**PROFESSIONAL SUMMARY**

* Business/Configuration Analyst with **8 years of experience** in health domain with a wide-ranging knowledge of all aspects of Software Development Life Cycle (SDLC)
* Experience working with Medicaid eligibility, benefits policy, budget management, long term care administration
* Proficient in Rally agile story management tool proficient in story writing (INVEST, and other patterns)
* Profound Knowledge of Rational Unified Process (RUP) methodology, Use Cases,
* Responsible for gathering MS CRM information for the customers to create reports forbusiness users and stakeholders.
* Extensive experience in gathering business requirements, business processes, identifying risks, GAP analysis and UML modeling.
* Knowledge and experience including HIPPA, **FACETS**, ICD-9 AND ICD-10
* Validated EDI files 837 institutional, professional and dental
* Validated complex EDI files 837 with different revenue and diagnostic codes.
* Knowledge with end to end process in**Member Management, Provider Management.**
* Managing reporting, analysis and decision-making for a change request using tools like ClearQuest and Excel.
* Build and maintain strong relationships with business partners, customers, technology teams and Data Management team to build Business Intelligence solutions.
* Experience in conducting Joint application development (JAD) sessions for gathering requirements, and Rapid application development (RAD) sessions to converge early toward a design acceptable to customer.
* Extensive knowledge of Medical Management Information Systems (MMIS), National Provider Identification (NPI), Health Insurance Portability & Accountability Act (HIPAA) standards, Electronic Data Interchange (EDI), Health Level -7 (HL7), HIX (Health Information Exchange), EMR/EHR, Health Care Reform and Patient Protection and Affordable Care Act (PPACA).
* Medical Claims experience in Process Documentation, Analysis and Implementation in 835/837/834/270/271/277/997(X12 Standards) processes of Medical Claims Industry from the Provider/Payer side
* Knowledge of health information and health care services regulatory environment including HIPAA, Medicaid/Medicare, EDI and XML.
* Knowledge and experience including QNXT, **FACETS**, NASCO, ICD 9 and ICD-10 as a configuration analyst.
* Experienced in executing test cases using HP QTP, logging them and making sure they are fixed before release.
* Strong HIPAA EDI 4010 and 5010 with ICD9 and ICD10, analysis & compliance experience from, payers, providers and exchanges perspective, with primary focus on Coordination of benefits.
* Experienced in various Healthcare areas like Enrollment, Benefits, Claims, Medicare, and implementation of HIPAA key EDI (ANSI X12) transactions.

**TOOLS AND SKILLS:**

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| --- | --- |
| **Platforms** | Windows, Mainframe |
| **Testing tools** | Trizetto **FACETS** 5.01, HP Quick Test Professional |
| **Change Management Tools** | Rational, Clear Quest, Test Director, HP Mercury Quality |
| **Office Tools** | Project, MS Office, MS Visio |
| **Database** | MS SQL Server, MS Access, and Oracle |
| **Bug Reporting Tools** | Quality Center, QTP |
| **SDLC Agile, Waterfall, Spiral, RU** | Agile, Waterfall, Spiral, RUP |

**PROFESSIONAL EXPERIENCE:**

**Cigna – Health spring, TN – Nashville June 2014 to Present**

**Business/ Configuration Analyst**

Cigna-Health spring is a leading health services company with Medicaid and Medicare Advantage offering. Trizetto **FACETS**is a third-party Enterprise Managed Care System used at Cigna-Health spring for claims processing and care

Management. As an Analyst I was involved in the migration from legacy MHC to Trizetto **FACETS** system for data

Management and configured all sorts of contracts

**Responsibilities**

* Analyze change requirements for Providers, Contracts and Claims processing modules configuration in **FACETS**system for Medicaid and Medicare Advantage for AL, FL, GA, IL (ICP &MMAI), IN, MD, MS, NC, SC, PA and TN plans.
* Configure Providers (Individual, Group and IPAs) per Provider Change Management application (PCMA) load information and utilize Contracts module to identify appropriate contracts and networks for non/credentialed providers using legacy fee tables crosswalks, signed contracts, NPI Registry, EDI 837 Claim image (1500 & UB04).
* Utilize Member module to verify eligibility, benefits and PCP assignment to maintain accuracy.
* Update and analyze Claims 101 edit errors for missing contracts in an accurate and timely manner to avoid penalties.
* Ensure system configuration and functionality adheres to HIPAA 5010, Medicare, Medicaid other market-specific regulations and business rules.
* Involved in testing EDIs according to code set X12 835 Claim Payment & Remittance Advice Claims processing and 837 Claim transactions
* Validated EDI files 837 institutional, professional and dental
* Validated 835 files through QNXT as well as EDI.
* Validated complex EDI files 837 with different revenue and diagnostic codes.
* Analyzed HIPAA EDI transactions in XML and X12 responses and of 270 and 276 and looked for defects for amendment.
* Monitored EDI Eligibility/Inquiry/Response (270/271) transactions via reports generated by the developers.
* Used CRM to track patient referrals to product orders.
* Manage the CRM systems throughout the project lifecycle and ensure the project advances as per the determined standards.
* Executing SQL Queries  for the reports before mass and after mass reports to check for claims routing.
* Coded complex SQL queries to retrieve data from the database depending on the business logic.
* Understanding of entire Medicaid Procurement and Systems Development Life Cycle
* Experience and knowledge of Medicaid Long Term Services and Supports
* Working knowledge of Federal and State long term care rebalancing initiatives
* Document the steps taken in CRM projects and ensure each step contributes to the success of the CRM projects.
* Ability to handle fluctuation volumes of work and be able to prioritize work to meet deadlines and need.
* Correct and maintain audit errors log to ensure high accuracy and productivity.
* Worked on configuration of Providers and Contract - Provider demographics, Provider Contract and Contract Info using QNXT.
* Used provider-credentialing module in **FACETS** to change the status of the provider.
* Worked on affiliating provider with new groups & service locations & adding required contracts, Plan affiliations using **FACETS**
* Configuration of Benefits and plan - Benefit Plan, Benefits, Org Policy etc.
* Configuration of Providers and Contract - Provider demographics, Provider Contract and Contract Info
* Involved in one to one interviews JAD sessions with stakeholders, SME’s and business owners to discuss to collect business requirements.
* Accurately interpret specific state or federal benefits
* Maintain thorough and concise documentation for tracking of all provider, contract, benefit or reference table configuration change request forms for quality audit purposes
* Able to research and resolve claim/ encounter issues, pended claims and update system as necessary
* Identify the client/organizational needs and provide suitable agile system based solutions.

**Environment:**UAT, MS office, MS Visio, Quality Center, Used Cases, SDLC,CRM, HIPAA, ICD, SQL, QNXT. BI

**Ohio Department of Medicaid, Columbus – Ohio Sept 2013 to May2014**

**Business/ Configuration Analyst**

As an Analyst I was involved in migration of date from in house application to **FACETS**, ICD 10 data and data warehouse support and Medicaid expansion projects

**Responsibilities**

* Worked as a liaison between technology and the business clients to improve business processes and support critical business strategies.
* Facilitated JAD sessions for defining business requirements and follow-up for Project Plan updates.
* Have experience with user story creating through agile software development methodologies.
* Responsible for the UAT testing of HIX, ICD 9 to ICD 10 Diagnostic and Procedure codes, and FIDA while reviewing the information to ensure accuracy.
* Designed use-cases and use-case models to further refine the requirements and understand the business processes.
* Involved in processing of the claims on **FACETS**and then sharing the test result with the business according to test acceptance criteria during the UAT phase
* Partners with development team members to monitor efficacy of information exchange
* Experience working with Medicaid eligibility, benefits policy, budget management, long term care administration.
* Industry experience in Medicaid Management Information Systems
* Experience and knowledge of Medicaid Long Term Services and Supports
* Involved in 835 files validations for HIX at Claim level, Line level, Service level and Transaction level.
* Involved in testing EDIs according to code set X12 835 Claim Payment & Remittance Advice Claims processing and 837 Claim transactions
* Analyzed HIPAA EDI transactions in XML and X12 responses and of 270 and 276 and looked for defects for amendment.
* Monitored EDI Eligibility/Inquiry/Response (270/271) transactions via reports generated by the developers.
* Gained consensus for business requirements being fully met and attainable technical development expectations.
* Worked closely with the QA Team to review and enhance the Test Plan and Test Cases.
* Reviewed development plans, quality assurance test plans, and user documentation to ensure correct interpretation of original specifications.
* Worked in the dynamic Agile methodology environment.
* Extensively used **SQL Queries** for data analysis, system verification and validation.
* Ability to handle fluctuation volumes of work and be able to prioritize work to meet deadlines and need.
* Helped in designing and implementing deployment process, and thus maintaining the application in post deployment process
* Constantly updated the BRD as per the changes in the requirement and informed the whole team regarding new
* changes
* Helped the QA team conduct the testing process by setting up the test environment.
* Performed forward and backward mapping between the two standards and documented the required changes.
* Validated claims such as professional and institutional with the related data in the reference subsystem
* Maintain thorough and concise documentation for tracking of all provider, contract, benefit or reference table configuration change request forms for quality audit purposes
* Able to research and resolve claim/ encounter issues, pended claims in **FACETS**
* Interpret and analyze data to determine appropriate configuration changes in **FACETS**
* Responsible for updating and maintaining benefit plans in **FACETS**

**Environment:** UAT, MS office, MS Visio, Quality Center, Used cases, SDLC, workflow modeling, SQL, JIRA, HIPAA,CRM, BI

**Affinity Health Plan, Bronx, NY    July 2012 to Aug 2013**

**Business Analyst**

As an Analyst I was involved in the implementation of **FACETS** administrative system, a new core system built by with updated technology to allow for more efficient claims processing, membership enrollment and provider data maintenance & getting access to customer records. X12 EDI and HIPAA standards were followed thorough the project.

**Responsibilities:**

* Independently studied ICD-10 requirements and studied the changes to be implemented using the General Equivalence Mapping (GEM)
* Performed forward and backward mapping between the two standards and documented the required changes.
* Conducted meetings, Joint Application Development (JAD) sessions and interviews with the business users to gather requirements.
* Work in agile environment to gather, elicit and analyze business requirements through JAD sessions.
* Lead story breakdown sessions with business users and agile teams
* Involved in the processing of the claims and then sharing the test results with the business according to test acceptance criteria during their UAT phase.
* Independently created Business Requirement Document (BRD) for the whole project.
* Created use case diagrams, activity diagrams, and flow charts to depict the interaction between the various actors and the system.
* Worked on the database analysis part by helping the technical team in identifying the data sources required for the application and coordination with the IT team in migration of the data within the databases.
* Developed non-functional requirements and documented them to be presented to the technical team
* Helped the QA team in writing the Test Plan and conducting the quality assurance phase.
* Worked with the QA team in testing the application using HP QTP.
* Logged application bugs and was involved in all stages of the bug life cycle.
* Used CRM to track patient referrals to product orders.
* Guide the CRM teams on using the CRM systems effectively, up to its maximum potential
* Manage the CRM systems throughout the project lifecycle and ensure the project advances as per the determined

Standards.

* Documented the steps taken in CRM projects and ensure each step contributes to the success of the CRM projects.
* Inform all existing customers about the new products launched, new features introduced and new schemes announced for customers
* Responsible for **Data Manipulation** and **Data Validation** using **SQL** queries in a **MS SQL Server.**
* Dealt with Project lead, stakeholder and endusers regarding any issues encountered during the project.
* Developed non-functional requirements and documented them to be presented to the technical team
* Helped the QA team in writing the Test Plan and conducting the quality assurance phase.
* Involved in database interactions for retrieving appropriate data and generation of output file and reports.
* Involved in GAP analysis both at the time of requirement gathering and later after development with the Testing team to identify areas and possible scenarios that might have been overlooked.
* Additional responsibilities included mapping the requirements in Caliber to the Test Cases and Scenarios in Quality Center.

**Environment**: MMIS, UAT, MS office, MS Visio, Quality Center, SDLC, **FACETS**, SQL, Use Cases

**Harmony Information System, Reston, VA Jun 2010 to June 2012**

**Business Analyst**

I worked as a Business Data Analyst at Harmony Information Systems. Harmony was working with EDS for the State Of Virginia. The objective of the project is reverse engineering the technical documents and standardizing them to meet the HIPAA Compliance Standards and getting them insync and up to date with the business rules using the Microsoft BizTalk Server along with testing the application manually from the backend. I worked extensively on their Claims processing, which was a part of the Harmony Financial Suite.

**Responsibilities:**

* Created documents that incorporated both the technical and functional details.
* Involved in standardizing the documents to meet the HIPAA Compliance Standards.
* Involved in creating documents and diagrams for Claims Processing and Claims Management according to the HIPAA Compliance Standards for Claims Processing.
* 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
* Authored Test cases for HIPPA EDI Transactions 270/271, 276/277, 837/835.
* Tested HIPAA Transactions and Code Sets Standards such as 270/271, 276/277 transactions.
* Executed Test cases manually by composing 270, 276 EDI files and dropped inbound and check response 271,277 using interleaves in outbound.
* Involved in updating and/or reworking previous documentation on their Claims Management System to get them in sync and up to date with their current new system in place.
* Involved in creating test cases and test documents based on the technical documents I created.
* Involved in manually testing the application from the backend to carry out data validation.
* Attended Joint Application Mapping (JAM) Sessions with my team to map the business needs.
* Used requirement elicitation techniques such as JAD Sessions and Document Analysis to gather information regarding the application from the SME
* Lead pin drop sessions with business to review stories from each agile team and place them in the process flows for traceability.
* Maintained open and clear communication with the team on change requests.
* Involved in weekly status meetings for updates.
* Ensured that all Entrance and Exit criteria were properly met.
* Hosted all the documents in Share Point and assigned them to the requisite individuals for review along with using Share Point as a document management tool.
* Created UI Documents as supporting documents for the Business Requirements Documents.
* Involved in Data Flow/Business Process Diagrams to illustrate the flow, input and output of data.
* Used Mercury Quality Center as our bug reporting and defect-tracking tool.
* Performed manual testing of the functional items by checking a summary of all claims entered and submitted.

**Environment:** MMIS, UAT, MS office, MS Visio, Quality Center, Water Fall, JIRA

**CIGNA HEALTHCARE, Durham, NC June 2008 to May 2010**

**Business System Analyst**

As a SA, I was involved in developing fully automated, real-time claims processing system for complete, on-line mediation of medical, dental, vision, and disability claims and encounters as per HIPAA guidelines. System allowed the efficient and timely management of all relevant data clinical, financial, and administrative throughout the organization enabling the sharing of information between subsystems.

**Responsibilities:**

* Managed software system development and integration projects through all phases of project life cycle - analysis, design, development, testing, implementation, and post-production support.
* Interacted with stakeholders to get a better understanding of client business processes and gathered requirements.
* Designed a claim processing system for the healthcare management client system. It allowed the user to inexpensively capture information regarding patient, summary of medical history, symptoms (ICD-9 codes), and treatment (CPT).
* Responsible for gathering the functional requirements for the health benefit claims receiving and processing system.
* Involved in Requirement Scoping and analyzing high priority requirement. Conducted sign-off meetings with IT teams to lock down the requirements.
* Created high-level Use Cases from Business Requirements and created UML diagrams like Use Case and Activity diagrams using MS-Visio.
* Conducted JAD sessions to allow different stakeholders to communicate their perspectives with each other, resolve any issues and come to an agreement quickly.
* Tracked stakeholder requested enhancements and changes using Requirement Traceability Matrix (RTM).
* Involved with the following list of HIPAA-EDI Transaction Code sets: 837, 835, 270/271,277/275 and 276/277
* Executed SQL queries to test the database for records that detect and submit functional acknowledgement and remittance advice in the claims application.
* **Use of SQL queries** to analyze the requirements and for testing the files and reports.
* Involved with the Quality Assurance Team to develop and design test plan and test cases.
* Conducted User Acceptance Testing (UAT) of the application with the QA team.
* Created and maintained SQL scripts and Unix as a part for back-end testing on the oracle database.
* Worked with business analysts for UAT testing.
* Wrote test plans for UAT and created a time line for execution.
* Executed SQL statements to check if the data integrity has been maintained.
* Create internal reports using Dashboard and basic SQL queries in the tool to track activities of the teams.

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

**EDUCATION**

***Bachelors in Business Administration fromStrayer University, Arlington, VA***