**Pavitar**

**SUMMARY**

* Eight Years of Hands-on experience with Rational Unified Process (RUP) and Unified Modelling Language (UML) for developing Object Oriented (OO) models for various IT applications.
* Proven expertise in Systems Development Life Cycle (SDLC) from requirements gathering to final implementation and customer training, and Iterative as well as Waterfall Project Management Life Cycle methodologies.
* Exposed to Medicare and Medicaid domains of the healthcare systems and industry for inpatients, outpatients, Reimbursement Methodology.
* Knowledge and Experience on Membership, Billing, Claims Payment Processing in relation to HIPAA, EDI 4010, 5010 X12,HL-7 ICD-9 & ICD-10, codes 834, […] and 270, 271.
* Functional Knowledge of Medicaid Management Information System (MMIS).
* Created data mapping documents based on Red Cards specification which involved working with FACETS, claims, membership& plan data model.
* Responsible for defining necessary business requirements related to the company’s implementation of the managed care contract system portfolio by conducting information gathering meetings with members within the company at all levels.
* Utilized Microsoft Access and Excel to run daily quality assurance reports on trade requests processed by the MDS team.
* Monitored contracts and payments and worked with the Billing, Claims, Benefits and Authorization departments and the Managed Care companies to resolve differences and ensure correct reimbursement.
* Knowledge of EMR/EHR, Patient Protection and Affordable Care Act (PPACA).
* Experience in Software Development Life Cycle (SDLC) and Software Testing Life Cycle (STLC) in different methodologies such as Agile, Scrum, Waterfall, RUP etc.
* Documented ICD9 to ICD 10 mappings (one to one/one to Many according to the GEM files from CMS with the functional and structural changes related to the conversion.
* Involved in the full HIPAA compliance lifecycle from GAP analysis, mapping, implementation, and testing for processing of Medicaid Claims.
* Analysed CMS comparison documentation highlighting changes of 4010 format and ICD9 diagnosis and procedure codes.
* Provided real-time access to information related to authorization and referrals, care planning activities, claims, PCP selection, encounter data, HEDIS Alerts for missed services and provider profiling scorecards.
* Worked Subject matter expert for various departments regarding system logic as it relates to AHCA/CMS regulations and pricing, in conjunction with, contract interpretation for system purposes.
* Performed analysis on the Affordable Care Act (ACA) law & corresponding Centre for Medicare and Medicaid Services (CMS) and Connecticut Health Insurance Exchange (HIX) business requirements.
* Organized many Joint Application Developments (JAD) sessions and Joint Requirement Planning sessions (JRP), walkthrough, Interviews, Workshops and Rapid Application Development (RAD) sessions with end-user/clients/stake holders and the IT group.
* Managed Health plan oversight for approving all claim system change requests, as well as, claim work processes.
* Produced reports through the use of SQL for departmental analysis and trending for configuration and claims.
* Developed straightforward DBMS queries, knowledge of HL7 and xml interface messaging.
* Focussed on process improvement and auditing opportunities for completed system configuration.
* Conducted internal audits to validate the accuracy of change requests and provider setups are accurate in relationship to the claim submission.
* Successfully used Agile/Scrum Method for gathering requirements and facilitated user stories workshop.
* Performed gap analysis of NC MITA 2.0 and 3.0 Business Architecture Assessment "As Is" capability maturity levels and created "To Be" BPM matrixes.

**EDUCATIONAL BACKGROUND**

**Bachelors in Biological Sciences 2004-2008**

**California State University, Stanislaus**

**WORK EXPERIENCE**

**Business Analyst**

**Cognizant Technology Solutions, Naperville, IL October 2016 to December 2016**

**Project Description:**

“Retail” is a hot topic in the health insurance industry today for good reasons. From the creation of health insurance marketplaces, to the rise of private exchange, the sale and delivery of health insurance requires an increase in focus on the individual consumer. To keep up with the industry, there is a need for the HCSC to revisit their process. The detailed assessment of the process revealed some gaps and inefficiencies in the process that leads to an increased turnaround time for the application.This assessment directed our focus on the following areas to improve the member enrolment process and the observations were carefully reviewed and approved by the leadership.

Responsibilities:

* Responsible for leading multidisciplinary teams to investigate issues in real time and managing quality improvement initiatives impacting core processes
* Performed workflow analysis to understand the inefficiencies in the AS-IS system and documented them accordingly and successfully defined work flows, jobs, and reporting relationships to obtain optimum effectiveness.
* Createdhuddle tool kit for the Supervisors, Training Manual (Playbook) for the teams to understand the future process
* Proficient in conducting Business Process Modelling (BPM), Feasibility Studies, Impact Analysis, Cost/Benefit Analysis, ROI Analysis, Gap Analysis and Risk analysis, SWOT analysis.
* Experienced in extracting data from external sources, processing and loading data files (ETL process).
* Conducted Joint Application Development (JAD) sessions as a facilitator to gather requirements from the technical team.
* Formed a Production Control Team to streamline the retail enrolment process, and held daily meetings
* Built support for studies from executive management to key individual contributors.
* Monitored process pilots on projects and oversee training.
* Established performance metrics, optimize resources, identify potential issues, measure and encourage organizational performance improvement and efficiently implement cloud-computing platforms.
* Ensured compliance to critical paths, reducing operation costs and implementing agile methodologies when applicable.
* Specialized in analysing qualitative and quantitative data to resolve faulty operations by engineering and improving system design, Lean Six Sigma DMAIC to manage identified issues and drive process improvement.
* I worked primarily on analysing current state and determining pain points, bottle necks and problems with the existing infrastructure and incorporated them into the future state requirements.
* Conducted extensive brain storming sessions and requirement gathering sessions to work on documenting future state needs
* Created a landing page structure and walked the executive leadership through the future state designs
* Created CRS (customer requirements specifications), Business requirements, Functional requirements, Process flows, Work flow diagrams, User Interface/ Interaction diagrams and Landing Page structure
* Launched new initiatives and follow through to completion with the desire to improve software development process
* Interacted with Project Managers, development team and system engineering team to improve the quality of the products.
* Analysed software metrics data and provide key process indicators for projects
* Monitored quality indicators for development lifecycle and advice projects on preventive and corrective actions.
* Reported quality deviations and collaborated with project management teams on resolutions
* Developed, maintained, and reported results on automation tools developed to gather software metrics data
* Interacted with development team and system engineering team for new feature development
* Participated in requirement clarification to work towards customer satisfaction.

**Business Analyst**

**Tenet Healthcare Corp., Dallas, TX**

**February 2015 to September 2016**

Project Description:

Tenet Healthcare Corporation (THC) is a holding company that owns and operates 86 hospitals in the United States. The project was to develop an application for the hospitals to use as a central repository for storing reports from different departments of the hospital. Major modules included Enrolment/Registration, Billing and Reports. This System was being developed using HIPAA guidelines and regulations which keeps track of Healthcare transactions like Eligibility Request/Response (270/271), Request and Response for Claims Status (276/277), Prior Authorization (278), and Claim/Encounter (837I/837P).

**Responsibilities**:

* Gathered business, system, and functional requirements by conducting detailed interviews withbusiness users, stakeholders, and Subject Matter Experts (**SME's**).
* Conducted group (**JAD**) sessions with business units and stakeholders to define project scope and deliverables.
* Validate the Business-to-Business data exchanges between data exchange partners; validate the internal processing of the **MMIS**, or other transaction processing system.
* Provide technical support for the Minimum Data Set (**MDS**) and the Outcome and Assessment Information Set (**OASIS**) Systems to enable the electronic transmission for patient data for the purpose of payment and quality of care analyses for the Medicare and Medicaid Programs.
* Responsible for: creating artefacts for Rational Unified Process (**RUP**) - use cases, system architecture document, supplemental requirements document, architecture diagrams; verifying technical production infrastructure; designing and executing performance tests; and documentation.
* Worked on Medicare Advantage (A, B, C), **Medicare Part D** (**MA-PD**), Medicaid Options (Under 65 and Over 65) and Managed Care (Care, Disease and Case Management and also in Insurance regulations and Claims Processing and claim scrubbing in **HMO**, **PPO**, **Medicare** and **Medicaid**.
* Assisted in loading managed care contract rates into managed care contracting information systems.
* Also, worked with other departments to provide managed care information and identify improvement opportunities.
* Also performed complete reconciliation of the Explanation of Payments (EOP) and check remittances as they received from Managed care Contracts
* Entered Minimum Data Set (**MDS**) into computer database and transmitted them to the Medicare website
* Designed and maintained managed care contract databases to streamline collection, analysis, and dissemination of contract information.
* Performed the requirement analysis, impact analysis and documented the requirements using Rational Requisite Pro.
* Prepared client process maps for the consumer, broker, employer and provider transactions for the Facets process.
* Developed and wrote test script walkthroughs with developers and Quality Analysts.
* Set and continually managed project expectations with team members and stakeholders.
* Worked on **EDI** transaction **835** to identify key data set elements for designated record set. Interacted with Claims, Payments and Enrolment hence analysing and documenting related businessprocesses.
* Incorporated **HIPAA** standards, **EDI** (Electronic data interchange), transaction syntax like **ANSIX10**
* Developed straightforward **DBMS** queries, knowledge of **HL7** and xml interface messaging.
* Assisted in monitoring ancillary data transactions and addressed problems with **HL7** messages.
* Involved in analysis for wide range of **Six Sigma** and Web-based initiatives, including user requirements.
* Data mapping, logical data modelling, created class diagrams and ER diagrams and used **SQL** queries to filter data within the Oracle database.
* Analysed and Documented Business Requirement Document (**BRD**), Functional Specification Documentation, and System Requirement Documentation, using **UML** methodologies
* Conducted meetings to understand the workflow, their processes and assisted in gap analysis to derive requirements for existing systems enhancements.
* Reviewed test scripts and made sure that the **Test scripts** covered all scenarios of the requirements.
* Create technical design documentation for the data models, data flow control process, metadata management.

**Environments:**

Oracle, MS Office, RUP, MS Windows7, MS Visio, JIRA, Rational Rose, Rational Requisite Pro, FACETS,

**Business Analyst**

**Coventry Health Care, Richmond, VA**

**January 2012 – December 2014**

**Project description:**

The project was regarding the Electronic Medical Claim Software System that facilitates providers to send electronic claims in short time, and thereby ultimately increase the revenue cycle efficiency. The primary feature of the software included Electronic verification of insurance eligibility, Electronic claims status inquiry, Financial Ledger, Essential system reports and automated reminders. The system's goals were to maximize the value of online health information; expand utilization of programs, services and products. The project scope also included ICD 10 Care Management Impact Analysis including Care Management that utilized multiple software systems to support the intake and processing of authorization requests. The authorization requests consumed ICD 9 codes that needed to be replaced by ICD 10 codes to meet the mandate date.

**Responsibilities**:

* Gathered Business Requirements through brainstorming sessions on global calls.
* Facilitated **JAD** sessions for Requirement Validation with HPA to gather requirements for the new **MMIS**.
* Involved in the full **HIPAA** compliance lifecycle from **GAP** analysis, mapping, implementation, and testing for processing of **Medicaid** Claims.
* Responsible for defining necessary business requirements related to the company’s implementation of the managed care contract system portfolio by conducting information gathering meetings with members within the company at all levels.
* Analyse, and document business and functional requirements via uses cases for **Medicare** billing transaction-based middleware/database layers with **SOA**&**XML**.
* Was responsible for supporting the Managed Care contracting and revenue growth initiatives by creating contract, financial and predictive models.
* Validating the **EDI837** claim billing (professional, institutional and dental claims) &**835** (remittance advice or payment) claims adjudications.
* Mapped provider data from source to target **Facets**data layout for the claims and benefit configuration.
* Assisted in monitoring ancillary data transactions and addressed problems with **HL7** messages.
* Exposed to using **ICD 9/ICD 10** coding standards in **Medicare** and **Medicaid** domains of the healthcare systems and industry for inpatients, outpatients, reimbursement methodology.
* Designed and developed **Use Case** Diagrams for the **Facets** process modules.
* Assisted **JAD** sessions to identify the business flows and determine whether any current or proposed systems are impacted by the **EDIX10** Transaction, Code set and Identifier aspects of **HIPAA**.
* Documented and tracked requirements in Mercury Quality Center.
* Interpreted government and commercial payer managed care contracts and translated contract reimbursement rates into the corresponding data elements.
* Designed and implemented **HIPAA835** Payment Advice Transaction, **837** Health Care Claim Transaction. Populated **ICD-9**, NDC Disease code sets as per the standards. Experience with transaction sets **835**, **837**, **270**, **271**, **276**, **277** and **5010**.
* Provided suggestions and ideas more from a strategic and long term perspective.
* Developed data conversion programs for membership, claims, and benefit accumulator data converted thirteen corporate acquisitions. Developed data field mappings. Provided programming and support for claims processing functions and auto-adjudication.
* Effectively implementation of the System Development Life Cycle **SDLC**, the **BABOK** and **RUP** methodologies from Initiation to Deployment.
* Used Requisite Pro for the Requirement Documents Preparation and Prepared Business Process Models that includes modelling of all the activities of the business from the conceptual to procedural level. Followed top down, levelled technique for building Business Process Models.
* Designed and developed **Use Cases** using **UML** and Business Process Modelling.
* Used **MS-Visio** for flow-charting, process model and architectural design of the application.
* Designed and developed project document templates based on **SDLC** methodology
* Analysed and translated business requirements into system specifications utilizing **UML** and **RUP** methodology

**Environments:**

Rational Requisite Pro, Rational Rose, RUP, MS Project, ANSI X12 - EDI, Rational Rose, HP Service Desk, MS Visio, MS Word, MS Excel, Mercury Quality Center, SQL.

**Business Analyst**

**Molina Healthcare, Long Beach, CA June 2010 to November 2011**

**Project Description:**

Molina HealthCare Services is one of the nation’s largest and most respected healthcare management companies. Faced with factors such as continuing fast growth, new health-care regulations and the need to ensure maximum performance and efficiency, it reengineered their existing system. The result is a highly scalable, flexible Windows Forms application that positions the company to add new services and users easily and cost-effectively as the company continues to expand. Web based system provides a facility for their clients to make a secure login and choose and calculate health benefits from various options.

Healthcare Reforms, Healthcare.gov, CoveredCalifornia.com, Member Portal, Provider Portal, SOX Auditing, Provider Online Directory, Pharmacy Benefits Management, Direct Enrollment for Marketplace, New Mexico Centennial Care Expansion-ABP and IL- Duals, Single Sign on with CVS/Caremark, Mypharmacy Benefits, Pharmacy Benefits Management(Drug and Pharmacy), ICD 10, HEDIS, Claims, Clinical Lab Data, Stake Holder Experience, Stake Holder Management, Claims Adjudication, Usability Enhancement, NextGen EMR/PHR Implementation, Affordable Care Act/ObamaCare. The project is on the conversion of 4010 to 5010 for different transactions such as 837, 277 and 276.

**Responsibilities:**

* Performed analysis on the Affordable Care Act (**ACA**) law & corresponding Centers for **Medicare** and **Medicaid** Services (**CMS**) and Connecticut Health Insurance Exchange (**HIX**) business requirements.
* Built Product roadmap for delivering and implementing **HIX** features and functionality.
* Working knowledge in membership, employer groups, benefits, providers, claims, and provider networks areas of healthcare industry with projects involving Health Exchange (**HIX**), **ICD**-**10** implementation, **EDI** transactions and codes.
* Successfully used **Agile**/**ScrumMethod** for gathering requirements and facilitated user stories workshop.
* Involved in meeting with Provider communities to discuss the conversion of the Legacy System to New **MMIS** system.
* Was responsible for data mapping of **HL7** messages into relational database.
* Monitored contracts and payments and worked with the Billing, Claims, Benefits and Authorization departments and the Managed Care companies to resolve differences and ensure correct reimbursement.
* Participated in providing implementation assessment for Rational Requisite Pro, Rational Clear Quest using Unified Modelling Language (**UML**) and Rational Unified Process (**RUP**).
* Developed **UseCases**, Sequence Diagrams, Activity Diagrams and Class Diagrams.
* Facilitated Joint Application Development (**JAD**) Sessions for communicating and managing expectations and to gather the Business requirement.
* Designed Activity, Sequence and process flow diagrams using MS Visio to simplify and elaborated certain selections and filter conditions.
* Worked closely with QA and Developer Team to understand a Business Requirement Document.
* Performed **GapAnalysis** to identify the deficiencies of the current system and to identify the requirements for the change in the proposed system.
* Documented Requirement Traceability Matrix (**RTM**) for traceability of requirements.
* Ensured that **EDI** files were in compliance with **ICD-10** standards.
* Worked on **EDI834**, **837**/**835** transactions according to test scenarios and verify the data on different modules.
* Worked on impact analysis on **834**, **270**/**271**, and **837(P-I)** for transitioning from **ICD9** to **ICD10**.
* Worked on As-Is To-Be analysis of ICD**-**9 to **ICD**-**10** conversion for the new qualifiers used in the **837** claims for the Diagnosis and Surgical Procedure codes.
* Conducted **Back-End Testing** Using **SQL** ComAmerican privately owned online health companymands.
* Extensively used **SQL** statements to query the **Oracle** Database for Data Validation and Data Integrity.
* Logged defects (**QC**/**ALM**) and worked collaboratively with the Business Analysts & Developers to resolve issues identified during the System and Regression testing.
* Created **Use Case** diagrams using **UML** and Business Process Models using **MS-Visio.**
* Experience in **ICD9**-**ICD10** conversion and expertise in forward and backward **mapping** using **GEM**.
* Worked within a growing knowledge of **X124010HIPAA837I, P, D, 835, 834, 820**, **270, 271, 276, 277, 278, EDI,** Privacy, Security, and **Medicaid**.

**Environments:**

Agile, JIRA, MS Excel, MS Power Point, MS Visio, MS Project, Clear Case, HPQC, Oracle SQL, GEM, Rally.

**Business Analyst**

**Addiction Medical Solutions, Columbia, MD August 2008 to April 2010**

**Project Description:**

The main objective of the project was to gather requirements from new clients to implement Revenue Cycle Management (RCM) modules, documented the current and to be processes, worked closely with Product Development Team to provide "the voice of the customer" in new product and solution development and worked on new requirements/CRs for the existing clients.

**Responsibilities:**

* Extensively involved in implementation of effective requirements practices, including gathering User Requirements, and analysing User Requirement Document (**URD**), and functional specification document (**FSD**), use and continuous improvement of a requirement gathering processes.
* Applied agile methodology with its various workflows, artefacts and activities to manage life cycle from inspection to transition phase.
* Involved in development of Business and Technical Requirements in preparation of Design and Functional Specifications for Business Needs and Processes.
* Worked as liaison between external clients and **SMEs** to generate and standardize product requirements specification documents.
* Employed **UML** methodology in creating **UML** Diagrams such as **UseCases**, Sequence   
  Diagrams, State diagrams, Activity Diagrams and business process and **workflows**.
* Assisted **JAD** sessions to identify the business flows and determine whether any current or proposed systems are impacted by the **EDIX12** Transaction, Code set and Identifier aspects of **HIPAA**.
* Involved in **GAP** analysis, mapping, implementation, and testing for processing of   
  **Medicaid** Claims.
* Worked on **EDI** transactions: **270**, **271**, **835**, and **837** to identify key data set elements for designated record set.
* Assisted team lead in developing Requirements Traceability Matrix (**RTM**) to trace the relationship between business and functional requirements to **testcases**.
* Prepared and executed different **TestCases** and **TestScripts**.

**Environments:**

User Acceptance Testing (UAT), Rational Unified Process (RUP), Rational Clear Quest, Joint Application Development (JAD), MS Access, Rational Test Manager, MS Office.