STATE OF MINNESOTA
CLASS SPECIFICATION

Class Code: 003125
Barg. Unit(s): 214

HEALTH CARE PROGRAM INVESTIGATOR, SENIOR

KIND OF WORK

Professional health care provider/recipient investigatory work including leadwork direction of investigatory staff.

NATURE AND PURPOSE

Under limited supervision in the role of leadworker, trains and directs staff; investigates (independently or as leader of a team), and resolves cases of potential fraud and misuse of medical assistance programs reimbursement so that services billed to the program are provided as billed and that violations of rules and regulations are corrected. This class was Hay rated 11/20/90 and was established January 1991.

EXAMPLES OF WORK (A position may not include all the work examples given, nor does the list include all that may be assigned.)

Identifies training needs and opportunities by reviewing, and evaluating the work of assigned staff and existing training programs within the work unit; and identifies new or unique training and modifies existing training so that staff receive the training they need and so that available training programs are effective and include current changes, issues, and strategies for conducting investigations.

Develops and conducts training sessions for unit staff so that staff are prepared to conduct a variety of investigations and are exposed to new ideas and strategies for conducting investigations.

As leadworker, plans, organizes, sets priorities, and schedules work tasks for assigned staff so that necessary work is completed in an effective and efficient manner.

As leadworker, identifies and assigns/reassigns work tasks to staff so that work assignments are defined, work loads are balanced, and adequate personnel are available to accomplish unit objectives.

Identifies suspected cases of Medicaid fraud or misuse by health care providers/recipients so that probable law violations may be investigated by collecting, analyzing and reporting evidence and resolving cases where no evidence of fraud exists.

Investigates and resolves cases of identified fraud and misuse by Medicaid providers so that state and federal laws are enforced and program integrity is preserved. This is accomplished by conducting on-site audits of providers' medical and financial records, assessing medical necessity of services provided, and employing criminal investigative techniques.

Refers cases requiring administrative hearing, civil, or criminal action to the Attorney General so that cases of suspected fraud and misuse are resolved. This is achieved by collaborating with the assigned attorney, attending and testifying at court hearings, and preparing and executing administrative sanctions and monetary recoveries.

Develops evaluation standards and evaluates requests for prior authorization of new providers, medical programs and services so that reimbursement under Medicaid remains in compliance with applicable state and federal laws, rules, regulations, department policies, and professional standards. This is accomplished by researching and analyzing statutory requirements and available literature; writing documentation to support standards; and applying existing standards to prior authorization requests for new services programs and providers.

Recommends departmental Medicaid policies to ensure compliance with administrative procedures, rules and regulations by identifying the need for and seeking background information relative to the policy content area, writing policies and notifying providers of new and changed policies.

Promotes public support for Medicaid fraud and misuse prevention programs to enhance public awareness by speaking before professional and interagency groups, writing news releases and bulletins, answering client questions and following up on client complaints.

Collaborates with computer systems staff to develop and implement automated systems so that data necessary for investigative activities can be stored, manipulated and retrieved in an expeditious manner and federal reporting requirements are met. This is accomplished by assisting in the development of computer programs; analyzing computer reporting performance; and by effectively recommending system designs to develop effective reporting systems

KNOWLEDGE, SKILLS AND ABILITIES REQUIRED

Knowledge of:

Basic principles of staff development sufficient to assess needs and develop and deliver effective training sessions.

Federal and state administrative and statutory requirements sufficient to analyze individual program participation to determine potential for fraud or misuse, develop standards for and evaluate requests for prior approval of providers and services, and write departmental policies.

Medical terminology, medical recordkeeping and health care delivery systems sufficient to evaluate the necessity and quality of billed services.

Criminal investigatory techniques sufficient to gather and preserve required evidence and information.

Generally accepted accounting principles and auditing procedures sufficient to determine if manipulation of records for fraudulent and abusive purposes has occurred.

Data management processes and techniques sufficient to identify areas of adaptation to computerized recordkeeping.

Standard statistical treatments sufficient to analyze relevant data.

Ability to:

Provide leadwork direction to assigned staff sufficient to ensure the accurate and timely completion of work.

Write reports of investigation processes and outcomes.

Research, write and interpret standards and policies.

Speak effectively to groups and to prepare and deliver testimony and hearings.

Est.: 1/91 T.C.:
Rev.: Former Title(s):