**Shirish**

**SUMMARY OF QUALIFICATIONS:**

* A Business System Analyst with extensive experience in the field of Healthcare& Health Insurance.
* Diverse experience in Information Technology with focus on Business Analysis, Business Modeling, Requirement Gathering, Documenting Requirements (BRDs/FRDs/Use Cases), and Software Validation.
* Extensive knowledge of Facets Billing, Enrollment and Claims processing.
* Expertise in documenting the Business Requirements Document (BRD), Technical Requirement Document (TRD), generating the UAT Plan, maintaining the Traceability Matrix and assisting in Post Implementation activities.
* Good experience in the EDI transactions and knowledge on EDI transaction process flows.
* Knowledge and Implementation experience in Eligibility System, Facets Data model, Configuration Implementation of FACETS module.
* Strong experience and understanding of health care industry, claims management process, Knowledge of Medicaid and Medicare Services.
* Involved in using FACETS for various health insurance areas such as products, enrollment, members and other modules related to FACETS.
* Expert in creating Use Cases, Use Case Diagrams, Class Diagrams, Sequence Flows using MS Visio and UML concepts.
* Experienced in EDI and HIPAA Testing Privacy with multiple transactions exposure such as Inbound 834Membership Enrollment, 837Institutional, 837Professional, 837 Dental, 835 Claim Payment/Remittance Advise, 270/271 Eligibility Benefit Inquiry/Response, 276/277 Claim Status Inquiry/Response Transactions and testing in Client Server systems and Mainframe Applications.
* Strong knowledge of managed Claims management process, Knowledge of Medicaid and Medicare Services. CMS, Health Assessment Systems, Medicare and Medicaid Insurance Billing, Hl7 Standards, HIPAA, EDI, HEDIS, NCQA, PPACA (Patient Protection and Affordable Care Act), 834, 835,837, Compliance issues, HL7 Message Validation, ICD9, ICD10, Electronic Health Records, Electronic Medical Records.
* Excellent knowledge Claim Processing flow and vendor pricing in the FACETS systems.
* Worked with different Business Areas like Claims and Enrollment to document proposed ICD 9 – 10 Code changes.
* For Executing Scripts manually, Involved in preparing data in FACETS.
* Knowledge and expertise in working with Claims, Provider, Enrollment, Finance, Benefits, and Vendor Management Business Areas.
* Strong knowledge of Facets and actively involved in end-to-end implementation of Facets Billing, Enrollment, Claim Processing and Subscriber/Member module.
* Maintained the Traceability Matrix table to track the Business Requirements to the design to the testing keeping track of all requirements in the BRD.
* Ability to comfortably converse with all facets in the client organization.
* Change Control Process – Led the Change Control Process for changes submitted for the BRD once the document was submitted to IT department.
* Experience in conducting User Acceptance Testing (UAT) and documentation of Test Cases.

**TECHNICAL SKILLS:**

**Business Modeling Tools:** Rational Enterprise Suite, Requisite Pro, Rational Rose, Clear Case, Visio, UML, Share Point, Microsoft Office.

**SDLC Methodologies** Agile, Waterfall, Spiral, Spiral, Rup Process and Prototyping

**Project Management**

**/ Business Applications:** MS Project, MS Visio, MS Office, FACETS.

**Operating System:** Windows 95/NT/2000/XP.

**Databases:** SQL Server, MS Access, MySQL.

**PROFESSIONAL EXPERIENCE:**

**CareSource, Dayton, Ohio June 2014 – Present**

**Business Analyst**

Implementation of new system for Electronic Remittance Advice/Explanation of Benefits (835) along with review design, extracting and reconfigure of Facets following data as Provider Master, Paid Claim Header, Paid Claims Detail, Provider Adjustments into FSCD, ECC.

**Responsibilities:**

* Responsible for understanding the **“AS Is”** business process and defining the **“To Be”** business process from **FACETS** to **FSCD, ECC.**
* Proficient in using Agile Scrum methodologies, performed roles of Scrum Master following sprint/standup sessions and used Excel extensively to write user stories, analyzed the Iteration charts and reviewed defects.
* Worked closely with the project manager, business lead and technical lead to identify research and escalate issues and risks to the appropriate work stream for resolution.
* Extensively involved in extract data from FACETS to Financial System Collection Disbursements (FSCD)
* Developed Data Mapping and Crosswalk documents.
* Involved in heavy data analysis, customer support/consultation, and software vendor communication for clients that sought to sell durable medical equipment **under Part B Medicare/Medicaid regulations**.
* **Worked on ICD conversion from 9 to 10 with respect to the claims related to Medicare (Part A, Part B, Part C, Part D).**
* Successfully used Agile/Scrum Method for gathering requirements and facilitated user stores workshop. Documented User stories and facilitated Story Point discussions to analyze the level of effort on project specifications.
* Extensively involved in decision making, such as bring all providers in Facet’s ONLY, CVS Providers, for instance, will not be included.
* Involved in demo FPL9 & FMCACOV Transaction for the business so they can see the transaction.
* Worked closely with Product Owner to understand the “To Be” and to gathered accurate requirements for Business Requirement Document.
* Attended Deep Dive Sessions with Deloitte including program manager, project manager, finance experts, Facets experts, SAP experts, BPA, SQA, developer and business owners.
* Extensively used Visio to create data flow diagrams for each phase of the project and posted on SharePoint.
* Worked with multiple teams and coordinated with them to do various releases. Involved in forward mapping from FACETS to FSCD to create Sub Ledger.
* Gathered requirements for Process Integrator to store files like Provider Master, Paid Claim Header, Paid Claims Detail, and Provider Adjustments data and extract into FSCD.
* Involved in sending data at Sub Ledger level to ECC to store in General Ledger.
* Extensively used MS Word to migrate F-030 documentwhich Deloitte created into CareSource BRD format. Created Functional Specifications (Interfaces) for SAP.
* Involved in SAP modules like, E-Sourcing, BPC, FSCD and Technical.
* Helped in e-Sourcing to create data flow diagrams from “AS Is” process to “To Be” completed module, helped in gathering requirements from business users.

**Environment**: Agile, Waterfall, SharePoint, Daptiv, MS Visio, MS project, XML, UML, HPALM, MS SQL Server, MS Office

**Humana, Louisville, KY November 2012- May 2014**

**Business System Analyst**

I worked on a project involving Electronic Claims (EDI) Handling and Transaction Processing of Claimants' records. The project included enhancing applications to include duplicate claim numbers in various systems. I also worked on internet-based application to improve its health insurance claim processing by automating receiving and processing health benefit claims including Medicare.

**Responsibilities:**

* Responsible for gaining a good understanding of User needs and accurately representing them in a well-documented software functional specifications document.
* 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
* Served as a liaison between the internal and external business community (Claims, Billing, Membership, Capitation, Customer service, membership management, provider management, advanced Healthcare management, provider agreement management) and the project team.
* Gathered Business Requirements, Interacted with the Users, Designers and Developers, Project Manager and QA Team to get a better understanding of the Business Processes.
* Helped in preparing the training material of the providers and insurance companies using the software supporting ICD 10.
* Participated in creating Facets data model.
* Followed a structured approach to organize requirements into logical groupings such as requirements for Customer, Client, Group, Member, and Reporting that critical requirements are not missed.
* Load new providers, modify existing provider information, request from other departments for troubleshooting or set-up related issues.
* Worked on billing system a cash management module and enhanced the encrypting standards that are required for the application.
* Research and resolve issues with provider pricing configuration and system set-ups. Validate provider contracting status, provider type, category of service and/or provider affiliation to support the Health Plan’s workflow and processes.
* Involved in configuration of benefits, pricing, provider and customer service modules.
* Updated existing pricing process flow charts, used Visio to create pricing flow diagrams in pricing application.
* Performed Data Mapping to map the EDI 834 data to XML.
* Work closely with Health Insurance Trading Partners and with other contractor companies to ensure the quality of the cases.
* Done claims processing, benefits, provider reimbursement, provider set, billing and accounts receivable.
* Reviewing and testing reported defects in the concerned applications in both UAT and Production testing environments
* Involved in claim adjudication process of FACETS application.
* Identified Use Cases from the requirements. Created UML Diagrams including Use Case Diagrams, Activity Diagrams, Sequence Diagrams, and Collaboration Diagrams using MS-Visio.
* For Project management purpose worked on Microsoft Project, used Microsoft Share Point for maintaining the updated Documentation.
* Worked on the EDI 834-file load to Facets through MMS (Membership maintenance sub-system)
* Perform Extensive EDI testing on X12 837,835, 270 etc, worked with state vendor to validate inbound /outbound EDI transactions to Facets.
* Facets support systems were used to enable inbound/outbound HIPAA EDI transaction in support of HIPAA 834, 835, 837 270/271 transactions.
* Microsoft Office (Outlook, Word, Excel, Visio, Access) at various phases of development for documenting the requirements.
* Facilitated JAD sessions with business and technical units to fine tune prioritize and detail requirements and use cases.
* Participated in daily defect meetings with team during UAT testing phase.
* Conducted JAD Sessions and discuss the UAT with developers on regular basis and also updated daily status report to the PM.
* Involved in Validation of HIPAA/EDI for 270/271, 276/277, 837, 837i and 835 claims used for professional, Institutional and Dental billings by Writing Test cases, Test Plans
* Involved in drawing data flow diagrams and process flow diagrams using MS Visio for the Claim Adjudication module.
* Primarily support Enrollment, Billing and Fulfillment systems for Individual and Group products
* Involved in testing EDIs according to code set X12 835 Claim Payment & Remittance Advice Claims processing and 837 Claim transactions.
* Executing SQL commands performed back-end testing.
* Executed SQL statements to check if the data integrity has been maintained.
* Created Test Scenarios, Test Cases, Test Scripts in Quality Center.
* Involved in conducting Manual and Automated testing at various phases of the project development.
* Worked on developing the business requirements and use cases for Facets batch processes.
* Prepared test data for positive and negative test scenarios as per application specifications and application requirements and wrote test plans.
* Maintain MMIS (Medicaid Management Information System) billing, remittance, and accounts receivable systems.
* Participated in the bug review meetings, updated requirement document as per business user feedback and changes in the functionality of the application.
* Organized meetings to discuss outstanding issues with QA team and developers.
* Coordinated with the development team in documenting End User Manual.

**Environment:** UML, JAD, RUP, BRD, FRD, Quality center, SQL, Oracle, MS-Visio, Oracle, SQL, MS Access, MS Visio, MS Office (PowerPoint, MS Word, MS Excel, MS Access).

**Emblem Health, New York, NY January 2010– August 2012**

**Business System Analyst**

Emblem Health is the largest health insurer based in New York State serving nearly 3.4 million people with over 92,000 providers in 150,000 locations across the tri-state region. Emblem Health's Care Management System provides a solution in simplified and a smart way to manage the health of members, which improves the quality and affordability of care.

**Responsibilities:**

* Business Analyst involved in documenting changes to the Benefits Administration, Enrollment Processing and Claims Processing Systems based on the Medicare Plan Changes initiative.
* Gathered Business Requirements from the Subject Matter Experts (SMEs) and documented the requirements in the BRD. Utilized data flow diagrams, use case diagrams and process flow diagrams to represent information provided by the Business Owners.
* Maintained the Traceability Matrix table to track the Business Requirements to the design and testing, keeping track of all requirements in the BRD.
* Analyzed and worked with HIPAA specific EDI transactions for claims, member enrollment, and billing transactions.
* Organized meetings and led JAD sessions to ensure legal and compliance deadlines of CMS (Centers for Medicare and Medicaid Services) are met.
* Worked aggressively towards timely completion of High Priority Tasks.
* Worked with Development Team to resolve issues and clarify Business Requirements from the Business Owners.
* Documented the UAT Plan for the project and worked with the UAT Team to ensure every acceptance criteria for the requirements has been included in the UAT task plan.
* Performed audits to determine what gaps exist in the internal controls policies, payroll, medical billing, and p-cards with pulling reports.
* Worked on billing system a cash management module and enhanced the encrypting standards that are required for the application.
* Worked with Business Owners of Market Prominence, the Enrollment Processing System, to ensure that the enrollment process for the new members is updated with changes.
* Worked with the UAT and QA teams to conduct an assessment and determine how effective UAT and QA guidelines can help the company achieve timely completion of projects.
* Worked with Top down Systems, a vendor specialized in automated letter generation, to convert manual letter generation to automated generation of the Medical Management Letters.
* Effectively elaborated the current process and gave a clear picture of the proposed process for the projects in the organization.

**Environment:** JAD, MS Access, ORACLE, MS Word, Excel, and PowerPoint.

**EDUCATION:**

Bachelor of Science

Master in Business Management