**Amrit Timsina**

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| **Professional Summary** |

* Over 6+ yrs. of industry experience as a Business Analyst. The diverse experience is not limited to successful projects ranging from requirement gathering, documentation, UML diagrams, Business Intelligence, Documentation UAT and experience in **HIPPA 4010** and 5010 **EDI** healthcare transactions such as **270/271,835, 834 and 837.**
* Good knowledge of business analysis methodologies and iterative **software development lifecycle** using **Rational unified process**. Thorough knowledge of implementing **RUP** in all four phases of a project.
* Experience in working in domain like **Healthcare and IT.**
* Strong work experience in with tool like **TOAD SQL Developer**, **SQL Navigator SQLPLUS, PL/SQL** Developer.
* Involved in claims adjudication process of **FACETS** application.
* Expertise in designing and developing **test plans.**
* Assisted QA’s and end user to understand functionality and technical requirements.
* Strong knowledge **on HIPAA standards,ICD9/ICD10**, EDI transactions &**4010/5010versions, Medicare and Medicaid Services**.
* Experience in working with **GAP analysis** between **HIPPA Gateway 4010A1** and **HIPPA Gateway 5010** for **Medical Medicare members (MMIS).**
* Ability to organize document and **track changes** and defects using the **rational clear quest** and archive change request in clear case.
* Good communication skills with strong **analytical, qualitative, quantitative and problem solving skills.**
* Expert in current industry standards such as **Medicaid, Medicare, FACETS, HIPAA, ED**I & other supporting applications for insurance providers and service providers.
* Excellent understanding of **software development life cycle.**
* Implemented **EDI transaction 837,835, 270/271,276/277 and 834** for medical members
* Expertise in interacting with the client and the IT department and thus acted a s a facilitator between both clients and IT department to resolve conflicts through **co-ordination, negotiation and interpersonal skills.**
* Worked on operators in PL/SQL like union, union all intersect and minus
* Experience with **Medicare and Medicaid (MMIS)** claims processing, Medicaid billing, Medicare membership and eligibility verification and care management.
* Knowledge on Relational database management system **(RDBMS).**
* **FACETS** support systems were used to enable inbound/outbound **HIPAA EDI** transaction in support of **HIPAA 834, 835, 837 270/271** transactions.
* Experience with **enrollment transactions**.
* Expertise to **design Business Requirement Specification (BRD)**, **System Requirement Specification (SRS)**, **User Requirement Specification (URS)**, **Use Cases Document**, **Work Breakdown Document (WBD),** and **Requirement Traceability Matrix (RTM**)
* Assisted in performing various types of testing like **Functional Testing, Unit testing, Integration Testing, System Testing, Performance Testing, Regression Testing, User Experience with premium payment transactions**
* Knowledge of **X12 standards** development processes
* Excellent communication and writing skills and adept at facilitating walkthrough and training sessions.

**SKILLS:**

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| **Microsoft Technologies:** | MS Project, Visio, Excel, Word, Outlook, PowerPoint |
| **Requirements Management** | Rational Requisite Pro |
| Business Modeling | Rational Rose, MS Visio |
| **Defect Tracking Tools** | HP Quality Center, Rational ClearQuest, Facets |
| **Languages/Standards** | SQL, XML, HTTP, HIPPA 4010/5010, ICD9/10, ANSIX12 |
| **Methodologies** | Rational Unified Process (RUP), Agile, Waterfall, Six Sigma , CMM , UML |

**Work History**

**Client: Cognosante, McLean, VA**

**Role: EDI Business Analyst January 2016- Present**

Cognosante connects Minds on health and changing the future of healthcare.Cognosante provides consulting, information technology, and business process outsourcing services for health organizations. With over 25 years of experience, Cognosante is a leader in healthcare reform and a trusted partner to the public and private sectors. Their services and solutions are helping to implement the provisions of the Affordable Care Act, modernize Medicaid programs and health systems, lower administrative costs, improve quality, optimize shared services, streamline ICD-10 transition, and curb fraud, waste, and abuse.X12 EDI and HIPAA standards were followed through the1095A project.

**Responsibilities:**

* Responsible for collecting and analyzing **Business Requirements**, Process Modeling and preparation of Functional Design Specifications by employing use case scenarios, sequence diagrams.
* Created use cases, activity diagrams and process diagrams using Microsoft Visio.
* Gathered requirements for **HIPAA 5010** migration.
* Followed the Business Rules, and ensured that **HIPAA compliant** Rules are followed to display minimum benefit information that the Provider is required to pass on the **EDI transactions.**
* Managed the privacy and security environments of healthcare data that was governed by **HIPAA** and other government mandates.
* Validated the **EDI 837-**claim billing (**professional, institutional and dental claims**) &**835** (**remittance advice or payment**) claims adjudications.
* Management of few departmental projects including programming for **HEDIS** measures for **NCQA accreditation through FOCUS and SQL programming.**
* Prepared high level and detailed system requirements documents for the application
* Analyzed **ICD-10 standards for 837** transactions, related to providers, payers, subscribers and other related entities.
* Identified the requirements for accommodating **ICD-10 standards for 837** transactions and captured these requirements to create **BRD.**
* Participated in the walkthroughs and meetings specifically for **Claims and Membership modules.**
* Validated the process flow for “**AS IS”** system and understand where **exactly ICD-9 Procedural** and **Diagnosis Codes** are used.
* Translated the requirements gathered during interview with **SME’s** and created process flow diagram based on the requirement captured.
* Identified various points of integration among the new and existing applications and required integration with other **IT** components.
* Practical experience on claims processing system and different types of claims such as **837I (Institutional), 837P (Professional), 837D (Dental) and Pharmacy Claims (NCPDP D.0.**
* Good experience with **FACETS** Claims Adjudication.
* Develop ad-hoc reports on data from the other applications on claims, benefit plan, provider and financials using **Business Objects Enterprise XI, Desk Intelligence, SQL Developer, MS Access and Excel, SQL, and Oracle.**
* Extract **claims detail** including **ICD-9**, procedure codes, diagnosis codes; member eligibility data for analysis, claim overpayment projects.
* Validate data analysis and extractions against **FACET**S front-end system.
* Manage membership analysis; **FACETS** claims analysis and ad-hoc reports.
* Compile **SQL Queries** to validate the data integration between the various Database tables.
* Involved in mapping and validation of different EDI transaction used for claims filing like **ANSI X12 837 (I, P, D)** for claim submission, **ASC X 12 270/271** for the eligibility/benefit inquiry and response, **ASC X12 276/277** for the claims status enquiry and response and **ASC X12 835** for the healthcare claim payments.
* Involved in **mapping data** from different **EDI** files onto database using different routing transformations.
* Performed gap analysis for migration of **HIPAA** transactions from **4010** standard versions to **5010** standard versions.
* Work together with the **architects and team** responsible for supporting rules processing tools during the project to assist with the required support.
* Work closely with the business team, development team and the **Quality Assurance** team to ensure that desired functionalities have been achieved by the application
* Assisted the project with **Change requests** and held responsible for **weekly changes** to the applications. Maintained and recorded the ticket numbers for request changes on **CR manager** tool.
* Involved in testing **Facets Member/Subscriber, Billing, Medical Plan, Dental Plan** modules.
* Provide business and technical suggestions and recommendations during the project life cycle.

**Environment:** ICD, Agile, TriZetto Facets 4.71/4.81 /5.01 and, Mercury Quality Center, ANSI X12, JavaScript, HTML, XML, HIPAA, EDI, UML, MS Office, Windows XP/, Java/J2EE.

**Client: Affinity Health Plan, Bronx, NY    September 2014 – December 2015**

**Role: Business Analyst**

Affinity Health Plan is an independent, non-profit managed care plan that serves the needs of over 210,000 residents of the New York Area and provides healthcare coverage through its family health plus, Medicare & Medicaidprograms. Affinity Health Plan implemented FacetsEnterprise administrative system, a new core system built by TriZetto, 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:**

* Worked with a cross functional and diverse team of business users and developers to enable accurate communication of requirements and ensure consensus for **BRD and FRD** and business docs.
* Analyzed data and created reports using SQL queries for all issued Action Items. Performed the **Gap Analysis** to find the existing gap between the **HIPAA 4010 and HIPAA 5010 EDI transactions.**
* Involved in the testing of web portal of New **MMIS system**
* Acted as a liaison and conducted meetings**, JAD sessions** and presentations with the teams
* Involved in preparing several **Use Cases, Business Process Flows, and Activity Diagrams using Microsoft Visio.**
* Involved in the full HIPAA compliance lifecycle from **GAP analysis**, **mapping, implementation, and testing for processing of Eligibility. Worked on HIPAA Standard/EDI standard transactions: 270, 271, 276, 277, 278, 834, 835, and 837 (P.I.D), 997 and 999** to identify key data set elements for designated record set. Interacted with **Eligibility, Payments and Enrollment hence analyzing and documenting related business processes.**
* Worked on requirements of the **835 HIPAA projects, 276/277, 278, 837, and HIPAA EDI Transactions** across enterprise.
* Initiated with a comparison report of migration of **4010 to 5010. 270 Eligibility**, Coverage or **Benefit Inquiry (V4010X092A1) vs. 270 Eligibility**, Coverage or Benefit Inquiry **(V5010X279), 278** Prior Authorizations.
* Assisted in Testing the**ANSI X12 Version 4010 / EDI transactions (HIPAA) like 270, 271, 276, 277, 278,820, 837P, 837I, 837D, 835 remittances)**
* Used General Equivalence Mappings **(GEM)** to **convert ICD9 to ICD10.**
* Worked on the existing mainframe system, documented the system requirements and came up with **Use Cases** from the analysis.
* Wrote Test scenarios and test cases for testing the migration of **EDI 4010 to 5010** and the processing of member enrollment and benefits, batch jobs corresponding to the claims **(837)** and real time transactions like **270/271/276/277.**
* Worked with multiple teams and coordinated with them to do various releases. Involved in forward mapping from **ICD9 to ICD10** and backward mapping from ICD10 to ICD9 using General Equivalence Mappings **(GEM).**
* Performed **Gap Analysis** for **HIPAA 4010 837P and 835 transactions and HIPAA 5010 837P and 835 transactions.**
* Involved in impact analysis of **HIPAA 5010 835 and 837P** transaction sets on different systems.
* Re-engineering and capturing of EDI transactions with legacy systems **[Enrollment -834, Eligibility Transaction (270/271), Claims (837), Claim Status Request and Response (276/277), Remittance (835)].**
* Performed Migration and Validation **per SDLC standards**. Interacted with the Test Team and reviewed **Test Plans and Cases**.
* Assisted in **Regression Test, System Test, and UAT**.
* Worked with the business/functional unit to assist in the development, documentation, and analysis of functional and technical requirements within **FACETS.**

**Environment:** MMIS, UAT, ORACLE, MS SQL Server, MS office, MS Visio, Quality Center, WaterFall, Facets

**Client: Henry Ford Health System, Detroit, MI May 2013- August 2014Role: Business Analyst**

HFHS is one of the prominent health care providers, offering a seamless array of acute, primary, tertiary, quaternary and preventive care backed by excellence in research and education. The main purpose of this assignment was to create an integrated solution to deliver quality health care, enhanced process flows, and increased patient flows to the clinic and give excellent experiences in all services provided. The project worked on HIPAA Claims Processing and ICD 10 readiness.

**Responsibilities:**

* Responsible for collecting and analyzing **Business Requirements**, Process Modeling and preparation of Functional Design Specifications by employing use case scenarios, sequence diagrams.
* Created use cases, activity diagrams and process diagrams using Microsoft Visio.
* Gathered requirements for **HIPAA 5010** migration.
* Followed the Business Rules, and ensured that **HIPAA compliant** Rules are followed to display minimum benefit information that the Provider is required to pass on the **EDI transactions.**
* Managed the privacy and security environments of healthcare data that was governed by **HIPAA**and other government mandates.
* Validated the **EDI 837-**claim billing (professional, institutional and dental claims) &**835** (remittance advice or payment) claims adjudications.
* Management of few departmental projects including programming for **HEDIS** measures for **NCQA accreditation through FOCUS and SQL programming.**
* Prepared high level and detailed system requirements documents for the application
* Analyzed **ICD-10 standards for 837** transactions, related to providers, payers, subscribers and other related entities.
* Identified the requirements for accommodating **ICD-10 standards for 837** transactions and captured these requirements to create **BRD.**
* Participated in the walkthroughs and meetings specifically for Claims and Membership modules.
* Validated the process flow for “**AS IS”** system and understand where **exactly ICD-9 Procedural** and **Diagnosis Codes** are used.
* Translated the requirements gathered during interview with **SME’s** and created process flow diagram based on the requirement captured.
* Identified various points of integration among the new and existing applications and required integration with other **IT** components.
* Practical experience on claims processing system and different types of claims such as **837I (Institutional), 837P (Professional), 837D (Dental) and Pharmacy Claims (NCPDP D.0.**
* Good experience with **FACETS** Claims Adjudication.
* Develop ad-hoc reports on data from the other applications on claims, benefit plan, provider and financials using **Business Objects Enterprise XI, Desk Intelligence, SQL Developer, MS Access and Excel, SQL, and Oracle.**
* Extract **claims detail** including **ICD-9**, procedure codes, diagnosis codes; member eligibility data for analysis, claim overpayment projects.
* Validate data analysis and extractions against **FACET**S front-end system.
* Manage membership analysis; **FACETS** claims analysis and ad-hoc reports.
* Compile **SQL Queries** to validate the data integration between the various Database tables.
* Involved in mapping and validation of different EDI transaction used for claims filing like **ANSI X12 837 (I, P, D)** for claim submission, **ASC X 12 270/271** for the eligibility/benefit inquiry and response, **ASC X12 276/277** for the claims status enquiry and response and **ASC X12 835** for the healthcare claim payments.
* Involved in **mapping data** from different **EDI** files onto database using different routing transformations.
* Performed gap analysis for migration of **HIPAA** transactions from **4010** standard version to **5010** standard version.
* Work together with the **architects and team** responsible for supporting rules processing tools during the project to assist with the required support.
* Work closely with the business team, development team and the **Quality Assurance** team to ensure that desired functionalities have been achieved by the application
* Assisted the project with **Change requests** and held responsible for **weekly changes** to the applications. Maintained and recorded the ticket numbers for request changes on **CR manager** tool.
* Involved in testing **Facets Member/Subscriber, Billing, Medical Plan, Dental Plan** modules.
* Provide business and technical suggestions and recommendations during the project life cycle.

**Environment:** ICD, Agile, TriZetto Facets 4.71/4.81 /5.01 and, Mercury Quality Center, ANSI X12, JavaScript, HTML, XML, HIPAA, EDI, UML, MS Office, Windows XP/, Java/J2EE.

**Client: Qual Choice Inc.Little Rock, AR March 2012- April 2013**

**Role: Business Analyst**

Project involved development of In-house claim management system using TIBCO for the employees to work on the customer's health insurance plans and offer Web services to their members, which included online consultation with their associated physicians, providing new customizable health insurance plans, and third party vision and dental insurance products in accordance with the compliance of HIPAA (Health Insurance Portability and Accountability Act) regulations.

**Responsibilities:**

* Collected weekly status reports to ensure that all deliverables are met on time and on schedule.
* Conducted JAD session with management, senior management executives, and other stakeholders for open and pending issues on the development of the project.
* Created Use Cases from the list of requirements and prepared use case diagrams using Rational Rose.
* Conducted Web Meetings with Off-Shore team members to ensure that everybody is on the same page.
* Managed and developed EDI specifications, for data feeds and mappings for integration between various systems, to follow ANSI X12 4010 formats including 270 Eligibility/Benefit Inquiry, 271 Eligibility/Benefit Information, 276 Claim Status Request, 277 Claim Status Response, 810 Invoice, 820 Payment Order/Remittance Advice, 834 Benefit Enrollment, 835 Remittance Advice and 837 Claims and encounter, to meet and exceed HIPAA requirements set forth by the federal government.
* Performed **EDI** activities that comply with government reporting requirements and standards.
* Overseeing and maintaining the EDI inquiry problem database including the evaluation of problems or issues through resolution.
* Perform analysis on **EDI 270/271,837, ANSI-12XN** etc. **HIPPA** code sets for Medicaid health plan members.
* Assisted in tailoring the views and applets for opportunities, accounts and contacts etc., as per **the client requirements.**
* Worked on **FACETS** up-gradation project (from version 4.41 to 4.47)
* Validated the member information of different groups against **FACETS** during the batch enrollment.
* Set up the subscriber/member Group, Sub Group, Plan, Product etc. using GUI application and help of batch process.
* Entering Claims and Customer Service Tasks into the **FACETS.**
* Further analysis of the requirements was performed using rational rose through the use of sequence, **entity relationship diagram** and **class diagram.**
* Conducting regular audits of **EDI transaction** of **Medicaid members** to determine accuracy and areas for improvement and maintaining EDI maps and business rules for **HIPPA validation software.**
* Responsible for creating and reviewing **business requirements, functional specification project schedules, documentation and test plans.**
* Coordinated with **project managers** to resolve risk issues and ensure compliance of security system -related to the **HIPPA**.
* Assisted testing teams in creating test scripts and **UAT** to check the security of the **CRM** system to improve stability and help better customer satisfaction.
* Closely interacted with **designers** and **software developers** to understand application functionality, navigational flow and updated them about end user sentiments.
* Assisted in the improvement of the **CRM system** of the organization by carrying out **JAD Sessions** to **enhance usability and functionality of the system.**
* Extracted the Business Requirements from the Business Users and documented it for the developers following the HIPAA guidelines by conducting JAD sessions and Interviews.
* Worked Extensively with Inbound **837 I and 837 P and 835 (Out bounds) claims processing systems.**
* Used **Query Analyzer, Execution Plan to optimize SQL Queries**.
* Interacted with client and the **Technical Team** for requirement gathering and translation of **Business Requirement** to Technical specifications.

**Environment: .**Net, MS Visio, MS Project, Agile, UML Modeling tool, Microsoft Word, Microsoft Excel, Microsoft PowerPoint, Rational Requisite Pro, Rational Rose, Quality Center, and Window XP.

**Client: Keystone Mercy Health Plan,Philadelphia, PA March 2011- February 2012**

**Role: Business Analyst**

The Keystone Mercy Health Plan Family of Companies provides healthcare solutions (Medicaid) for the underserved. The company owns, operates, and administers Medicaid managed care plans and related businesses throughout the United States. The project goal was to identify the changes required in the HIPAA Transactions and implement the federal mandate HIPAA rules. HIPAA required covered entities to use mandated standards in the electronic transmission of healthcare transactions, including claims, remittance, eligibility, claims status requests, their related responses, and privacy and security standards.

**Responsibilities:**

* Maintained clear understanding of project goals among stakeholders by conducting walkthroughs and meetings involving various leads from BA, Development, QA and Technical Support teams.
* Facilitated **Joint Application Development (JAD)** Sessions for communication and managed Net Meetings.
* Conducted meeting with the **EDI team** and other stakeholders team members to discuss the requirements.
* Prepared gap analysis document for each transaction.
* Analyzed **“AS IS” and “TO BE”** scenarios, designed new process flows and documented the business process and various business scenarios.
* Wrote use cases and relevant **UML diagrams** such as **Use Cases, Activity and Sequence diagrams.**
* Wrote high level and low level business requirements for the project.
* Developed and conducted statewide **HIPAA 5010 and ICD-10** awareness program for all AMFC staff in the Philadelphia Campus.
* Worked on analysis of **FACETS claims** processing system and gathered requirements to comply with **HIPAA 5010** requirements.
* Analyzed **HIPAA 4010 and HIPAA 5010** standards for **837I/P, 27x’s and 835** transactions and
* Presented the process improvement solutions to the client, performed **Project Management Office (PMO)** activities.
* Worked closely with the **business team, development team and the quality assurance** team to ensure that requirements are understood as intended in order to achieve the desired output.
* Participating in all facets of the standard **project life cycle** and ensured smooth transition of projects to production support
* Involved in creating mappings for the conversion **of EDI X12** transactions code sets version **4010 to 5010**and translation of **ICD 9 codes into ICD 10** codes**.**

**Environment:** SQL, Agile, Oracle, Quality Center, HTML, MS Office, Visio

**Education: Bachelor of Science in Business and Management.**

**Reference: Available Upon Request**