Healthcare Fraud Investigator II - Medicare Parts C&D

Qlarant, Inc.

Job Location: REMOTE

Full Time/Days

JOB SUMMARY:

The Investigator II performs evaluations of investigations and makes field level judgments of potential Medicare and/or Medicaid fraud, waste, and abuse that meet established criteria for referral to law enforcement or administrative action.

RESPONSIBILITIES:

- Utilizes leads provided by the team and referrals from government and private agencies, works with the team to prioritize complaints for investigation, and then investigates, conducts interviews and reviews information to make potential fraud determination.
- Determines investigation or case appropriateness of fraud, waste and abuse issues in accordance with pre-established criteria.
- Based on contract requirements, may refer potential adverse decisions to the Lead Investigator/Manager/Medical Director or designee.
- Conducts interviews of witnesses, informants, and subject area experts and targets of investigations.
- Identifies, collects, preserves, analyzes and summarizes evidence, examines records, verifies authenticity of documents, and may provide information to support the preparation of attestations/referrals
- Drafts investigation reports, evaluates investigation reports, and promotes effective and efficient investigations.
- Initiates and maintains communications with law enforcement and appropriate regulatory agencies including presenting or assisting with presenting investigation or case findings for their consideration to further investigate, prosecute, or seek other appropriate regulatory or administrative remedies.
- Testifies at various legal proceedings as necessary.
- Identifies opportunities to improve processes and procedures.

REQUIRED SKILLS:

To perform the job successfully, an individual should demonstrate the following competencies:

- **Analytical** - Synthesizes complex or diverse information; Collects and researches data; Uses intuition and experience to complement data.
- **Problem Solving** – Gathers and analyses information skillfully; Identifies and resolves problems.
- **Written Communication** - Writes clearly and informatively; Able to read and interpret written information.
- **Verbal Communication** - Ability to effectively present information and respond to questions from groups of managers, clients, customers, and the general public.
- **Judgment** - Supports and explains reasoning for decisions.
- **Other Skills and Abilities**
    - Ability to work independently with minimal supervision.
    - Ability to communicate effectively with all members of assigned team.
    - Ability to grasp and adapt to changes in procedure and process.
    - Ability to effectively resolve complex issues.
    - Ability to mentor other associates.

REQUIRED EXPERIENCE:

- Bachelor's Degree and two years' experience in investigations/fraud detection or healthcare programs. Equivalent education and experience may be combined.
- Experience in health care fraud investigation/detection preferred.
- Prior successful experience with CMS and OIG/FBI or similar agencies preferred.
- Certification in an applicable program such as Certified Fraud Examiner or Accredited Healthcare Anti-fraud Investigator Certification or successful completion of a law enforcement academy preferred.
- Ability to utilize Microsoft Office and other computer applications to meet contract deliverables

FOR MORE INFORMATION/TO APPLY:

https://jobs.silkroad.com/qlarant/careers/jobs/1702