

# TennCare Field Investigator Position

Interested candidates who meet the following criteria, please submit resumes to [dawn.frazier@tn.gov](mailto:dawn.frazier@tn.gov)

**Company/Division:** State of Tennessee, Bureau of TennCare, Provider Investigations Unit

**Location:** Nashville, Tennessee

**Working Title:** Investigator

**Status:** Executive Service position

**Employee Type:** Full-Time

**Description:** Seeking a qualified professional to assist in monitoring the integrity of TennCare's provider claims. This unit's responsibility is to monitor provider claims to ensure that they are reasonable, appropriate and comply with TennCare's Rules and Policies. This will be accomplished by performing audits and investigations to prevent and detect overpayments due to fraud, waste and abuse.

## Position Responsibilities:

- Have working knowledge of TennCare's Medicaid program, medical terminology, medical records to support claims, as well as the claims processing systems of TennCare's contractors.
- Analyze, audit and investigate TennCare/Medicaid recipient payment data for trends and anomalies to determine if Fraud, Waste or Abuse have occurred.
- Conduct research and in-depth reviews of medical records and payment data (e.g., claims history, procedural codes, and clinical guidelines).
- Provide well written reports including pertinent case information and resources to support findings.
- Present cases to management and outside agencies through formal presentations.
- Consistently create and manage aggressive workloads and special projects.

## Requirements:

- Candidate MUST have experience in fraud investigations.
- Proficient in Microsoft applications including Outlook, Word, Excel and Power Point.
- Ability to analyze claims data through use of software applications (Excel, Power Pivot, Pivot tables, Access).
- Detail oriented and able to conduct independent interviews, research, and compile reports and present findings to support possible recoupment of overpayments.
- Knowledgeable of TennCare/Medicaid (CMS) and provider guidelines to correctly review payment coverage.
- Knowledgeable of Medical terminology, Procedure Codes (ICD-9, ICD-10, HCPCS, CPT, DRGs) and Medicaid processing.
- Extensive experience with report writing, research, and collecting facts with supporting documentation to formulate reports. Will be expected to demonstrate writing competency.
- Coders (CPCs) will be expected to demonstrate competency through coding medical records at appropriate levels.

## Preferred Experience:

- 3-5 years of experience with medical records reviews/audits, fraud detection/investigations, and presenting cases.
- Experience auditing various specialties (OB-GYN, pharmacy, dental, behavioral, long-term care etc.)
- Data Analyst experience with data mining and analyzing claims data for trends and anomalies. Familiar with analytical and statistical software RAT-STATS, SAS etc.

## Preferred Certifications/Education

- Certified Fraud Examiner (CFE), Certified Professional Coder (CPC), Certified Coding Specialist (CCS), Registered Nurse (RN).
- Bachelor's Degree or higher in Healthcare or Criminal Justice preferred or equivalent combination of education and experience.