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**PROFESSIONAL SUMMARY**

* Business Analyst with 7 years of experience including an understanding of Business Process Flows, Case Tools, and Business Analysis.
* Good understanding of SDLC and have worked on different methodology such as Agile, waterfall and RUP.
* Use Cases, Object Oriented Analysis and Design (OOAD).
* Have tested on client server and web based server application
* Created documents like test scenarios, test cases and assisted in creating test plan
* Wrote and executed test cases manually and using automated tools.
* Familiar with UNIX commands.
* Extensive experience in preparing Healthcare Effectiveness Data and Information Set (HEDIS) reporting.
* Facets support systems were used to enable inbound/outbound HIPAA EDI transaction in support of HIPAA 834, 835, 837 270/271 transactions.
* Build and maintain strong relationships with business partners, customers, technology teams and Data Management team to build Business Intelligence solutions.
* Created RTM to map requirement to test cases to validate all required requirements
* Have extensive knowledge of gap analysis and bug life cycle.
* Used QC extensively to handle bugs.
* Familiarity with numerous data warehousing concepts like pivoting, data slicing/dicing, data cleaning/scrubbing, metadata, data mart, fact table, dimension table, star schema, snowflake schema, fact less fact table, etc.
* Utilized complicated SQL queries to analyze and validate test databases for data integrity
* Used SQL extensively to perform back end testing using inner and outer join
* Generated different kinds of reports
* Expertise in EDI and HIPAA Testing Privacy with multiple transactions
* Performed forward mapping, backward mapping and cross word table on the conversion of ICD9 to ICD10
* Have good understanding of 4010 to 5010 conversion.
* Have full understanding of claim processing (COB, Medicare, Medicaid).
* Team player, result-oriented, fast learner, excellent written and verbal communication skills with strong research capability.

**TECHNICAL SKILLS**

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| --- | --- |
| **Databases** | Oracle, SQL Server |
| **Change Management** | Rational Clear Quest |
| **Testing Tools** | HP Quality Center, Jira, Bugzilla |
| **Other Tools** | Toad, SQL**+**, Squirrel, Notepad++/EditPlus, FileZilla/WinSCP |

**WORK EXPRIENCE**

**Client: WellCare, Tampa, FL**

**Nov 2015- Present**

**Business Analyst**

The scope of the project was to streamline the HEDIS reporting. This reporting would enable on time reporting to the NCQA.

**Responsibilities:**

* 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.
* Facilitated & conducted JAD sessions for requirement gathering, requirement review, and requirement approval.
* Performed Gap Analysis, Feasibility Studies, and Impact Analysis to for implementation of HEDIS changes.
* Responsible for maintaining of HEDIS Measures as per the NCQA specification.
* Gathered the requirements through the meeting, created agenda for the meeting and sending the meeting minutes for the whole team who are part of the project and created Business Required Documents for different type of domains such as Claims, Enrollment and Provider Management.
* Responsible for the development and implementation of functional requirements to support Medicare Part D.
* Performed In-Depth analysis of systems and business processes of Medicare Part D as per CMS rules and procedures.
* Managed Medicare Part D programs, resources and project timelines.
* Perform duties in pre-authorization ICD-10 codes.
* Created Business Requirement Documents for HEDIS reporting.
* Gathered requirements and worked on the accessibility, digital transformation and digital payment.
* Facilitated Joint Application Development (JAD) Sessions for communicating and managing expectations.
* Performed analysis on the member/eligibility information on claim.
* Shared best business practices on all the domain areas.
* Worked directly with implementation team such as developers and configuration team to ensure clear communications on requirements.
* Created Solution summary document.
* Worked on mobile application in digital transformation.
* Provided daily project status report to project manager and project presentation to the high level management on weekly basis.
* Prepared business process and extended features to implement digital transformation using specific web applications.
* Involved in writing extensive SQL Queries to retrieve the data for the purpose of data analysis.
* Implemented Agile approach for requirement gathering continuously prioritized requirements as per needs.
* Developed Data Mapping and Crosswalk documents.
* Worked on different modules of Facets such as Members/subscriber, commissions, provider, billing.
* Membership/enrollment and billing-entered information on Facets to ensure correct eligibility, etc
* Used FACETS to provide seamless transactions between the provider, members and the plan.
* Reviewed Functional Requirements Specifications and documented Test-Scripts and executed Test Cases for MMIS Medicaid billing system functional areas such as Third Party Liability and Claims Front End.
* Involved in preparing several Use Cases, Business Process Flows, and Activity Diagrams using Microsoft Visio, Context diagram and Event Response Table.
* Tested the billing and rendering provider, member subscriber, and payment modules of FACETS in the UI as well as in terms of database validation through SQL Queries.
* Worked on requirements of the 835 HIPAA projects, 276/277, 837, and HIPAA EDI Transactions across enterprise.
* Developed, coordinated and supported Information Technology Division on all operational requirements of FACETS claims processing system and production management.
* Facilitated Brainstorming Session involving business unit stakeholders, technical analyst, SME, portfolio managers to gather requirements and have better understanding of business process.
* Worked in testing the professional, institutional claims processing and adjudication and validate data with facets.
* Assisted in Regression Test, System Test, and UAT.

**Environment**:  Microsoft SharePoint, MS Visio, HEDIS, MS Office, UML, HP ALM/Quality Center, .NET, Toad for Oracle, Team Track, AGILE/SCRUM methodology, Facets.

**Client Celtic Health Insurance, Chicago, IL**

**Nov 2013- Oct 2015**

**Position: Business Analyst**

Celtic Insurance Company is one of the leading health insurance providers in Chicago. The company currently runs its business on Facets for claims adjudication and billing and provides medical plans.

**RESPONSIBILITIES:**

* Worked as a liaison between the business client and development team for the in compliance with HIPAA standards.
* Identified the business functions and processes, and prepared system scope and objectives based on user needs and industry regulations.
* Defined terms, conducted stakeholder analysis, elicited business needs, conducted business process modeling, and facilitated JAD sessions. Elicited, documented requirements and use cases. Analyzed, validated & prioritized requirements; traced requirements to related project documentation (process models, designs, test scenarios & scripts).
* Responsible for architecting integrated HIPAA, Medicare solutions, Facets.
* Documented the Requirements and circulated them to Business & Technical teams for Signoffs.
* Participated and led daily stand-up meetings in line with Agile Scrum methodology.
* Used agile methodology for gathering requirements and testing them.
* Involved in creating the UI design for the mobile applications for member portal.
* Created User Interface for displaying various information related to providers and claims.
* Gathered, documented and analyzed requirements on implementation of Obama Care Affordable ACT on ELIGIBITY, COVERAGE And PROCEDURE AUTHORIZATIONS.
* Gathered and documented Requirements on New Obama Care Health Insurance exchange pool and Laws governing the implementation.
* Created 837 I & 837 P claims using macro enabled claim spreadsheets.
* Order Process Management – Designed techniques to implement a new Billing and Inventory Management Tool to better track the expanding business' products.
* Processed EDI 837P, 837I, 834 and 837D transactions, verified 837 transactions were converted correctly to XML file format and verified the claims data loaded to Facets for further processing.
* Worked on analysis of FACETS claims processing system and gathered requirements to comply with HIPAA
* Conduct JAD sessions to gather and document requirements that enhance a wide range of functionalities including claims processing, eligibility and enrollment, provider networks, and electronic data interchange for our Facets core application.
* Created a new project using SoapUI and run request with input XML to receive a response XML for the request sent
* Identified testing scenarios and defined Test Cases for detailed functional testing and UAT.
* Facilitated claims processing while passing 837 claims for a compliance check and running through load processing.
* Worked with ANSI X12 HIPAA EDI Transactions 270, 271, 276, 277, 837, 835 and 997
* Created and maintained data mapping document(s) in reference to the HIPAA transactions: 270/271, 276/277, 837, and 835.
* Involved in forward mapping of ICD 9 to ICD 10 and backward mapping of ICD 10 to ICD 9 using General Equivalence Mappings (GEM).
* Developed a Schedule and identified project milestones.
* Reported project progress to the team, senior management and all stakeholders periodically.
* Performed testing of the health benefit claims receiving and processing system to ensure that the system adheres to project standards, performance criteria, and functional specifications
* Identified risk and project impact and performed risk assessment and mitigation.

**Environment:** SQL, MS Access, Software/Tools Micro-Strategy, Visio, agile, Rational Rose, .NET, HIPPA, 5010, Quality Center, MS Project.

**Client: CNSI/State of MD, Rockville, MD**

**Jan 2012- Oct 2013**

**Position: Business Analyst**

Re-engineering suite of Medicaid management products and creation of a core application called Enterprise. Worked for the team that is responsible for receiving, documenting, tracking and addressing the problems encountered by the customers of Flagship software product EPM (Enterprise Practice Management) while generating 837 Professional, Institutional, and Dental claims, Functional Acknowledgement 997, Claim Status Inquiry/Response 276/277 Unsolicited for their destination direct Payers or Clearinghouses such as ProxyMed, WebMD, Per Se, THIN, ViaTrack, NaviCure, McKesson, Champus-TriCare, PayerPath, ViaTrack, Access, etc. The product was also integrated with Trizetto's Facets application for Claims processing.

**Responsibilities:**

* Facilitated JAD sessions to collect requirements from system users and prepared business requirement that provided appropriate scope of work for technical team to develop prototype and overall system.
* Involved in gathering, documenting and verifying business requirements.
* Involved in requirement gathering phase (Provider, Claim components and HIPAA)
* Met with report users and stakeholders to understand the problem domain, gathered customer requirements through surveys, interviews (group and one-on-one) along with JAD sessions.
* Involved in understanding the current business process, defining scope of the project along with position statement.
* Wrote BRD, FRD, use cases, test scenarios, test cases for testing the functional requirement.
* Implemented automated COB processing of Medicare claims into Facets
* Validated business rules and all artifacts with users, got approval and sign off.
* Experience with Trizetto Facets System implementation, Claims and Benefits configuration set-up testing, Inbound/Outbound Interfaces and Extensions, Load and extraction programs involving HIPPA 837 and proprietary format files and Reports development.
* Set claim processing data for different Facets Module.
* Involved HIPAA regulations in Facets HIPAA privacy module
* Involved EDI Claim Process according to HIPAA compliance.
* Coordinated with the Release Management Team in order to complete the overall release plan.
* Used Requisite Pro for writing/analyzing project vision, goals, specifications and requirements.
* Compiled Vision and Scope documents to better define the rationale for the project. Gathered requirements from business to determine the functionality that should be provided to the users.
* Created business requirement documents as well as system requirement specification after the JAD session.
* Extensively worked with ANSI X12 HIPAA EDI Transactions 270, 271, 276, 277, 837, 835 and 997
* Involved in testing the Medical and Hospital claims in Facets based on Service, Agreement and Pricing Id's
* Tested the Web interfaces and Web Service Applications
* Worked with ANSI X12 (835, 837, 834) EDI Transactions
* Extensively used UNIX shell scripts
* Responsible in providing regular test reports to the management
* Reported the defects to the developers using Quality Center
* Tested and delivered Inbound/Outbound Facets UI interfaces.
* Developed a detail project plan and helped manage the data conversion migration from the legacy mainframe system to the target SQL Server database.
* Responsible for architecting integrated HIPAA, Medicare solutions, Facets
* Helped in project testing efforts for doing integration tests, regression tests and user acceptance tests.
* Worked on Data mapping, logical data modeling used SQL queries to filter data within the Oracle database tables.
* Made sure that the systems complied with the rules of HIPAA.
* Documented the dimensional models of ETL system.

**Environment:** Java, MS Office Tools, MS Project, RequisitePro, Rational Rose, ClearCase, PowerPoint, SharePoint, MS-Word, MS-Excel, Facets

**CIGNA Healthcare, Raleigh, NC**

**April 2010– Dec 2011**

**Position: Business System Analyst**

CIGNA Healthcare provides quality health insurance at affordable prices. I worked particularly on analyzing Facets interfaces involving a new feature for SPP (Strategic Partnership program). My duties included working with claims module and processing them for various scenarios. I had responsibility of testing mainframe systems for CBoR (Claim Book of Records). As an analyst, worked on ETL projects to construct and verify data requirements. Experienced working on ANSI X12 270-271 EDI Transaction. Involved in documenting EDIs according to code set X12 835 Claim Payment & Remittance Advice Claims processing and 837 Claim transactions .

**RESPONSIBILITIES:**

* Responsible for the requirement-gathering phase and project plan.
* Responsible for the full HIPAA compliance lifecycle from gap analysis, mapping, implementation and testing for processing of Medicaid Claims.
* Used HIPAA 4010 transactions to support the analysis of current business processes and work with management to improve and implement enterprise solutions to ensure compliance and involved in designing future state processes for HIPAA 5010 transaction processing EDI’s 837, 835, and 834.
* Created Use Cases diagram and Activity diagram to depict the interaction between the various actors and the system in Rational Rose for the Business Use Case and System Use Case. face
* Tested the changes for the front-end screens in FACETS related to following modules, test the FACETS batches (membership, Billing, Provider, etc.).
* Interacted with database developers for formulating the ER diagrams and data flow diagrams.
* Worked with a QA lead in validating Test Plan and Test Scenarios.
* Assisted Business User during deployment in formulating User Acceptance Testing (UAT) for customized application and getting confirmation for product Release

**Environment:** SQL, MS Visio, MS Office Suite, MS BizTalk Rules Engine Deployment Wizard, .NET, Oracle and Windows NT, Visio, Requisite Pro

**Education:** Bachelor in Mechanical Engg.