**Renita D. McPherson**

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**OBJECTIVE**

A challenging position that allows utilization of my proven analytical and customer service skills.

**WORK HISTORY**

**2010- Present Aerotek-The Hartford (contract) – Windsor, CT**

Underwriter Assistant

* Review and process Group Life and Disability insurance applications while accessing risk for approval/denial.
* Meet and exceed Production and Quality goals.
* Review best practices and submit suggestions on enhancing workflow or systems enhancements.
* Review case specific spreadsheet for Case Exception processing.
* Refer to multiple systems while processing.
* Review medical guidelines to determine eligibility
* Adhere to The Hartford compliant/non compliant guidelines for accurate processing.

**2010-2010 Anesthesia Healthcare Partners – Duluth, GA**

Client Service Representative

* Identified and resolved anesthesia charges entry.
* Ensured accurate and complete data was available for entry of inpatient and outpatient anesthesia charges.
* Accountable for the full range of provider relations and services interactions within AHP, including working end-to-end anesthesia claims.
* Designed and implemented programs which built and nurtured positive relationships between internal/external customers.
* Served as a liaison between the charge entry staff, call center, IT, EDI, Credentialing, facilities and ASC’s.
* Proactively communicated with Clients on issues and obtain solutions.
* Called insurance carriers/patients to verify coverage.
* Updated client/patient information in Centricity and on remote spreadsheets.

**2009-2010 HCA - Atlanta, GA**

High Dollar Collection Specialist

* Assumed responsibility for high profile accounts.
* Monitored insurance claims from assigned pools or by running appropriate reports and contacting insurance companies to resolve claims that are not paid in a timely manner.
* Identified coding or billing problems from EOBs and work to correct the errors in a timely manner.
* Identified problem accounts and escalate as appropriate.
* Updated the patient account record to identify actions taken on the account; follow up on actions in a timely manner until account is resolved.
* Worked with guarantors to secure payment on outstanding account balances.

**2008-2009 Medventive - Waltham, MA**

Credentialing Specialist

* Coordinated and maintained all aspects of credentialing activities in accordance with required time frames, including initial applications, reappointments and temporary privileges.
* Worked closely with medical staff leadership, medical staff credentials representatives, members of the Interdisciplinary Practice Committee.
* Maintained knowledge of the Credentialing Department Policies and Procedures.
* Stayed abreast of NCQA and regulatory guidelines.
* Conducted audits of completed initial and re-appointment credentialing applications.

**2005-2008 ARGYLE Solutions (HealthCare Division) – Atlanta, GA**

Client Service Representative

* Acted as the primary point of contact internal and external clients.
* Established, improved upon and followed best practice collection practices.
* Worked with team members and managers to ensure performance standards met/maintained.
* Invoicing assistance including review of invoices and statements.
* Researched questions or issues from the clients regarding TAT, Quality, technology and overall service from the Service Center.
* Provided assistance in compiling and presenting performance reviews to existing clients. Also, supported sales with demonstrations and presentations as needed.
* Responsible for issue resolution, coordinating client's reporting needs, monitoring trends, completing data analysis, managing client's training and communication needs and helping in the development and execution of strategic and tactical planning.
* A/R analysis: Short payment research, Reconciliation and Exception Reports  
  Post payments/adjustments/reversals

**2003-2005 ARGYLE Solutions (merged from Nationwide Credit September 2005) HealthCare Division**

Senior Early Out/Self Pay Customer Service Representative

* Assisted Customer Service Representatives in soft collections on accounts 30-120 days old, with the goal of bringing accounts back to current status by negotiating payment plans and settlements with patients and/or insurance companies based upon the client parameters.
* Supervised and directed the daily workflow of collectors and support staff, monitored compliance with account policies and HIPPA compliance.
* Worked with management to improve processes, increase accuracy, create efficiencies and achieve the overall goals of the department.
* Interviewed prospective employees and provided hiring recommendations to Sr. Management.
* Assessed training needs and coordinated in-service training for staff.

**2001-2003 Perot Systems Harvard Pilgrim Health Care Account – Boston, MA**

Internal Audit Supervisor

* Supervised and directed the daily workflow, stats, goals and HIPPA compliance of InLine Auditors and support staff.
* Reviewed and monitored measurements to ensure accuracy and timeliness of date completion to attain nnx standards.
* Assisted in interviewing prospective employees and make hiring recommendations.
* Assessed training needs and coordinated in-service training for staff.
* Assisted in the development of departmental policies and procedures.
* Conducted formal annual employee performance evaluations and made recommendations for merit increases.

**1998-2001 Perot Systems Harvard Pilgrim Health Care Account – Boston, MA**

Quality Project Analyst Team Leader / Quality Project Analyst

* Responsible for running various reports (daily, weekly, and monthly) and distributed to the appropriate people.
* Completed audits on all manual reports and external groups provided feedback to supervisors to monitor staff development and improve claims processing procedures.
* Performed in-line quality review of claims processed (Facility & Professional) for all Harvard Pilgrim Health Care products (HMO, PPO, POS & Government products).
* Identified processing error trends, made recommendations on quality improvement of claims processing.

**SKILLS**

* Strong math/accounting and analytical skills
* Complex problem solving; ability to understand business needs of healthcare payers
* Knowledge of CPT-4, HCPCS and ICD-9 coding & medical terminology
* Professional verbal and written communication skills
* Proficient user of Microsoft Word, Excel, FoxPro, BRIX, View, Pulse, Amisys, AS400, ES9000, FACS, SMS, STAR, Citrix, CACTUS, SunCare, Devine Conversations (Dialer Center), Magellan, Report Writer, Invision, Meditech, Artiva, Medical Mutual of Omaha (Medicare), Centricity & various payer websites.