SIU Investigator - Fully Remote

Magellan Health
Job Location: USA, Remote
Full Time/Days

JOB SUMMARY:

This position is responsible for comprehensive management and ownership of fraud, waste and abuse investigations including development and presentation of investigative results. This individual carries out analytical and process management tasks with a high degree of autonomy. This individual serves as a corporate resource on fraud, waste and abuse issues and recommends cost containment projects with an emphasis on fraud prevention.

RESPONSIBILITIES:

INVESTIGATIONS

- Prioritize, triage and manage workload to meet internal performance metrics, regulatory and contractual requirements
- Use independent judgment to create investigative work plans and develop case strategies based upon analysis of referral data and contractual/regulatory requirements
- Analyze data and select audit samples using various sampling methodologies
- Plan and conduct desk audits, field audits and/or site visits
- Collect and analyze information to evaluate facts and circumstances through an extensive review of data from professional and facility providers, member data, contractual relationships, payment policies, Medicaid/Medicare rules and statutes, etc.
- Conduct research on medical policies and practices, provider characteristics, and related topics
- Interview patients, providers, provider staff, and other witnesses/experts
- Prepare correspondence
- Obtain and preserve physical and documentary evidence to support investigations
- Maintain comprehensive case files

FRAUD, WASTE AND ABUSE DETECTION

- Triage and prioritize leads from internal and external sources
- Use knowledge of healthcare coding conventions, fraud schemes, and general areas of vulnerability, reimbursement methodologies, and relevant laws to find suspicious patterns in claims data, provider enrollment data, and other sources
- Remain up to date on published fraud cases, schemes, investigative techniques and methodologies, and industry trends

PACKAGING OF FINDINGS AND RECOMMENDATIONS

- Organize data and prepare a written summary of investigative steps, conclusions, recommendations with attention to detail and a high level of accuracy
- Prepare clear and concise investigatory reports to support findings of potential fraud, waste and abuse

CASE RESOLUTION

- Identify, communicate and recover losses as deemed appropriate
- Present case to internal department(s), law enforcement and/or regulatory agencies
- Support legal proceedings as needed, including testifying in court or working with law enforcement personnel to prepare cases for civil or criminal actions
- Negotiate settlement agreements with subjects and/or attorneys
- Assist in preparation, execution, and follow-up of settlement agreement terms

CUSTOMER INTERACTIONS

- Make presentations to customers, prospects, conference audiences, and law enforcement
- Collaborate, consult, and coordinate regularly with clients on the status and direction of assignments
- Develop and maintain contacts/liaisons with law enforcement, regulatory agencies, task force members, other company SIU staff and external contacts involved in fraud investigation, detection and prevention

MISCELLANEOUS DUTIES

- Represent client at industry task force meetings and meetings with regulatory agencies
- Measure and report performance metrics
- Identify opportunities and make recommendations for reduction of exposure to fraud, waste and abuse
- Consult on anti-fraud policies and procedures
- Other duties as assigned

QUALIFICATIONS:

- Minimum of five years of experience in fraud investigations, claims processing, auditing or provider networks.
- Demonstrated abilities in time management and establishing priorities.
- Strong listening and observation skills.
- Impeccable work ethic, completely dependable, and proactive; a problem solver.
- Proven ability to effectively handle cases of fraud and abuse in a discreet, confidential, and professional manner.
- Demonstrated strategic and analytical thinking skills, with ability to effectively communicate conclusions and recommendations to management.
- Comprehensive, practical knowledge of complex and diverse fraud investigative techniques and methodologies utilized in program audits.
- Understanding of insurance terms and policy interpretation.
- Ability to work to tight timelines when necessary.
- Works independently; collaborates well with peers and customers.
- Demonstrated ability to manage and prioritize case load with limited supervision.
- Strong computer skills consisting of Microsoft Excel, Access, Outlook, Word, and Power Point.
- Minimum of five years fraud investigations, claims processing, auditing or provider networks.

REQUIRED EDUCATION:

- A Combination of Education and Work Experience May Be Considered., Bachelors

PREFERRED LICENSE AND CERTIFICATIONS:

- AHFI - Accredited Healthcare Fraud Investigator - Enterprise, CFE - Certified Fraud Examiner - Enterprise, CPC - Certified Professional Coder - Enterprise, RN - Registered Nurse, State and/or Compact State Licensure - Care Mgmt

FOR MORE INFORMATION/TO APPLY:

https://careers.magellanhealth.com/us/en/job/R00000052386/SIU-Investigator-Fully-Remote