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**PROFESSIONAL SUMMARY:**

* Over 6+ years of experience in Information **Technology as a EDI Business Analyst** with expertise in implementation of IT projects using Project Management methodologies such as RUP, waterfall
* Extensive experience in business requirement gathering, analysis, modeling and project management.
* Successfully conducted interviews, brain storming sessions, group interviews, prototyping, focus group sessions and JAD sessions in order to gather requirements. Proficient in using UML to create Activity diagrams, Sequence diagrams, Use case diagrams.
* In depth knowledge of Business process modeling, Business process management and workflow management.
* **Excellent knowledge of Medicare (Part A, B, C and D) and Medicaid Health Insurance Policies and reimbursement forms.**
* Experienced in various Healthcare areas like Enrollment, Benefits, Claims, Medicare, and implementation of HIPAA key EDI (ANSI X12) transactions.
* Dealt with the complexity of migrating from the ICD-9 set of diagnostic codes to ICD-10.
* Good working knowledge of Claims processing, HIPAA Regulations and 270, 837P, 837I, 837D EDI Transactions for health care industries  
  Knowledge of MMIS, ICD 9 and ICD 10, and various HIPAA 4010/5010 formats
* Expert in all phases of Requirement Management, including gathering, analyzing, tracking requirements and quality assurance.
* Extensive knowledge of Software Development Life Cycles (SDLC). Thorough understanding Waterfall and Agile methodologies. Expertise in all phases of the software development lifecycle including requirements analysis, design, development, testing, implementation, integration, documentation, configuration management, training, enhancements.
* Experience with EDI transactions such as EDI 834 (Benefit Enrollment and Maintenance), 277/275,820,(Health Care Claim Request for Additional Information and Response), 276/277 (Health Care Claim Status Request and Response), 835 (Health Care Claim Payment/Advice), 837P (Health Care Claim: Professional), ICD9, CPT and NDC Codes.
* Proficient in developing Analysis Model, Use Case Diagrams, Activity Diagrams, Behavior Diagrams, Class Diagrams using MS Visio for business process modeling and designing data flow diagrams (DFD).
* Experienced in complete AGILE, RUP, SDLC, Client /server architecture providing a well-balanced understanding of business relationships, business requirements, worked for financial and technical solutions and help the team at all levels until final product release.
* Expert in writing UAT test cases, test plan, test strategies based on the process requirements. Proficient in quality control and quality assurance testing techniques.

**TECHNICAL SKILLS:**

**EDI Standards**: EDI X12, EDIFACT, XML, Application Files

**Business Modeling Tools:** Rational Rose, MS Visio

**RDBMS:** SQL Server, MS Access, Oracle My SQL

**Operating Systems**: MS-DOS, Windows 98/NT/2000, Win XP, UNIX

**Healthcare Tools**                     Facets &, EDIFECS, HIPAA, 4010, 5010, EDI.X12. ICD 10 CM and ICD 10

**Software Tools/Utilities** MS Word , MS Excel, MS Power Point , MS Access, IBM

**DB Tools:** Oracle, MS Access, Microsoft SQL server, Toad, SQL Developer, Transact - SQL (Query Analyzer)

**Languages/Dev Tools:** VB, SQL, PL/SQL, Test Scripting Language, C++, Java, SOAP UI, XML

**Scripting Language:** HTML, XML, VBScript, TSL, UNIX shell scripts, SQA basic

**PROFESSIONAL EXPERIENCE:**

**Client : state of Minnesota Sr.EDI Business Analyst               May-2013-Jan-2015**

The objective of the project was to provide core services like student achievement, housing assistance, child care assistance, Medicaid, LaCHIP and many others. The scope of the project included updates pertaining to the regulatory compliance related to X12 837 (Institutional/Professional)/Encounter Claims and 835, and during the later phases to enable readiness for the next phase of regulatory change ICD-9 to ICD-10.

**Responsibilities:**

* Utilized the RUP Software Development Methodology for the creation of the new operations system.
* Coordinated with Business Owners, Application Vendor, Payers and Clearinghouses to bring all processes to a level of execution to mitigate any impact to current revenue flow under the 5010-compliancy requirements
* Accomplished projects and design documents on HIPAA 835 and 837 calculations and EDI transactions, Health Statements and Explanation of Benefits, Healthcare Reform and 5010 CMS occurrence and field expansion for 835 and 837 EDI formats. Utilized Agile Methodology to configure and develop process, standards and procedures.
* Followed standards according to Medicare (A, B, C, D) and Medicaid, HIPAA compliance and ANSI X12 837 formats.
* Performed Analysis of ICD9 Procedure and Diagnosis Codes in accordance with ICD 10 CM and ICD 10 PCS Conversion Compliances.
* Organized meetings and led JAD sessions to ensure legal and compliance deadlines of CMS (Centers for Medicare and Medicaid Services) are met.
* Developed maps for EDI transaction sets supporting EDI Health Care Eligibility Inquiry/Response i.e. 270 and 271, Benefit Enrolment and Maintenance Set i.e. 834, Claim Submission i.e. 837 and Claim Payment Transaction Set 835.
* Proposed strategies to implement HIPAA in the new MMIS system and worked on planning and documentation
* HIPAA 4010–5010 Conversion Analysis – Involved in the documentation of HIPAA 5010 changes to EDI 837, 834, 835, 276, 277,820, Transactions.
* Documented the UAT Plan for the project and worked with the UAT Team to ensure every acceptance criteria for the requirements has been included in the UAT task plan.
* Used gap analysis framework to identify AS-IS processes of claims transactions of HIPAA X12 4010/4010A standard and TO-BE processes (ICD-10-CM and ICD-10-PCS compliance requirements) of 5010 standard.
* Extensive knowledge of ANSI X12 Healthcare transaction sets like Enrollment, Eligibility, Claims, and Premiums and Control.
* Worked with Business Owners of IDX, the claims adjudication system, and documented updates and enhancements to the application.
* Effectively elaborated the Current process and gave a clear picture of the proposed process for the projects in the organization.
* Analyzed the EDI X12 data elements in the existing system to validate it against the data elements required in new system.
* Developed an implementation guide for Partners for HIPAA 5010EDI X12 transactions such as 837 (medical claims), 835 (medical claim payments), 270 (eligibility inquiry), 271 (eligibility response), 276 (claim status), 277 (claim status response), 820 (enrollment), and 834 (premium payments).
* Vendor Management – Worked as a facilitator for Testing Efforts and New Requirements between the Healthcare Company and its various Vendors.
* Maintained the Traceability Matrix Table to uniquely trace the identified business requirements to general design to testing as proof that requirements requested have been developed into a solution and that it has been tested and tracked.

**Environment:** HIPAA, 4010, 5010,EDI. ANSI X12 , ICD,9,ICD,10MS Visio, Word Excel, PowerPoint, Rational Rose, Requisite Pro, SQL, Quality Center and Oracle.

**Client : Magellan Health Services Inc. Avon, CT EDI Business Analyst**   **Oct-2011-Apr-2013**Health Services, Inc. provides managed behavioral healthcare, radiology benefits management, specialty pharmaceutical management, and Medicaid administration products and services in the United States. Accounts receivable management and collections, Reporting, and Filing Claims through EDI (ANSI) X12 transaction sets in compliance with HIPAA standards which included the conversion of the 837 Benefit Enrollment and Maintenance EDI format from 4010 X12 formats to the 5010 X12 format as per HIPAA compliance. The project was also to upgrade and integrate ICD 10 and HIPAA 5010   
**Responsibilities:**

* Worked with the statisticians and underwriting team to analyze and validate run-time decision models.
* Gathered and analyzed requirement for HIPAA 5010 and ICD 10 changes.
* Extensive experience with claim Transactions such as 837 (submit medical claims), 835 (medical claim payments), 270 (benefit/eligibility inquiry), 271 (benefit/eligibility response), 276 (claim status request), 277 (claim status notification), 820 (premium payments), and 834 (enrollment)
* Analyzed and documented the changes in the compliance rules for adverse action redesign.
* Worked on different EDI scenarios for batch processing.
* Ensure day-to-day EDI transmission, Reject tracking and Reconciliation.
* Run EDI Reconciliation reports daily and document in MS Excel.
* Involved in up-gradation of HIPAA X12 4010 transaction to HIPAA X12 5010 and ICD 9-CM (Clinical modification) to ICD-10-CM/PCS (Clinical modification/procedure coding system) simultaneously.
* Involved in creating sample mappings for the conversion of EDI X12 transactions code sets version 4010 to 5010 and translation of ICD 9 codes into ICD 10 codes.  
  Analyzed CMS comparison documentation highlighting changes of 4010 format and ICD 10 diagnosis and procedure codes.
* Involved in Data Analysis & Mapping to track all data elements used in the application from the user interface through different interfaces to the target databases in which they are stored.
* Developed tables, views, stored procedures and triggers using SQL Scripting
* Worked extensively with the users and with different levels of management to identify requirements, use cases and to develop functional specifications.
* Conducted Asset Management, Risk Analysis of the Requirements and Traceability focus areas of the various projects and worked with the project team to help them identify the high-risk areas..
* Design specifications and Test Case usages for the HIPAA 837i, 270/271, 276/277, 835, 824, 275 and others.
* Involved in assembling, organizing and analyzing patient information, including medical history, symptoms, examination results, test results and prior treatments for EHR software development.

**Environment:** MS SQL, Windows XP, Requisite Pro, Clear Case, UML, Business Objects, MS Visio, MS Project, MS Excel

**Client : SCAN Health Plan, Long Beach, CA EDI Analyst                Apr-2010-Sep-2011**

The project was focused on the redesign of health insurance claims processing system covering the configuration of existing with benefits, eligibility & claims, compliance check of various transactions according to HIPAA rules (834, 278) and EDI X12 standards, re-engineering and capturing of transactions with legacy systems [Enrollment -834, Health Plan Premium-820, Eligibility Transaction (270/271), Service request for review and response (278), Claims (837) Claim Status Request and Response (276/277), Remittance (835)

**Responsibilities:**

* Gathered Business Requirements from the Subject Matter Experts (SMEs) and documented the requirements in the BRD.
* Analyzed HIPAA 5010 related to 837,835, 270, and 271. Transactions and performed gap analysis between the 4010 and 5010 focusing on how current transactions and system was going to be effected by the new 5010 compliance.
* Gathered and documented functional requirements for testing and verification of HIPAA.
* Was involved in testing EDI transactions like ,820,270, 271, 276, 277, 278, 834,837P, 837I, 837D and 835
* Created process flow diagrams describing provider and member access to the web portals. Elicited and documented business, user, functional and non-functional requirements.
* Healthcare system implementation including enterprise Electronic Medical Records (EMR) software.
* Gathered requirement for HIPAA 4010-HIPAA 5010 and ICD 9 (clinical modification) to ICD10 conversion.
* Involved in the EDIFECS claims mapping and Gems mapping of values for the other claim sub systems Slam dunk candidate will have experience testing
* Developed, communicated, and validated requirements package with business and developers.
* Engaged with clients to understand business processes and determine their specific requirements.
* Facilitated Joint Application Development (JAD) Sessions for communicating and managing expectations
* Validate EDI Claim Process according to HIPAA compliance.
* Tested HIPAA regulations in Facets HIPAA privacy module.
* Extensively used Agile Methodology in the process of the project management based on SDLC.
* Involved in up-gradation of HIPAA X12 4010 transaction to HIPAA X12 5010 and ICD 9-CM (Clinical modification) to ICD-10-CM/PCS (Clinical modification/procedure coding system) simultaneously.
* Conducting business validations, covering the following deliverables: FACETS Providers, Facets Claims and Facets Membership and Operational reports.
* Created process flow diagrams describing provider and member access to the portals
* Tested the HIPPA EDI, 834, 270/271, 276/277, 837/835 transactions according to test scenarios and verify the data with Facets on different modules.
* Participated in frequent Agile team meetings (Scrum planning, daily stand-ups, retrospectives) to provide UX input and guidance to an Agile product development process.
* Designed and developed scenarios based on business requirements.
* Followed RUP methodology for the entire SDLC.
* Designed Test Plans for Manual Testing, System Testing, Integration Testing and Performance Testing, of the applications and used EDIFECS spec builder to look for the severity of HIPAA Edits.
* Design, development, implementation and roll-out of Micro Strategy Business Intelligence applications, Rational Unified Process (RUP) was used to implement iterative SDLC.
* Tested the ANSI X12 Version 4010 / EDI transactions (HIPAA) like,820,,834 270, 271, 276, 277, 278 837P, 837I, 837D, 835 remittances)
* Create Data Flow Diagrams (DFD) to depict the source-to-Target Mapping and Data Lineage Analysis

**Environment:**, Prime Suite RUP, UML, HTML, EDIFECS, EDI, Agile, JAVA, MS VISIO, MS OFFICE (Word, Excel, MS Access, PowerPoint, Project), Basel II

**Client : UNICARE, Minneapolis, MN Business Analyst Jul-2008-Mar-2010**

Unicare is a national organization dedicated to the delivery of quality health care plans and products to its customers. This project aimed at developing software for auto-adjudication of claims process to improve the efficiency in processing claims. The system primarily aimed at handling Medicare / Medicaid insurance claims and process exceptions.  
**Responsibilities:**

* Analyzed current business process flow by understanding preset business rules and conditions.
* Conducted formal interviews, Live Meetings and JAD sessions with business users Subject Matter Experts (SME’s)
* Designed and developed Use Cases, Activity Diagrams and Sequence Diagrams using UML.
* Involved in Backend Testing to verify data integrity by using SQL.
* Documented, organized and tracked the requirements using Rational Requisite Pro.
* Created Data Flow Diagrams (DFDs), ER diagrams for data modeling and Web-page mock-ups using MS Visio for acceptance from end users.
* Defined project milestones, schedules, and monitored progress using MS-Project and updated plans as required.
* Analyzed and tested Data Interface needs with external systems.
* Analyzed, manipulated and updated Database using SQL.
* Gap Analysis: Analyzed the client’s applications programs to determine the impact of the HIPAA rule on EDI Transaction Set and Code List implementation and defined the changes to bring the affected systems into HIPAA compliance.
* Assisted with user testing of systems and maintained quality procedures and ensured appropriate documentation is in place.
* Maintained Requirement Traceability Matrix (RTM) and Utilized Clear Quest for change requests and defect tracking.
* Claim validation and Pend/Denied Claims Analysis for the Health plans Medicaid programs.
* Worked closely with the technical team to look up for the best possible solution on requirements by keeping business needs and technical constraints in mind.
* Updating, transferring and sharing Files using FTP between Windows and UNIX machines.

**Environment:** UML, MS Word, Rational Requisite Pro, Rational Clear Quest, Quality Center, SQL, FTP, Telnet