

**U.S. Office of Personnel Management  
Classification Appeal Decision  
Under section 5112 of title 5, United States Code**

**Appellant:** [appellant's name]

**Agency classification:** Claims Assistant  
GS-998-5

**Organization:** [activity]  
Veterans Affairs Medical Center  
Veterans Health Administration  
U.S. Department of Veterans Affairs  
[city and state]

**OPM decision:** Claims Assistant  
GS-998-5

**OPM decision number:** C-0998-05-03

/s/ Judith A. Davis for

\_\_\_\_\_  
Robert D. Hendler  
Classification and Pay Claims  
Program Manager  
Merit System Audit and Compliance

11/30/2012

\_\_\_\_\_  
Date

As provided in section 511.612 of title 5, Code of Federal Regulations (CFR), this decision constitutes a certificate which 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 (Introduction)*, appendix 4, Section G (address provided in appendix 4, section H).

The appellant's Standard Form (SF) 50 includes an Office Automation (OA) parenthetical to the title of his position while his position description (PD) does not reflect an OA parenthetical. Our review of the appellant's work confirmed the addition of an OA parenthetical is inappropriate; therefore, the SF 50 must be corrected to comply with the official classification of the position. As discussed in the decision, the appellant's PD of record must also be revised to meet the PD standard of adequacy in the *Introduction*. The servicing human resources office must submit a compliance report containing the revised PD and corrected SF 50 showing the personnel action taken. The report must be submitted within 30 days from the effective date of the personnel action to the U.S. Office of Personnel Management (OPM) office that adjudicated this appeal.

**Decision sent to:**

[appellant's name and address]

[name and address of appellant's servicing personnel office]

Director, Compensation and Classification Service (055)  
Office of Human Resources Management  
U.S. Department of Veterans Affairs  
810 Vermont Avenue, NW, Room 240  
Washington, DC 20420

## **Introduction**

On June 5, 2012, the OPM's Atlanta Oversight office accepted a classification appeal from [appellant's name]. The appellant's position is currently classified as Claims Assistant, GS-998-5, but he believes it should be classified at the GS-6 grade level. The position is located in the [activity], Veterans Affairs Medical Center, Veterans Health Administration, U.S. Department of Veterans Affairs (VA), in [city, state]. We received the agency's complete administrative report on September 12, 2012. On September 13, 2012, the appeal was transferred to the Dallas Oversight office for adjudication due to program workload considerations. We have accepted and decided this appeal under section 5112 of title 5, United States Code (U.S.C.).

## **Background and general issues**

The appellant's position was previously classified as Claims Assistant, GS-998-6. In August 2011, the [name] Health Care Network (Veterans Integrated Service Network (VISN) [number]) conducted a review of GS-998 positions in the appellant's organization. The VISN concluded the work performed by the claims assistants, including the appellant, was appropriately classified at the GS-5 grade level. The appellant's attempt to file a classification appeal with VA Central Office in September 2011 was rejected as the request was filed prior to the agency taking action to downgrade his position. On October 23, 2011, the appellant was officially assigned to his current Claims Assistant, GS-998-5, position (PD number [number]). He subsequently filed his appeal with OPM.

The appellant raises various concerns about the fairness and objectivity of his agency's position review (e.g., he stated the agency's evaluation was subjective, biased, and inaccurate). In adjudicating this appeal, our responsibility is to make our own independent decision on the proper classification of the appellant's position. Because our decision sets aside all previous agency decisions, the agency's classification review process are not germane to this decision.

The appellant stated his duties are similar to those performed by VA positions classified at a higher grade; e.g., he provided a table indicating 66 percent of claims assistant and authorizer positions in the fee basis organization are graded at the GS-6 level. By law, we must classify a position solely by comparing its current duties and responsibilities to OPM position classification standards (PCS) and guidelines (5 U.S.C. 5106, 5107, and 5112). Other methods or factors of evaluation are not authorized for use in determining the classification of a position, such as comparison to positions which may or may not have been properly classified.

The appellant also submitted three PDs (graded variously as Claims Assistant, GS-998-7; an Authorization Clerk, GS-303-6; and another with no apparent classification), which appear to describe duties and responsibilities similar to his position. Positions which may on the surface appear similar may include significantly different duties and responsibilities that affect the classification. Unlike the appellant's work, the GS-7 PD includes responsibility for management of the fee program; preparing and typing a wide range of correspondence including responses to inquiries from Members of Congress, service organizations, etc.; researching appeals of disallowed treatment and preparing Statements of the Case for submission to the Board of Veterans Appeals, as well as attending hearings as the hearing recorder. We conclude the GS-7

PD describes duties and responsibilities substantially different from those performed by the appellant and, thus, may support a different classification. The GS-6 PD does not include an Optional Form (OF) 8 or any other required documentation indicating the VA certified the classification of the position at that grade level. Thus, the limited information provided by the appellant is insufficient to warrant our tasking VA with an intra-agency classification consistency report based on the positions cited by the appellant.

However, like OPM, the appellant's agency must classify positions based on comparison to OPM's PCSs and guidelines. Under 5 CFR 511.612, agencies are required to review their own classification decisions for identical, similar, or related positions to ensure consistency with OPM certificates. Consequently, the appellant's agency has primary responsibility for ensuring its positions are classified consistently with OPM appeal decisions. If the appellant believes his position is classified inconsistently with another, then he may pursue this matter by writing to the human resources office of his agency's headquarters. He should specify the precise organizational location, series, title, grade, and responsibilities of the positions in question. The agency should explain to him the differences between his position and the others, or classify those positions in accordance with this appeal decision.

### **Position information**

The appellant's position is assigned to the Centralized Fee Unit (CFU) of VISN [number], which encompasses [number] VA medical centers and [number] community-based outpatient clinics in [state, state, and state]. The fee basis program provides for non-VA care in the event VA cannot provide needed care, a non-VA provider is more economical, or travel to a VA facility is not medically feasible in an emergency. The VA may also place veterans in private or State-run nursing homes when the VA nursing home is either at full capacity or is too far from the patient's residence. Fee based services generally fall into any of the following categories: short-term acute inpatient care usually followed by transfer to a VA facility; community nursing home care; emergency outpatient treatment; home-based care; or ongoing outpatient treatment when the nearest VA facility is too far from the patient's residence.

The Fee Supervisor (a Supervisory Legal Administrative Specialist, GS-901-11, position) serves as the first-level supervisor for the appellant and approximately six other claims assistants. The appellant performs work related to authorizations for emergency care, inpatient care, and home health care at non-VA facilities within the VISN. CFU management requires that employees involved in the authorization process are not also involved in the claims payment process; his position involves the authorization and fee obligation steps of the claims process. The appellant's work entails completing information forms, verifying the veteran eligibility for services, making initial determinations regarding whether the diagnosis and proposed care are within coverage guidelines, and ensuring the CFU's fee basis physician has necessary information to determine if the authorization for requested care is appropriate.

The appellant estimates spending approximately 50 percent of his time on authorizations related to inpatient and emergency care; 25 percent on home health care admissions; 10 percent on follow up calls to providers and veterans relating to the claims authorization process; and 15

percent on tracking short-term authorizations and admissions, researching claims, processing pharmacy authorizations, and other miscellaneous support duties.

The CFU receives authorization requests from non-VA providers, VA facilities, or notes generated via VA's Computerized Patient Record System. The appellant determines if the request is complete and includes all information required by the fee basis physician approving or disapproving the request. If the request is incomplete, he contacts either the veteran or the service provider for additional information via telephone, email, facsimile, etc. Once the request is complete, he verifies the veteran's eligibility for care. Eligibility for the majority of requests is readily determined by searching several information databases. For example, requests from veterans already recognized in the VISN's record system proceed to the next step. For other requests, the appellant conducts searches of VISN databases resources, military records databases, and other non-VA sources to verify eligibility for care. He notifies the veteran and service provider when the VA cannot determine eligibility and, therefore, cannot authorize the care request.

Once an eligibility determination is verified, the appellant then determines if the diagnosis and proposed care is in line with the veteran's eligibility (factors include identifying the type of approved services based on the veteran's disability rating, whether the diagnosis is service connected, etc.). The request is subsequently forwarded to the fee basis physician for review. If the appellant is uncertain that a request is appropriate for either the diagnosis or the veteran's level of eligibility, the fee basis physician reviews the request and makes a determination. The appellant then notifies the veteran and service provider of the physician's decision.

Authorizations for home health care follow a similar processing path but require additional steps relating to the obligation of funds. The appellant makes calculations based on pre-set low utilization payment adjustment rates and the number of instances of care authorized on a monthly basis. He obligates the funds by completing VA Form 1358, Estimated Miscellaneous Obligation or Change in Obligation. The appellant checks claims monthly against the obligated funds. He contacts the service provider if no claim is made for dispersal of funds, and he de-obligates the funds if the service provider confirms no services were rendered. The appellant tracks home health care authorizations and generates reports used by CFU management to forecast the budget.

The appellant and supervisor certified to the accuracy of the appellant's PD. We find the PD of record covers the major duties assigned to and performed by the appellant. However, the PD and evaluation include statements not supportable either by the duties described in the record or information obtained during the telephone interviews. The PD includes statements that are overstated ("Independently carries out a wide range of difficult contacts involving atypical problems or very complex situations."), not germane to the position classification process ("The complexity of this position is extraordinary in its demands....This requires infinite versatility in time and task orientation and a great amount of emotional control."), or unsubstantiated ("The accuracy in processing claims affects the viability of research conclusions in funding for the social, physical and economic well being of veterans who are entitled to treatment at VA expense."). Because PDs must meet the minimum standard of adequacy as described in the *Introduction*, the appellant's PD must be updated so that there is a clear understanding of the

duties and responsibilities that represent the approved classification. Regardless, an OPM decision classifies a real operating position and not simply a PD. We have decided this appeal based on an assessment of the actual work assigned to and performed by the appellant.

To help decide this appeal, we conducted a telephone audit with the appellant on September 27, 2012, in addition to a telephone interview with his immediate supervisor on October 1, 2012. In deciding this appeal, we fully considered the interview findings and all information of record provided.

### **Series, title, and standard determination**

The agency assigned the appellant's position to the GS-998 Claims Assistance and Examining Series, titled it Claims Assistant, and graded by application of the grading criteria in the Job Family Position Classification Standard (JFS) for Assistance Work in the Legal and Kindred Group, GS-900 (900 JFS). The appellant agrees his work 'fits' the GS-998 series and has based his appeal rationale by application of the 900 JFS. After careful review of the record, we concur.

The appellant's SF 50 indicates the title of his position currently includes an OA parenthetical, which is used for positions requiring significant knowledge of OA systems and a fully qualified typist (40 words per minute) to perform word processing duties. However, the official PD does not include an OA parenthetical in its title and further states, "Knowledge/Ability of typing is required; however, the services of a qualified typist are not necessary." Careful study of the position's duties and responsibilities, in addition to the PD and discussions with the appellant and supervisor, indicates the work does not require the skills of a fully qualified typist. Therefore, adding an OA parenthetical to the position's title is inappropriate.

### **Grade determination**

The GS-900 JFS is written in the Factor Evaluation System (FES) format, under which factor levels and accompanying point values are assigned for each of the nine factors. The total is converted to a grade level by use of the grade conversion table provided in the JFS. Under the FES, each factor-level description demonstrates the minimum characteristics needed to receive credit for the described level. If a position fails to meet the criteria in a factor-level description in any significant aspect, it must be credited at a lower level unless an equally important aspect that meets a higher level balances the deficiency. Conversely, the position may exceed those criteria in some aspects and still not be credited at a higher level.

The appellant disagrees with the agency's evaluation of Factors 1, 5, and 7. We reviewed the agency's determination for Factors 2, 3, 4, 6, 8, and 9, concur, and have credited the position accordingly. Therefore, our evaluation will only address Factors 1, 5, and 7.

#### *Factor 1, Knowledge Required by the Position*

This factor measures the nature and extent of information or facts that an employee must understand to do acceptable work (e.g., steps, procedures, practices, rules, policies, theories, principles, and concepts) and the nature and extent of the skills necessary to apply that knowledge.

At Level 1-3, the employee has knowledge of, and skill in applying, standardized rules, processes, and procedures sufficient to perform the full-range of legal support assignments. He or she makes simple determinations; assists others to acquire information; and identifies documentation and time requirements. The employee uses personal computers and office software programs to retrieve and sort information from files or records and to prepare documents with complicated formatting; e.g., headers and footers.

At Level 1-4, the employee has knowledge of, and skill in applying, an extensive body of rules and procedures gained through extended training or experience sufficient to perform interrelated and nonstandard legal support work. He or she examines documents where the information and facts are straightforward and readily verifiable, need little development, require limited searches of reference, file, or historical material; and entail comparisons with explicit criteria; plan, coordinate, and/or resolve problems in support activities. The employee uses a wide range of office software applications to prepare complex documents containing tables or graphs; and uses online legal resources to obtain information accessible over the Internet, as needed.

The appellant's position meets Level 1-3. As at Level 1-3, his duties entail obtaining information and documentation from a variety of databases including the Veterans Information Systems and Technology Architecture, the VA's medical records system; Hospital Inquiry for information pertaining to the veteran; medical documentation; or from direct contact with the veteran, non-VA service provider, etc. The appellant also reviews military records to identify periods of service, type of discharge, and the service-connected conditions identified by the VA adjudication division. Similar to Level 1-3 work applying standardized rules, processes, and procedures to perform a full-range of support assignments, he verifies eligibility for care and provides program information to veterans and service providers. This work requires considerable knowledge of established VA regulations, directives, and handbooks related to program administration and eligibility for services; public laws including the Veterans Millennium Health Care and Benefits Act and the Prompt Payment Act; medical terminology related to treatment of disease and injury; coverage guidelines for private health care, Medicare, Tricare, and other means of reimbursement. Also like Level 1-3, the appellant uses personal computers and office software to retrieve and sort information, prepare letters and other documents, and create reports and graphs related to claims information.

The appellant's position is comparable to an illustration in the JFS at Level 1-3 where work requires knowledge of, and skill in applying standardized rules, processes, and procedures concerning claims processing and basic arithmetic sufficient to review claims and correct amounts for allowable items. The employee uses information furnished by claimants to determine the appropriate provisions under which claims should be submitted and the nature and amount of supporting evidence required to process the claim; assists claimants in preparing supporting evidence; examines files; determines allowable items; and calculates the correct amounts for allowed items.

The appellant seeks to credit his position at Level 1-4, stating his work involves performing interrelated and nonstandard legal support work; planning, coordinating, and/or resolving problems; and using online legal resources to obtain information. The illustration in the JFS at Level 1-4 describes claims examiner work as requiring knowledge of, and skill in applying, an extensive body of rules and procedures concerning claims, benefits, and/or obligations. This knowledge is used to analyze issues and make determinations on cases; explain current criteria for benefits or obligations applying directly to individuals; review guidelines and regulations to determine the specific provisions applicable to each case; review records presented by an individual or designated source within the agency to determine the status of the individual's case, and time span expected for processing the case. The employee determines claims amounts allowed per line item, considering such issues as depreciation, insurance, preexisting damage, and salvage value; and deducts amounts recovered by claimants from insurers' and carriers' money.

In contrast to Level 1-4, the appellant's position involves performing claims assistant work where the information is generally straightforward, readily verifiable, and requires minimal development. His work does not require applying an extensive body of rules and procedures to perform interrelated and nonstandard legal support work as described at Level 1-4. For example, his authorization work involves making a series of fact-based decisions related to emergency, inpatient, or home health care authorization requests. The appellant verifies the patient's eligibility for care, i.e., is the patient a veteran eligible for the requested service under the fee program. Eligibility will vary depending on type of service requested, status of the patient, and program requirements under which the referral is made (e.g., the appellant applies different eligibility rules for mental health admissions depending on if the patient is voluntarily or involuntarily admitted for evaluation). He decides if the proposed service meets a patient's specific eligibility level, which involves a comparison of the diagnosis to the patient's service-connected conditions. The service provider may also submit a list of symptoms without identifying a specific diagnosis, requiring the appellant to apply practical knowledge of the symptoms and medical terminology to clarify the diagnosis before forwarding authorization requests to fee physicians for approval. This and other work involves deciding which of the applicable standard fee processes, procedures, and regulations are relevant to the authorization request, but his work does not require the in-depth analysis of issues expected at Level 1-4. The appellant obtains information regarding the authorization request. However, the fee basis physician and others are responsible for approving or disapproving requests. Unlike Level 1-4, he uses a wide range of software applications to prepare letters and gather basic quantitative authorization-related data into tables, graphs, and other easily readable formats rather than the qualitative, comparative, and other statistical data in complex tables and graphs indicative of Level 1-4.

Level 1-3 is credited for 350 points.

*Factor 5, Scope and Effect*



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

At Level 5-2, work involves specific rules, regulations, or procedures. Work is constrained by well-defined and precise conditions. Work includes reviewing documents for missing information; searching records and files; verifying and maintaining records of transactions; and answering routine procedural questions. Work affects the quality of services performed by the office and provides the basis for subsequent actions taken by the organization to provide services to the public.

At Level 5-3, work involves treating a variety of routine problems, questions, or situations within the work environment. The employee advises and assists applicants or other individuals requesting benefits or services with a variety of problems, questions, or situations in conformance with established criteria. Work may involve subjective considerations, such as looking for misrepresentations, fraud, or other illegal activity. Work affects the accurate and timely attainment of licenses, permits, or other legal documents, rights, or privileges; the accurate and timely resolution of claims; and the economic well-being of individuals requesting benefits, claims, and/or services.

The appellant's position meets Level 5-2. Like Level 5-2, his work involves applying specific rules, regulations, and procedures related to the fee basis program. Work entails reviewing authorization requests for missing information, searching records and files, verifying and maintaining records, and using software to prepare correspondence and reports. Also like Level 5-2, the appellant's work directly affects the overall quality of services performed by the fee basis unit, as well as the subsequent actions taken by the fee basis physician. The JFS provides an illustration at Level 5-2 of positions assisting claimants in preparing supporting evidence, searching files for claims-related information, retrieving computerized information concerning claims, and using personal computer and word processing software to prepare correspondence and memoranda. The Level 5-2 illustration describes positions affecting the accurate and timely resolution of claims. The scope of the appellant's work and its impact on the accuracy and timely resolution of claims are consistent with the Level 5-2 illustration.

The appellant seeks to credit his position at Level 5-3, stating his position requires extensive knowledge and understanding of fee policies and regulations critical to making eligibility determinations. He also said his work involves authorizing actions subject to appeal by veterans or Congressional inquiry. We credited his position's knowledge of fee policies and regulations under Factor 1. The appellant's position involves verifying eligibility related to inpatient, emergency care, and home health care authorizations. However, unlike Level 5-3, the work does not involve assisting with a variety of problems, questions, or situations nor does it involve making subjective considerations equivalent to identifying misrepresentations, fraud, or other illegal activities.

The JFS illustration at Level 5-3 describes claims examiner work including reviewing guidelines and regulations to determine the specific provisions applicable to each claims case; reviewing records presented by an individual or designated contacts to obtain information and facts

surrounding the claim; determining the status of the individual's case, time span expected for processing the case, and other factors. The Level 5-3 illustration describes the work as affecting the ability of individuals, partnerships, corporations, and others to negotiate settlements or compromises. In contrast, his work involves reviewing records for missing information and searching databases for existing records and files. Unlike the Level 5-3 illustration, the appellant's work does not involve reviewing records to gather case-related information and facts (his work entails identifying and obtaining missing information, not considering and filtering case information to make decisions on the relevancy of facts based on the merits of the case); determining the status of the individual's case (his work does not require determining the appropriate case status as authorization requests progress through established steps); or determining the timespan expected for case processing (timeframes are established by CFU and others). His work also does not directly impact the ability of individuals and others to negotiate settlements or compromises, or the economic well being of individuals requesting benefits, claims, or services as described at Level 5-3.

Level 5-2 is credited for 75 points.

*Factor 7, Purpose of Contacts*

This factor includes face-to-face and telephone contacts with persons not in the supervisory chain. Levels described under this factor are based on what is required to make the initial contact, the difficulty of communicating with those contacted, and the setting in which the contact takes place.

At Level a, the contacts' purpose is to acquire or exchange information or facts needed to complete an assignment.

At Level b, the contacts' purpose is to plan or arrange work efforts; to coordinate and schedule activities; to resolve problems relating to documents or procedures; and to provide explanations of why approval was not given, discuss measures that might be taken to obtain approval in the future, and explain alternative options that may be available.

The appellant's position meets Level a. As at this level, his contacts with veterans, service providers, and CFU or VISN counterparts involve obtaining information necessary to the authorization process. He also answers eligibility-related questions from veterans.

The appellant seeks to credit his position at Level b, stating:

My activities require me to continually assess my workload and minute-by-minute activity because anything can happen at any time. I may receive a call from a Non-VA provider or Veteran requesting information or be asked questions about the VA's policies related to any program within the VA. This usually requires some research while on the phone or setting up a discussion with another responsible party.

The appellant's statements describe contact with veterans and others to obtain or exchange information related to the VA's fee basis or other program, the purpose of which is properly

credited at Level a. His contacts involve explaining the authorization process and related regulations and procedures; but the purpose in doing so is to exchange information, not to resolve operating problems or influence others as expected of Level b contacts. The appellant's contacts with employees at VA medical centers or facilities and other non-VA service providers are for the purpose of discussing availability, jurisdiction, transfer, and other authorization related issues. He occasionally obtains information from agitated or upset veterans and family members regarding authorization requests, but these and other contacts are not equivalent to influencing or motivating as described at Level b, e.g., to resolve fee program operating problems, present new program proposals, or explain why approval was not given. He also does not plan or arrange the work efforts of others, nor does he coordinate and schedule activities to the extent described at Level b.

Levels 6-2 and 7-a are credited for 45 points.

### *Summary*

<i>Factor</i>	<i>Level</i>	<i>Points</i>
1. Knowledge Required by the Position	1-3	350
2. Supervisory Controls	2-3	275
3. Guidelines	3-2	125
4. Complexity	4-2	75
5. Scope and Effect	5-2	75
6. & 7. Personal Contacts and Purpose of Contacts	2-a	45
8. Physical Demands	8-1	5
9. Work Environment	9-1	<u>5</u>
<i>Total</i>		955

A total of 955 points falls within the GS-5 range (855 to 1,100) on the grade conversion table in the JFS.

### **Decision**

The position is properly classified as Claims Assistant, GS-998-5.