**Nikita**

**SUMMARY:**

* Qualified professional with over 7+ years of extensive experience in the field of Business Systems Analysis, Requirements Analyst working with the technical staff to implement management and staff's business requirements into the software application in Healthcare Industry.
* Highly motivated team player with excellent communication, presentation and interpersonal skills, always willing to work in challenging and cross-platform environment.
* Experienced as a Business Analyst in using the iterative software development life cycle principles of Rational Unified Process to manage, develop and test distributed client/server, internet and intranet applications on heterogeneous environments.
* Highly proficient in working with users to gather requirements, analyze them and subsequently use the Rational project and design tools to model the requirements.
* In-depth knowledge of creating use cases, functional design specifications, activity diagrams, logical, component and deployment views to extract business process flow.
* Used Query Analyzer, Execution Plan to optimize SQL Queries.
* In depth knowledge in the analysis, design, and re-engineering of system applications and business processes, using structured system analysis methodologies, placement of business controls, diagramming data and process mapping, applying Unified Modeling Language (UML),and implementation of performance measures.
* Strong understanding of project life cycle and SDLC methodologies including RUP, RAD, Waterfall and Agile.
* Experience with health care Systems: FACETS.
* Strong knowledge of managed Claims management process, Knowledge of Medicaid and Medicare Services. CMS, Health Assessment Systems, Medicare and Medicaid Insurance Billing, Hl7 Standards, HIPAA, EDI, HEDIS, NCQA, PPACA (Patient Protection and Affordable Care Act), 834, 835,837, Compliance issues, HL7 Message Validation, ICD9, ICD10, Electronic Health Records, Electronic Medical Records.
* Interviewed SMEs and Stakeholders to get a better understanding of client business processes and gather business requirements.
* Experience in using strong communication skill in eliciting and analyzing requirements
* Expertise in broad range of technologies, including business process tools such as Microsoft Project, Primavera, Promodel, MS Excel, MS Access, MS Visio, technical assessment tools, Data Warehousing concepts and web design and development.
* Successful track record for delivered projects on schedule in Model 204 mainframe data software programming and database administration
* Extensive knowledge in all phases of Software Development Life Cycle (SDLC) with different methodology such as Waterfall. Strong Experience in interviewing End- Users, Stakeholder, Business Owners and Subject Matter Expertise.
* Proficient in developing Use Case Model, Analysis Model, Design Model, Implementation Model, Use Case Diagrams, Behavior Diagrams (Sequence diagrams, Collaboration diagrams, State chart diagrams, Activity diagrams), Class Diagrams based on UML using Rational Rose
* Ability to gather business and technical requirements from both formal and informal sessions utilizing a variety of software tools including, Use Cases and the Rational Unified Process
* Gathered and documented Non-functional requirements.
* Knowledge of healthcare standard Health Level Seven (HL7).
* Experienced in preparing Business Process Re-engineering Models
* Familiar with HIPAA EDI transactions such as 835, 837 (P, D, I) 276, 277, 278 etc
* Expertise in the EPIC Medical software application (EMR, HER) as it relates to hospital workflows and setting up the infrastructure for a software implementation in a clinic environment.
* In depth knowledge of SDLC and implementation of the Rational Unified Process (RUP) in all four phases of a project: Inception, Elaboration, Construction and Transition.
* Utilized a fusion of industry knowledge and technical programming to provide executive management the development and implementation of interactive busines[[1]](#footnote-2)s tools, and strategic analysis, vital for use in mission-critical decision-making
* Conducting requirement gathering sessions, feasibility studies and Impact Analysis and organizing the software requirements in a structured way using Rational RequisitePro to track development.
* Performed UAT and exposure to User Certification Testing (UCT) and Operational Readiness Testing (ORT)
* Expertise in understanding and supporting the client with Project Planning, Project Definition, Requirements Definition, Analysis, Design, Testing , System documentation and user training.
* Used Rational ClearQuest for tracking and prioritizing defects and for enhancements after base lining the requirements.
* Used Rational ClearCase for Version Control of requirement documents.
* Well versed in writing queries/Scripts for Data Analysis and QA reporting and testing.
* Experience in Change Management Process (Identify, Analyze, Evaluate, Plan, Implement, Review and Close).
* Expertise in Procurement and Management Services
* Experience in implementing Microsoft Office SharePoint 2007.

**TECHNICAL SKILLS:**

|  |  |
| --- | --- |
| **Skill Sets** | **Description** |
| **Programming Languages** | C, C++, HTML, XML, SQL |
| **Data Base** | MS Access, Oracle (SQL Series), MODEL 204,DB2 |
| **Reporting Tools** | Crystal Reports 8.0 |
| **Operating Systems** | MS-DOS, Windows95/98/NT/2000/XP, Apple McIntosh, Linux |
| **Software** | MS Office Suite(Word, Excel, Access, PowerPoint & Outlook), MS Visio, Rational Rose, Rational Requisite Pro, Adobe Acrobat, MS Office FrontPage, Lotus Notes |
| **Processes/Technologies** | Rational Unified Process (RUP), Waterfall, UML & Microsoft Office SharePoint 2007 |
| **Automation Tools** | Requisite Pro, Win runner, QTP, Test Director, Quality Center |

**PROFESSIONAL EXPERIENCE:**

**CareSource, Dayton, OH   Feb 2015 – Apr 2016**

**Business System Analyst/** **Requirements Analyst**

CareSource is currently 2 releases behind for Facets.  The purpose of this project is to upgrade Facets to the latest release by Trizetto (software vendor) to the 5.3 version. The expected outcome is successful implementation of Facets with minimal negative impact on the business. At the end of the project, be in position to no longer incur fees for updating out-of-date software.

**Responsibilities:**

* Prepared the Business requirement Document (BRD) and Functional requirement document (FRD) for the enhancement of the existing services.
* Conducted JAD sessions with business units and stakeholders to define project scope.
* Created workflow diagrams, UML diagrams, process models, activity diagrams, use cases, for incorporating design changes in the order creation/ management system.
* Tested the ANSI X12 Version 5010 / EDI transactions (HIPAA) mainly on 837 Professional and Institutional Claims
* Developed and analyze business and user requirements for clarity, completeness, scope, and technical feasibility.
* Decompose business and user requirements into system and software functional requirements.
* Define system quality and operational attributes, external interfaces, constraints, rules, and other non-functional requirements.
* **Responsible for understanding the “AS IS” business process and defining the “To Be” business process from Member Claim Submission**
* Performed requirements modeling and develop UML diagrams which depict various perspectives of the system’s functional behavior, to include, activity diagrams, sequence diagrams, and state diagrams.
* Performed Smoke (Sanity) testing, Functional testing, SIT, UAT and End to End Testing of API, GUI, Web Applications and Web services.
* Involved in claim adjudication process of facets application.
* Performed User Acceptance Testing (UAT), documented in details the defects using Quality Center.
* Did gap analysis for HIPAA 4010 837P and 835 transactions and HIPAA 5010 837P and 835 transactions.
* Involved in Integration Testing, Functional Testing, and UAT.
* Utilized Agile Methodology to configure and develop process, standards and procedures.
* Did GAP analysis and Impact analysis for the facets up gradation system.
* Attended daily SCRUM and guided QA and Developer regarding the defects, Technical Specification Documents and Mapping Documents.
* Used SQL Navigator for Writing and execute Queries.
* Checked the data flow through the frontend to backend and used SQL Queries to extract the data from the database.
* Involved in writing extensive SQL Queries for back end testing oracle database.

**Environment:**Requisite Pro, Rational Rose, Agile, HL7 Interfaces, PL/SQL, HTML, MS Office, MS Visio, EDI, UML.

**Cognosante, McLean, VA Jan 2014 – Jan 2015**

**EDI Analyst / Requirements Analyst**

**Description:**

Cognosante is a leading provider of IT services to healthcare organizations. They assist their clients in developing, managing and executing complex healthcare information programs and infrastructures. Their expertise includes standards development; interoperability, business and technical architecture, modular system integration, health informatics, Medicaid, health information exchanges, improper payment, health insurance exchange, NwHIN, and The Direct Project. Cognosante's Standards Practice bid to be a prime contractor to CMS for part of the work of supporting the marketplace.

**1095-A Interim Process:**

Marketplace must give consumers information about their health coverage so they can:

* File their taxes
* Reconcile advance payment of the premium tax credit (APTC)
* Claim the premium tax credit ( PTC)
* The federally-facilitated Marketplace will send a Health Insurance Marketplace statement, Form 1095-A for tax year 2014 on or before February 2,2015
* Consumers will complete Form 8962; and will submit only form 8962 to IRS as part of their tax returns

**Enrollments Disputes**:

The focus of the project was to work on records during the leisure-dispute, Process to address all discrepancies regarding.

* Applied APTC
* Start and End dates of policy
* Date of birth
* Exchange assign policy id
* Exchange assign subscriber id
* Premium amounts
* QHP id
* Missing 1095 A
* Mailing Address update

**Responsibilities:**

* Assigned in Special Project team fro the project beginning.
* Performed Testing thoroughly with document issues
* Responsible for troubleshooting and resolving errors in 834 and 820 transactions for health insurance exchanges and performing root cause analysis.
* Involved in numerous smaller projects(workbook generations, QA review, cleaning up the directories ,Working on customer clients)With in 1095A projects.
* Analyzed the 1095 a form data element
* Worked closely team lead to identify and escalate findings and overall impact of the discrepancies on the claims.
* Worked in claim adjudication process of facets application.
* Recommended changes to benefit whole project while evaluating the clients.
* Generated the work book to analysis the complaints.
* Extensive utilization of analytical skills in solving the customer clients
* Generated many documents for the process flow of the whole 1095A project. Which includes from the beginning like assigning the case,analyzing the case ,decisions matrix. And several other documents.
* Worked on the EDI 834-file load to Facets through MMS (Membership maintenance sub-system).
* Also worked on the correlated case like FFM number has several cases related to that and documents how to work on them.
* Reviewed numerous clients to observe requirements specifies by the organization
* Extensive use of excel work to analyze the case for the given scenarios.
* Created the formula for the data to pull form the database .
* Extensive use of House data base to evaluate customer clients to come up with conclusion
* Involved in using sensitive information like PII to evaluate and process the customer clients.
* Involved on removal process of unwanted errors entry on VPN drive after mapping the data.
* Coordinate with differ EDI analysts to various teams on the project in resolving the back log cases.
* Created Unit test plans and reviewed and updated all test cases in Excel and SharePoint, and managed the Requirements Traceability Metrics (RTM)
* Extensive use HICS website regarding complaints lodge on website and also use to map complaints HICS numbers for possibility of other associated claims for particular customer.
* Worked as interim Team lead in the absence of team lead and took the responsibility of all the work and documents everything for the reference.
* Executing SQL commands performed back-end testing.
* Executed SQL statements to check if the data integrity has been maintained.
* Created SQL queries for data validation.
* Performed manual Back-End testing on the application by writing complex SQL queries.
* Used to take the meeting minutes and document them and send across the teams. Used to conduct the team meetings. Power point presentations.
* Environment: MS Windows, MS Visio, MS Project, Facets, MS Office (PowerPoint, MS Word, MS Excel, MS Access), SQL, Oracle

**Blue Cross Blue Shield, Baton Rouge, LA Sep 2012 - Dec 2013**

**Business System Analyst**

The main objective of the HIPAA 5010 Project was to move from the current 4010 system into the 5010 system. The project mainly involved working on the 270/271 Eligibility request and response, 276/277 claim status request and response and 837/835.

**Responsibilities:**

* Gathered business requirements through discussion with stakeholders and SME’s.
* Analyzed the ICD conversion information provided by the CMS and gained understanding of ICD-9 versus new ICD-10 codes sets.
* Performed Gap Analysis for HIPAA 5010.
* Involved in activities to make sure proper documentation and standards are being followed.
* Wrote Business Requirement Document after collecting requirements through conducting interviews, JAD sessions and brainstorming sessions.
* Created Use Case diagrams by analyzing the business process followed by Activity diagrams using MS-Visio and participate in production of HIPAA 5010 EDI Test data.
* Analyzed HIPAA 4010 and 5010 standards for 837P EDI X12 transactions related to providers, payers, subscribers and other related entities.
* Developed use case Designed process flow diagrams using MS-Visio and also Business Context Diagrams.
* Created Data Mapping to document to migrate data from the existing system to the new system.
* Worked on the EDI 834-file load to Facets through MMS (Membership maintenance sub-system).
* Work directly with Center for Medicare and Medicaid Services (CMS) and providers to get requirements for the project.
* Strong Documentation and Report Generation skill and experience by Use case approach.
* Participated in software upgrades for claims workflow and EDI transactions (835, 278) upgraded from Version 4010 to 5010.
* Involved in claim adjudication process of facets application.
* Worked extensively on EDI transactions 837 and 835 Involved in writing test cases for different LOB’s (ITS, FEP and Regular) for SIT, Parallel and UAT.
* Worked on 270,271 Eligibility request and Eligibility response and on 276,277 Claim status request and response.
* Performed Integration, System, Regression, Functionality, Security, Performance, Positive, Negative and User Acceptance testing on Payment Eligibility Screen, CMS ICD Screens and Center for Medicare and Medicaid Services (CMS) Eligibility Screens.
* Used Agile testing methodology for achieving deadlines in UAT testing.
* Validated that the 270/271 generated is in accordance with the 5010 implementation guide.
* Mapped EDI 834 transaction to BCBS LA enrollment/eligibility system to comply with State of Los Angeles Health Care Reform Project. Ensured accurate enrollment data for health plan products across multiple systems.
* Assisted developers in troubleshooting and resolving EDI issues by collaborating with internal and external business partners to define business processes and information requirements by building on intermodal industry best practices and ANSI X12 EDI standards.
* Setup, co-ordinate & conduct system & UAT testing with Business Analysts and end-field users
* Used FACETS: Subscriber/Member, Medical Plan to validate the Eligibility benefits received in the 271 response.
* Performed parallel testing for the 83x transactions to ensure comparable results between 4010 and 5010 transaction processing with the help of XC file comparisons, Keyword file comparisons, and other significant file structures with end-to-end testing cycle Analyzed and provided ‘compare results’ for production XC’s (External Claims) and test XC’s for all LOB’s after every build to validate if the defect were fixed.
* Make presentations to the end client during UAT.
* Constantly involved in review meetings and made sure testing is done based on the QA master plan and deadlines are met.
* Used FACETS to provide seamless transactions between the provider, members and the plan.
* Used SQL Queries to verify the data from the Sybase database.
* Executing SQL commands performed back-end testing.
* Executed SQL statements to check if the data integrity has been maintained.
* Creating and consolidating SIT Test Cases and UAT test Cases using MS Excel or Quality Center.
* Was involved in working with the offshore testing team to co-ordinate Regression Testing.
* Preparing sample Test Data and executing Test cases using Quality center.
* Provide support to end users while execution of UAT with proper test scenarios & test data.
* Monitored RTM to close the defects/cases as and when developers resolved the defects
* Communicated with developers and Business Analysts through all phases of testing to prioritize defect resolution.
* Reporting the Test Execution status to the project manager on daily basis.
* Good understanding of 5010 conversion initiative
* Actively involved in weekly walkthrough meetings and Daily Defect calls to verify the status of the testing efforts meeting the deadlines & mid-term targets

**Environment:** MS Visio, Microsoft SQL Server 2005, Quality Center, Sybase, Facets, MS Word and MS Excel.

**Health Partners Inc. Philadelphia, PA. June 2010 - Aug 2012**

**Business Analyst**

Worked on their NCPDP project where their Clearing House (Switch) sends this client Claims, Reversal, Rebill, Eligibility and Prior Authorizations files. Our team was then responsible to weed out any potential transaction problems and in turn send outbound transactions to their Medicare/Medicaid trading partner.

**Responsibilities:**

* Extensively studied 5010 requirements and the existing EMR application being sold by the company at the time.
* Logged all the issues with the old application and suggested improvements to the business team for review.
* Worked in preparing the EDI transmission files, dropping them in Inbound, Outbound Interfaces and validate the data according to the test scenarios.
* Tested the HIPAA EDI, 834, 270/271, 837/835 transactions according to test scenarios.
* Validated the date from EDI transaction with Facets.
* Coordinated with developer and testers for transition of EDI X12 4010 series to 5010 series. Maintained traceability BUR and FRD through updates to RTM using Requisite Pro.
* Created wireframes for the new application design based on the old applications design.
* Wrote Business Requirement Documentation (BRD) for the project.
* Performed typical BA related tasks such as requirement gathering, conducting meetings, and documenting them.
* Constantly updated the BRD as per the changes in the requirement and informed the whole team regarding the new changes.
* Reviewed Test Cases for EDI transactions and executed them in Quality Center testing environment
* Wrote SQL query for back end data validation with table joins, insert etc.
* Involved in testing HIPAA Transactions & Code Sets Standards like (820- Premium Payment for enrolled health plan members, 834(X12) - Enrollment /Dis-enrollment to a health plan, 835, 837.
* Helped the QA team conduct the testing process by setting up the test environment.
* Used HP QTP in executing the test cases, logging them and directing it to the right team for any issues encountered during the testing phase.
* Created Data Mapping, Database Queries, and Data Dictionaries.

**Environment:** Rational Rose and Requisite Pro, Facets, MS Visio, Agile, MS Project, UML, XML, Windows XP, HTML, XML, HTML, Oracle.

**Dept. of Health and Human Resources, Lincoln, NE April 2008 - May 2010**

**Business System Analyst**

**Project 1:** worked on Development of NE Provider Portal that allowed users to perform various functions such as Request for Prior Authorization (PAR), Check for Prior Auth. Status, Member Eligibility inquiries, and Claim status inquiry by interacting with NE MMIS Clinical Department and legacy claim system.

**Project 2:** Worked for the team that was responsible for receiving, documenting, and processing the claims including the eligibility verification. The team was responsible to implement the changes into the system due to the change in current policies, rules & regulations. Also, tracking and addressing the problems in timely manner encountered by the providers, billers as well as the third party vendors, health plan groups while generating Remittance Advice 835, Eligibility Inquiry/Response 270/271.Worked closely with legacy MMIS department and also was a part of initial 4010 to 5010 conversion analysis.

**Responsibilities:**

* Business System Analyst for outsourcing all paper claims and correspondence documents to an outside vendor. Defined requirements for receiving 837 claims files and MACESS files into our imaging software and work flow software
* Created Use Case diagrams using UML and Business Process Models using MS-Visio.
* Gathered requirement on FACETS EDI 834 Benefit Enrollment and Maintenance subsystems
* Responsible for Business Process Management (BPM) for development of various projects.
* Developed Use Cases, Sequence Diagrams, Activity Diagrams and Class Diagrams.
* Analyzed the impacts of HIPPA 5010 project on inbound 837 claims.
* Performed manual testing by building 837 claims, converting them into EDI file, uploading them into mainframe region and doing error resolution & testing for 5010 requirements & NPI crosswalk.
* Conducted the Functional, System, Integration, Regression, UAT, performance Tests of the Application.
* Perform Extensive EDI testing on X12/4010 837,835, 270 etc, worked with state vendor to validate inbound /outbound EDI transactions to Facets.
* Researched and resolved pended claims in MACESS.
* Verified and Reported of all issues/defects from small to big raised by UAT team
* Built and updated existing Ques using MACESS doc workflow for business migration project.
* EDI file testing for checking the HIPAA 5010 (X12) compliance of the inbound 837 claims.
* Performed Gap Analysis for 5010 enhancement using the TR3 implementation guides and side-by-side HIPAA 4010 to 5010 guides provided by CMS (Center for Medicare & Medicaid Services)
* Facets support systems were used to enable inbound/outbound HIPAA EDI transaction in support of HIPAA 834, 835, 837 270/271 transactions.
* Performed Smoke (Sanity) testing, Functional testing, SIT, UAT and End to End Testing of API, GUI, Web Applications and Web services.
* Analyzed System-level requirements and managed changes as they affected test cases and procedures, Worked collaboratively with project team including development, business analyst, and QA resources in Affordable Care Act - Center for Medicare and Medicaid (CMS),Active participant in Eligibility and Enrollment [EE] modules
* Worked on FACETS claims processing, payment adjustments, claims inquiry, benefits,
* Responsible for Performing Integration Testing, UAT testing.
* Assisting the project manager in creating detailed project plans and scheduling and tracking project timelines.
* Responsible for testing of new Power MACESS releases.
* Worked on CMS (Centers for Medicare & Medicaid Services) requirements within the project.
* Responsible for Business Process Management (BPM) for development of various projects.
* Incorporated FDA guidelines (21CFR) and HIPAA (Health Insurance Portability and Accountability Act).
* 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.
* Worked with various Business Intelligence tools for reporting and decision making.
* Worked with Healthcare Benefits Online (HCBO) to test online portals of different clients and functional testing of Real Time and Batch jobs using EDI.
* Tested the ANSI X12 Version 5010 / EDI transactions (HIPAA) like 837P, 837I, and 837D.
* Developed various reports for user verification like Cross Tab Reports and Sub Reports, various charts and graphs like Bar chart, line graphs, and Pie charts by using Crystal Reports and exported reports into formats like PDF, HTML, Excel, Word and RTF.
* Created product documentation including online help, printed user manual, and training materials.
* Scheduled meetings with developers, Business Analyst's (BA) and testers to identify resource allocation and project completion using MS Project.

**Environment:**Windows 2000/XP, Microsoft Office SharePoint 2007,MACESS, Rational Requisite Pro,HL7,MS Office, SQL Server, Agile, MS Project, MS FrontPage 2003, MS Visio, MS Access, EDI,UML

**EDUCATION:**

Bachelor’s in Computer Science

1. [↑](#footnote-ref-2)