### SUMMARY

* 7+ years of professional experience as a Business Analyst in **Healthcare Domain**.
* Skilled in gathering business and application requirements, Business Processes, identifying risks, impact analysis, UML modeling, and Sequence and Activity Diagrams using Rational Rose and Microsoft Visio.
* Extensively worked on analysis & compliance ofICD 9 to ICD 10 and HIPAA (Health Insurance Portability and Accountability Act) 4010 and 5010 EDI transactions.
* Experience with **Medicare, Medicaid** and commercial insurances in HIPAA ANSI X12 formats including 270/271,276/277,820, 835, 837, 997
* Proficient in authoring **Business Requirement Document**, Narrative Use Cases, creating Use Case diagrams, Sequence Diagrams, Activity Diagrams and other UML based diagrams using MS Visio, Rational Rose.
* Extensive knowledge about the various types of health insurance programs such as **: Medicaid, Medicare, PPO (Preferred provider organization), HMO (Health maintenance organization)**
* Experience with **claims process and adjudication** in the Medicare, Medicaid & Private Insurance Sectors
* Worked on the **MMIS (Medicaid Management Information Systems) for State governments.**
* Extensive Experience in all the phases of **Software Development Life Cycle** including: **Requirements Gathering, Feasibility study, Analysis, Design, Development, Testing, Deployment and Maintenance**.
* Demonstrated skills in critically conducting the **GAP Analysis** throughout the projects in evaluating/ analyzing the existing standards and policies to determine the improvements
* Expertise in **Business Modeling** and **UML Diagrams** (**Use Case Diagrams, Activity Diagrams, Sequence Diagrams**) using **MS Visio** and **Rational Rose**.
* Expertise in reviewing Test Procedures, creating Test plans, defining System & Integration Test Cases, executing Test Cases, Test Data reviewing and maintaining and executing detailed Test scripts for User Acceptance Testing **(UAT),** analyzing bugs, interacting with team members in fixing.

### Computer Skills

**Methodologies**: RUP, UML, SDLC, JAD, AGILE SCRUM

**Databases:** Oracle, SQL, MySQL server, MS Access,

**Tools:** MS Office (Word, Excel, Project etc.), Visio, Rational Rose, Requisite-Pro, Clear quest

**Platforms:** Windows, UNIX, Mainframe

**Reporting Tools**: Business Objects, MS Excel, Crystal reports, Cognos

### Projects

**Care More/Well Point – Cerritos, CA Duration: Aug 2013 to Present**

**Role: Sr. Business Analyst**

# The new Claims Processing MMIS (Medicaid Management Information System) was initiated by the Care More to replace their 20 yrs old legacy system with a new SOA based system that will be based on the Microsoft .NET Platform. The new system would automate all the business areas with minimum human inter-vention. I was the Business Systems Analyst for the all the Claims Processing data which needed to be migrated from the Mainframe to the SQL Server environment. I had to constantly interface with the legacy team & the new MMIS design team for data & design related issues. As a Business Analyst, I was involved in all aspects from beginning to end of the entire legacy migration project.

# Worked on Duals, Medicare, Business Operations, Case Management, Claims, Clinical Analytics, Clinical Operations, Compliance, EDI Validations, Finance and Accounting, Healthcare Code, Member Services, Membership and Eligibility, Network Operations Management (OM), OPMR, SOX Auditing, ICD10, Pharmacy, Pharmacy Benefits & Claims, Practice Management, Regional Performance Management, Sales, Terms and Conditions, Trainings and Utilization management, Revenue Cycle, EPIC Implementation & EMR Reporting. Project included technical and professional services related to analysis and assessment of the current MMIS and EDI claims, documentation of business and technical requirements, preparation of cost analysis and implementation of new MMIS automation system.

**Roles and Responsibilities**

* End to End working experience of Medicare, Medicaid, Duals, Hospice, LTSS, Vision, Dental, Pharmacy and behavioral health benefits projects from Patient/Member Eligibility, Patient/Member Registration to Patient/Member departure.
* Experience with Patient Billing, Payer Compliance, Payer Reporting and Analytics.
* Worked with HIPAA 4010 implementation in designing EDI X12 (837,834,278,270) transaction to the newly implemented Duals System.
* Propose strategies to implement HIPAA 4010 in the new MMIS system and eventually move to HIPAA 5010
* Interviewed the stakeholders to gather high level requirements.
* Responsible for gap analysis in changing old MMIS to new MMIS.
* Did Gap analysis on the ICD9 to ICD 10 conversion and subsequently the mapping between those
* Performed workflow analysis toward automated disability claims process.
* Experience with Clinical, HL7, CCDs, EMR and EHR projects.
* Implemented Healthcare Enterprise Core Administration Platforms such as FACETS and Electronic Health Record & Practice Management applications such as NEXTGEN. Also involved in migrations and customizations of these systems.
* Experience in migration of clinical data from ICD 9 to ICD 10.
* Designed and Developed various Business Intelligence reports against ODS, Claims systems such as Facets, HER systems such as NEXTGEN and Care Management systems, Network Management systems, Revenue Cycle Management systems.
* Involved in SSAS Cubes design by creating KPI, Actions and Perspective from huge dataset using SQL Server 2008 Analysis Services (SSAS).
* Designed and developed matrix and tabular reports with drill down, drill through and drop down menu and used gauge reports with KPI’s in SSRS.
* Converted the logical request and response documents into the physical XML schema, compile a Data Dictionary and convert the logical data model into a physical data model that will be implemented within SQL Server RDBMS.
* Develop interfaces to third party system and create business rules and data transfer mappings using XPath, XSLT,and XML.
* Designing and Implementation of XSD schemas using XML Spy Tool keeping reusability in view across the systems.
* Analyzed customer needs and existing functions in the area of HIPPA transactions to determine feasibility, consistency with the established scope of work.
* Clearly understood coding standards required for all Medicare Part D Users transactions involving electronic data interchange as provided by department of health and human services and incorporated at every stages of the project wherever found necessary.
* Prepared user stories using JIRA. User stories are dissolved to the granular level and are supported by acceptance criteria which are in turn used by both development and QA team for both development and testing throughout the iterations. Also was involved in writing test cases for checking the functionality of the processing system constructed.
* Created SSRS reports from raw data to answer executive management questions on many topics.
* JIRA has been thoroughly used for maintaining the Test Plans, Test Cases repositories along with the Defects.
* Involved in writing SQL queries to test the mappings and to track the requirements as per the user requirements.
* Validated the following: 837 (Health Care Claims or Encounters), 835 (Health Care Claims payment/ Remittance), 270/271 (Eligibility request/Response), 834 (Enrollment/Dis-enrollment to a health plan).
* Involved in creating requirements that comply with HIPAA and HL7 regulations to protect the privacy of the employee insured under any policy and also regulations for claim submission that is required by Medicare and Medicaid policies.
* Used SDLC (System Development Life Cycle) methodologies such as the Agile (Scrum) and the waterfall.

**Environment:** MS Office; ICD-10 and ICD-9; GUI; Quality Center; MS Visio; Agile Scrum; XML; UAT; and SQL Server, HIX, MMIS, MMARS,

**Client: State of Maryland - Linthicum Heights, MD Duration: June 2011 to July 2013**

**Role: Business Analyst**

Cognosante being the implementation partner is one of the leading Healthcare transformation enterprises. The changes it has implemented were relating to Health Insurance Exchange (HIX) and Eligibility and Enrollments in Compliance with Affordable care Act (ACA) to improve and access quality healthcare. The primary function of this role included scope definition, specification, requirement gathering and eligibility determination to fulfill the requirements of the Maryland Health Insurance Exchange (MD-HIX) which in turn will assist in determination of the eligibility of individuals enrolling on the Health Insurance Exchange portal.

**Roles and Responsibilities**

* Participating in reverse engineering method, comprising of documenting a FSD (Functional Specification Document), which outlines the Workflows, Use Case diagrams, Reports and Technical Requirements explaining the HIX application and portal for following needs from Business Units: functionality and its benefits; features and attributes; integration; Business Rules; processing new application, health plans and claims; frontend and backend interfaces.
* Gathering data and performing analysis on frontend and backend interfaces of HIX Web application/portal.
* Retiring MD21 legacy application and replacing it HIX Web Portal.
* Engaging in analysis and testing of 'as-Is' State of Payments data exchanged between MD 21 MMARS (Middleware) and MD 21, in comparison to 'To-Be' State of similar Payments processing flow in MD HIX.
* Organizing and evaluating data in regards to migration of data comprising of claims, payments and remittance from MD 21 to HIX.
* Analyzing and designing Integration workflow displaying HIX interaction with other systems consisting of MMIS (Medicaid Management Information System), Medicare Claims Processing Systems and other Healthcare Systems at State, Federal level as well as Third Party Companies.
* Interacting with EDI and ICD operations team and technologists in monitoring the conversion of these protocols and standards for HIPAA 4010 to 5010.
* Conducted Analysis and Design of existing transaction sets, and modification of these transaction sets to ensure HIPAA compliance.
* Performed data analysis, created data mapping and data interface documents and kept the documents updated with changes in requirements and functional specifications.
* Worked on developing the business requirements and use cases for automating the billing entity and commission process.
* Coordinated the upgrade of Transaction Sets 837 HIPAA compliance.
* Documented gap analysis for HIPAA 4010 837P Transactions and HIPAA 5010 837P Transactions.
* Involved in impact analysis of HIPAA 5010 835 and 837P Transaction sets on different systems
* Created mapping table for the Transactions accepted by the Sybase translator move into an Interface Database for 837 Transactions.
* Wrote SQL queries related to NPI and Data migration from ICD 9 to ICD 10.
* Collaborated with Business Units regarding different Work streams including: Infrastructure of Contact Center, Call Center and IVR; Enrollment and Eligibility; Contractual Policies; CRM; and Health Plan Policies.
* Writing Test Cases/Test Scripts for System, System Integration and UAT concerning HIX and its communication with other Systems.

**Environment:** MS Office; MS Visio; ICD-10 and ICD-9; GUI; Quality Center; Agile Scrum; XML; UAT; and SQL Server, HIX, MMIS, MMARS, ACA.

**Client: State Of Nebraska, Department of Health and Human Services - Lincoln, NE**

**Duration: Jan 2010 to Jun 2011**

**Role: Business Analyst**

As a Business Analyst, I was involved in multiple projects, primarily focused on ICD-9 to ICD-10 Mapping and Modeling Implementation process, claims processing (Medical/Dental), provider and Reimbursement segment. I provided support through the entire lifecycle for multiple projects involving web service and user interface development, covering Provider, Claims and Reimbursement Processing domains. Also the project aimed to extend and expand the Physical Health Managed Care to all counties in the State of Nebraska. As a part of this project, Coventry Cares of Nebraska and Arbor Health Plan were brought in along with the already existing Plan and Managed Care services were provided to all the counties.

**Roles and Responsibilities**

* Acted as a liaison between Business area Subject Matter Experts (SMEs) & development team throughout all phases of SDLC.
* Identified AS-IS process flow of ICD-9-CM and ICD-10-PCS compliance requirements using the gap analysis for the existing United HealthCare community Plan.
* Updated data processes, data reporting, data collection tools and other processes such as problem lists, writing orders, referrals according to ICD-10 code set.
* Worked for maintaining eligibilities for members with Medicaid and Medicare with support of the Medicaid Management Information System (MMIS).
* Reviewed state documents (policies, manuals, business processes, systems documents, banners, bulletins) from various divisions. Analyzed and performed quality assurance to determine areas impacted by ICD-9 related data
* Generated numerous Business Requirement Documents & Functional requirements specification documents, Use cases, system flow and work flow diagrams.
* Worked with the Managed Care Subject Matter Expert (SME) and Users to ensure that all the requirements for system change are covered.
* Developed business and detailed functional requirements related to changes to be made to the claim entry screens, including Practitioner, Crossover Practitioner, Dental and Hospital Claim Entry Screens.
* Involved in remediation of the legacy MMIS to meet the minimal functionality necessary to electronically send, receive and process the HIPAA compliant standard transactions, and fully implement all components of NPI Compliance.
* Incorporated and updated all MMIS screens for NPI Implementation within the MPS1 subpart used for paying claims
* Created new screen layouts and identified locations for new fields being added and existing fields which are being moved.
* Developed business and functional requirements for the National Provider Identifier (NPI) Crosswalk and Crossover Claims Crosswalk solution.
* Developed Test Plans and Test Execution Procedure Document based on the Business & Functional Requirement Document and numerous Test Cases and Test Scenarios to cover overall aspect of quality assurance.
* Successfully tested all the test conditions, documented the defects and discussed with technical analysts the discrepancies between expected and actual results for the test conditions.
* Conducted knowledge transfer sessions which were used to make the users and other teams aware of all the changes being made in the system as part of various projects.
* Assisted End User in performing User Acceptance testing and performed testing of the end result files created by the development team to verifying whether all the User Requirements were catered to by the development effort.

**Environment:** MS Office, SQL Server, MS Project, MS Visio, UNIX, J2ee, Java, XML, Windows XP

**Client: Humana-Louisville, KY Duration: Jan 2008 – Dec 2009**

**Role: Business Analyst**

The scope of this project included offering OSB’s (Optional Supplemental Benefits) to Individual MAPD plans with higher Premiums, and also to plans that no longer offer any Dental/Vision benefits, or any other benefits such as, alternate medicine, international coverage etc. The advantage of offering these OSB plans is giving seniors the choice of selecting optional packages along with their base plan, which in turn allows them to customize their health care coverage depending on their individual needs.

**Roles and Responsibilities**:

* Analyzed, documented, and managed all project requirements and changes to requirements throughout the software development lifecycle.
* Created the architecture flow, rating modules structure and the database structure of the Optional Supplemental Benefits (OSB) which was used by the downstream systems
* Responsible for the team status meetings, reporting and updating reports in the eRoom Documentum
* Facilitated the group discussions with the architects on the ways of structuring the benefits, benefit codes, rate type codes, package keys and OSB relationships
* Developed all the required documents (SRS, Design Document, Use cases, Data Flow diagram, Test Plan, Test Cases, UAT testing template etc.) using MS Visio and MS Office
* Developed the design specification, testing information (use cases), installation instructions, and user documentation which provided end-to-end IT Service Management based on ITIL
* Created and monitored various departmental metrics and new project impact reports
* Designed and implemented cost and staffing models
* Documented the workflow structure of creating the questions for the benefits, approving the benefits and rates from CMS, enrolling customers and groups to the benefits, billing cycles, claims and information printed on the ID cards
* Facilitated the User Acceptance Testing process, developing rollout plans and procedures
* Created various business process quick reference guides and process flowstop help business partners understand the CMS guidelines, their work and responsibilities
* Responsible for implementation and coordination of the automated testing tool – Certify for the regression testing of the renewal cycles, batch jobs and various screens in the mainframe system

**Environment**: MS Office, SQL Server, MS Project, MS Visio, Unix, J2ee, Java, XML, Mainframes, Windows XP.