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| CS-214  REV 1/2006 |  | 1. Position Code |
|  | State of Michigan **Department of Civil Service**  Capitol Commons Center, P.O. Box 30002  Lansing, MI 48909 |  |
| Federal privacy laws and/or state confidentiality requirements protect a portion of this information. | POSITION DESCRIPTION |  |

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| This form is to be completed by the person that occupies the position being described and reviewed by the supervisor and appointing authority to ensure its accuracy. It is important that each of the parties sign and date the form. If the position is vacant, the supervisor and appointing authority should complete the form.  This form will serve as the official classification document of record for this position. Please take the time to complete this form as accurately as you can since the information in this form is used to determine the proper classification of the position. **THE SUPERVISOR AND/OR APPOINTING AUTHORITY SHOULD COMPLETE THIS PAGE.** | | | |
| 2. Employee’s Name (Last, First, M.I.) | | 8. Department/Agency  MDHHS-Office of the Inspector General | |
| 3. Employee Identification Number | | 9. Bureau (Institution, Board, or Commission)  Office of Inspector General | |
| 4. Civil Service Classification of Position  Departmental Analyst-E | | 10. Division  Office of Medicaid Program Integrity Division | |
| 5. Working Title of Position (What the agency titles the position)  Healthcare Fraud Investigator | | 11. Section  Southeast/Outstate Investigation Section | |
| 6. Name and Classification of Direct Supervisor  Investigation Unit Manager | | 12. Unit  Investigation Unit | |
| 7. Name and Classification of Next Higher Level Supervisor  Jacob Kwasneski/Renee Johnson-Maybee, Investigation Section Manager | | 13. Work Location (City and Address)/Hours of Work  Various/ Monday through Friday 8:00 am to 5:00 pm | |
| 14. General Summary of Function/Purpose of Position  As a Healthcare Fraud Investigator of the Office of Inspector General, this position investigates allegations of health  services fraud, waste, and abuse for referral for administrative action and prosecution. This position assists in the overall  planning, development, and direction of fieldwork, including fraud prevention and investigation involving programs  administered by the Department of Health and Human Services (DHHS) for referral for criminal prosecution and/or civil  recovery and repayment actions.  This position has the responsibility for complex investigations into allegations of fraud, waste and abuse involving  Michigan's Health Services Programs, including Michigan's Medicaid Program, Mental Health Program, MIChild Program  and Children's Special Health Care Services Program.  These investigations may result in referral to law enforcement agencies (e.g., Attorney General Health Care Fraud Division)  for criminal prosecution.  The powers and duties of the Office of Inspector General include, but are not limited to, the following:  - Solicit, receive, and investigate complaints related to fraud, waste, and abuse in health services programs.  - Undertake and be responsible for MDHHS' duties under federal law with respect to fraud, waste, and abuse for the  administration of the health services programs in Michigan.  - Actively seek out fraudulent billing practices of providers and develop techniques and procedures for detecting suspect  billing patterns through the use of existing database resources managed by MDHHS and available from federal sources.  - Pursuant to Section 8 of The Social Welfare Act, 1939 PA 280, MCL 400.8, subpoena and enforce the attendance of  witnesses, administer oaths or affirmations, examine witnesses under oath, and take testimony as the Inspector General  deems relevant or material to an investigation, examination, or review undertaken by the Office.  - Require and compel the production of such books, papers, records, and documents as the Inspector General deems to  be relevant or material to an investigation, examination, or review undertaken by the Office.  - Examine and copy or remove documents or records of any kind related to health services programs or necessary for the  Office to perform its duties and responsibilities that are prepared, maintained, or held by, or available to, any state agency  or local unit of government entity or contractor to a state agency or local unit of government.  - Pursue administrative and civil enforcement actions or collections against any individual or entity that engages in fraud,  abuse, or illegal or improper acts or unacceptable practices perpetrated within health services programs, including but not  limited to:  o Referring information and evidence to regulatory agencies and licensure boards.  o Excluding providers, vendors, and contractors from participation in the Medicaid program.  o Imposing administrative sanctions and penalties in accordance with state and federal laws and regulations.  o Pursuing any other formal or informal enforcement action relating to fraud, waste, and abuse that MDHHS is authorized  to take under state or federal law, including, but not limited to, any actions under Sections 111 a to 111 h of The Social  Welfare Act, 1939 PA 280, MCL 400.111 a to 400.111 h, or 1979 AC, R 400.3401 to 400.3425.  - Promptly provide information and evidence relating to suspected criminal acts to the Medicaid Fraud Control Unit of the  Department of Attorney General, or any successor entity, to the extent required by federal law.  - Prepare cases, provide testimony, and support administrative hearings and other legal proceedings. | | | |
| For Civil Service Use Only | | | |
| 15. Please describe your assigned duties, percent of time spent performing each duty, and explain what is done to complete each duty.  List your duties in the order of importance, from most important to least important. The total percentage of all duties performed must equal 100 percent. | | | |
| Duty 1 **General Summary of Duty 1 % of Time 45**  Investigates allegations of health services fraud, waste, and abuse for referral for administrative action and prosecution. Completes data queries, analyses and reviews necessary to support audits and investigations of health services providers for fraud, waste, and abuse. Screens and analyzes computer generated data, including accessing and retrieving claims processing and other information directly from mechanized claims processing systems.  **Individual tasks related to the duty.**   * Accesses and retrieves claims processing and other information directly from mechanized claims processing systems including CHAMPS, the MDHHS data warehouse, and other available State and federal database resources necessary to initiate, support, and complete audit and investigative activities. * Analyzes electronic data to recognize and select relevant and material claims processing and other information from systems to detect health services fraud, waste, and abuse (e.g., patterns of inappropriate billing, coding, etc.). * Recommends system edits to prevent payment of potentially fraudulent claims. * Other duties as assigned. | | | |
| Duty 2 **General Summary of Duty 2 % of Time 45**  Performs professional investigative staff work to resolve complex investigations (involving possible criminal acts) that involve health services programs by fact finding, forensic accounting investigations, legal and compliance analysis, criminal justice procedures, and claims identification, adjudication and disposition. Maintains records, prepares reports, and composes correspondence relative to program integrity and accountability.  **Individual tasks related to the duty.**   * Performs research of applicable statutes including the State Social Welfare Act, Health Care False Claim Act, and Administrative Procedures Act, Title XIX of the Federal Social Security Act and title VI of the Patient Protection and Affordable Care Act, supporting regulations under the Code of Federal regulations and supporting case law and applicable promulgated rules. * Performs investigative research activities, including the review and analysis of financial, transactional, and operational records, data, and claims information of health services providers and suppliers in order to determine compliance with applicable health services laws, rules, policies, and regulations. * Identifies and reviews medical records for medical necessity, utilization, up-coding, and health services performed that are inconsistent with beneficiary diagnosis and treatment. * Interviews involved parties and obtains statements. * Calculates the amount of fraud, waste, or abuse through the analysis of evidence, electronic data, business and medical records, accounting information, and the application of state and federal law, rules, policy, and regulations. * Prepares written reports, memoranda, case summaries, and analysis for administrative or civil enforcement actions against health services providers suspected of health services fraud, waste, and abuse. * Drafts and serves subpoenas. * When appropriate, refers suspected fraud to the Attorney General’s Health Care Fraud Division. * Prepares records and information necessary to support testimony at civil, criminal, and administrative proceedings. * Other duties as assigned. | | | |
| Duty 3 **General Summary of Duty 3 % of Time 10**  Monitors, reviews, evaluates, and analyzes health services programs policies and procedures.  **Individual tasks related to the duty.**   * Recommends steps necessary to improve internal controls to prevent and detect health services fraud, waste and abuse. * Partners with MDHHS Medicaid Policy staff to develop, establish, and improve Medicaid policy. * Makes recommendations to MDHHS Policy and Legal Affairs, Attorney General, and the Michigan Administrative Hearings System to develop and improve administrative hearings processes for provider appeals. * Other duties as assigned | | | |
| 16. Describe the types of decisions you make independently in your position and tell who and/or what is affected by those decisions. Use additional sheets, if necessary.  As a healthcare fraud investigator, the type of decisions made: the depth or degree of the investigation to be followed to determine fraud or no fraud, the necessary evidence or witnesses to be pursued to confirm or disprove fraud allegations based on applicable laws and applicable health services policy. The department, employee and suspect being investigated may be affected by the decisions; the department could suffer a loss of recoverable misspent funds if an inaccurate decision is made. | | | |
| 17. Describe the types of decisions that require your supervisor’s review.  When policy or procedure problems are encountered or the investigations require referral for prosecution. Typically, the manager reviews investigation reports involving providers. | | | |
| 18. What kind of physical effort do you use in your position? What environmental conditions are you physically exposed to in your position? Indicate the amount of time and intensity of each activity and condition. Refer to instructions on page 2.  Health care fraud investigations may require direct contact in areas where safety and security are not controlled and contact with individuals that may be involved in alleged criminal acts or who have been charged with alleged criminal acts by law enforcement authorities may be more inclined to violence and thereby create additional job hazard. This factor together with the necessity for precise and timely investigation, referral to prosecutorial authorities and presentation of evidence at criminal and administrative proceedings enhances stress. Extended use of a computer may result in eye and upper body strain. Regional coverage requires travel to address fraud prevention and detection in geographical areas. | | | |
| 19. List the names and classification titles of classified employees whom you immediately supervise or oversee on a full-time, on-going basis. (If more than 10, list only classification titles and the number of employees in each classification.) | | | |
| NAME | CLASS TITLE | NAME | CLASS TITLE |
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| 20. My responsibility for the above-listed employees includes the following (check as many as apply):  Complete and sign service ratings.Assign work.  Provide formal written counseling.Approve work.  Approve leave requests.Review work.  Approve time and attendance.Provide guidance on work methods.  Orally reprimand**.** Train employees in the work. | | | |
| 21. *I certify that the above answers are my own and are accurate and complete*.    **Signature Date** | | | |

**NOTE: Make a copy of this form for your records.**

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| TO BE COMPLETED BY DIRECT SUPERVISOR 22. Do you agree with the responses from the employee for Items 1 through 20? If not, which items do you disagree with and why? |
| 23. What are the essential duties of this position?  This position acts as a healthcare fraud investigator for the OIG’s healthcare fraud, waste, and abuse investigation program. Travel to provider offices, OIG central office, community agencies, courts and prosecutor offices is expected. |
| 24. Indicate specifically how the position’s duties and responsibilities have changed since the position was last reviewed.  N/A |
| 25. What is the function of the work area and how does this position fit into that function?  The Office of Inspector General is responsible for conducting and supervising activities to prevent, detect and investigate fraud, waste and abuse in health services programs. This position acts as a healthcare fraud investigator for the OIG's healthcare fraud, waste, and abuse investigation program. Travel to provider offices, OIG central office, community agencies, courts and prosecutor offices is expected. |
| 26. In your opinion, what are the minimum education and experience qualifications needed to perform the essential functions of this position? |
| EDUCATION:  Possession of a bachelor’s degree in any major.  Degree in Accounting, Criminal Justice, or a skilled medical related field, or a Juris Doctorate from an ABA accredited law school is preferred. |
| EXPERIENCE:  Departmental Analyst 9 - No specific type or amount is required.  Departmental Analyst 10 - One year of professional experience.  Departmental Analyst P11 - Two years of professional experience, including one year of experience equivalent to the intermediate (10) level in state service. |
| KNOWLEDGE, SKILLS, AND ABILITIES:  Effective oral and written communication skills.  Must successfully interact with members of diverse groups.  Must be computer literate.  Ability to identify with, and meet organizational objectives.  Must have documented ability to present and instruct on complex subjects.  The MDHHS mission is to provide opportunities, services, and programs that promote a healthy, safe, and stable  environment for residents to be self-sufficient. We are committed to ensuring a diverse workforce and a work environment  whereby all employees are treated with dignity, respect and fairness. |
| CERTIFICATES, LICENSES, REGISTRATIONS:  Valid Michigan driver's license required. |
| *NOTE: Civil Service approval of this position does not constitute agreement with or acceptance of the desirable qualifications for this position.* |
| 27. *I certify that the information presented in this position description provides a complete and accurate depiction of the duties and responsibilities assigned to this position.* |
| **Supervisor’s Signature Date** |
| TO BE FILLED OUT BY APPOINTING AUTHORITY |
| 28. Indicate any exceptions or additions to the statements of the employee(s) or supervisor. |
| 29. *I certify that the entries on these pages are accurate and complete.*    **Appointing Authority’s** **Signature Date** |