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**SUMMARY**

* **6+ years** of comprehensive experience as a **Business Analyst** in the **Healthcare/Insurance Industry**.
* Exposed to using **ICD 9/ICD 10/ANSI/4010/5010 coding standards in**the healthcare systems and industry for both inpatients, outpatients,  Reimbursement methodology, etc
* Have **Process documentation** creation experience and ability to **facilitate requirement  sessions** and proof of concept sessions
* Have strong experience in **requirements gathering**by **conducting interviews** with end  users
* Comprehensive knowledge of **Software Development Life Cycle (SDLC)**, having  thorough understanding of various phases like **Requirements, Analysis/Design,  Development and Testing**
* Exposure in Forward **Mapping and Backward Mapping analysis of ICD 9 – ICD 10**
* Have exposure to**EDI, Web Portal, DSS and System documentation**
* Experience in conducting **UAT (User Acceptance Testing) and documentation of test  cases,**ability to **communicate both on a business and technical level**and experience in**coordination with business and technical resource**
* Good control on**MS Office suite, MS Visio and MS Project.**
* Adept at **creating and transforming business requirements** into functional  requirements and designing business models using **UML diagrams – Context, Use  Case, Sequence, Activity diagrams in MS Visio and Rational Rose**
* Organized many **Joint Application Developments (JAD) sessions, scrum meetings and  Joint Requirement Planning sessions**(JRP), walkthrough, Interviews, Workshops and  Rapid Application Development (RAD) sessions with end-user/clients/stake holders and the IT group
* Excellent presentation skills with **MS Power Point,** which was extensively used in different JAD sessions and to track progress. Communication ability with prospective  vendors
* Knowledge of the following **HealthCare EDI Transactions for 4010/5010 like (278) Referral Certification and Authorization, (834) Benefit and Enrollment, (835) Payment & Remittance Advice, (837 I & P) Institutional and Professional HC Claim**
* Comprehensive knowledge of **RUP, Agile, Scrum, FDD, Waterfall** Methodologies
* Extensive experience in **gathering, managing and documenting business  requirements and functional requirements**, communicating effectively with upper  management, senior BAs, developers and QA engineers
* Excellent track record for meeting deadlines and submitting deliverables on time
* Excellent documentation, communication and interpersonal skills

**SOFTWARE SKILLS**

**Requirements:** Requisite Pro, Requirements Composer, Visio

**Testing**: ALM/HP Quality Center, Rational Clear Quest

**Language** SQL, SQL Plus

**Project**   MS Project, VISIO

**PROFESSIONAL EXPERIENCE**

**Providence Health Plan, Beaverton, OR May 2013 – Present   
Business Analyst**

Federal Exchange (FEDHIX)/Affordable Care Act Project-834 Enrollment & Reconciliation Providence Health Plan is a Health payer organization which implemented Affordable Care Act Program by Enrolling members through government web portal using Federal Exchange program by processing 834 EDI transactions for Individual and Small Group Enrollments using TriZetto Facets. As an EDI Analyst, I am responsible for creating user stories, processing 834 Files and verifying the standards and complete the Membership Enrollment Process in TriZetto FACETS using Agile/Scrum Methodology.

**Responsibilities:**

* Responsible for business process analysis that includes requirements facilitation, definition & analysis, Business process design and data mapping.
* Performed Data mapping and data modeling and used Canonical data model to map data from X12 834 transactions
* Performed forward and backward data mapping between fields in Mainframe and Facets
* Extensively involved in testing of Facets Batches( Membership)
* Analyzed the mainframe Reports for Member/Eligibility/Claims and mapped the fields with Facets batch jobs and reports.
* Worked extensively on Claredi's system to trace out the exact root cause of Errors in the 834 test files.
* Converted X12 834 files using Ultraedit tool in a readable format to understand the exact 834 file structure
* Involved extensively in writing **Agile** User Stories in Team Foundation Server (TFS) and reviewed with Business lead and project manager for Sign Off
* Extensively worked on creating Business Requirements Documents (BRD's) and Technical Specification Documents.
* Participated in daily Scrum Meetings to review the Business, functional and Non-Functional Requirements and to discuss the status of Product/Sprint Backlogs.
* Participated Actively in Sprint Planning Meetings to discuss about the User Stories, Story Points and Product/Sprint Backlog created and had Brain Storming sessions with Product Owner, PMO's, Developers and Business Users
* Extensive knowledge of **Patient Protection** **and Affordable Care Act** (PPACA)
* Trace and inform business requirement changes through the lifecycle of the project using Rational Requisite Pro while maintaining customer needs and maintain a Requirements Traceability Matrix (RTM) to keep the stakeholders informed of the progress of the project.
* Understand and have the ability to configure, test, and resolve transmission set up for standard files (SFTP, FTP)
* Hands on experience with the **834 ANSI X12** transaction understanding loops, segments, elements and structure
* Extensively participated in verification of EDI file formats against **HIPAA ANSI X12** Standards
* Maintained Excellent team collaboration with Developers, QA Team and tracking from time to time regarding the status of the bugs detected and updating them in TFS.
* Gathered detailed business and technical requirements and participated in the defining the business rules and data standards.
* Transform business requirements or policy documentation into Features, test plan, test cases and scenarios.
* Extensively worked on Data mapping of EDI Segments from **834 FFM** (Federally Facilitated Marketplace) to Facets database and vice-versa.
* Analyzed and compared data present in **HIX** Middleware Canonical (BizTalk/Windows Service Bus) to Facets by writing SQL Queries.
* Excellent knowledge creating and working on Change in Circumstances (Cic834) and Reconciliation Scenarios and User Stories in TFS.
* Profound Knowledge working on Inbound (I834) and Outbound (IC 834) 834's according to FFM (Federally Facilitated Marketplace) and Issuer perspective.
* Hands On experience working on 820 Payment order Remittance Files in order to validate the 834 Enrollment payment data to and from **CMS.**

**Environment**: Facets 5.01,FFM, HIX Middleware, TFS, Facets, Biz Talk, Dot Net, EDI, Microsoft Excel, Visio, One note, SQL, Windows Service Bus, Microsoft Test Manager (MTM).

**Florida Blue, Jacksonville FL Jan 2012 - Apr 2013**

**Business Analyst**

Florida blue earlier known as Blue cross Blue Shield of Florida is a leading health care provider with affordable and wide range of health care benefits.

Currently working on multiple projects across the team with focus on processing health care claims in Diamond Claims Processing System also knows as Common Platform Claims Processing System

**Responsibilities**

* Gathering and documenting project requirements/specifications and experience with the Software Development Life Cycle using **Agile** methodology
* Developing and executing **SQL queries** against data warehouses to support data mapping and ad-hoc analysis.
* Managed requirement activities using an iterative and incremental methodology such as **Agile** for writing User stories and Acceptance Criteria
* Conducted one on one interviews with high level management team and participated in the JAD session with the SME’s.
* Transitioning design deliverables to the development team and supporting development team during build and unit test phase.
* Followed Workgroup for **Electronic Data Interchange** standards for testing that need to comply with the HIPAA guidelines.
* Involved in project planning, coordination and QA methodology in the implementation of the Facets in the **EDI transaction** of the claims module.
* Executing system test scripts on query output and quantifying, analyzing, and summarizing test results.
* Gathering business requirements and converting them into functional requirement specifications and user requirement specifications. Used Rational RequisitePro for Requirement Document preparation.
* Conducting data driven analyses to help break down, prepare and analyze data for testing, auditing, and improvement of query performance.
* Involved in Testing the Member portal website and worked on the requirement gathering and Analysis for developing the Ad-hoc reports that are extracted from the consumer portal back end data.
* Effectively communicating with internal teams and external clients to deliver functional requirements like **GUI**, screen and interface designs
* Conducting reviews of **SRS** written by peers and junior colleagues.
* Conducted and participated in walkthroughs to generate consensus, maintaining quality and resolve issues among different stakeholders in the SDLC.
* Created Process Flow diagrams, **Use Case Diagrams**, **Class Diagrams** and **Interaction Diagrams**.
* Created Use cases, activity report, logical components and deployment views to extract business process flows and workflows involved in the project. Carried out defect tracking.
* Maintained proper communication with the developers ensuring that the modifications and requirements were addressed and also monitored these revisions.
* Involved in compatibility testing with other software programs, hardware, Operating systems and network environments.

**Environment:** MS Office, MS Visio, ALM/ Quality Center, **Agile**, PL/SQL, MS Project, SQL, SQL, Server, Rational RequisitePro

**CVS Caremark, Scottsdale AZ                      Aug 2010 – Dec 2012**

**Business Analyst**

**CVS Caremark** is the largest pharmacy health care provider in the United States with integrated offerings across the entire spectrum of pharmacy care. The project was to convert of ICD-9 CM and PCS codes to ICD-10 (Clinical Modification and Procedure Coding System) codes and conversion of all EDI HIPAA X12N-4010 transactions to HIPAA X12N-5010 version and prepare necessary supporting mapping/crosswalk documents as part of project deliverables.

**Responsibilities:**

* Gathering requirements from **business** users based on new market rules and Desk level procedures.
* Worked with Architects to Create **Data flow model**for Government owned Facilities**,**and for new oncoming ROSTERS.
* Created **business requirements document** (BRD) **& functional requirements document** (FRD) to map the **business** rules as documented using hybrid methodology (Waterfall/**Agile**)
* Wrote Use cases and test cases for testing and the processing of member enrollment and benefits.
* Documented various key elements of HIPAA compliance and made sure that they are understood by the development teams. Test cases written for the project were HIPAA complaint.
* **ICD-9 and ICD-10 solution** for parallel processing and step-up or step down processing.
* Implementing and expertise in **ICD-9/ICD-10 and CPT related products (i.e. DSM IV-TR, DRG, APG, APC and HCC).**
* Created **Gap Analysis Document for changes of the EDI Transactions (837, 835, 276/277, 270/271)**
* Created SQL queries to check the updates in Oracle database and executed SQL queries in Oracle to check the redundancy of data.
* Setup of batch job with parameter to process claims from HIPPA Gateway
* EDI Processing, the retrieval of **Medicare/Medicaid claim files**, delivery of acknowledgement reports, **'835' Remittance Advice, '837' Professional and Institutional claim files**
* **Set up runbook for Inbound and Outbound EDI transactions.**
* Created Test data and test cases in MS Excel to test numerous scenarios, for setting up **Providers in FACETS.**
* Worked with **Facets Architects** to get in-depth knowledge on **Providers life cycle** and how can **Members and Claims** get affected with Providers Network setups.
* Did **Reconciliation of Data on Providers** back-end table to gauge the quality and enhance quality of existing entities.
* Worked with Facilities to get the correct count on number of **Members/ Eligibility** and Demographic information to set **Groups/Subgroups/Subscribers/Members** accurately in **facets**
* Reconciled the Relation **tables** to ensure the dependencies does match with **Health products** selected.
* Worked with **Operational** and **Implementation** team to built a system where loading Providers and Eligibility checks can be made successfully which overcomes efforts of keying records through GUI.
* Reported Vendors about the data issues and required Data Quality.
* Created **Pivot tables** to show the oncoming **new adds Vs Terms** from new vendors.

**Environment: Facets, MS Office suite, SQL Server 08, Quality center,** Visio, Oracle, .Net, SQL, Quality Center, XML

**DHHS, Augusta, ME Oct 2009 – July 2010**

**Business Analyst**

**The Department of Health and Human Services (DHHS),** Clinical Labs were reimbursed at 96% of Medicare payable along with the non-DHHS Labs and Sole Community hospitals and the service request was to increase their reimbursement fees to 100% of the Medicare Payable amount to comply with the CMS request. The reimbursement of 100% of the Medicare payable was done by adding using a Pricing Provider Indicator (PPI) to increase the reimbursement percentage. Since it was a pricing change the project had impacts on Compass 21 claims processing system and Vision 21 Data Warehouse.

**Responsibilities:**

* Conducted **user interviews, gathered requirements**, and analyzed the requirements for existing legacy application for**patient enrollment and care management**
* Gathered high level requirements and created **business use cases** and **functional requirements documents** for care program administration ad patient enrollment using Microsoft Visio and word
* Conducted **workshops** with legacy teams as well as customer service teams around care management
* Created **wire frames** to visually represent specific functionality such as **payer, patient and prescriber search and set up**
* Worked closely with the Administration team to identify ,document and set up**questions for care plans** of various specialty diseases (Multiple Sclerosis, Diabetes, Cancer)
* Involved in documenting **business** processes such as setting up the care plan, enrolling the patient, initiating drug therapy management by identifying requirements and also finding the system requirements
* Worked with end users to identify **reporting requirements**
* Created and **reviewed test cases and traceability matrixes** for setting up and administering care plans
* Coordinated testing efforts and updated management on the test plan on a daily basis
* Provided full support to user community by **preparing training documents and communication materials**on the release processes.
* Acted as a liaison for the outsourced development team in India and the onshore functional team in Northbrook, IL
* Researched and documented the laboratory’s existing **business** processes ensuring that a clear and accurate picture of the current state is captured prior to initiation of LIMS upgrading process
* Participated in laboratory engagements and workgroup kick-off meetings to help bridge the gap between the lab experts and the LIMS Implementation Specialists

**Environment:** MS Office, SQL, Oracle, Microsoft Visio, Mainframe, Custom Java applications