**LaJeune Brown-Williams**

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**PROFESSIONAL SUMMARY:**

Healthcare professional with 16+ years multidisciplinary group leadership, accreditation standards auditing, compliance, staff training, project management, research, HEDIS medical record abstraction and investigation. Successful record of accomplishment in process improvement initiatives. Successful record of accomplishment in coordination of documentation assessments for accreditation and compliance meeting 100% expectation.

**WORK EXPERIENCE:**

**Aetna Better Health, Hartford, CT. February 2011 – June 2011**

***HEDIS Data Abstractor***

* Attend weekly conferences on HEDIS data abstraction measures, detail guidelines, principals and purpose according to NCQA.
* Assigned a 1600 provider chase list of members for services provided for numerator compliance.
* Electronic email notification submitted to all Hospitals, Federally Qualified Health Center (FQHC), and private practices of HEDIS audit.
* Populated member list and submitted via secure fax per PHI guidelines for request of medical record.
* Abstracted medical data from medical records pertaining to Adolescent Well Care, Prenatal/Postpartum Care, Frequency of Ongoing Prenatal Care, Weeks of Pregnancy, Cervical Cancer Screening, Immunizations for Adolescents, Well-Child First-15 months, and Well-Child (3-6 yrs).
* Performed follow-up to offices for 100% completion rate.
* Passed 100% pre-audit of Frequency of ongoing Prenatal Care and Well Child First-15 months.

**Centene Corporation, St. Louis, MO. January 2006 – April 2010**

***Quality Analytics Coordinator***

* On-site corporate liaison to multiple end user daily operations of internal Database management system (DBMS).
* Obtained and wrote analyses of outcome/results of selected Medicaid member performance measures.
* Operated, monitored and analyzed activities related to contract compliance.
* Timely access calls, Timely response to member complaints quality issues, performance improvement projects, performance measures and tracked trends.
* Submitted revisions and a proposal to streamline departmental flow processes and management of complaints. Revisions were accepted and implemented.
* Periodically met and collaborate with Providers to improve health check and immunization status.
* On-going Health Check and Medical Record audits and analysis based on NCQA standards.
* On-going identification and processing of quality of care events/complaints.
* On-going contribution to development of the internal intranet website.
* Participated in community-based events related to quality initiatives (health fairs, school based organizations and health activities).
* Produced monthly/quarterly quantitative reports for outside vendors utilizing secure encrypted PHI format.
* Created an Access Quality Complaint tracking database designed to meet NCQA standards (accepted and implemented).

**1ST Medical Network, Atlanta, GA. May 2002 – January 2006**

***Provider Service Representative/Database Analyst***

* Department Preceptor: Periodically coach and orient new employees to existing processes.
* Resolved claim issues and fee schedule request for providers by acting as liaison with other departments.
* Tracked and trended all complaints received and offered resolution with 48 hours.
* Maintained databases for provider adds/terms/changes for ongoing data audit.
* Prepared monthly activity reports to management, staff and providers, identifying areas of improvement regarding incorrect coding, billing, and missing data elements in claim submission.
* Researched and responded to member/provider network issues and follow up with education.
* Ensured providers met compliance guidelines pursuant of network contractual requirements.

**K-Force Consulting Corporation April 1996 – May 2002**

***Project Management Healthcare Consultant***

* Lead several long-term project commitments for large hospitals (*Tulane University, Duke University, Providence Alaska, Memorial Hermann*) in successful collections of multi-billion dollar recoupment of denied insurance claims.
* Audited claims for invalid coding, billing and denial issues for resubmission within timely filing guidelines.
* Strategically lead team in collections of 80% recovery of bad debt balances on self-pay accounts through persistent follow-up.
* Facilitated Appeals on, *HMO, PPO, Managed Care, Medicaid, Medicare and Commercial* claims.
* Assisted providers, payers, and members through toll free number overflow, by answering claim related questions and resolving issues.
* Identified and increased organizations billing profit in excess of 65% by auditing high dollar DRG coding, incorrect CPT and DX, consultation E/M codes, critical care, Chargemaster review, modifiers and encounter forms.

**CLINICAL/ TECHNICAL SKILLS:**

Proficient in Anatomy and Physiology, Medical Terminology, ICD-9, CPT4, HCPC Level II, Coding, Insurance Billing, Auditing, Collections, Microsoft Windows Programs, Electronic Medical Records documentation, Business Objects, CareEnhance Clinical Management Software (CCMS) CRMS, HEDIS, NCQA, CATALYST, and various software system applications.

**EDUCATION:**

Devry University, Decatur, GA. **March 2012**

**Associates of Science**

Health Information Technology

*Currently Enrolled in AHIMA Health Information Management courses*

**PROFESSIONAL MEMBERSHIPS:**

AHIMA (American Health Information Management Association)