**Subin Raj Shrestha**

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**Executive Summary:**

* 6+ years of IT and Management experience in **Software Development Life Cycle (SDLC)** and **Project Life Cycle working** as **Business Analyst** in **PBM/Healthcare domain.**
* Strong in depth understanding of **Agile and Waterfall Methodology, Rational Unified Process (RUP)** and programing concepts of project development.
* Developing **Use Case Diagrams** and creating **Use Case Specification Documents.**
* Proficient in conducting **Joint Application Design (JAD) sessions, Interviews, User Stories,** and **Brain Storming sessions.**
* Experienced in working with Trizetto **QNXT/Facets** System Implantation, Claims and Benefits configuration set-up testing, Inbound/Outbound interfaces and extensions, load and extraction programs and proprietary format files.
* Extensive experience in **Business Requirement Documents (BRD),** based on each requirement written a use case in a **Use Case Documents,** and converting the user requirements in BRD to **Functional Requirement Documents (FRD)**, also maintained a **Traceability Matrix.**
* Worked with various Rational tools like **RequisitePro**- Requirement gathering/maintenance, Use Case document maintenance, **ClearCase**- version control and **ClearQuest/TestDirector** for bug tracking, **Rational Rose** for **Use case diagrams**, and **Activity diagrams.**
* Experienced in process modeling using **Unified Modeling Language (UML),** including **Use Case,** and **Data Flow Diagrams.**
* Experienced in remediation of **ICD-9 CM to ICD-10 CM**.
* Worked on migration of **HIPAA 4010 to HIPPA 5010.**
* Worked on Claims Process and adjudication in the **Medicare (Part A, B, and C, D),Medicaid** and Private Insurance Sectors.
* Configuration of claims adjudication systems, i.e. **Facets, and QNXT.**
* Extensive knowledge about **X12** formats including **270/271. 276/277, 834, 835, 837** for interfaces and images to third partner vendor applications.
* Command in **Mercury Quality Center (QC)** writing **Test Plans**, executing and tracking defects.

**Technical Skills:**

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| **Methodologies** | Waterfall Process, Scrum and Agile Unified Process |
| **Modeling Tools** | Software Development Life Cycle (SDLC), MS Visio, Rational Rose, Rational RequisitePro, Rational ClearQuest. |
| **Operating System** | Windows 8/Vista/XP/2000/98/NT, Unix, MS DOS |
| **Office Tools** | MS Office, Word, Excel, Access, and Power Point, One Note |
| **Databases** | MS SQL server, DB2, MS Access, MySql, Oracle |
| **Testing Tool**  **Quality Management** | Mercury Quality Center, ClearQuest, QTP, TestDirector, WinRunner, Load Runner, TestLog, ClearCase, MS SharePoint, RequisitePro  HIPAA, Six Sigma, TQM |

**Professional Experience:**

**Catamaran, Rockville, MD January 2014-Present**

**Sr. Business Analyst**Catamaran (formerly SXC/Catalyst Rx) is redefining pharmacy benefit management (PBM) by providing a broad range of pharmacy spend management solutions and information technology capabilities by providing software applications, application service provider (ASP) processing services, and professional services. Involved in multiple projects that was based on creating an applications by automating and processing the claims.

**Responsibilities:**

* Involved in complete cycle of SDLC using **Agile/Scrum** methodology and lead the team when needed.
* Facilitated JAR/JAD sessions to understand and gather requirements.
* Worked on Project Change Request (PCR) and changed the project plan and documentation
* Created Desktop Level Procedure (DLP) for Facets 5.01.
* Assisted in release plan and iteration plan for the project while working with the stakeholders.
* Managed the planning / test process for Medicare Part D Pharmacy Claims **(PBM)** & NCPDP code sets.
* Worked on adjudication and on eligibility- Enrollment, Billing, Group/Member Insurances;
* EDI transactions like 835, and 837 to identify key data set elements for designated record set.
* Worked on **ICD 9 (4010) - ICD 10** (5010) conversion and interacted/interviewed with business users, vendors and technical teams.
* Worked closely with business and **TriZetto** development team to identify opportunities for making **enhancements** to the new Facets system.
* Involved in periodic testing with QA team and have worked on business process (BPMN)
* Data mapping, data governance, and enterprise content management system (ECM).
* Designed the online screens and reports for the **CMS, Medicaid** Online Electronic Claims
* Strong working knowledge on Microsoft Word, Project, Excel, PowerPoint, Visio.
* Experience with Health Insurance Packaged Application like **Facets.** Providing US Health Insurance domain and **TriZetto’s FACETS.**
* Experience in configuration of claims adjudication systems, i.e., Amisys, **FACETS.**
* Requirements were divided into two sections: Data feed section (source system sending data to data warehouse) and Data Mart section (various data elements will place under different universes.
* Maintained requirements in **JIRA** for tracking and testing purposes
* Analyzed and tested various Common Eligibility Outbound Interface Process and other Inbound/Outbound Facets interfaces.
* Wrote test cases and test scripts for the User Acceptance Testing (UAT)
* Strong knowledge in BI (Business Intelligence) tools like **SSIS, SAS** and **SSRS** to perform ETL.
* Analyzed and Prioritized permission levels based on roles of user and created blueprint of system architecture for the web-based application created for internal users.
* Identified the roll-up or aggregation rules, granularity or hierarchy rules in data mart for all the data elements.
* Prepared graphical depictions of Use Case diagrams and process flow diagrams.
* Tracked daily issues and dependencies and coordinated with common team to work on the impediment list.
* Worked with change control board to initiate/manage change requests.

**Environment:** Facets5.01, Waterfall, SQL Server 2005, Sybase, MS Word, MS Excel, MS PowerPoint, MS-Visio, MS Project, PowerBuilder, Clear-Quest, Rational Test Manager, HTML, XML.

**Cerner Health Care Corporation, Overland park, KS March 2012 - Dec 2013   
Business Analyst**  
Cerner is the leading U.S supplier of **Healthcare** information technology solutions that optimize clinical and financial outcomes and has established a solid record of supplying superior claims management processing systems and HIPAA compliant claims processing software to a wide range of health plans serving the Medicare, Medicaid HMO, commercial and federal health programs.Web-based service application developed for streamlining office workflow processes involved in electronic data interchange (EDI) transactions and benefits in claims management cycle based on HIPAA Guidelines. It involves accepting pharmacy medical claims from different vendors and route the claims into batch Adjudication system and online Adjudication process.Also provides the **consumer transparency** and **consumer-driven health plan** as a part of **Affordable Care Act.**

**Responsibilities:**

* Worked on the new **transparency tool**to enhance and expand on **Affordable Care Act.**
* Configuration of **APTC Delinquency Rules** in Facets for Exchange Members.
* Configuration of **Fee Calculation** and **Fee Definition** for **QHP Individuals** Grandfathered Small Group and Large Group.
* Created training documents for **Health Care Reform Guide.**
* Accurately process healthcare claims utilizing Trizetto Networx software.
* Setting up Fee Calculation in FACETS for QHP Individuals, Grandfathered/Transitional Small Group, QHP Small Group and Large Groups.
* Conducted the walkthrough meeting with Business user to illustrate **HCR Group Structure, HCR Plan and Product, HCR APTC Billing Group.**
* Performed the requirement analysis, impact analysis and documented the requirements using **Rational Requisite Pro.**
* Testing both inbound and out bound **EDI and EXML files.**
* Analyzed inbound **X12 HIPAA** files and execute **Trading partner** testing and integration
* Worked directly with the trading partners to test and verify **EDI transactionslike Member Enrollment/Disenrollment (834), Claim file (837) and Remittance (835).**
* Performed **Gap assessment** between the **HIPAA 4010 transaction** and the new **HIPAA 5010 mandated requirements.**
* Created **BRD, Process flow diagrams, Use Cases, Use Case diagrams for Pharmacy Claim adjudication.**
* Participated in **ICD-9** to **ICD-10** codes conversion requirement gathering session and created high level business requirements.
* Experience with Health Insurance Packaged Application like. Providing US Health Insurance domain and TriZetto’s Facets (version 4.31) system training and mentoring to other internal Business Analysts.
* **Performed Requirements planning and analysis of the different requirements and validate them with the HIPPA.**
* Worked with **MEDICARE PART A, B, C, D systems.**
* Involved extensively in **Trizetto Facets** System implementation, **Claims** and Benefits configuration set-up testing, Inbound/Outbound Interfaces and Extensions, Load and extraction programs involving **HIPAA 837** and proprietary format files and Reports development.
* Conducted user interviews, gathered requirements, and analyzed the requirements to conduct **GAP Analysis and Impact Analysis.**
* Experienced with **User SharePoint** to collaborate with team to work together on and publish documents, maintain task lists, implement workflows, and share information.
* Involved system testing on EDI transaction **207/271** for both inbound and outbound using **EC.**
* Analyzed trading partner specifications and created **EDI mapping guidelines.**
* Documented the **Traceability Matrix** for tracing the test cases and requirements related to them.
* Facilitated preliminary sessions with SEMs for the upcoming **5010** transaction sets on Claims and Payments.
* Review **QA/UAT Test Strategy, Test Plan and Test Scripts**.
* Oversee planning/ test process for **Medicare Part D** pharmacy claims (PBM) & NCPDP code sets.
* Assisted in creating User training documentation.

**Environment:** Windows 2000/XP,MS SharePoint Services 2007, Rational Requisite Pro, MS Office, SQL Server, Agile, MS project, Facets 4.31.

**Meridian Health Care Management, Woodland Hills, CA Nov 2010–Feb 2012  
Business System Analyst**  
Meridian heath care management is an outsource company that provides administrative and technology services to healthcare providers and payers. Meridian Health Care Management implemented an internet-based application to improve its health insecure claims processing by automating receiving and processing health insecure benefits claims. Health care facilities can send their claims over the internet. The TIBCO B2B system imitates all the necessary procedures, standardizes and validates the data according to HIPAA regulations, and provides error-processing for the transactions that could not be fully processed through the systems. The new application also allows the agents to track and manage the status of a health insurance benefit claim.

**Responsibilities:**

* Responsible for gathering the functional requirements for the health insurance benefit claims receiving and processing system.
* Participated in brainstorming sessions and walkthroughs with **Subject Matter Experts (SME**).
* Participated in **JAD sessions.**
* Developing **Use Case Models**, **Entity Relationships Diagram (ERD), Activity Diagram, State Diagram and Data Flow Diagrams (DFD) using Rational Rose.**
* Prepared a detailed functional requirement document using Requisite.
* Analyzed **HIPAA 5010 standards for 837P** transactions, related to providers, payers, subscribers and other related entities.
* Identified the requirements for accommodating **HIPAA 5010 Standards for 837P** transactions and captured these requirements to develop new **GUI** for the internet based application.
* Identified various business processes and developed process flow diagrams for the business processes and validated the processes with SME.
* Worked as a liaison between business users, tester and application development team so that all teams understand business needs and take them into consideration
* Involved in incidents reporting and change control procedures using **CLEAR QUEST** to track the process of changes and determine the current quality of the application requirements.
* Validating all the information from **HIPAA** to **FACETS.**
* Using SQL queries to extract data from the RUMBA Mainframe systems
* Participated in and conducted weekly meetings to validate and verify the testing process.
* Worked to fully implement test phase entry and exit quality criteria, standard tests reporting metrics and standards test artifacts.
* Prepared FSD for **5010 from 4010A.**
* Created different traceability views to maintain the **traceability** of the requirements for black box system testing integration testing and **User Acceptances Testing**.
* Experienced in writing **SQL** queries to manipulate Oracle database and performing manual testing.
* Troubleshoot any problems found within **FACETS 4.71** batches or GUI application.
* Performed client demons, presentations, and training.

**Environment:** FACETS 4.71, Rational Requisite Pro, HIPPA Rational Clear Quest, MS Visio, MS Project, Windows, Oracle, UML, RUP, SDLC, Mercury Test Director

**HealthMarkets, Irving, Tx Mar 2008 – Nov 2010  
Business Analyst**  
The HealthMarket group of insurance Companies is one of America’s leading providers of affordable health insurance for the self-employed individuals and families, as well as small businesses. It’s underwriting companies - The MEGA life and health insurance Company, Mid-West National Life Insurance Company of Tennessee and The Chesapeake Life Insurance Company. This project involved creating the medical claims processing system. It consisted of different module like provider enrollment, member enrollment, programs and coverage. This project also involved the maintenance of claims workstation that automatically handles the entire claims life cycle.

**Responsibilities:**

* 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 got involved in designing future state processes for **HIPAA 5010** transaction processing **EDI’s 837, 835, 270, and 271.**
* Worked on **HIPAA 5010 EDI Transaction for 835/837 Transaction.**
* Performed the requirement analysis and documented the requirements.
* Participated in Automated regression and **Non-Functional test plans.**
* Assisted informational needs in mapping of **Test Cases.**
* Analyzed inbound **X12 HIPPA** files and execute Trading partner testing and integration.
* Designed and developed **Use Cases, Activity Diagrams, Sequence Diagrams, OOAD using UML.**
* Involved system testing on **EDI Transaction 270/271** for both inbound and out bound processing.
* Designed Use Case in **Requisite Pro** by gathering and documenting the requirements that are critical to business Mission.
* Created **Use Cases, Workflows,** and Screen Shots.
* Developed the business and functional requirement specification describing and prioritizing of the requirements.
* Performed **GUI** testing, **Integration Testing,Regression Testing**, **Negative Testing**, **End to End Testing**, **User Acceptance testing** on multiple projects.
* Wrote **Test Scenarios**, **Test Cases** in excel sheet and imported them to Test Director and used **Clear Quest** to track the bug.
* Logged defects in **Quality Center**, **Test Director,** re-tested defects, analyzed defect with Users and Developers.
* Performed **Load Runner** for the Load testing, performance testing.

**Environment:** RUP, Requisite Pro, Rational Rose, Clear Case, Clear Quest, Java, Visio, Oracle 9, UNIX, XML, LINUS, HTML, Load Runner.