U.S. Office of Personnel Management
Office of Merit Systems Oversight and Effectiveness
Classification Appeals and FLSA Programs

Philadelphia Oversight Division
600 Arch Street, Room 3400
Philadelphia, PA 19106-1596

Classification Appeal Decision
Under section 5112 of title 5, United States Code

Appellant:	[appellant's name]
Agency classification:	Health Insurance Specialist GS-107-14
Organization:	Division of [name] [name] Group Center for [name] Centers for Medicare and Medicaid Services Department of Health and Human Services Woodlawn, Maryland
OPM decision:	Health Insurance Specialist GS-107-14
OPM decision number:	C-0107-14-01

Robert D. Hendler

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Robert D. Hendler
Classification Appeals Officer

December 3, 2001

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Date

As provided in section 511.612 of title 5, Code of Federal Regulations, this decision constitutes a certificate that is mandatory and binding on all administrative, certifying, payroll, disbursing, and accounting officials of the government. The agency is responsible for reviewing its classification decisions for identical, similar, or related positions to ensure consistency with this decision. There is no right of further appeal. This decision is subject to discretionary review only under conditions and time limits specified in the *Introduction to the Position Classification Standards* (PCS's*)*, appendix 4, section G (address provided in appendix 4, section H).

Decision sent to:

[appellant's name]
[appellant's address]

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Introduction

On July 30, 2001, the Philadelphia Oversight Division of the U.S. Office of Personnel Management (OPM) accepted a classification appeal from [appellant's name]. Her position is currently classified as Health Insurance Specialist, GS-107-14. She believes the classification should be Health Insurance Specialist, GS-107-15. The appellant appealed to her agency, which issued its final decision on March 31, 2001. She works in the Division [name], [name] Group, Center for [name], Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services, Woodlawn, MD. We received the complete appeal administrative report on September 17, 2001. We accepted and decided this appeal under section 5112(b) of title 5, United States Code (U.S.C.).

General issues

In her July 25, 2001, appeal to OPM, the appellant states that her agency failed to meet its due process requirements in applying internal policies in classifying her position. She refers to the CMS Human Resources Management Group Impact-of-the-Person-on-the-Job Classification Process and Classification Audit and Appeal Procedures. OPM is required by law to classify positions on the basis of their duties, responsibilities, and qualification requirements by comparison to the criteria specified in the appropriate PCS or guide (5 U.S.C. 5106, 5107, and 5112). The law does not authorize use of other methods or factors of evaluation, including whether an agency followed its internal procedures correctly. Our decision sets aside all previous agency decisions regarding the classification of the position in question.

The appellant asks that she be given a retroactive pay increase "effective on the date that is 45 days from the date of the original filing." However, the U.S. Comptroller General (CG) has held that an employee is entitled only to the salary of the position to which he or she is actually appointed, regardless of the duties performed. When an employee performs the duties of a higher grade level, the employee is not entitled to the salary of the higher grade until actually promoted. Consequently, backpay is not available as a remedy for misassignments to higher level duties or improper classifications (CG decision B-232695, December 15, 1989, and B-240239, October 29, 1990). This rule was reaffirmed by the United States Supreme Court in *United States v. Testan,* 424 U.S. 392, at 406 (1976).

As part of the appeal administrative report process, the appellant's position description (PD) of record (PD #[number]) was revised. The appellant's immediate and second level supervisors certified the accuracy of the new PD on August 21, 2001.

Position information

The appellant serves as the team leader for the [name] ([acronym]) related quality improvement programs. CMS contracts with 18 [acronym] Network non-profit organizations that oversee the appropriateness of services and protection for [acronym] patients. In 1994, CMS reshaped its approach to quality assurance and improvement to improve the care of [acronym] Medicare patients. It was renamed the [acronym] Health Care Quality Improvement Program. The 1994 Core Indicators Project (CIP) was CMS's first nationwide population study designed to assess

and identify opportunities to improve [acronym] patient care, and established the first consistent clinical [acronym] database. The 1997 Balanced Budget Act (BBA) required CMS to develop and implement a method to measure and report the quality of [disease treatment] services provided under the Medicare program. As part of this initiative, CIP was merged with the [acronym] Clinical Performance Measures (CPM) Project in 1999.

The appellant technically directs and leads the CPM Project and related initiatives, assisted by two other division members. The appellant's responsibilities include developing reports for surveys, developing reports for consumers, and [acronym] Network Improvement Projects. She is responsible for developing, implementing and evaluating an agency-wide implementation plan that incorporates all aspect of the agency performance measurement strategy. Her work requires working with a wide variety of internal and external [acronym] stakeholders. This includes leading the Adequacy of [treatment] Workgroup and the CMS [acronym] Steering Committee, and communicating with a wide variety of Government agencies, professional organizations, and congressional audiences.

We conducted telephone audits with the appellant on November 14 and 26, 2001, and a telephone interview with the appellant's immediate supervisor, [supervisor's name], Director, Division of [name], on November 27, 2001. The appellant's PD of record furnishes more details about the appellant's duties and responsibilities and how they are performed and is incorporated by reference into the record.

Series and title determination

The agency placed the appellant's position in the Health Insurance Specialist Series, GS-107, for which there is a published PCS, and titled it Health Insurance Specialist. The appellant did not disagree with these determinations, and we agree. Therefore, the appealed position is allocated properly as Health Insurance Specialist, GS-107.

Standard determination

The GS-107 series does not have published grade level criteria. The agency applied the Administrative Analysis Grade Evaluation Guide (AAGEG) for grade level evaluation. The appellant did not disagree. The *Introduction to the PCS's* states that when there is no directly applicable PCS, a position should be classified using criteria that are comparable in scope and difficulty, and that describe similar subject matter and functions.

The Social Insurance Administration Series, GS-105 PCS, belongs to the same occupational family as the appellant's position and shares similar characteristics in terms of the required analytical, writing, and judgmental skills. While the GS-105 PCS describes Government social program administration work related to the appellant's own, it does not contain certain factor level criteria necessary to address the appellant's grade level concerns. The AAGEG contains criteria designed to evaluate staff analytical duties of positions primarily engaged in program administration. Because it offers criteria germane to the appellant's program development and administration work at levels above those defined in the GS-105 PCS, it will be used to extend the criteria of the GS-105 PCS as required in the *Introduction to the PCS's*.

Grade determination

The GS-105 PCS and AAGEG are written in Factor Evaluation System (FES) format. Positions graded under the FES format are compared to nine factors. Levels are assigned for each factor and the points associated with the assigned levels are totaled and converted to a grade level by application of the Grade Conversion Table contained in the PCS. Under the FES, factor level descriptions mark the floor threshold for the indicated factor level. If a position fails in any significant aspect to meet a particular level in the standard, the next lower level and its lower point value must be assigned, unless the deficiency is balanced by an equally important aspect that meets a higher level.

The agency credited Levels 1-8, 2-5, 3-5, 6/7-3d, 8-1, and 9-1. The appellant agrees, but notes that the agency credited the points for Level 6/7-3c rather than 3d. We contacted the agency and corroborated that they intended to credit the points associated with Level 6/7-3d. After careful analysis of the record, we concur with the agency's analysis of the uncontested factor levels and have so credited the position. The appellant believes that her position should be credited at Levels 4-6 and 5-6. Our analysis of Factors 4 and 5 follows.

Factor 4, Complexity

This factor covers the nature, number, variety, and intricacy of tasks, steps, processes, or methods in the work performed; the difficulty in identifying what needs to be done; and the difficulty and originality involved in performing the work.

As at Level 4-5, the appellant's [acronym] quality improvement program involves analyzing and evaluating broad and significant aspects of agencywide operations to develop policies that implement new legislation, i.e., [acronym] BBA quality measurement requirements. She develops and provides advice and guidance to top levels of CMS and other stakeholders on alternative approaches to [acronym] quality improvement issues. The appellant works with uncertainties resulting from continuing changes in the program, e.g., congressional interest in mandating daily [treatment]. She also deals with unusual and unexpected developments that require creative investigation, examination and analysis, e.g., the impact of payment policies on [medical procedure] access choices and the impact of those choices on the quality of patient life. Typical of that level, the appellant develops policy proposals to establish the CMS [acronym] quality improvement position that contributes to the effectiveness with which the [acronym] program is administered.

As at Level 4-5, the appellant delves into areas of potential conflict, e.g., balancing the cost of increasing the number of patients covered for [disease] drug treatments with improved quality of life and potential decreases in hospitalization for related conditions. Her assignments are further complicated by the need to deal with subjective concepts such as value judgments, e.g., balancing congressional measurement objectives with efforts to improve the overall quality and reliability of [acronym] data and patient care practices. Typical of Level 4-5, the [acronym] CPM and related performance measure initiatives are measurable primarily in predictive terms

based on intensive analysis of interrelated data, e.g., the relationship among various clinical characteristics that are predictive of effective care and quality of life.

The appellant's work does not meet Level 4-6, where the employee plans, organizes, and carries through to completion analytical studies involving the substance of key agency programs. While the appellant's work surfaces clinical and reimbursement issues, these [acronym] program policies and processes are controlled by other CMS components; i.e., [name] Group. Therefore, neither the appellant's organization nor her position may be credited with this responsibility. While the appellant functions in a lead capacity and coordinates the work of others, [acronym] quality improvement program proposals and interventions are not of the complexity envisioned at Level 4-6, e.g., proposed changes in basic Medicare legislation or regulations. The [acronym] program reflects part of the administrative, technical, political, economic, fiscal and other components, and the magnitude of their interactions found at Level 4-6, e.g., assignments dealing with planning and implementing major legislative changes in Medicare entitlements. However, the appellant's revision of strategies and methods in dealing with [acronym] quality improvement is only one aspect of a key agency program and, therefore, does not fully meet Level 4-6. Level 4-5 (325 points) is assigned.

Factor 5, Scope and effect

This factor covers the relationship between the nature of work; i.e., the purpose, breadth, and depth of the assignment, and the effect of work products or services both within and outside the organization.

As at Level 5-5, the purpose of the appellant's work is to analyze and resolve broad [acronym] quality problems and issues of critical importance to the agency, and to develop agencywide strategies and approaches to improving the quality of [acronym] services to the affected community. Typical of this level, quality improvement strategies are intended to establish new and innovative ways to foster advancements in the quality of clinical services and patient quality of life, e.g., developing [treatment] facility specific measures for consumer reports, and working with the National Institutes of Health (NIH) and the National Institutes of [three names] Diseases to develop studies that will help to better understand the [acronym] patient populations and their needs. These projects involve coordination of the efforts of major segments of the operational, program policy, and systems components of the CMS and other agencies.

Typical of this level, her work affects how key officials in the agency carry out programs, the capacity of the agency to resolve critical problems, and the extent to which major legislative decisions are implemented in a timely and correct manner, i.e., BBA quality measurement requirements. Her proposals are of major significance to top management, and lead to major changes in approaches to program operations, e.g., using the NIH to perform clinical trials on daily [treatment], and identifying ways to measure patient satisfaction. As at Level 5-5, the projects affect a broad range of agency activities; i.e., [acronym] clinical and payment functions, and that class of beneficiaries.

The appellant's work does not meet Level 5-6, where the purpose is to perform very broad and extensive study assignments related to government programs which are of significant interest to

the public and Congress. The programs studied typically cut across or strongly influence a number of agencies, e.g., public assistance programs and, in many cases, are of major importance to each of several departments and agencies. Because legislation may be conflicting or unclear, there may be disagreements about which department or agency has primary responsibility for significant aspects of the function. Studies frequently involve extensive problems of coordination in fact-finding and in reviewing and testing recommendations in interested agencies or with outside groups, e.g., functioning as the project leader studying the national drug program in several agencies, including the role of the agencies involved. Recommendations involve highly significant programs or policy matters and may have an impact on several departments or agencies, including the realignment of functional responsibilities, the expansion or contraction of key governmental functions or other equally significant changes in the future direction of programs. Results of work are critical to the mission of the agency or affect large numbers of people on a long term, continuing basis.

While the appellant's work cuts across agency lines and routinely involves professional societies and other stakeholders, her authority does not routinely extend to the range of issues covered at Level 5-6, e.g., recommending the realignment of functional responsibilities between agencies or other equally significant changes in clinical and reimbursement program direction or policy. Although [acronym] is a national healthcare system issue, changes to the [acronym] quality improvement program are not of the breadth, depth, scope or impact equivalent to major changes in the operation of national and local drug enforcement programs or national energy policy envisioned at Level 5-6. Therefore, this factor is credited at Level 5-5 (325 points).

Summary

In summary, we have credited the position as follows:

Factor	**Level**	**Points**
1. Knowledge Required by the Position	1-8	1,550
2. Supervisory Controls	2-5	650
3. Guidelines	3-5	650
4. Complexity	4-5	325
5. Scope and Effect	5-5	325
6. Personal Contacts and 7. Purpose of Contacts	3d	280
8. Physical Demands	8-1	5
9. Work Environment	9-1	5
Total Points		3,790

A total of 3,790 falls within the GS-14 grade level point range of 3,605-4,050 points in the Grade Conversion Table in both PCS's.

Our analysis fully considers the appellant’s publications, and input from external parties knowledgeable of her work. This information was instrumental in supporting the factor levels credited above.

Decision

The position is properly classified as Health Insurance Specialist, GS-107-14.