**Muhammad WaliUddin**

**SUMMARY**

Over6 years of professional experience as Business Analyst with expertise in Software Development Life Cycle (SDLC) and Business Process Reengineering in Health Care Sector with prime focus on claims adjudication, provider, eligibility and prior authorization for Medicaid and Medicare programs in web environments.

**Summary of Professional Skills:**

* Experience in all phases of software development life cycle (**SDLC**), including Requirement gathering and documentation, **Analysisand Design**, **Quality Assurance, Testing** and End user support working as Business Analyst mainly in Healthcare sector.
* Experience in developing detailed functional specs through **JAD** sessions, interviews, on site meetings with business users and development team.
* Conducted User Acceptance Testing (**UAT**) and verification of performance, reliability and fault tolerance issues for web based and client/server applications.
* Documentation: **BRD** (Business Requirement Document), **FRD** (Functional Requirement Document) and **Non-functional Requirement Document**.
* Extensively worked with HTML, creating and developing websites.
* Experience with **PMO** techniques such as Rational Unified Process (**RUP**), **Agile**&**Waterfall** life cycle.
* Experience in testing Client-Server and Web-Based Application. Front end and backend tests.
* Have extensive knowledge in Insurance products like HMO, **PPO**, **POS**,**HIPAA** and Regulations.
* Worked on requirement change management to upgrade integration process of revised warehouse system and involved in planning, analysis, UX design, development and testing.
* In depth knowledge **of Requirements Traceability Matrix (RTM)**.
* Extensive experience in developing use cases, creating screen **mock ups**, conducting **GAP** analysis, **SWOT Analysis**, Report Requirement Specification and **Risk Analysis**.
* Strong knowledge of **EDI Claims**, member enrollment, Eligibility as well as **ICD9 and ICD10** conversion.
* Experience working in web environments with web services tools like SOAP UI, GUI, XML, etc.
* Experience using **SOAP UI** for validating the Real Time Request and Response transactions like 270/271 and 276/277, and also validating if the claim is in the database.
* Experienced in supporting the UAT team in performing acceptance testing.
* Extensive knowledge in functional testing, integrations testing, r**egression testing, system testing**, User Acceptance Testing (UAT), Performance and load testing, black box testing, GUI testing, back-end testing, **Positive and Negative testing**, **Smoke testing**, browser compatibility testing, Component testing on windows, UNIX environments.
* Experienced in various Healthcare areas like **Enrollment, Benefits, Claims, Medicare**, and implementation of HIPAA key EDI (ANSI X12) transactions.
* Well versed experience in all EDI transactions like **834, 820, 837 P, 835, 27x** and conversion of **4010 to 5010.**
* Good Knowledge of Medicare, Medicaid, claim process and Pharmacy Benefit Management (**PBM**).
* Expertise in impact analysis on the key application systems (claims processing, reporting, payments) and business process of health insurance companies.
* Writing Manuals (training material for business users and Deployment guides).
* Working experience in a cross-functional team environment/different geographical locations teams.
* Experience with health care Systems: **FACETS**.

# TECHNICAL SKILLS

**Requirement tools :** IBM doors, SharePoint, requisite pro

**Forecasting tools :** HUMMER, EXCEL

**Financial Platform :** Bloomberg Terminal

**UML tools :** Visio, EP, Rose

**Languages :** C, SQL, HTML, XML

**Works flow tools :** JIRA, Clear Quest, Share point

**Database :** Oracle, SQL Server

**Testing tools :** SOAP UI, Bugzilla, HP ALM

**Other tools :** MS project

# EXPERIENCE

**CareSource, Dayton, OH**

**Business Analyst**

**Jan 2016 – Oct2016**

I worked in FACETS implementation project. I was involved in implementing HIPAA EDI transactions in the application especially 835/ 837. Involved in Claims Adjudication, Claims Payment, and Coordination of Benefits (COB), dental implementation, membership and UAT .

**Responsibilities:**

* Performed analysis on the Affordable Care Act (ACA) law & corresponding Centers for Medicare and Medicaid Services (CMS) and Health Insurance Exchange (HIX) business requirements.
* Built Product roadmap for delivering and implementing HIX features and functionality.
* Tested EDI 837, 835, 834 files in compliance with HIPPA 5010 and ICD10.
* Creating Test Cases after analyzing the BRD's.
* Set claim processing data for different FACETS Module.
* Involved in FACETS Implementation, involved end to end testing of FACETS Billing, Claim Processing and Subscriber/Member module.
* Worked on migrating ICD 10 codes and mapping ICD-9 and ICD 10 codes.
* Wrote and Executed Test cases manually by composing 270, 276 EDI files and dropped inbound and check response 271, 277 using interleaves in outbound.
* Entering Claims and Customer Service Tasks into the FACETS.
* Involve in testing of FACETS Implementation, involve in end to end testing of FACETS Claims Processing module, Membership and benefits.
* Extensively worked on all kind of joins and operators to fetch data from multiple tables.
* Tested and validated the database tables using SQL queries and Stored Procedures and performed Data Validation and Data Integration.
* Conducted Data integrity and Data validation test manually.
* Checked the data flow from front end to backend and used SQL queries to extract the data from the database.
* Oracle table data manipulation using SQL queries and UNIX commands/UNIX scripts.
* Executed the UNIX shell scripts that invoked SQL loader to load data into tables
* Responsible for performing User Acceptance Testing.
* Used agile methodology for the Software Development Life Cycle of the application.
* Interacted with developers, business analysts and discussed technical problems and reported bugs.
* Maintained Test Matrix and Requirement Traceability Matrix.

**Environment –** MS Office Tools, Windows XP, MS Project, RequisitePro, MS Visio, MS PowerPoint, HP Quality Center, MS-SharePoint, MS-Word, MS-Excel, Facets.

**Assurant Health, Milwaukee, WI**

**Business Requirement Analyst**

**June 2014 – Dec 2015**

Assurant Health provides health insurance coverage for more than 1 million people in the United States. The assigned project was to build a Web Based system called EASE (Electronic Agent Sales Experience) in collaboration with Capgemini a consulting company to establish a competitive advantage by making it easier for independent agents and customers to obtain insurance quotes and submit policy applications. Other major functionality includes e-mail notifications for agents, detailed quotes and medical underwriting. Other projects include such as My Web Page which is a health insurance agent's own personal Web site that can be easily set up with some technical help by the company.

Worked on creation of a new Pharmacy Benefit management system (PBM) for the company that satisfied the member coverage for another company using this PBM system with Assurant Health

**Responsibilities:**

* Created Use Case diagrams using UML and Business Process Models using MS-Visio.
* Gathered requirement on FACETS EDI 834 Benefit Enrollment and Maintenance subsystems.
* Responsible for Business Process Management (BPM) for development of various projects.
* Created Data Mapping documents for data transfer from Claims Processing System to EDW (Enterprise Data Warehouse)
* Created Requirements Traceability Matric (RTM) in Team Foundation Server (TFS) to link business requirements to test cases
* Developed Use Cases, Sequence Diagrams, Activity Diagrams and Class Diagrams.
* Analyzed the impacts of HIPPA 5010 project on inbound 837 claims.
* Performed manual testing by building 837 claims, converting them into EDI file, uploading them into mainframe region and doing error resolution & testing for 5010 requirements & NPI crosswalk.
* Identified the requirements for accommodating HIPAA 5010 standards for 837P transactions and captured these requirements to develop new GUI for the internet based application.
* Extract pharmacy claims, benefit and eligibility data for studies. Gather any necessary enrollment, formulary, pricing, benefit and trend information from internal departments and the Pharmacy Benefit Management(PBM)
* Analyzed user/business requirements, functional specifications and Use Case System documents.
* Interacted with cross functional teams to facilitate gathering of business requirements.
* Conducted user interviews and organized workshops to understand and articulate business requirements and converted requirements into technical specifications.
* Created and maintained documents for Business Process Testing, Usability Testing, UI Testing, and Web Portal Testing.
* Mapped documents from/to various formats including but not limited to x12, EDIFACT, XML, SQL and text utilizing ODBC and other connectivity methods
* Involved in testing of FACETS Implementation, involve in end-to-end testing of FACETS Claims Processing module, Membership and benefits.
* Involved in Data Analysis for the data warehouse and data mart system for the Configuration of Benefits with Members.
* Conducted series of meetings, joint sessions, and interviews with the health insurance experts, operations experts, subscribers, and technical people to properly identify and understand the problems with claims management
* Involved in Functionality Testing and GUI Testing.
* Worked on pharmacy benefit management (PBM) systems to make use of our existing web applications that provide pharmacy/Rx related member functionality
* Performed Gap Analysis for 5010 enhancement using the TR3 implementation guides, Washington Publications and side-by-side HIPAA 4010 to 5010 guides provided by CMS (Center for Medicare & Medicaid Services).
* Worked on the PBM’s Medical Claim Data feed, Data Dictionary layout and definition, Eligibility files and various File Transfer
* Conducted ETL with XML as source and tables in the data warehouse as target.
* Responsible for preparing the Software Requirement Specifications (SRS) document, Standard Operating Procedures (SOPs), Functional Specification Document (FSD).
* Conducted requirement gathering sessions, Impact Analysis, Cost/Benefit analysis and Risk analysis.
* Understand the overall business model of Medicare Part D products and the PBM claim adjudication system and translate concepts into practice.
* Helped in preparing the training material of the providers and insurance companies using the software supporting ICD 10.
* Work closely with Health Insurance Trading Partners and with other contractor companies to ensure the quality of the cases.
* Drafted the Physical Data Mapping document for the data flow from Facets to the data warehouse.
* Responsible for Business Process Management (BPM) for development of various projects.
* Involved in System Integration, Compliance and User Acceptance Testing and Validation of Medicaid claims processing and Electronic Data Interchange (EDI) translation in compliance with the 4010A and 5010A Health Insurance Portability and Accountability Act (HIPAA) transactions 837 I/P, 835 and 997 Acknowledgement.
* Tested the ANSI X12 Version 5010 / EDI transactions (HIPAA) like 837P, 837I, and 837D.
* Developed various reports for user verification like Cross Tab Reports and Sub Reports, various charts and graphs like Bar chart, line graphs, and Pie charts by using Crystal Reports and exported reports into formats like PDF, HTML, Excel, Word and RTF.
* Scheduled meetings with developers, System Analyst's (SA) and testers to identify resource allocation and project completion using MS Project.

**Environment** –**Agile**, ANSI X12 834,837,270,271 EDI transactions, Oracle, HTML, XML, SOAP UI, TOAD, WSDL,MS Office, MS Project, MS Visio, Quality Center

**Nevada Division of Welfare and Supportive Service, Carson City, NV**

**Business Analyst**

**Sept 2013 - June 2014**

The **Nevada Child Care System (NCCS),** administered through the Division **of Welfare and Supportive Services**, is a comprehensive child care resource system which replaced the private system currently being used. The new systems operational functions include administering **child care funds for eligible** parents in Nevada, supporting the collection, storing and reporting of information to the federal government, determining participant eligibility, providing resource referrals, processing attendance rosters, providing case management capabilities and authorize payments to child care providers.

**Responsibilities:**

* Implemented RUP and followed iterative approach followed Use Case driven process for requirement documentation and deployment. Analyzed Business Requirements and implemented it to develop Use Cases, Activity Diagrams/State Diagrams.
* Worked on monthly TANF Loans Issued and Debt reports requested by I&R (Investigation and Recovery) and the Accounting department.
* Performed testing for Medicare, Medicaid and X-Over claims for Medicaid Management Information System (MMIS).
* Worked closely with Child Care Administration Department to gain knowledge of procedures and laws
* Analyzes Eligibility for State Children’s Health Insurance Program (S-CHIP), Food Stamps (SNAP), Child Care and Temporary Assistance to Needy Families (TANF) (CHIP, SNAP, TANF).
* Work on Claims and Check draft systems for child support recovery payments.
* Collaborating with other SME’s to scope the proposed project, make time and quantify business benefits and preparing the business case.
* Developed the systems implementation project management plan with milestones and steps from procurement of vendors to project implementation and maintenance.
* Utilized OOAD and UML to create use cases, UI development, usage models, layout and wireframes, test cases and user training.
* Wrote SQL Queries to extract data from the SQL Server Databases.
* Worked with SQL queries using SQL Server for data manipulations.
* Conducted user interviews to complete the BRD, analyzing the requirements using Requisite pro.
* Created issue logs, work request template, change request template and problem request template for the users.
* Analyzed data and investigated service related issues to identify root cause of problem(s).
* Identified and communicated business needs as required.
* Participated in presentations to internal and external audiences.
* Translated business requirements and assisted IT with the development of technical specifications
* Worked on the service requests and changed requests for the Agency.

**Environment** –Waterfall, Clear Quest, JIRA, Microsoft Office, MS Project, SQL and Microsoft Visio

**Blue Care Network, Southfield, MI**

**Business Analyst**

**Nov 2011 – July 2013**

Blue Care Network of Michigan is a nonprofit health maintenance organization owned by Blue Cross Blue Shield of Michigan with its Headquarters in Southfield, Michigan. BCN being the largest HMO in Michigan since 1998 has better and affordable coverage to its member as the motto. BCN is implementing Care Advance to replace existing Blue Connect for Nursing and Reporting Purpose for better service to members.

**Project 1:** (Facets Up- gradation) the objective of the project was to upgrade Trizetto’s Facets application software I worked in Health care claim module and Enrollment module.

**Project 2:** (Care Advance) Care Advance is being implemented for replacing the existing Blue Connect to become compatible with FACETS upgrade and better reporting Functionality.

**Responsibilities:**

* Prepared the Business requirement Document (BRD) and Functional requirement document (FRD) for the enhancement of the existing services.
* Managed requirement backlog and involved in streamlining existing processes.
* Write requirements for the development team to correct issues.
* Analyze business requirements and perform current/target/gap analysis.
* Analyzed and resolved the ongoing issues with the Data Warehouse and the upstream and downstream applications.
* Worked on GUI Modeling/Mock up and Prototyping.
* Conducted JAD sessions with business units and stakeholders to define project scope.
* Created workflow diagrams, UML diagrams, process models, activity diagrams, use cases, for incorporating design changes in the order creation/ management system.
* Tested the ANSI X12 Version 5010 / EDI transactions (HIPAA) mainly on 837 Professional and Institutional Claims
* Participate in Requirements Review sessions with business and technical teams.
* Worked on Pharmacy Benefit Management (PBM) System and Health Insurance in the United States, in depth knowledge of Health Care Laws and ICD Standards.
* Involved in System Integration, Compliance and User Acceptance Testing and Validation of Medicaid claims processing and Electronic Data Interchange (EDI) translation in compliance with the 4010A and 5010A Health Insurance Portability and Accountability Act (HIPAA) transactions 837 I/P, 835 and 997 Acknowledgement.
* Conducted Web Application testing, Using SQL Commands
* Utilized Team Foundation Server (TFS) for change management, documenting process of implementation and best practices.
* Coordinated the upgrade of Transaction Sets 837P, 835 and 834 to HIPAA compliance.
* Involved in claim adjudication process of facets application.
* Worked on the EDI 834-file load to Facets through MMS (Membership maintenance sub-system).
* Worked on the PBM’s Medical Claim Data feed, Data Dictionary layout and definition, Eligibility files and various File Transfer Specifications.
* Used Facets for various health insurance areas such as enrollment, member, Products and other Facets related modules
* Successfully worked on Pharmacy Claims processing chiefly: Direct Claims, Retail Claims and Card/Mail Order Claims developing a complete understanding of Pharmacy Claims Gateway.
* In depth knowledge of Health Insurance process, Claims, HIPAA & its approved transaction codes.
* Utilized Agile Methodology to configure and develop process, standards and procedures.
* Did GAP analysis and Impact analysis for the facets up gradation system 4.71 to 5.01.
* Attended daily SCRUM and guided QA and Developer regarding the defects, Technical Specification Documents and Mapping Documents.

**Environment: Agile**, SharePoint, MS Visio, MS project, XML, UML, Oracle, MS SQL Server, MS Office

**John Hopkins Hospital, Baltimore, MD**

**Business System Analyst**

**July2010 – Oct 2011**

The Johns Hopkins Hospital is the teaching hospital and biomedical research facility of Johns Hopkins School of Medicine, located in Baltimore, Maryland. The Johns Hopkins Hospital is widely regarded as one of the world's greatest hospitals.

**Project:** The JHH PQRS registry is a CMS qualifies registry, offering and easy-to-use, comprehensive tool, to manage patient data from John Hopkins Hospital. The Registry Reporting Method requires providers to select a registry which has been approved by CMS as a qualified registry for data collection and once or twice per year data submission. This method is expected to become preferred method for many providers since they can review the data add key clinical information regarding the patient at any time. Additionally, providers Do NOT need to select CPT codes for registry reporting since the registry performs the measure calculations and performance data is submitted separately from the billing process.

**Responsibilities:**

* Worked with the project manager for planning and organizing the project activities, and in communicating with other business center mangers and stakeholders of the project.
* Followed **Agile/Scrum** Methodology for Software Development Life cycle.
* Gap Analysis of client requirements, generated workflow process, flow charts and relevant artifacts.
* Ensure quality of claims, and provider data acquired from health insurance plans.
* Acted as liaison to the physicians, nurses, and professional staff incorporating business and clinical requirements into PQRS and other applications.
* Gathered requirements for Claim Based Reporting, Registry Based Reporting, and EHR based Reporting, Lab Data Reporting and Group Practice based Reporting for PQRS system.
* Submitted claims to insurances and Processed payment from insurance companies. ,
* Worked with EDI team to assure the collection and transfer of accurate data in order to report PQRS data.
* Coordinated with the EDI team in developing and documenting the detailed testing work plans and created the various testing documents for the assigned EDI transactions.
* Followed the complete 1095-A cycle, from assigning a case to closing the case in Health Insurance Caseworks
* Designed Use Cases using UML and managed the entire functional requirements life cycle using Agile/Scrum.
* Involved in writing and implementation of the test plan, and various test cases for UAT.
* Provided overall project management to multiple projects successfully completing them on-schedule and on-budget.
* Prepared the Business Workflow using MS-Visio with input, output, and Pre and Post conditions.
* Used SharePoint for tacking Change Process Requests, adding/updating/modifying Requirement Documents.
* Used Rally for creating user stories, tracking status of project for faster and improved quality.

**Environment** –Agile, Clear Quest, MS Office, Oracle Identity and Access management, TOAD, MS Share Point

**Education:** Masters of Science in Information System

Bachelor of hospitality and tourism management (Hons)