**Munira**

**SUMMARY**

Extensive professional experience as Business Analyst with expertise in Software Development Life Cycle (SDLC) and Business Process Reengineering in Health Care Sector with prime focus on claims adjudication, provider, eligibility and prior authorization for Medicaid and Medicare programs in web environments .

**Summary of Professional Skills:**

* Experience in all phases of software development life cycle (SDLC), including Requirement gathering and documentation, Analysis and Design, Quality Assurance, Testing and End user support working as Business Analyst mainly in Healthcare sector.
* Experience in developing detailed functional specs through JAD sessions, interviews, on site meetings with business users and development team.
* Conducted User Acceptance Testing (UAT) and verification of performance, reliability and fault tolerance issues for web based and client/server applications.
* Documentation: BRD (Business Requirement Document), FRD (Functional Requirement Document) and Non-functional Requirement Document.
* Extensively worked with HTML, creating and developing websites.
* Experience with PMO techniques such as Rational Unified Process (RUP), Agile&Waterfall life cycle.
* Experience in testing Client-Server and Web-Based Application. Front end and backend tests.
* Have extensive knowledge in Insurance products like HMO, PPO, POS,HIPAA and Regulations.
* Worked on requirement change management to upgrade integration process of revised warehouse system and involved in planning, analysis, UX design, development and testing.
* In depth knowledge of Requirements Traceability Matrix (RTM).
* Extensive experience in developing use cases, creating screen mock ups, conducting GAP analysis, SWOT Analysis, Report Requirement Specification and Risk Analysis.
* Strong knowledge of EDI Claims, member enrollment, Eligibility as well as ICD9 and ICD10 conversion.
* Experience working in web environments with web services tools like SOAP UI, GUI, XML, etc.
* Experience using SOAP UI for validating the Real Time Request and Response transactions like 270/271 and 276/277, and also validating if the claim is in the database.
* Extensive knowledge in functional testing, integrations testing, regression testing, system testing, User Acceptance Testing (UAT), Performance and load testing, black box testing, GUI testing, back-end testing, Positive and Negative testing, Smoke testing, browser compatibility testing, Component testing on windows, UNIX environments.
* Experienced in various Healthcare areas like Enrollment, Benefits, Claims, Medicare, and implementation of HIPAA key EDI (ANSI X12) transactions.
* Well versed experience in all EDI transactions like 834, 820, 837 P, 835, 27x and conversion of 4010 to 5010.
* Good Knowledge of Medicare, Medicaid, claim process and Pharmacy Benefit Management (PBM).
* Expertise in impact analysis on the key application systems (claims processing, reporting, payments) and business process of health insurance companies.
* Writing Manuals (training material for business users and Deployment guides).
* Working experience in a cross-functional team environment/different geographical locations teams.
* Experience with health care Systems: FACETS.

**TECHNICAL SKILLS:**

**Requirement tools:** IBM doors, SharePoint, requisite pro

**Forecasting tools:** HUMMER, EXCEL

**Financial Platform:** Bloomberg Terminal

**UML tools:** Visio, EP, Rose

**Languages:** C, SQL, HTML, XML

**Works flow tools:** JIRA, Clear Quest, Share point

**Database:** Oracle, SQL Server, MS-Access

**Testing tools:** SOAP UI, Bugzilla, HP ALM

**Other tools:** MS project

**EXPERIENCE**

**Care Source, Dayton, OH March 2015- Present**

**Business Requirement Analyst**

FACETS is part of TriZetto's suite of enterprise administration systems. It supports medical and dental claims processing and offers comprehensive consumer-directed health capabilities with advanced HSA/HRA functionality FACETS is a comprehensive healthcare management and administration suite of software designed exclusively for payers. FACETS manage all relationships between the payer organization and its members and providers.

I worked in FACETS implementation project. I was involved in implementing HIPAA EDI transactions in the application especially 835/ 837. Involved in Claims Adjudication, Claims Payment, and Coordination of Benefits (COB), dental implementation, membership and UAT .

**Responsibilities:**

* Worked with a cross functional and diverse team of business users and developers to enable accurate communication of requirements and ensure consensus.
* Conducted interviews with the Business Users for requirement elicitation and gathering, interviewed SMEs (Subject Matter Experts) and ensured that contributors and all key stakeholders were motivated to complete assigned tasks.
* Produced client information metric reports utilizing various tools, including: Business Objects, MSExcel, MS Access, and PowerPoint to organize and present data.
* Created Use Cases that defined the role of users who receive claims, users who process claims, and users who adjudicate claims. Used MS Visio to develop UML diagrams
* Coordinate with Health Exchange HIX program staff and other stakeholders to define and develop requirements for correspondence generation across various business lines.
* Kept abreast of legislation and industry trends related to Patient Protection and Affordable Care Act (PPACA), Medicare and Medicaid.
* Facilitated & conducted JAD sessions for requirement gathering, requirement review, and requirement approval.
* Developed a file tracking application that organizes the location for all trust operations records. Used by business managers to request trust records with VB 6.0, MS Access.
* Implemented Agile approach for requirement gathering continuously prioritized requirements as per needs.
* Involved in creating various SQL, stored procedures, views, functions and temporary tables for data input into crystal reports.
* Worked on FACETS for claims processing.
* Involved in preparing several Use Cases, Business Process Flows, and Activity Diagrams using Microsoft Visio, Context diagram and Event Response Table.
* Worked on requirements of the 835 HIPAA projects, 276/277, 837, and HIPAA EDI Transactions across enterprise.
* Develop, coordinate and support Information Technology Division on all operational requirements of FACETS claims processing system and production management.
* Prepared test plan and determined testing approach and time slots for task completion.
* Coordinate with other test team, define the functionalities to be tested and assigned the tasks to other team members.
* Used Crystal Reports and SQL Systems Management Studio to create new reports,    
  modify existing reports and gather data for verifying report output.
* Automated execution of multi-user performance tests, used online monitors, real-time output messages Analyze, interpret, and summarize meaningful and relevant results in a complete Performance Test.
* Wrote Test Cases and design test steps according to the requirements specifications in Excel.
* Conducted walk through with Business analysts and business owners get the test case sign off.
* Created and documented performance testing plan and approach for enterprise wide projects.
* Worked closely with test management team to establish performance testing criteria.
* Exported test cases into Mercury Quality Center.
* Worked in testing the Professional, Institutional Claims processing and adjudication and validate data with FACETS.
* Tested EDI transactions 270/271, 837, 835, 834(X12) according to the test scenarios.

**Environment:** Agile, ANSI X12 834,837,270,271 EDI transactions, MS Access, Oracle, HTML, XML, SOAP UI, TOAD, WSDL,MS Office, MS Project, MS Visio, HP ALM.

**Kaiser Permanente, CA Nov 2013- Feb 2015**

**Business Analyst**

I worked for the Kaiser Permanente as a Business Analyst. I have participated in full software development life cycle implementations (SDLC) from project initiation to final deployment. I have worked with various Business Areas like Enrollment, Claims, Finance, Providers, and Benefits Admin.

The project involved gathering Business Requirements for the Claims Business Area and updating EDI Transactions like EDI 834, 837, 835, 276 and 277 with the HIPAA 5010 Changes. I have experience in development of Web Portals in the Healthcare Industry. I developed a Referral Web Portal that was used by providers and members to view their referral information.

I was also involved in the documentation of ICD 9 – 10 Conversion's Impact Analysis of the Diagnosis and Procedure Codes.

**Responsibilities:**

* Conducted user interviews at both in-house and client locations, gathering and analyzing requirements using Requisite Pro and Requisite Web
* Extensively used Agile Methodology in the process of the project management based on SDLC.
* Designed and developed Use Cases, Activity Diagrams, Sequence Diagrams, Object Oriented Design (OOD) using UML
* Gathered and documented Business Requirements, created Functional specifications and translated them into Software Requirement Specifications.
* Performed Gap analysis by identifying existing technologies, documenting the enhancements to meet the end state requirements
* Responsible for checking member eligibility, provider enrollment, member enrollment for Medicaid and Medicare claims.
* Developed test cases and test scripts and assisted Quality Assurance activities, with system integration testing and user acceptance testing (UAT), developing and maintaining quality procedures and ensuring that appropriate documentation is in place.
* Responsible for the full HIPAA compliance lifecycle from gap analysis, mapping, implementation and testing for processing of Medicaid Claims.
* Involved in claim adjudication process of FACETS application.
* Responsible for working with the State to review and modify process flows to increase productivity and effectively utilize FACETS features not provided by the legacy systems.
* Responsible to meet the information demands of our business users by delivering timely, accurate, meaningful and standardized data and reporting.

**Environment:** Windows, MS Project, MS Office MS Visio, SQL, Facets, Oracle, Quality Center.

**Blue Care Network, Southfield, MI Jan 2012– Oct 2013**

**Business Analyst**

Blue Care Network of Michigan is a nonprofit health maintenance organization owned by Blue Cross Blue Shield of Michigan with its Headquarters in Southfield, Michigan. BCN being the largest HMO in Michigan since 1998 has better and affordable coverage to its member as the motto. BCN is implementing Care Advance to replace existing Blue Connect for Nursing and Reporting Purpose for better service to members.

**Project 1:** (Facets Up- gradation) the objective of the project was to upgrade Trizetto’s Facets application software from version 4.71 to 5.01. I worked in Health care claim module and Enrollment module.

**Project 2:** (Care Advance) Care Advance is being implemented for replacing the existing Blue Connect to become compatible with FACETS upgrade and better reporting Functionality.

**Responsibilities:**

* Prepared the Business requirement Document (BRD) and Functional requirement document (FRD) for the enhancement of the existing services.
* Managed requirement backlog and involved in streamlining existing processes.
* Write requirements for the development team to correct issues.
* Analyze business requirements and perform current/target/gap analysis.
* Analyzed and resolved the ongoing issues with the Data Warehouse and the upstream and downstream applications.
* Worked on GUI Modeling/Mock up and Prototyping.
* Tested the ANSI X12 Version 5010 / EDI transactions (HIPAA) mainly on 837 Professional and Institutional Claims
* Participate in Requirements Review sessions with business and technical teams.
* Worked on Pharmacy Benefit Management (PBM) System and Health Insurance in the United States, in depth knowledge of Health Care Laws and ICD Standards.
* Involved in System Integration, Compliance and User Acceptance Testing and Validation of Medicaid claims processing and Electronic Data Interchange (EDI) translation in compliance with the 4010A and 5010A Health Insurance Portability and Accountability Act (HIPAA) transactions 837 I/P, 835 and 997 Acknowledgement.
* Conducted Web Application testing, Using SQL Commands
* Coordinated the upgrade of Transaction Sets 837P, 835 and 834 to HIPAA compliance.
* Involved in claim adjudication process of facets application.
* Worked on the EDI 834-file load to Facets through MMS (Membership maintenance sub-system).
* Worked on the PBM’s Medical Claim Data feed, Data Dictionary layout and definition, Eligibility files and various File Transfer Specifications.
* Used Facets for various health insurance areas such as enrollment, member, Products and other Facets related modules
* Successfully worked on Pharmacy Claims processing chiefly: Direct Claims, Retail Claims and Card/Mail Order Claims developing a complete understanding of Pharmacy Claims Gateway.
* In depth knowledge of Health Insurance process, Claims, HIPAA & its approved transaction codes.
* Utilized Agile Methodology to configure and develop process, standards and procedures.
* Did GAP analysis and Impact analysis for the facets up gradation system 4.71 to 5.01.
* Attended daily SCRUM and guided QA and Developer regarding the defects, Technical Specification Documents and Mapping Documents.

**Environment:** Agile, SharePoint, MS Visio, MS project, XML, MS Access, UML, Oracle, MS SQL Server, MS Office

**MMIS State Govt. of Nebraska (DHHS - Medicaid) July 2010– Dec 2011**

**Business Analyst**

The Nebraska Medicaid initiated a MMIS HIPAA 5010 Implementation project for making the Medicaid claim processing system compliant with the HIPAA 5010 regulations by enhancing from the current 4010 legacy system. The ICD-9 to ICD-10 conversion Project is also undertaken for making the system compliant for the ICD-10 CM & PCS codes from the current ICD9 codes (VOL I, II, III).

Also worked on internet-based application to improve its health insurance claim processing by automating receiving and processing health benefit claims including Medicare .

**Responsibilities:**

* Under general direction, gathered, defined and documented highly complex business requirements for NPI crosswalk.
* Experience in all phases of software development life cycle (SDLC), including Requirement gathering and documentation, Analysis and Design, Quality Assurance, Testing and End user support working as Business Analyst mainly in Healthcare sector.
* Review and understand the claims process and complex requirements for the enhancement of the current system created under the Requirement Specification Documents after conducting interviews with End Users, JAD Sessions and analyzed their current systems.
* Analysis and Design of existing transaction sets, and modification of these transaction sets to ensure HIPAA compliance.
* Designed and developed Use Cases using UML and Business Process Modeling.  Consulted with healthcare insurance company to develop conversion specifications for other insurance Coordination of Benefits (including Medicare).
* Did gap analysis between ICD 9 and ICD 10.
* Develop business requirements for new projects involving federal and state government initiatives regarding Health Insurance Exchanges (HIX).
* Documented complex Business requirements and made process flow diagram for the 837, 270/271, 276/277 & 835 Remittance transactions as per the 4010 to 5010 implementation for the Medicaid claim processing system enhancement.
* Worked on Data Mapping documents explaining flow of data from one-to-another table for the system enhancement purpose required by HIPAA 5010 implementation.
* Serve as liaison between State-Based Exchanges (SBEs) contacts and health insurance issuers regarding state policy and development.
* Facilitated various brainstorming, requirement gathering sessions, and provided training on HIPAA Compliance, HIPAA Standard transactions and current version of X12 HIPAA 4010A1.
* Incorporated HIPAA standards, EDI (Electronic data interchange), Implementation and Knowledge of HIPAA code sets, ICD-9, ICD-10 coding and HL7.
* Verify health insurance benefits, collect co-pays, and assist with patient inquiries.
* Work with technical staff and business users to problem-solve and identify workable solutions.
* Maintained Requirements Traceability Matrix (RTM) throughout the project.
* Conducted meeting and facilitate Joint Application Development (JAD) sessions with different users and internal stakeholders for defining business requirements and User Acceptance Testing (UAT) standards.
* Developed Companion Guides for the business users and managed User Acceptance Test (UAT) for business users to explain Mainframe CICS screens for claim processing.
* Answer questions and inquiries about system functionality and provide user support, including training, help and instructions for the Trading Partner Application used by Nebraska Medicaid.
* Worked on As-Is To-Be analysis of ICD 9 for the new qualifiers used in the 837 claims for the diagnosis and procedure/HCPCS codes.

**Environment:** Waterfall, Clear Quest, JIRA, Microsoft Office, MS Project, SQL and Microsoft Visio

**Education:**

* MBA in International Business From Virginia International University, Fairfax, VA, USA.