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**Summary**

* Over 7 years of IT industry experience with a proven skill in the field Business Analyst, Software Testing and Business Analysis. Medicaid to include Medicaid and EDI Experience
* Solid Experience in documentation of User Requirements, as well as organizing interviews, User meetings, workshops, JAD sessions and requirement elicitation sessions.
* EDI transaction codes such as 270/271(inquire/response health care benefits),276/277(Claim status), 834(Benefit enrollment), 835(Payment/remittance advice),837(Health care claim)
* Using Facets for various health insurance areas such as enrollment, member, Products and other FACETS related modules
* Performed data stage designing, extracting data packages, transforming and loading data packages, stored procedures, process design and implementation.
* Experience in testing Facets applications and EDI transactions
* Experienced working with x12 version 5010 transactions and ICD -10-CM and ICD-10-PCS Code set changes analysis, design and migration strategy.
* Have excellent knowledge of HIPPA 4010 /5010 versions.
* Experience working and testing mapping for X-12 transactions using Integration tools like SYBASE, TIBCO, EDIFECS and Sterling GIS suites..
* Well versed with code set rules such as 837-Institutional, 837-Professional, 835-Claim Payment/Remittance Advise, 270/271-Eligibility Benefit Inquiry/Response, 276/277-Claim Status Inquiry/Response Transactions and testing in Client Server systems..
* Worked in the performance tuning of the programs, ETL Procedures and processes.
* Extensive experience with Data Warehousing, Extraction, Transformation and Loading (ETL) and Business Intelligence (BI) tools.
* Knowledge in the ETL (Extract, Transform and Load) of data into a data ware house/date mart and Business Intelligence (BI)
* In depth knowledge Rational Unified Process (RUP) methodology, Use Cases, Software Development Life Cycle (SDLC) processes, Object Oriented Analysis and Design (OOA/D).
* Experienced in conducting GAP analysis, User Acceptance Testing (UAT), SWOT analysis, Cost benefit analysis and ROI analysis
* Expertise in writing SQL scripts used in manual testing both front-end and back-end
* Proficient in creating UML diagrams including Use Case Diagrams, Behavioral Diagrams (Sequence Diagrams, Collaboration Diagrams, Activity Diagrams and State Chart Diagrams), Class Diagrams and Data Flow Diagrams (DFD)
* Facets support systems were used to enable inbound/outbound HIPAA EDI transaction in support of HIPAA 834, 835, 837 270/271 transactions.
* Extensive experience in writing and executing complex SQL queries using TOAD to validate data within SQL Server database.

**Technical Skills Inventory**

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| --- | --- |
| **Healthcare Tools** | EDI 834, 837,270,820 ,HIPPA, Facets,MMIS,ICD,10 To ICD 9 MITA,DDI |
| **Modeling Tools** | Rational Rose, MS Visio, Waterfall, RUP, Agile, UML |
| **Requirement Management Tool** | Rational Requisite Pro, CMMI |
| **Testing and defect tracking Tools** | Rational Robot, Rational Clear Quest, Rational Clear Case, Quality Center**,** Win Runner, Load Runner, and Quick Test Pro (QTP) |
| **Project Management Tool** | MS Project |
| **Operating System** | Windows Vista/XP/2000/98/95, Dos, Unix |
| **Integration/ Middleware Tools** | TIBCO, STERLING-GIS, PERVASSIVE |
| **Languages** | JAVA, JAVA Script, .Net, VB, COBOL, C, C++ |
| **DBMS** | MS SQL Server 2005/2000/2008/2012, Oracle, MS Access 7.x, PL/SQL |
| **Web Technologies** | ASP, .CSS, HTML, DHTML, XML |

**Professional Experience:**

**State of Oregon Healthcare Department – Salem, OR Sr.Business Analyst May-2013-Jan-2014**

The Oregon Health Plan (OHP) provides health care coverage to low-income Oregonians through programs administered by the Division of Medical Assistance Programs (DMAP). Managing analysis and development of upgrading to 837ECV, HIPAA 5010, ICD-10, NCPDP NCPDP D. Batch and Subrogation, 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

**Responsibilities:**

* Utilized Rational Unified Process (RUP) to configure and develop process, standards and procedures.
* Prepared the business requirement document (BRD) and system requirement document (SRD).
* Worked extensively on HIPAA 4010A1 all X12 transactions -837(P, D and I), 835-Remitance advice, 276/277-Claims status and response, 834-Member enrollment, 820- premium payment advice, 278- Prior authorization.
* HIPAA 5010: Worked on various transactions like Claims (837), Claim Payment/Advice (835), Claim Status Request (276), Claim Status Notification (277), Prior Authorization / Referrals (278), Eligibility Inquiry (270) Eligibility
* Created workflow diagrams, UML diagrams, use cases, swim lanes, process flow, and Provider Interface testing, Creating Test cases, Test Plans and Test Scripts.
* Gained a good understanding and knowledge of Medicaid Information Technology Architecture (MITA) system for claim processing and generating patient information
* Managing cross department gap analysis of 837ECV, HIPAA 5010, ICD-10, NCPDP ,NCPDP  Batch , and Subrogation  from previous versions.
* Conducted Joint Application Development (JAD) sessions with stakeholders throughout SDLC to resolve open issues.  
  Participate in stage gate sessions, transition to release (DDI) and all other ESDM lifecycle meetings for projects
* Implemented NPI for transactions EDI (X12) 837, 834, 820, 835,999, 276, 277(Claims, Provider, Portal, Billing, Benefits) Transactions.
* Analyzed HIPAA EDI transactions in XML and X12 responses and of 270 and 276 and looked for defects for amendment.
* Did data analysis for various version changes of EDI messages on different sub-systems.
* Extracted patients Electronic Medical Records (EMR), Patients Medical Records from the Medical Management system, for testing.
* Designed, prepared and implemented test cases for system testing as well as for User Acceptance testing.
* Involved in claims submission and payment (remittance) retrievals by using ASCX12N 820 for the In- bound premium payments ASC x12N 834 for the Inbound Enrollment and Maintenance
* Validated mapping of ICD 9 codes with corresponding ICD 10 Diagnosis/Procedure Codes..
* Involved in creating automated Test Scripts representing various Transactions, Documenting the Load Testing Process and Methodology. Created meaningful reports for analysis and integrated the Performance Testing in the SDLC
* Tested interfaces and ANSI X12 / EDI Version 4010/5010 transactions
* Tested Section 508 compliance, HIPAA infrastructure EDI transactions for Claims (837P, 837I, 837D, 834, 835, 270/271,276/277 and 278)
* Generated reports on DDI testing script execution in system test and UAT environments.

**Environment:** EDI X12N 4010, EDI X12N Pro, Rational Rose, Clear Case, Mercury Quality Center, Quick Test Pro, Oracle , Crystal Reports, SharePoint,

**DHHS State of Maine/ Deloitte ME Business Analyst Jun-2011-Apr-2013**

DHHS State of Maine/ Deloitte Worked on the implemantation of MIHMS which is the new solution of MMIS (Medicaid Management Information System) for the state of Maine. Involved in the testing efforts of Claims. The project was in Coordination of Benefits (COB), a Federal Health Care Financing Administration (HCFA) Program. Medicare Coordination of Benefits is the process for ensuring that payment of Medicare beneficiaries’ claims is properly shared among insurers when the beneficiary is covered by private insurance in addition to Medicare. By coordinating benefits, the COBC assists Medicare in paying claims more accurately the first time, which saves costly follow up and mistaken payments.

**Responsibilities:**

* Worked on HIPAA Standard Transaction Forms X12-837 for Equivalent Encounter Information, X-12-835 Claims Payment and Remittance Advice, X12-Health Care Claim status request and response, X12-270/271 Eligibility for a Health Plan and X12-820 Premium Payments
* Creating document and diagrams for membership enrollment according to HIPAA 834 compliance standard for membership enrollment.
* Conducted Stakeholder interview/analysis during MMIS Initiation Phase and identified GAPs between the Current AS-IS and Target TO-BE processes. In the course performed MITA GAP analysis, including Business Process Re-engineering efforts for process improvement.
* Responsible for checking Medicare eligibility and verifying claim payment.
* Created, co-created, and/or maintained EDI modules, programs and applications with strict adherence to HIPAA, ANSI ASC X12 industry
* Created various database objects like views, tables, and procedures to extract data and support the end user reporting data ware house requirements.
* Checked inbound/outbound HIPPA regulated EDI transactions facets
* 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).
* Wrote standard and complex SQL queries using MS SQL Server and also in Mainframe for data validation process.
* Prepared BRDs (Business Requirement Documents) supporting documents containing the essential business elements, detailed definitions, and descriptions of the relationships between the actors to analyze and document business data requirements from Data ware house.
* Experience working with RH, DV, MH, SA Claims, Eligibility, Status Inquiry, Authorization and Referral transactions for members with disabilities under the 508 Compliance Act provided by the Federal rules.
* Reviewed various Project Artifacts like High Level Design, Detailed Design, Unit Test Cases, and Integrated Test Plans.
* Regression Testing of Web applications and applications dealing with MEDICAID and MEDICARE Services
* Performed GAP analysis of business rules, business and system process
* Worked on solving the errors of EDI 834 load to Facets through MMIS.
* Analyzed the changes made to different EDI ANSI X12 transactions (837 I and P, 278, 270 and 271) under HIPAA 5010.
* The project involves creation of custom tables, developing custom forms to load data into the custom tables and creation of a XML report to compare sales values against the data in oracle. The custom tables are populated from a third party data ware house on a regular basis.
* Performed Data Analysis using procedures and functions in PL/SQL.
* Designed Activity, Sequence and process flow diagrams using MS Visio to simplify and elaborate certain selection and filter condition.
* Perform integration testing for a Medicaid Management Information System MMIS database conversion project.

**Environment:** EDI X12N 4010, EDI X12N 5010,MS Visio, SDLC, UML, Rational Clear Quest, Rational Clear Case, Rational Tools Suite, AGILE methodology, Windows, XML, HTML,.

**Computer Science Corp, NY, NY Business Analyst Nov-2009-May-2011** Computer Science Corp. has supported the Department of Health, NY for Health and Dental Insurance Claims and Eligibility efforts. The core data is in MMIS Legacy system and can handle the processing of different Claims within POS in MVS Site D and AIX Box. The MMIS can handle the HIPAA EDI transactions such as 835, 837 (P, D, I) 276, 277, 278.

**Responsibilities:**

* Responsible for defining the scope and implementing business rules of the project, gathering business requirements and documentation.
* Analyzed Business Requirements and segregated them into high level and low level Use Cases, Activity Diagrams / State Chart Diagrams using Rational Rose according to UML methodology thus defining the Data Process Models.
* Responsible for architecting integrated HIPAA, Medicare solutions, Facets.
* Identify Member, Provider, Coverage, Medicare, and Medicaid.
* Involved in claims submission and payment (remittance) retrievals by using ASC x12N 834 for the Inbound Enrollment and Maintenance; ASCX12 276/277 for the claims status enquiry and response; and ASC X12 835 (Explanation of Benefits) for the healthcare claim payments.
* Analyzed the functionality and came up with test scenarios for split-billing process on FACETS.
* Worked on customizing the claim module of FACETS for repricing Nursing home claims.
* Analyzed and translated business requirements into system specifications utilizing UML and RUP methodology
* Performed Data analysis, Data Warehousing, Data Modeling, Data Mapping and Reports analysis.
* Created Source to target Mapping Matrix for the ETL developers.
* Performed Data Analysis using procedures and functions in PL/SQL.
* Prepared report templates and reports using SSRS and Crystal Reports
* Developed Use cases, Use case models, Activity models, sequence diagrams and other UML’s to define the functioning and desirability of the application.
* Assisted with building the EDI 837, 835, 270/271, 276/277, 278, 820 and 834 transactions processing flow from the Trading Partners to the translator.
* Maintained a requirement traceability matrix throughout the project.
* Facilitated review of Enrolment, Claims, Commissions, and membership port designs with architects.
* Conducted working sessions to gather and document high level business requirements and detailed level business requirements for different business units impacted by ICD 10 such as EDI Claims Intake, FACETS- Claims Adjudication, Medical Management- Utilization Management, Case management and Provider Reimbursement- Provider Payment.
* Created SQL tables with referential integrity and developed queries using SQL and SQL\*PLUS.
* Sourced procedure codes and medications from the data store of FACETS claims.
* 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.
* Understand rules and regulations of HIPAA as imposed during Electronic Data Interchange (EDI).

**Environment:** Facets, MS Office, Rational Requisite MS Project, MS Visio, MS SharePoint, MS Excel, Agile/Scrum, RUP, Quick Test Pro , Quality Center, SQL, SQL Server , SSIS, SSRS, Crystal Reports,

**Siemens Healthcare, Philadelphia, PA Business Analyst Feb-2008-Oct-2009**

Siemens Healthcare is a sector of Siemens AG, is a leading healthcare solutions provider worldwide. The company is known for bringing together innovative medical technologies, healthcare information systems, management consulting, and support services. The portfolio of innovative products and professional services ranges from clinical and administrative IT solutions, diagnostic imaging systems, laboratory diagnostics, and hearing instruments.  
**Responsibilities:**

* Participated in project planning activities to determine testing scope.
* Created Test plans, Test conditions, Test scripts, and execution of scripts, validation of results.
* Responsible for creating Test cases and executed based on functional requirements and design documents.
* Prepared Traceability Matrix and mapped Requirements and Test cases
* Performed regression, integration and functional testing on the builds of the application
* Conducted Backend test using SQL queries to verify the Integrity of the Database.
* Designed, implemented, reviewed, and improved local performance related processes.
* Executed and managed various test types including Functional, Regression and Integration testing during scheduled phases of test development cycle
* Executed test cases on each build of the application and verified the actual results against requirements using Mercury Quality Center.
* Used Oracle SQL Developer for writing SQL Queries to verify and validate the uploaded data in database.
* Performed impact analysis for deadliness of ICD-10 conversion.
* Worked with FACETS Team for HIPAA Claims Validation and Verification Process (Pre-Adjudication).
* Created ICD-9-CM/ICD-10-PCS comparison document and dealt with Diagnosis Related Groups (DRGs).
* Involved in creating flow charts and record layouts for 271 transaction sets.
* Designed and developed eligibility (270/271), claim status (276/277), service review and response (278), enrollment (834), and claim submission (837).
* Detected Defects, communicated to the developers using Bug Reporting Tool and tracking the Defects using Quality Center.
* Understanding Business requirements, creating test scenarios, test cases and defects from MS Excel, MS Word to Quality Center.
* Worked with Claims, enrollment, eligibility verification for members and providers, benefits setup, and backend payment cycle in Facets

**Environment:**, Requisite Pro, Uses cases, Rational Rose, MS Outlook, UNIX, Windows SOAP UI , EDIFECS ,FACETS , Quality Center , Oracle 10g, XML, IBM Mainframe.