Fraud Waste and Abuse Investigator I (Remote)

UPMC Health Plan
Job Location: Pittsburgh, PA
Full Time, Days

DESCRIPTION

Under the direction of the manager, The Fraud, Waste and Abuse (FWA) Investigator I is responsible for investigating assigned FWA cases, as well as researching and analyzing claims data in order to identify potential FWA. The FWA Investigator I is also responsible for maintaining the FWA case system with accurate and detailed investigative activities related to assigned cases.

RESPONSIBILITIES

- Investigative actions include member/provider outreach, financial tracking, prepay claims review, adhering to compliance regulations, and making healthcare oversight referrals.
- Plan, organize and execute investigations or audits utilizing document review, witness interviews, and data analysis to identify, evaluate and measure potential healthcare fraud and abuse to determine valid cases for appropriate action.
- Risk Assessments on FWA trends using fraud detection software and/or as assigned by Manager.
- Oversight or assistance with the Medicaid Recipient Restriction program.
- Present FWA trainings to internal staff.
- Assist with the FWA hotline and referral intake.
- Perform chart reviews to assess compliance with coding and billing regulations. Utilize standard coding guidelines, principles, and coding clinics to monitor the appropriate ICD and CPT codes for all record types to ensure accurate reimbursement.
- Document and track activity in an internal database, provide case updates on the progress of the investigation and coordinate with management recommendations and further actions and/or resolutions.
- Conduct detailed research to identify and apply appropriate regulatory, contractual, and industry requirements to the different benefits and products within investigations.
- Maintain or exceed designated quality and production goals.
- Understand and adhere to HIPAA privacy requirements.
- Perform special projects as assigned by Management.

QUALIFICATIONS

- Bachelor's Degree or equivalency and/or 2-4 years of experience In lieu of a degree,
- 2-4 years of related experience in investigations, claims, medical coding, auditing, or compliance or analyst, data reporting, risk management and/or data analysis required.
- Experience with the Community Health Choice Laws of Business, Auditing, and Microsoft experience.. especially excel.
- Experience in Healthcare, Law Enforcement, Insurance and Risk Management preferred.
- The ability to problem solve and communicate professionally.
- Detail oriented individual with excellent organizational skills.
- High degree of oral and written communication skills.
- Proficiency in MS Office/PC skills including Microsoft Excel and Word.
- Preferred Skills: Experience conducting investigations within a healthcare environment preferred.
- Knowledge of CPT and ICD-10 coding of procedures and diagnosis is preferred.
- Knowledge of medical terminology, human anatomy/physiology, pharmacology, and pathology is preferred.

FOR MORE INFORMATION/TO APPLY:

https://careers.upmc.com/jobs/9390121-fraud-waste-and-abuse-investigator-i-remote