

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

**Appellant:** [appellant et al.]

**Agency classification:** Program Support Clerk  
GS-303-5

**Organization:** Insurance File Management Section  
Patient Financial Services Product Line  
Veterans Integrated Service Network [#]  
Business Office  
Veterans Affairs Medical Center  
Veterans Health Administration  
U.S. Department of Veterans Affairs  
[city and state]

**OPM decision:** GS-303-5  
Title at agency discretion

**OPM decision number:** C-0303-05-22

/s/ Kevin E. Mahoney

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Kevin E. Mahoney  
Acting Deputy Associate Director  
Center for Merit System Accountability

July 10, 2007

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Date

As provided in section 511.612 of title 5, Code of Federal Regulations (CFR), 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*, appendix 4, section G (address provided in appendix 4, section H).

**Decision sent to:**

[appellants]

Program Support Clerk

[location] VAMC

[address]

[city, state, zip code]

[resource officer]

Human Resources Officer

[location] VAMC

[address]

[city, state, zip code]

[specialist]

HR Specialist (Agency POC)

[location] VAMC

[address]

[[city, state, zip code]

[representative]

President AFGE Local 2280

[address]

[city, state zip code]

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## **Introduction**

On September 26, 2006, the Chicago Field Services Group of the U.S. Office of Personnel Management (OPM) accepted a group classification appeal from Messrs./Meses. [appellant 1], [appellant 2], [appellant 3], [appellant 4], [appellant 5], [appellant 6], [appellant 7], [appellant 8], [appellant 9], [appellant 10], and [appellant 11], who currently occupy identical additional positions, hereinafter referred to as position, classified as Program Support Clerk, GS-303-5, in the Insurance File Management Section, Patient Financial Services (PFS) Product Line, Veterans Integrated Service Network (VISN) [#] Business Office, Veterans Administration Medical Center (VAMC), Veterans Health Administration (VHA), U.S. Department of Veterans Affairs (VA), at [city and state]. The appellants believe their position should be classified as Program Support Assistant, GS-303-6, with a target grade of GS-303-7. [appellant 1] was designated as lead appellant, and [representative] was designated as the appellants' representative. We received the initial agency administrative report (AAR) on November 20, 2006, and the complete AAR on February 2, 2007. We accepted and decided this appeal under section 5112 of title 5, United States Code (U.S.C.).

To help decide the appeal, an OPM representative conducted a telephone audit with the appellants and a telephone interview with their immediate supervisor on February 16, 2007, and a telephone interview with the appellants' second-level supervisor on February 22, 2007. In reaching our decision, we carefully considered the audit and interview findings and all other information of record furnished to us by the appellants and the agency.

## **Background**

In 2000, VA reorganized the PFS product line function and selected VISN [#] as one of three "consolidated" VISNs to handle financial services for the medical centers and outpatient facilities within their network. The appellants appealed the classification of their position because they believed the consolidation fundamentally increased the volume and complexity of their work, as well as the independence with which they perform it. The agency appeal decision did not result in any change in title, series, or grade but did result in the reclassification of the appellants' position description (PD) on June 27, 2006. The action, however, only added an addendum to their official PD listing duties related to the E-Pharmacy system and to the Medicare Remittance Advice (MRA) system for reviewing rejected claims. Subsequently, the appellants filed an appeal with OPM.

## **General Issues**

The appellants are assigned to PD Number [###-#####]-A. The appellants' first-and second-level supervisors certified to the accuracy of the current PD on October 10, 2006. However, the appellants do not believe the updated PD is an accurate description of their duties. They believe their work is more complex and technical than described, and also disagree with the grade assigned.

A PD is the official record of the major duties and responsibilities assigned to a position by a responsible agency official; i.e., a person with authority to assign work to a position. A position

is the work that makes up the duties and responsibilities performed by an employee. Classification appeal regulations permit OPM to investigate or audit a position and decide an appeal based on the duties assigned by management and performed by the employee. We classify a real operating position and not simply the PD. Therefore, this decision is based on the actual work assigned to and performed by the appellants.

Implicit in the appellants' rationale is a concern their position is classified inconsistently with other positions since they refer to a position in another VA office which performs similar work, but is classified at the GS-6 grade level. Like OPM, the appellant's agency must classify positions based on comparison to OPM standards and guidelines. Section 511.612 of title 5, Code of Federal Regulations (CFR), requires agencies to review their own classification decisions for identical, similar, or related positions to insure consistency with OPM certificates. The agency has the primary responsibility for insuring that its positions are classified consistently with OPM appeal decisions. If the appellants consider their position so similar as to warrant the same classification, they may pursue the matter by writing to their agency headquarters HR office. In doing so, they should specify the precise organizational location, classification, duties, and responsibilities of the positions in question. If the positions are found to be basically the same, the agency must correct their classification to be consistent with this appeal decision. Otherwise, the agency should explain the differences between the appellants' position and the others.

The appellants indicate they previously worked on accounts receivable to resolve billing discrepancies which they believe were considered to be duties at a higher grade level than GS-5. In their appeal, they state, "although the level of performance [of this work] had never [been] documented as a requirement, it had become [a performance] level expected of our section to effectively assist the other sections in successfully performing their duties." When management discovered that the appellants were performing this work, they recognized the work belonged to other positions in PFS. The appellants were instructed to refer those types of discrepancies to their supervisor for further referral or resolution. In adjudicating classification appeals, 5 U.S.C. 5112 states OPM will: "ascertain *currently* the facts as to the duties, responsibilities, and qualification requirements of a position." Therefore, duties performed in the past which are not part of the regular and recurring work assigned to and performed by the appellants may not be considered in or control the classification of their position.

The appellants also believe their position warrants a higher grade because they must gather, update, and maintain information in the appropriate VA database for health plan benefits, plan limitations, and claim-filing procedures for the more than 5,000 health insurance carriers who provide health benefits for clients serviced by VISN [#] facilities. This also requires them to gather, maintain, and update benefit coverage information for many of the more than 50,000 insurance plans in the database. However, while the VA database does cover this large number of carriers and lists the many insurance plans claimed, the appellants are responsible only for updating information for the insurance providers and benefit plans for veterans or their relatives serviced by VISN [#]. In any case, the volume of work is listed as a factor which cannot be considered in determining the grade of a position (*The Classifier's Handbook*, chapter 5).

The appellants also state they occasionally provide training to other VISN employees on software applications, such as E-Pharmacy and MRA, but have not received credit for it. However, the reason they are asked to share the information is because they piloted the new systems. Their training others to use equipment or software is typical of the workplace where more-experienced employees train new or untrained co-workers in the work of the unit. This requires application of the same level of skill and knowledge required to perform their own work and, therefore, it does not impact the grading of the appellants' position.

The appellants make various other statements about their agency and its evaluation of their position, and point to internal agency discussions regarding the possible upgrading of the subject position. By law, we must classify positions solely by comparing current duties and responsibilities to OPM position classification standards (PCSs) and guidelines (5 U.S.C. 5106, 5107, and 5112). Therefore, we have considered statements made by the appellants and their representative only insofar as they are relevant to making a comparison of the appellants' duties to the appropriate position classification standards and guides. Because our decision sets aside all previous agency decisions, the appellants' concerns regarding their agency's classification review process are not germane to this decision.

### **Position Information**

The appellants perform insurance verification duties in the PFS product line which functions as a virtual team within the VISN [#] Business Office handling financial services for the seven medical centers and over 30 outpatient facilities within their network. PFS is comprised of four divisions: Coding/Billing, Collections, Process Improvement, and Utilization Review/Denials Management. The Collections Division is comprised of three sections, Accounts Receivable, First Party (Patient) Inquiries, and Insurance File Management, where the eleven appellants work.

The primary purpose of the appellants' position is to gather, update, and maintain personal identification, contact information, and health insurance coverage information for each VISN [#] patient in VA insurance files in the Veterans Health Information Systems and Technology Architecture (VISTA) database. The appellants obtain this information from insurance carrier Web sites, through e-mails and telephone calls to Medicare and other insurance carriers, and through communications with enrollees, other Government agencies (e.g. the Social Security Administration), and other VA staff who are involved with patient intake and insurance billing. As insurance verifiers, the appellants are also required to perform follow up work on insurance related rejected claims to determine the cause of the rejection and to update the insurance files with any new information they obtain as a result of their review. The appellants also provide benefit coverage information to patients and share benefit coverage information with Medicare and other insurance carriers to assist in coordination or clarification of benefits as needed. This exchange of information is conducted over the telephone, by e-mail, or in person.

The appeal record, including the official PD, contains descriptive information about the major duties and responsibilities assigned to and performed by the appellants. The PD is adequate for classification purposes and we incorporate by reference into our decision.

### **Series, Standard, and Title Determination**

The agency placed the position in the GS-303, Miscellaneous Clerk and Assistant Series, and the appellants do not disagree. Based on a careful review of the record, we concur with the agency's determination. Similar to positions in the GS-303 series, the primary work performed by the appellants includes clerical work for which no other series is appropriate. The agency titled the appellants' position as Program Support Clerk, but the appellants disagree and request a change to Program Support Assistant. However, OPM has not prescribed titles for positions in the GS-303 series. Therefore, the agency may construct a title in keeping with the nature of the support work performed. In doing so, the agency should adhere to the position titling guidance according to section III.H.2 of the *Introduction to the Position Classification Standards*.

### **Grade Determination**

The agency evaluated the position using the Grade Level Guide for Clerical and Assistance Work (hereafter called the Guide) to grade the appellant's administrative support work, with which the appellants do not disagree. After a thorough review of the record, we concur with the agency's use of the Guide and will use the Guide to evaluate the appealed position. The Guide covers the work of processing transactions and performing various office support and miscellaneous clerical and assistance duties within a framework of procedures, precedents, or instructions. The Guide describes the general characteristics of each grade level from GS-1 through GS-7 and uses two criteria for grading purposes: *Nature of Assignment* (which includes the knowledge required and complexity of the work) and *Level of Responsibility* (which includes supervisory controls, guidelines, and contacts).

#### *Nature of Assignment*

At the GS-5 level, work consists of performing a full range of standard and non-standard clerical assignments and resolving a variety of non-recurring problems. Work includes a variety of assignments involving different and unrelated steps, processes, or methods. The employee must identify and understand the issues involved in each assignment and determine what steps and procedures are necessary and the order of their performance. Completion of each transaction typically involves selecting a course of action from a number of possibilities. The work requires extensive knowledge of an organization's rules, procedures, operations, or business practices to perform the more complex, interrelated, or one-of-a-kind clerical processing procedures.

The nature of the appellants' assignments fully meets the GS-5 level. The primary PFS goals are to ensure proper and accurate billing to all parties involved in health care for clients serviced by VISN [#] facilities, and to maximize VA revenue collections. The billing and revenue collection functions of VISN [#] depend on the accuracy and timeliness of the information in the VISTA database files maintained by the appellants. The appellants accomplish this by obtaining, updating, and maintaining personal identification and insurance benefits information for patients of VISN [#] facilities. The appellants must interpret and apply the nuances of each plan and its corresponding procedures, as part of their verification duties, so the files they maintain contain current and accurate coverage information. They interpret the distinctive terminology used by each of the insurance carriers so that the definitions of terms used by each are clearly understood

and properly applied. Because identical or similar terms used across carriers may have different definitions for each carrier, the appellants must draw upon their experience to discern these differences or query carriers to obtain clarification. In addition, appellants also apply a practical, basic knowledge of medical terminology used in the health care industry in order to communicate with insurance carriers and others regarding insurance coverage benefits.

As at the GS-5 level, the appellants must use judgment and experience to select and apply appropriate laws, regulations, policies and directives to various work situations. In addition, they adapt to continual changes in the health care/insurance industry and properly apply those changes to relevant parts of their work. They are responsible for resolving recurring and non-recurring problems, such as following up on E-Pharmacy/MRA rejected claims when the reason for rejection is not a billing error. They determine why claims were rejected (e.g., patient identification issues, effective dates of coverage conflicts, lack of coordination of benefits, unidentified Medicare replacement policies, type of service not covered, etc.). The results of their review determine whether a claim should be canceled, resubmitted for billing, written off as uncollectible, or referred to the regional counsel for further action. As required at the GS-5 level, the appellants have an extensive understanding of the operations of other parts of their organization, such as patient intake, billing, coding, and accounts receivable, and they understand the impact their duties have on those functions.

At the GS-6 level, the Guide describes the work as either clerical or technical assistance. Clerical work typically entails a wide variety of transactions for more than one type of assigned activity or functional specialization. Assignments are subject to different sets of rules, regulations, and procedures. Such issues must be examined that a course of action has substantive impact on the outcome of the assignment. Work requires comprehensive knowledge of rules, regulations, and other guidelines related to the completion of assignments in the program area assigned. This knowledge is usually gained through extensive, increasingly difficult, and practical experience and training in the subject-matter field. The clerical work also involves the ability to interpret and apply regulatory and procedural requirements to process unusually difficult and complicated transactions. However, while it is an acquired knowledge, not completely covered in a manual, the judgment required to apply the knowledge is not deep.

Technical assistance work at the GS-6 level involves duties that require considerable evaluative judgment within well-defined commonly occurring aspects of an administrative program or functions. It may involve providing direct assistance to specialists or analysts by performing a segment of their work, or it may involve responsibility for a stream of products or continuing processes based on direct application of established policies, practices, and criteria. Assignments typically involve identifying issues, problems, or conditions and seeking alternative solutions based on evaluation of the intent of applicable rules, regulations, and procedures. They also involve problems or situations where there is not one absolutely correct solution, only a best or most appropriate one. This work requires practical knowledge of guidelines and precedent case actions relating to a particular program area equal to that acquired through considerable work experience or specialized training. The work also requires skill to recognize the dimensions of a problem and express ideas in writing.

The appellants perform clerical rather than assistant work. Typical of clerical functions, their work is transactional in nature and does not meet the type of clerical work envisioned at the GS-6 level. Although the appellants must deal with the diverse and numerous details and nuances of a large volume of insurance plans, the transactions they perform are limited in scope to one specialized area; i.e., enrollee and insurance benefits verification for the purpose of maintaining accurate and current insurance information in the VISTA database files. The types of changes directly affecting the appellants work are limited in scope, falling mostly into one of four categories: specific benefits covered; coverage options; choice of providers; and claim-filing procedures. These types of changes do not involve a wider variety of transactions for more than one type of assigned activity or functional specialization as described at the GS-6 level. Furthermore, the work is not characterized by the increasingly difficult or unusually complicated transactions found at the GS-6 level. Instead, most transactions that result from any changes are repetitive in terms of their type, scope, and difficulty. While appellants are routinely faced with handling numerous potential benefit coverage changes (e.g., number of days for prescription refills, routine examination coverage, or allowed length of hospital stay), they all fall into the same category of changes; i.e., health benefit coverage, and the general steps taken to verify these changes and update insurance files are basically the same.

The appellants do not perform technical assistance work or assignments that involve identifying issues, problems, or conditions and seeking alternative solutions based on assessment of the intent of applicable rules, regulations, and procedures typically reflective of the considerable evaluative judgment required at the GS-6 level. The fact-finding they perform does not require them to seek alternative solutions or “best” or “most appropriate” solutions in the absence of one absolutely correct solution. Instead, it requires the repetitive and consistent application of specific and pertinent procedures, rules, and regulations to ensure that health benefit charges are billed to appropriate parties consistently and in compliance with applicable rules and regulations. Changes in work procedures are limited in scope and type and are covered by the general guidance contained in standard operating procedures or other readily available guides. The appellants do not have the authority to deviate from the general guidance they use to do their work. Although the actual details of the changes themselves may be new with each transaction, the process by which the appellants handle a certain category of changes is well established and not increasingly difficult or unusually complicated, as required at the GS-6 level. Therefore, we have credited this factor at the GS-5 level

#### *Level of Responsibility*

At the GS-5 level, the supervisor assigns work by defining objectives, priorities, and deadlines and provides guidance on assignments which do not have clear precedents. The employee works in accordance with accepted practices and completed work is evaluated for technical soundness, appropriateness, and effectiveness in meeting goals. Extensive guides in the form of instructions, manuals, regulations, and precedents apply to the work. The number of guidelines and work situations require the employee to use judgment in locating and selecting the most appropriate guidelines for application and adapting them according to circumstances of the specific case or transaction. A number of procedural problems may arise which also require interpretation and adaptation of established guides. Often, the employee must determine which of several alternative guidelines to use. If existing guidelines cannot be applied, the employee refers the



matter to the supervisor. Contacts are with a variety of persons within and outside the agency for the purpose of receiving or providing information relating to the work or for the purpose of resolving operating problems in connection with recurring responsibilities related to the work.

The GS-5 level is met. Under general supervision, the appellants independently carry out their assignments and organize and prioritize their work to meet established timeframes. They assess work situations and use judgment to determine the appropriate course of action to take, with a focus on the common PFS goals of accurate insurance file maintenance and increased revenue collections. As at the GS-5 level, they use judgment to select and apply appropriate procedures from the extensive guides available, such as standard operating procedures, VA manuals, State regulations, and Federal laws. In many cases, standard operating procedures must be adapted to meet the needs of new circumstances, given the changeable nature of the healthcare industry, but cases where routine procedures do not apply or are outside of the scope of their duties are referred to their immediate supervisor.

Typical of the GS-5 level, the appellants are required to determine whether changes in health benefits affect coverage of an individual or a group, and if so, to alert other parts of PFS of the changes by entering appropriate “patient comments” or “group comments” notations to the file or files, and to notify billing personnel of the specific changes. The detailed steps may vary somewhat from case to case because of the specifics of the change, but the overall guidance for handling the type of change does not vary, as when the appellants are required to search and review contract and coverage provisions after insurance carriers make changes to mental health or pharmacy coverage. When changes occur that affect groups of patients, the unit supervisor reviews the appellants’ insurance files to ensure they have been appropriately and timely updated. While larger scale changes have occurred that required modification or creation of new standard operating procedures, the appellants’ involvement has been as team members to provide detailed input regarding work processes, such as when PFS had to develop new procedures for dealing with Tri-Care, the insurance carrier for active duty Department of Navy personnel when they began servicing former Great Lakes Naval Hospital patients last year; or modifying billing procedures as occurred recently when there was a split-billing problem with Blue Cross/Blue Shield at Madison which has since been applied to other situations with similar billing conflicts created by geographical jurisdiction issues. As at the GS-5 level, the appellants communicate with patients, insurance carriers, employees within other PFS sections, and other government agency representatives. These contacts are made to exchange information regarding enrollees and insurance benefits, to coordinate benefit coverage information, and to resolve enrollee identification or insurance coverage problems.

For GS-6 level clerical work, the supervisor reviews completed work for conformance with policy and requirements. The clerical employee is recognized as an authority on processing transactions or completing assignments within a complicated framework of established procedures and guidelines, often when there are no clear precedents. This recognition typically extends beyond the immediate office or work unit to the overall organization or, in some cases, outside the organization. The employee is regarded as an expert source of information on regulatory requirements for the various transactions, and is frequently called upon to provide accurate information rapidly on short notice. Guidelines for the work are numerous and varied, making it difficult for the employee to choose the most appropriate instruction and decide how

the various transactions are to be completed. Guidelines often do not apply directly, requiring the employee to make adaptations to cover new and unusual work situations. This may involve deviating from established procedures to process transactions which cannot be completed through regular channels, or involve actions where guidelines are conflicting or impracticable. Contacts are with employees in the agency, in other agencies, or with management or users or providers of agency services. The employees provide information, explain the application of regulations, or resolve problems relating to the assignment.

The appellants' duties do not fully meet the GS-6 level. The overall process of verifying a change, determining its impact, and updating the insurance files to reflect the change is repeatedly applied to other health plan changes, although the sub-steps may vary. Unlike GS-6 level work, it does not require or permit the appellants to function as expert sources of information on regulatory requirements since the changes they make are transactional in nature. The appellants do not work within a complicated framework of established procedures and guidelines as found at the GS-6 grade level where there often are no clear precedents, nor do they work with numerous and varied guidelines from which it is difficult to choose the most appropriate instruction and decide how the various transactions are to be completed. Instead, the work they perform is covered by a well-developed body of written and unwritten guidelines and procedures. When a problem in another unit within PFS is identified with or related to errors in insurance file information, the appellants may become involved in its resolution, since they are the gatekeepers of this information. Unlike the GS-6 level, this does not entail providing expert information on *regulatory* requirements. Furthermore, while the appellants must be aware of detailed program processing requirements, they do not deal with the range of interpretive regulatory issues or provide the depth of advice envisioned at the GS-6 grade level.

Supervisory control over work takes many different forms and requires careful evaluation. Routine or standardized work may appear to be performed with a high level of independence when, in fact, it is the work itself that is closely defined and prescribed. When this is the case, the employee does not have an opportunity to perform under less than general supervision. This is the case here where the overall criteria and procedures for conducting insurance verification and reviewing rejected claims follow up work are well established and clearly defined. The appellants' work does not include complex or unique situations where they would need to apply independent judgment in the absence of applicable guidance as present at the GS-6 level. Any deviation from these procedures can only be authorized by the immediate supervisor or higher-level managers within PFS who retain the authority for making necessary changes. Therefore, we have assigned the GS-5 grade level to this factor.

### *Summary*

Because both factors described in the Guide are credited at the GS-5 grade level, we find the work to be properly classified at the GS-5 grade level.

### **Decision**

The appellants' position is properly classified as GS-303-5, with title at the discretion of the agency.