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

Appellant: [names]

Agency classification: Financial Accounts Technician
GS-503-5

Organization: Medical Care Cost Recovery Section
Business Office
Veterans Affairs Medical Center
Department of Veterans Affairs
[city and State]

OPM decision: GS-503-5
(Title at agency discretion)

OPM decision number: C-0503-05-01

/s/ Jeffrey Sumberg
Jeffrey E. Sumberg
Deputy Associate Director
Center for Merit System Accountability

August 13, 2008
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 the 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).

Decision sent to:

[appellants]

[medical center]

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Introduction

On September18, 2007, the Philadelphia Oversight and Accountability Group of the Center for Merit System Accountability, U.S. Office of Personnel Management (OPM), accepted a position classification appeal from a group of employees who occupy identical additional positions (hereinafter referred to as position) classified as Financial Accounts Technician, GS-503-5, in the Medical Care Cost Recovery Section of the Business Office at the Veterans Affairs (VA) Medical Center in [city and State]. (This appeal was subsequently transferred to the Center's Washington, DC, office.) The appellants requested their position be classified at the GS-7 level. We accepted and decided this appeal under the provisions of section 5112 of title 5, United States Code.

General issues

The appellants compare their position to GS-6/7 positions at other medical centers. By law, we must classify positions solely by comparing their current duties and responsibilities to OPM standards and guidelines (5 U.S.C. 5106, 5107, and 5112). Since comparison to standards is the exclusive method for classifying positions, we cannot compare the appellants' position to others which may or may not have been properly classified as a basis for deciding this appeal.

Like OPM, the appellants' agency must classify positions based on comparison to OPM standards and guidelines. However, the agency also has primary responsibility for ensuring its positions are classified consistently with OPM appeal decisions. Copies of position descriptions submitted by the appellant show positions at other VA medical centers may be classified inconsistently with the appellants' position. Therefore, we have asked the agency to give our headquarters office an intra-agency classification consistency report. In making its report, the agency will review positions that are identical, similar, or related to the appellants' position to ensure that they are classified consistently with this appeal decision. The *Introduction to the Position Classification Standards*, appendix 4, section I, provides more information about such reports. We have asked the agency to inform the appellants of the results of its consistency review.

Position information

The appellants are responsible for all insurance verification and reimbursable billing activities for the hospital and its seven geographically dispersed satellite outpatient clinics. They verify insurance coverage for inpatient and outpatient services through a variety of sources, such as on-line and telephone contact with insurance carriers or through use of the on-line Medicare verification system, obtaining additional information directly from the patients as needed to resolve discrepancies. They verify policy numbers, effective/termination dates, and insurance company addresses/phone numbers; identify type of benefits covered (e.g., whether prescription plan is included or pre-certification is required for inpatient hospital stays); determine the processing requirements for billing professional versus facility services; and document these findings in the computer system. Upon receipt of billing sheets from the coding department, they generate bills by coordinating all forms completion with patients, administrative staff, and providers; ensure all patient information is correct, the correct primary and secondary insurances

are identified, and the codes on the bills match the associated medical diagnoses and procedures, referring discrepancies back to the coding department if errors are detected; and create separate bills for facility and physician charges and for individual medical procedures as indicated on the billing sheets. They process claims through the Medicare remittance advice (MRA) system as required and monitor their subsequent transmission to the secondary carriers for payment. For Tricare and ChampVA insurance, they research additional items beyond what is normally required for regular third-party billing and derive pharmacy charges by consulting the Redbook and verifying the correct charges by averaging the high and low costs. They resolve coding problems and other processing issues resulting in claim rejections and resubmit bills for payment.

This is intended only as a very brief summation of the appellants' duties and responsibilities. The appeal record contains much additional descriptive information which was fully considered in this evaluation, and we incorporate it by reference into our decision.

We conducted a telephone audit with the appellants and subsequent telephone interview with their supervisor. We decided this appeal by considering the audit findings and all other information of record furnished by the appellants and their agency, including their official position description and other material received in the agency administrative report on October 11, 2007.

Series and title determination

The appellants' position is properly assigned to the GS-503, Financial Clerical and Technician Series. This series is appropriate for positions engaged in carrying out financial management or fiscal operations not readily classified to another more specific series. Titles are not specified for positions in this series, except that positions graded at GS-5 and above should have a *technician* title.

Grade determination

Positions in the GS-503 series are evaluated by applying the grade-level criteria in the Job Family Standard for Clerical and Technical Accounting and Budget Work, GS-500. This standard is written in the Factor Evaluation System (FES) format, under which factor levels and accompanying point values are to be assigned for each of the following nine factors, with the total then being converted to a grade level by use of the grade-conversion table provided in the standard. The factor point values mark the lower end of the ranges for the indicated factor levels. For a position to warrant a given point value, it must be fully equivalent to the overall intent of the selected factor-level description. If the position fails in any significant aspect to meet a particular factor-level description, the point value for the next lower factor level must be assigned, unless the deficiency is balanced by an equally important aspect that meets a higher level.

Factor 1, Knowledge required by the position

This factor measures the nature and extent of information an employee must understand in order to do the work and the skills needed to apply that knowledge.

The knowledge required by the appellants' position meets Level 1-3. At this level, the work requires knowledge of a body of standardized regulations, requirements, procedures, and operations associated with technical duties related to the assigned financial management support function. This includes, for example, knowledge of the various steps and procedures required to perform a full range of financial management support duties related to recurring or standardized transactions; knowledge of various financial processing procedures to support transactions that involve the use of different forms and the application of different procedures; knowledge of one or more automated data bases associated with a specific financial management function to input a range of standard information or adjustments, understand recurring error reports and take corrective action, and generate a variety of standard reports; knowledge of the structure and content of financial management-related documents to investigate and resolve routine or recurring discrepancies, check documents for adequacy, or perform comparable actions covered by established procedures; and/or knowledge of frequently used and clearly stated regulations and rules to determine if a transaction is permitted or to respond to recurring questions from agency personnel or clients.

The standard provides the following illustration of Level 1-3 work:

> Employees review, examine, and process vouchers for billing various types of patient care to private insurance companies and perform other third-party collection, billing and accounting tasks. They compile and examine vouchers for submission to private insurance groups. They enter information into a computerized system. They check computer-generated billing for correctness and complete blocks requiring unique hospital information. They maintain ledgers on accounts receivable. They prepare quarterly reports regarding insurance amounts billed and collected.

This level fully represents the work performed by the appellants in their capacity as billing technicians. Their work requires knowledge of a body of standardized regulations, requirements, procedures, and operations directly associated with the billing function. This includes knowledge of the steps and operating procedures required to conduct on-line and telephone verification of insurance coverage; to document findings in the computer system; to generate bills directly from coded lists of medical services provided; to detect discrepancies between codes and associated diagnoses and medical services; and to understand error reports on rejected claims and take corrective action. Although this billing function does not involve the review and processing of vouchers, it is otherwise analogous to the Level 1-3 illustration cited above in terms of the basic knowledge required to perform third-party insurance billing work.

Looked at in its entirety, Level 1-3 includes such work as processing vouchers for third-party billing; reviewing purchase orders, contracts, travel orders, and other claims against obligated funds; auditing cash processing documents before authorizing payment from funds; providing payroll services; reviewing vouchers, purchase requests, work orders, and contract invoices to

verify account codes and dollar amounts and to assure that funds are available; examining standard tax returns; and auditing routine transactions used in disbursing insurance funds. All of these types of work require knowledge of a body of standardized procedures, requirements, and operations to process a limited set of forms where the individual tasks are relatively repetitive.

In contrast, at Level 1-4 the work requires in-depth or broad knowledge of a body of accounting, budget, or other financial management regulations, practices, procedures, and policies related to the specific financial management function. This includes, for example, knowledge of a wide variety of interrelated steps, conditions, and processes required to assemble, review, and maintain *complex* accounting, budget, or other fiscal transactions (such as processing tax returns with numerous supporting schedules or reconciling accounts with extensive subdivisions); knowledge of various accounting, budget, or other financial regulations, laws, and requirements; knowledge of a variety of accounting and budget functional areas and their relationships to other functions to research or investigate problems or errors that require reconciling and reconstructing incomplete information, conducting extensive and exhaustive searches for required information, or performing actions of similar complexity; and/or knowledge of extensive and diverse accounting, budget, or other financial regulations, operations, and procedures governing a wide variety of types of related transactions to resolve nonstandard transactions, complaints, or discrepancies, provide advice, or perform other work that requires authoritative procedural knowledge.

The appellants' work is clearly more analogous to Level 1-3 in that it involves processing a limited set of forms for one specific purpose. Although they must understand the requirements of, for example, billing primary versus secondary carriers, or professional versus medical services, this is not comparable to processing tax returns with multiple supporting schedules or reconciling accounts with extensive subdivisions. Work related to such functions as billing, purchasing, cash processing, and other relatively non-complex fiscal transactions is covered at Level 1-3; i.e., one party requests payment and the other party remits payment. Level 1-4, in contrast, covers more *complex and diverse* accounting, budgetary, or fiscal transactions. For example, one illustration provided by the standard at Level 1-4 involves conducting comprehensive reviews of military pay transactions including allowances, special incentive pay, debt collection, etc.; auditing and resolving cases involving overpayment or underpayment for several periods of service; and reviewing error reports and making corrections. In this situation, the work requires not just making or requesting payment but making independent determination as to whether payment was justified from a regulatory standpoint. Another illustration provided at Level 1-4 involves reviewing, correcting, and coding a variety of multiple-page tax returns, most of which have one or more schedules attached, where the employee identifies and codes potential unallowables, interprets the taxpayer's intent from available data, and completes documents in the required format. Likewise in this situation, the work requires not just noting whether payment was made but determining the taxpayer's liability as to payment. The appellants' work does not require an equivalent level of knowledge and is directly addressed at Level 1-3.

Level 1-3 is credited (350 points).

Factor 2, Supervisory controls

This factor covers the nature and extent of direct or indirect controls exercised by the supervisor, the employee's responsibility, and the review of completed work.

The level of responsibility under which the appellant works is comparable to Level 2-3 (the highest level described under this factor). At this level, the supervisor assigns work with standing instructions on objectives, priorities, and deadlines and provides guidance for unusually involved situations. The employee independently processes the most difficult procedural and technical tasks or actions and handles problems and deviations in accordance with instructions, policies, previous training, or accepted practices. The supervisor evaluates completed work for overall technical soundness and conformance to agency policies, legal, or system requirements. Completed work is spot checked for results and conformity to established requirements and deadlines. The methods used to complete the assignment are seldom reviewed in detail.

This accurately represents the manner in which the appellants are expected to operate. They are expected to carry out their work independently in accordance with established operating procedures and priorities, although the supervisor and work leads are available to provide assistance on difficult problems encountered and the implementation of new procedures. Their work is evaluated for achievement of processing goals within expected time frames.

Level 2-3 is credited (275 points).

Factor 3, Guidelines

This factor covers the nature of the guidelines used and the judgment needed to apply them.

The guidelines used by the appellants match Level 3-2. At this level, a number of established procedures and specific guidelines in the form of agency policies and procedures, Federal codes and manuals, specific related regulations, precedent actions, and processing manuals are readily available for doing the work and are clearly applicable to most transactions. The number and similarity of guidelines and work situations require the employee to use judgment to identify and select the most appropriate procedures to use, choose from among several established alternatives, or decide which precedent action to follow as a model. There may be omissions in guidelines, and the employee is expected to use some judgment and initiative to handle aspects of the work not completely covered. The employee may make minor deviations to adapt references or procedures to specific cases but refers situations where existing guidelines cannot be applied or significant deviations must be made to the supervisor or designated employee.

Correspondingly, the transactions carried out by the appellants are covered by specific written guidelines and procedures, although they are expected to use initiative in handling aspects of the work that may not be completely covered. For the most part, however, the work is processed in accordance with standard operating procedures, and situations without adequate precedent are referred to the supervisor for guidance.

The position does not meet Level 3-3. At this level, guidelines are the same as at Level 3-2 but because of the complicating nature of the assignments, they lack the specificity, frequently change, or are not completely applicable to the work. For example, when completing a transaction, the employee may have to rely on experienced judgment rather than guides to fill in gaps, identify sources of information, and make working assumptions about what transpired. The employee uses judgment to interpret guides, adapt procedures, decide approaches, and resolve specific problems. This includes, for example, using judgment to reconstruct incomplete files, devise more efficient methods for procedural processing, gather and organize information for inquiries, or resolve problems referred by others (e.g., those that could not be resolved at lower levels). The employee analyzes the results of applying guidelines and recommends changes, such as specific changes to the guidelines themselves, the development of control mechanisms, additional training for employees, or specific guidance related to the procedural handling of documents and information.

The written guidelines the appellants use for performing their work are specific and are generally applicable to the work. Although occasional changes in Medicare coverage affect billing procedures, these changes are not frequent in that they are usually issued at the beginning of the year. When completing a transaction, the appellants do not "fill in gaps," "identify sources of information," or "make working assumptions about what transpired" because these types of activities are not inherent to their work. Rather, they are provided specific information which they are required either to verify or to convert from a code directly to a billing document. In the case of coding discrepancies, for example, they are not authorized to "use judgment to reconstruct incomplete files" but rather return the transaction to the coding department for correction. This is a technical processing function, and the appellants take action based on the specific information provided to them. The work does not afford the latitude to process bills based on "assumptions" or to adapt processing procedures. As at Level 3-2, the exercise of judgment is limited to determining the particular processing procedures to use for the given transaction.

Level 3-2 is credited (125 points).

Factor 4, Complexity

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

The complexity of the appellants' work is comparable to Level 4-2. At this level, the work involves performing related procedural tasks in processing financial management transactions. For example, processing a transaction may involve verifying codes and other information; reconciling balances; assembling appropriate forms; entering data into automated file systems; and answering routine procedural inquiries. The employee makes decisions, such as how to sort incoming documents, locate and assemble information, and correct errors based on review or knowledge of similar cases or samples, or by selecting from among other clearly recognizable alternatives. For example, when investigating payment discrepancies, the employee considers which established approach best fits the circumstances. The employee takes action using

established instructions, practices, or precedents for the processing of documents. Actions taken are similar and well established, although the specific pattern of actions taken may differ.

The appellants' work varies from transaction to transaction depending on the particular insurance carrier involved. However, as at this level, the actions taken in generating bills are basically similar and prescribed. The work is governed by established instructions, procedures, and precedents for the processing of individual transactions and involves selecting from among clearly recognizable alternatives based on the insurance carrier being billed.

The position does not meet Level 4-3. At that level, the work involves performing various financial management support-related duties or assignments that use different and unrelated processes, procedures, or methods. The use of different procedures may result because transactions are not completely standardized, deadlines are continually changing, functions assigned are relatively broad and varied, or transactions are interrelated with other systems and require extensive coordination with other personnel. The employee decides what needs to be done by identifying the nature of the problem, question, or issue, and determining the need for and obtaining additional information through oral or written contacts or by reviewing regulations and manuals. The employee may have to consider previous actions and understand how these actions differ from or are similar to the issue at hand before deciding on an approach. The employee makes recommendations or takes actions (e.g., determines eligibility for deductions, entitlements, or claims, verifies factual data, or makes other financial determinations) based on a case-by-case review of the pertinent regulations, documents, or issues involved in each assignment or situation.

The appellants must use different billing procedures depending on the particular insurance carrier involved and the types of medical services that were provided. However, unlike Level 4-3, these different procedures are established and standardized and do not allow for latitude in "deciding on an approach." The work involves carrying out somewhat complicated but rote procedures; i.e., generating bills from coded billing sheets that do not pose any particular ambiguity in terms of deciding "what needs to be done by identifying the nature of the problem, question, or issue." Further, it does not involve making the kinds of recommendations or actions expected at Level 4-3, such as determining eligibility for deductions, entitlements, or claims. The work consists of processing bills by transmitting specific information regarding the medical services that were provided. It does not involve the comparatively more difficult work depicted at Level 4-3 where, for example, the employee reviews claims to determine if they should be paid.

Level 4-2 is credited (75 points).

Factor 5, Scope and effect

This factor covers the relationship between the nature of the work and the effect of work products or services both within and outside the organization.

The scope and effect of the appellants' work match Level 5-2. At that level, the purpose of the work is to perform a full range of related financial management clerical or technical tasks that are covered by well-defined and precise program procedures and regulations. The employee

completes standard clerical transactions in the functional area by reviewing documents for missing information, searching records and files, verifying and maintaining records of transactions, and answering routine procedural questions. The work affects the adequacy and efficiency of the financial management function and may also affect the accuracy of further processes performed by related personnel in various organizations.

Correspondingly, the purpose of the appellants' work is to perform a full range of clerical and technical tasks associated with the hospital's billing function. These tasks are covered by well-defined operating procedures and regulations. The appellants complete a range of transactions including conducting on-line and telephone verification of insurance coverage; documenting information in the computer system; generating bills from coded lists; and resolving errors on rejected claims. The work affects the timely reimbursement of medical care costs to the hospital by insurance carriers.

The position does not meet Level 5-3. At this level, the purpose of the work is to apply conventional practices to treat a variety of problems in financial management transactions. Issues might result, for example, from insufficient information about the transaction, a need for more efficient processing procedures, or requests to expedite urgently needed cases. The employee treats these or similar problems in conformance with established procedures. The work affects the quality, quantity, and accuracy of the organization's records, program operations, and service to clients. For example, the effect of the work ensures the integrity of the overall general ledger, its basic design and the adequacy of the overall operation of the accounting system and various operating programs; the amount and timely availability of money to pay for services; the economic well-being of employees being serviced; or compliance with legal and regulatory requirements. *The standard notes that only a few positions will be evaluated at this level.*

The appellants' work is not structured so as to meet this level. All of the appellants perform the full range of tasks associated with the work, as depicted at Level 5-2. None of the positions are specifically dedicated to resolving the particularly difficult problems encountered, or to improving the processing procedures or the design of the record system. Level 5-3 is reserved, in effect, for those positions that are structured in a manner that they operate beyond the parameters of the routine processing work of the organization.

Level 5-2 is credited (75 points).

Factor 6, Personal contacts
and
Factor 7, Purpose of contacts

This factor includes regular and recurring face-to-face and telephone contacts with persons not in the supervisory chain. The relationship between Factors 6 and 7 presumes that the same contacts will be evaluated under both factors.

The appellants' personal contacts match Level 2, where contacts are with persons in the same agency, but outside the immediate organization, with employees in other agencies who are

providing requested information, and/or with members of the general public in a moderately structured setting, such as with individuals who are attempting to expedite transactions.

Correspondingly, the appellants' regular and recurring contacts are with other hospital staff, administrative personnel of health insurance companies, and patients and their family members.

Level 3 is not met, where contacts are with persons in their capacities as representatives of others such as attorneys and accountants or congressional staff members making inquiries on behalf of constituents. These contacts are not recurring or routine and the purpose, role, and authority of each party must be established each time in order for the employee to determine the nature and extent of information that can be discussed or released.

The appellants do not have regular and recurring contacts of this nature. Although they may have occasional contact with patients' attorneys on torte cases, these are relatively routine and involve providing copies of billing documents. The nature of these contacts is not such that the appellants are responsible for determining what information can be discussed or released.

The purpose of the appellants' contacts matches Level b, where contacts are for the purpose of planning and coordinating actions, such as obtaining a customer's cooperation in submitting paperwork, requesting others to correct errors in documentation or data entry, or assisting others in locating information. For example, the appellants deal directly with patients in obtaining information needed to verify insurance coverage, contact insurance carriers for the purpose of verification, and work with the hospital's coding department to resolve errors detected when generating bills.

Level c is not met, where the purpose of contacts is to persuade individuals who are fearful, skeptical, uncooperative, or threatening to provide information, take corrective action, and accept findings in order to gain compliance with established laws and regulations.

The appellants' role is limited to verifying insurance coverage and generating bills. This is a technical processing rather than a regulatory compliance function.

Level 2b is credited (75 points).

Factor 8, Physical demands

This factor covers the requirements and physical demands placed on the employee by the work assignment.

The position matches Level 8-1, where the work is sedentary.

Level 8-1 is credited (5 points).

Factor 9, Work environment

This factor considers the risks and discomforts in the employee's physical surroundings or the nature of the work assigned and the safety regulations required.

The position matches Level 9-1, which describes a typical office environment.

Level 9-1 is credited (5 points).

Summary

Factors	Level	Points
Knowledge required by the position	1-3	350
Supervisory controls	2-3	275
Guidelines	3-2	125
Complexity	4-2	75
Scope and effect	5-2	75
Personal contacts/Purpose of contacts	2b	75
Physical demands	8-1	5
Work environment	9-1	5
Total		985

The total of 985 points falls within the GS-5 point range (855-1100 points) on the grade conversion table provided in the standard.

Decision

The appellants' position is properly classified as GS-503-5, with the title at agency discretion.