available class specifications, the class series concept (if one exists) followed by definition and distinguishing characteristics are primary considerations. While examples of typical work identified in a class specification do not form the basis for an allocation, they lend support to the work envisioned within a classification.

### Comparison of Duties to Medical Program Specialist 2

The Definition for this class states:

In the Health Services Analysis Office of the Department of Labor and Industries and in the Department of Health, leads professional staff engaged in the review, analysis, and monitoring of health care cost containment programs. Positions independently develop, plan, evaluate, promulgate policies and provide consultative services to medical providers and/or department staff regarding program administration.

[Emphasis added]

Mr. Pierce's position does not meet the primary allocating factors of the Definition of this class of working in the Health Services Analysis Office, and leading professional staff engaged in the review, analysis, and monitoring of health care cost containment programs.

#### Health Services Analysis Office

First, Mr. Pierce does not work in the Health Services Analysis Office of LNI. Mr. Pierce asserts and it is acknowledged that there are MPS positions within LNI which work outside of the HSA program. Ms. Yantis stated during the review conference and also in her comments that the MPS positions assigned outside of the HSA are organizationally aligned through a matrix reporting structure to the Health Services Analysis Office.

While it is acknowledged that fraud prevention is considered in a broader sense to be a cost containment measure, the Fraud Prevention and Compliance Program was specifically created in 2005 based on legislation which granted additional authority to LNI to investigate fraud and provide additional fraud prevention and stability to the workers compensation system (Exhibit B-14). According to Ms. Yantis, this Program area includes the Investigations Unit which in turn contains the Provider Fraud Program to which Mr. Pierce's position is assigned. The Provider Fraud Program is specifically tasked to identify medical providers who have billed for illegitimate or exaggerated services. This program is distinctly separate and apart from the HSA.

However, irrespective of reporting relationships and organizational alignment, in Byrnes v. Department of Corrections, PRB No. R-ALLO-06-005 (2006), the Board held that: "[w]hile a comparison of one position to another similar position may be useful in gaining a better understanding of the duties performed by and the level of responsibility assigned to an incumbent, allocation of a position must be based on the overall duties and responsibilities assigned to an individual position compared to the existing classifications. The allocation or misallocation of a similar position is not a determining factor in the appropriate allocation of a position." Citing to Flahaut v. Dept's of Personnel and Labor and Industries, PAB No. ALLO 96-0009 (1996).

#### Health Care Cost Containment Programs

Second, Mr. Pierce does not lead professional staff engaged in health care cost containment programs in a manner consistent with the requirements of this class. The HSA has specific program objectives, and positions assigned to the MPS 2 class lead professional staff engaged in the review, in-depth analysis of health care cost issues and monitoring of health care cost containment programs. Mr. Pierce's position does not meet this intent.

Positions allocated to the MPS 2 class perform tasks such as developing medical fee payment policies for medical treatments or services based on research and analysis in the medical field. They also provide rules review and legislative analysis consultation to management regarding the affects of care for injured workers. They plan, develop and evaluate time-limited studies. They review other state practices and publications for potential application to the health care cost containment program. They participate in research studies and plan and develop strategies for analyzing and reporting on medical provider delivery or injured worker utilization of medical services. Mr. Pierce's position does not have this focus or scope of responsibility assigned to his position.

Mr. Pierce's position focuses on identifying fraud and recouping losses from providers. Mr. Pierce works in the Provider Fraud Program and the majority of his duties involve supervising

professional auditors whose main focus is detecting fraud by auditing medical billing records from an accounting perspective rather than analyzing, evaluating and monitoring medical services for cost containment from a medical services perspective. The majority of his duties involve supervising and overseeing professional auditor staff in identifying, investigating and conducting forensic audits of provider fraud and theft for prosecution and/or civil action by state and county prosecutors.

### Policies and Consultation

Mr. Pierce's position does not independently develop, plan, evaluate, promulgate policies and provide consultative services to medical providers and/or department staff regarding health care cost containment programs as required.

Mr. Pierce's position performs professional-level auditing of medical provider billing activities. Through the forensic auditing process, Mr. Pierce identifies billing issues and makes policy and procedural recommendations to management. This includes developing language to change agency provider billing policies and to improve the provider fraud auditing process. However, these activities focus on provider fraud and are developed from an accounting rather than medical services perspective. Mr. Pierce does not develop medical fee payment policies for medical treatments or services based on research and analysis in the medical field.

Further, Mr. Pierce does not consult with administrative, supervisory, and operating personnel to determine and define problem areas with medical services provided to injured workers. Mr. Pierce confers with other departmental staff to ensure agency processes and procedures are done in accordance with provider billing requirements, rules and regulations. He also provides training and consults with Provider Fraud investigators and auditors, MIPS claim staff, and medical providers regarding policies and procedures related to provider billing and forensic audits and investigations.

It is undisputed that Mr. Pierce uses his medical billing knowledge and experience to supervise staff engaged in conducting provider fraud audits. However, the primary focus of Mr. Pierce's position is to supervise audits and investigations of medical records to detect fraud rather than to conduct medical analysis to determine and promulgate cost containment policies and to provide consultation to medical providers regarding medical services cost containment programs from a medical services perspective consistent with the MPS 2 class.

In total, the thrust of Mr. Pierce's position does not meet the intent or allocating requirements of this class.

### Comparison of Duties to Labor and Industries Auditor 5

The Definition for this class states:

Supervises Labor and Industries Auditors encompassing one or multiple work groups whose responsibilities are to identify non-compliance employers and perform professional audits and educational services to increase compliance with the Industrial Insurance laws, rules, and regulations; or serves as a regional litigation specialist conducting Industrial Insurance protest reconsiderations covering classification, rates, collections, and audit determinations, and assists the Attorney General's Office in appeals before the Board of Industrial Insurance Appeals. The Litigation Specialist has settlement authority in cases reconsidered or appealed. [Emphasis added]

The duties Mr. Pierce describes in the PRR for his position are fully consistent with the requirements stated in the Definition of the L&I Auditor 5 class. Mr. Pierce supervises two auditors who perform professional auditing functions which include providing educational services to providers to increase compliance with Industrial Insurance laws and rules. The primary function of Mr. Pierce position is to detect and prevent fraud by identifying providers who bill for illegitimate or exaggerated services.

In addition, the majority of Mr. Pierce's duties are closely aligned the typical work statements for this class.

For example, Mr. Pierce plans and coordinates with management, other supervisors, and multi-disciplined agency personnel to determine the direction of the Provider Fraud Program.

He disseminates current departmental information and coordinates policy procedure matters between management and audit staff. He evaluates audit information for program development and management reports. He also interprets RCWs, WACs, and department policies and consults with the field staff to ensure uniformity and program consistency;

Mr. Pierce supervises assigned auditing staff. He analyzes, manages, and assigns audits. This includes assisting his subordinates in establishing their audit plans. He coaches and supervises their work. Mr. Pierce conducts and assists and provides guidance to lower level staff during on-site audits. He reviews audit results to ensure consistent application of the laws, rules, and regulations. He conducts formal audit reconsiderations to reach agreement with employers on audit results. He also communicates with the medical providers regarding their rights and responsibilities under the industrial insurance laws.

Mr. Pierce develops and provides education and outreach to investigators and individual medical providers in workshops or presentations. He submitted an example of a Power Point presentation that he developed and presented regarding the Provider Fraud Program (Exhibit Z). Mr. Pierce's training includes such topics as detecting fraud and education about the Provider Fraud Program. Mr. Pierce also gathers statistics and prepares reports for management staff relative to Provider Fraud Program's operations.

In total, Mr. Pierce's responsibilities are closely aligned with the description of duties and level of responsibility described by the L&I Auditor 5 class.

When determining the appropriate classification for a specific position, the duties and responsibilities of that position must be considered in their entirety and the position must be allocated to the classification that provides the best fit overall for the majority of the position's duties and responsibilities. Dudley v. Dept. of Labor and Industries, PRB Case No. R-ALLO-07-007 (2007).

Further, positions are to be allocated to the class which best describes the majority of the work assignment. Ramos v DOP, PAB Case No. A85-18 (1985).

A position's allocation is not based on an individual's ability to perform higher-level work or on an evaluation of performance. Instead, a position's allocation is based on the majority of work assigned to a position and how that work best aligns with the available class specifications. In this case, the level, scope and diversity of the overall duties and responsibilities of Mr. Pierce's position best fit the L&I Auditor 5 classification. His position should remain allocated to that class.

**Appeal Rights**

RCW 41.06.170 governs the right to appeal. RCW 41.06.170(4) provides, in relevant part, the following:

An employee incumbent in a position at the time of its allocation or reallocation, or the agency utilizing the position, may appeal the allocation or reallocation to the Washington personnel resources board. Notice of such appeal must be filed in writing within thirty days of the action from which appeal is taken.

The mailing address for the Personnel Resources Board (PRB) is P.O. Box 40911, Olympia, Washington, 98504-0911. The PRB Office is located on the 4<sup>th</sup> floor of the Insurance Building, 302 Sid Snyder Avenue SW, Olympia, Washington. The main telephone number is (360) 902-9820, and the fax number is (360) 586-4694.

If no further action is taken, the Director's determination becomes final.

c: Michael Pierce, LNI  
Debbie Yantis, LNI  
Lisa Skriletz, SHRD

Enclosure: List of Exhibits

**MICHAEL PIERCE v LNI**  
**ALLO-12-043**

List of Exhibits

A. Michael Pierce Letter requesting Director's Review and Exhibits:

- A. Copy of the "Guide to Completing the Position Review Request" form
- B. Medical Program Specialist 2 class specification, 162F
- C. LNI Allocation Denial Letter from Debbie Yantis June 25, 2012
- D. Organizational charts and phone listings
- E. Article from NCSL titled, "Combating Health Care Fraud and Abuse – Health Cost Containment", April 2012
- F. Article from Indiana Insurance titled, "Cost Containment Strategies", June 2012
- G. Document titled, "Texas Employees Group Benefits Program Cost Containment and Fraud Report", FY 2009
- H. Article from NCLS titled, "Combating Health Care Fraud and Abuse – Health Cost Containment and Efficiencies", September 2010
- I. Article from NCLS titled, "Combating Fraud in Health Care: An Essential Component of Any Cost Containment Strategy", October 2009
- J. Definitions
- K. Position Description, Medical Program Specialist, Angela Emter
- L. Position Description, Medical Program Specialist 1, vacant
- M. Position Description, Medical Program Specialist 3, Sharon Brosio
- N. Position Description, Michael Pierce, dated September 9, 2011
- O. Copies of Documents regarding: Orthotics Case
- P. Policy Titled: "Provider Fraud - Pre-pay Review" and additional documents
- Q. Copy of redacted audit report for a Medical Doctor
- R. Copy of an audit report regarding: Interpreter Group
- S. Copy of an audit report regarding: Physical Therapy
- T. Advocate Policy Study Letter from Lawrence Yokoyama to Lee Benford, dated August 3, 2012
- U. Email and attached referral memo re: "Abuse of Activity Prescription Form", dated August 14, 2008
- V. Referral memo re: "Abuse of Case Management Services", dated March 3, 2011
- W. Memo from Lee Benford to Program Manager, HSA re: "Billing for Partial Days for SIMP, dated April 12, 2011
- X. Copy of "Note-to-File" and additional documents, regarding provider fraud referral
- Y. LNI Auditor 4-In Training Plan, dated February 7, 2008

- Z. Provider Fraud Program Outreach Package
- AA. Letter re: Case Issue HB5801, dated August 17, 2011
- BB. Document re: Interpreter Cases, dated April 25, 2011
- CC. Document titled, "Background" regarding hearing aid providers and manufacturers
- DD. Letters regarding billing dated July 28 and 29, 2011
- EE. Copy of "Note-To-File" regarding interpreter services case, dated May 23, 2011
- FF. Copy of "Note-To-File" regarding a Reconsideration Review for case 05-P-0013, dated February 4, 2008
- GG. Copy of "Record of Phone Call" documents regarding Idaho provider
- HH. Copy of "Notes-To-File" regarding OIC case, dated April 17, 2012
- II. Copy of Provider Fraud Data Base Screen Prints
- JJ. Copy of Provider Fraud Data Base Generated Reports
- KK. Copy of document re: Briefing Topics for Program Manager
- LL. Provider Fraud Program Reports
- MM. Copy of memo from Michael Pierce to Angela Emter with attached documents regarding Provider Fraud Referral to DTU, dated January 2, 2012

Additional exhibits submitted February 8, 2013:

- NN. Copy of RCWs 51.36.080, 51.36.100, 51.36.110
- OO. Copy of Fraud Prevention and Compliance: 2011 Annual Report to the Legislature titled, "Targeting Fraud and Abuse – In Washington State's Worker Compensation System"
- PP. Copy of 2012 Annual Fraud Report to the Legislature titled, "Partnering to Prevent Fraud and Abuse"
- QQ. Statistics chart titled: "Provider Fraud Fiscal Years 2012 – 2013"
- RR. Copy of Job bulletin: "L&I Medical Provider Fraud Auditor Senior"
- SS. Table titled, "Health Services Analysis (HSA) Initiatives"

Additional exhibit submitted during the review conference:

- TT. Opening statement from Michael Pierce

#### LNI Exhibits

1. Organizational Chart
2. Notification of Allocation Appeal from Director's Review Program dated July 24, 2012
3. DOP LNI Auditor 5 class specification
4. DOP Medical Program Specialist 2 class specification

5. Allocation Denial Letter to Mr. Pierce from Debbie Yantis dated June 25, 2012
6. Fraud Prevention & Compliance Mission and Program Objective
7. June 2012 Position Review Request from Michael Pierce
8. June 2012 Position Description Form #2878 for Michael Pierce
9. Position Description forms #2801 and #3423 – staff reporting to Mr. Pierce
10. Performance Planning and Appraisal Form for Michael Pierce 2010-11
11. Performance Planning and Appraisal Form for #3423 2010-11
12. Performance Planning and Appraisal Form for #2801 2010-11
13. Copy of September 2011 PRR and denial letter for allocation to AGO SR/Supervisor Investigator Analyst
14. September 2012 letter to Director's Review Program from Debbie Yantis submitting additional exhibits as rebuttal to Mr. Pierce exhibits
15. December 6, 2007 Director's Review decision for Barbara Boles for LNI position #2878
16. 2007 PDF for position #2878 included in Director's review
17. 2011 PDF for vacant Medical Program Specialist position #4509