

Job Title:	Investigator
Requisition Number:	JO-1508-3152
Grade:	12
Salary Range:	\$71,716.00 - \$91,750.00
Promotion Potential:	Yes
Agency:	Dept of Health Care Finance
Location:	441 4th St NW (One Judiciary Square)
Area of Consideration:	Open to the Public
Opening/Closing Date:	8/13/2015 - 8/27/2015

Job Summary

This position is located within the Department of Health Care Finance, Office of the Senior Deputy/Medicaid Director, Division of Program Integrity. The position serves as an Investigator conducting investigations of suspected fraud, and related activities to prevent, detect, and eliminate fraud and abuse by persons who provide and receive services financed by DHCF.

As assigned by Chief Investigator, independently conducts preliminary investigations of individual providers or beneficiaries of health care services, and drafts recommendations on the disposition of each case investigated, based on the extent to which the findings of the investigation suggest probable fraud or abuse.

Analyzes computer-generated data to identify individuals and organizations that are most likely to provide evidence to ascertain whether fraud or abuse is likely to have occurred. Interviews health care beneficiaries and their informal caregivers in their homes and by telephone to determine the extent to which health care services were delivered as billed and care was delivered in accord with program requirements.

Uses data collection instruments and protocols previously developed or adopted by the Division, and develops new data collection instruments as needed in the conduct of complex investigations. Actively participates in Investigations and Compliance Branch team meetings and meetings with other DHCF internal and external partners to collaborate on the detection and resolution of fraud and abuse.

Prepares case documents for referral to the Medicaid Fraud Control Unit and other external agencies involved in the prosecution of health care fraud. Assists in preparing testimony and other information requested by external agencies investigating or prosecuting Medicaid fraud.

Remains abreast of all federal and District of Columbia rules and laws applicable to fraud and abuse and program integrity in medical assistance programs administered by DHCF. Remains abreast of rules and laws applicable to medical assistance programs administered by DHCF and maintains copies of all manuals and rules.

Maintains active case files, including files of cases referred to the Medicaid Fraud Control Unit and other parties with whom information is shared. This includes complying with federal and District of Columbia confidentiality and security requirements.

Assists with training of DHCF staff in fraud and abuse prevention and detection, and with fraud and abuse prevention and detection activities of various local and federal law enforcement and regulatory agencies.

Performs other duties as assigned.

Collective Bargaining Unit: This position is in the collective bargaining unit represented by AFSCME 2401 and may require a union fee through payroll deduction.

Promotion Potential: CS 13

Number of vacancies: One (1)
Duration of Appointment: Career Service (Permanent)
Tour of Duty: Monday - Friday 8:15 am - 4:45 pm

Qualifications

In depth knowledge of health care delivery and health insurance claims processing procedures. Advanced knowledge of methods of detecting of fraud, waste and abuse in the health care industry.

Experience in analyzing claims data and clinical patient care records to identify probable health care fraud, abuse and waste. Experience in evidence collection and investigation practices and protocols.

Experience in conducting fact-finding interviews with individuals of diverse backgrounds. Knowledge of the office's mission, goals, programs, and administrative and operating procedures.

Ability to exercise tact, discretion and skill in dealing with persons at various grade levels and job categories. Knowledge of the prevention and detection of fraud, waste and abuse in the health care industry.

Knowledge of the Medicaid program, and state healthcare financing efforts Ability to analyze aberrant medical, clinical and claims practices to detect health care fraud, abuse and waste.

Skill in analyzing problems, interpreting guidelines and choosing between alternative selecting appropriate solutions. Skill in communicating effectively, both in writing and orally to ensure accurate and timely completion of all support staff assignments.

Skill in composing correspondence requiring broad knowledge of administrative procedures and practices. Knowledge of correspondence management processes in order to ensure the appropriate execution of all correspondence pertaining to office operations and activities.

Knowledge of principles, concepts, and technique related to the planning, organization and implementation office management systems to maintain the orderly flow of work in the office.

Skill in establishing and maintaining effective relationships with co-workers, supervisors, and representatives of activities studied to resolve routine problems and provide advice and assistance on routine matters.

Licensure, Certifications and other requirements

None

Education

Bachelor's Degree in a related field or an equivalent combination of education and experience is preferred

Work Experience

3 to 5 years of experience preferred

OR

To be creditable, at least one (1) year of specialized experience must have been equivalent to at least the next lower grade level in the normal line of progression for the occupation in the organization.

Work Environment

Office work is performed in an adequately lighted heated and ventilated office environment. On site beneficiary and provider investigation work is performed in the homes of health care beneficiary and may involve visits to the offices of health care providers.