**TARAN KAUR571-606-3588** [**tarankaur003@gmail.com**](mailto:tarankaur003@gmail.com)

**PROFESSIONAL SUMMARY:**

* I have7 years of diverse experience as a **EDI Analyst /Business Analyst** in developing and implementing innovative business processes.
* In-depth knowledge and experience in full SDLC with RUP, agile and waterfall methodologies.
* Functional experience in health Care Industry with vast knowledge on Medicare and Medicaid.
* Expertise in creating the companion guides on various **EDI transactions**.
* Good knowledge in **HIPAA5010** implementation including GAP analysis.
* Profound understanding of insurance policies like **HMO**, **PPO,EPO** and **POS** with proven experience in **HIPPA 4010 EDI** transaction codes such as **270/271 (**inquire/response healthcare benefits**), 276/277(**Claim status),
* **834**(Benefit enrollment), **835**(Payment/remittance advice), **837**(Health care claim). Knowledge in impact analysis on the key application systems (claims processing, reporting, payments) and business process of health insurance companies.
* Clear understanding of **ICD-9**-CM and **ICD-10**-CM/PCS.
* Good knowledge of **Facets** supports systems which were used to enable inbound/outbound HIPAA EDI Transaction in support of **HIPAA 834**, **835**, **837, 270/271**transactions
* Medical Claims experience in Process Documentation, Analysis and Implementation in **835/837/834/270/271/277/997** (X12 Standards) processes of Medical Claims Industry from the Provider/Payer side.
* Exceptional ability to maintain and build client relationships with business owners to identify, prioritize and document business requirements.
* Experience in Healthcare/Claims adjudication with knowledge of industry compliance standards like HIPAA and
* EDI X12 transactions (834,837,835,270/271and276/277).
* Well versed with ANSI X12, EDIFACT EDI and HL7 standards.
* Proficient in all phases of Requirement Management, including gathering, analyzing, detailing, and tracking requirements.
* Knowledge in creating prototypes and mock-ups for user interface designs.
* Knowledge in Claims, Subscriber/Member, Plan/Product, Claims, Provider, Commissions and Billing Modules of Facets
* Experience in Business Requirement and System Specifications Analysis.
* Specialized in creating UML Diagrams like Use Case, Activity and data flow diagrams using Rational Rose and MS-Visio and consistently translate business requirement into IT solutions.
* Extensive knowledge of reporting tools such as SQL and ACCESS for underlying database tables and resolve data issues.
* Knowledge in RDBMS concepts and running SQL queries.

**SKILLS:**

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| **Technologies/Tools:** | MS Project, Visio, Excel, Word, Outlook, PowerPoint, iRisestudio |
| **RequirementsManagement** | RationalRequisitePro |
| **BusinessModeling** | RationalRose,MS Visio |
| **DefectTrackingTools** | HP Quality Center, Rational Clear Quest |
| **Languages/Standards** | SQL,XML, HTTP,Java,HIPPA 4010/5010,ICD9/10,ANSIX12,WEDI |
| **Methodologies** | RationalUnified Process(RUP),Agile,Waterfall |

**PROFESSIONAL EXPERIENCE:**

**Cognosante, McLean, VA EDI Analyst March2015-Present**

**Project:** The main objective of the**1095-A Project** is to support all phases of the design, development and implementation of enrollment resolution and reconciliation process for health insurance exchanges. The project mainly involves in troubleshooting and resolving errors in **834** and **820 transactions** for health insurance exchanges and performing root cause analysis.

**Responsibilities**:

* Responsible for participating in the design sessions, reporting on project progress and identifying potential risks and issues.
* Prepared requirements documents for conversion of 834 4010 to HIPAA compliant 5010.
* Involved in claim adjudication process of facets application
* Worked on the EDI 834-file load to Facets through MMS (Membership maintenance sub-system)
* Worked with FACETS edits and EDI HIPAA Claims (837/835/834) processing.
* Assisted the EDI team in the development and documentation of the test strategies for the EDI transactions which included all standard transactions, auditing and error correction processes, and the creation of the transactions.
* Worked on HIPAA Transactions and Code Sets Standards according to the test scenarios such as 270/271, 276/277,837/835 transactions.
* 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.
* Defined and documented the vision and scope of the project.
* Gathered requirements, developed Process Model and detailed Business Policies.
* Worked with the project manager to estimate best/worst case scenarios, track progress with weekly estimates of remaining work to do, conducting informal meetings ad hoc and as needed.
* Used EDIFECS spec builder analyzer to perform HIPPA WEDI Snip Validation. Used EDIFECS analyzer to change the fields in the 834, 835,837IB for 837OB defect validation
* Involved in writing and implementation of the test plan, and various test cases for UAT.
* Worked with HIPAA compliant ANSI X12 834, 837, 276/277, 999 formats for both professional claims and institutional claims.
* Analyzed EDI transactions in XML and X12 responses.
* Prepared the Business Workflow using MS-Visio with input, output, Pre and Post conditions.
* Enhanced test cases and scripts by adding the required functionality as per the new business requirements.
* Responsible for analysis of discrepancies in the eligibility reconciliation process for multiple stakeholders and continuous process improvement of the reconciliation process.
* Providing content to and for collaboration with training staff on training stake holders on the transactions and the reconciliation process.
* Training other analysts on the transactions and on the reconciliation process.
* Participating in all phases of testing and working through document issues.
* Working the technical and development team to resolve identified issues in a timely manner.
* Direct knowledge and experience with the following elements ANSI X12 4010, EDIFACT, Multiple VAN’s Gentran /GIS.
* Reviewing documented training material for accuracy and assisting in end user training and support.
* Responsible for accomplishing business objectives by identifying and solving customer information and processing problems.
* Created XML configurations to accurately parse EDI, EDIFACT, CSV, and Excel data files into the Info Now Oracle database
* Applying triage, research, collaboration and technical knowledge to resolve transaction and processing issues with the use of supporting technology such as work flow management systems and case management software.

**Environment:** HIPAA,4010,5010,EDI, ANSI X12 ,WEDI,Workflow,UAT,XML,

**Blue Cross Blue Shield, Baton Rouge, LA Jun 2014 –Feb 2015**

**EDI Analyst**

The main objective of the **HIPAA 5010 Project** was to move from the current 4010 system in to the**5010** system. The project mainly involved working on the **270 / 271** Eligibility request and response, **276/277** claim status request and response and **837/835.**

**Responsibilities:**

* Gathered business requirements through discussion with stake holders and SME’s.
* Performed Gap Analysis for HIPAA 5010.
* Involved in activities to make sure proper documentation and standards are being followed.
* Wrote Business Requirement Document after collecting requirements through conducting interviews, JAD Sessions and brain storming sessions.
* Created Use Case diagrams by analyzing the business process followed by Activity diagrams using MS-Visio and participate in production of HIPAA 5010 EDI Test data.
* Analyzed HIPAA 4010 and 5010 standards for 837P EDI X12 transactions related to providers, payers, subscribers and other related entities.
* Worked on HIPAA Standard/Gstandard 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.
* Developed use case Designed process flow diagrams using MS-Visio and also Business Context Diagrams.
* Created Data Mapping to document to migrate data from the existing system to the new system.
* Strong Documentation and Report Generation skill and experience by Use case approach.
* Participated in software upgrades for claims work flow and EDI transactions (835,278) upgraded from Version
* 4010 to 5010
* Worked extensively on EDI transactions 837 and 835 Involved in writing test cases for different LOB’s ( ITS, FEP
* And Regular) for SIT, Parallel and UAT
* Worked on 270,271 Eligibility request and Eligibility response and on 276,277 Claim status request and response.
* Validated that the 270/271 generated is in accordance with the 5010 implementation guide.
* Mapped EDI 834 transaction to BCBS LA enrollment/eligibility system to comply with State of Los Angeles Health Care Reform Project. Ensured accurate enrollment data for health plan products across multiple systems.
* Assisted developers in trouble shooting and resolving EDI issues by collaborating with internal and external business partners to define business processes and information requirements by building on intermodal industry best practices and ANSI X12EDI standards.
* Used FACETS 4.71: Subscriber/Member, Medical Plan to validate the Eligibility benefits received in the 271 response.
* Performed parallel testing for the 83xtransactions to ensure comparable results between 4010 and 5010 transaction processing with the help of XC file comparisons, Keyword file comparisons and other significant file structures with end-to-end testing cycle Analyzed and provided compare results for production XC’s (External Claims) and test XC’s for all LOB’s after every build to validate if the defect were fixed.
* ConstantlyinvolvedinreviewmeetingsandmadesuretestingisdonebasedontheQAmasterplanand deadlines are met.
* Used FACETS to provide seamless transactions between the provider, members and the plan.
* Used SQL Queries to verify the data from the Sybase database.
* Used Edifecs Transaction Management tool to verify that the batch and real-time files are generated correctly.
* Used the iLink Blue Provider Suite to test that the 270/271 eligibility requests and responses and the 276/277
* Claim status Request and Response are generated according to the 5010 format. Validated the same.
* Creating and consolidating SIT Test Cases and UAT test Cases using MS Excel or Quality Center.
* Was involved in working with the offshore testing team to co-ordinate Regression Testing.
* Preparing sample Test Data and executing Test cases using Quality center.
* Provide support to end users while execution of UAT with proper test scenarios & test data.
* Monitored RTM to close the defects/cases as and when developers resolved the defects
* Communicated with developers and Business Analysts through all phases of testing to prioritize defect resolution.
* Reporting the Test Execution status to the project manager on daily basis.
* Good understanding of 5010 conversion initiative
* Actively involved in weekly walkthrough meetings and Daily Defect calls to verify the status of the testing efforts meeting the deadlines & mid-term targets

**Environment:** MS Visio, Edifecs Transaction Management, iLink Blue Provider Suite, Microsoft SQL Server 2005, Quality Center 10.0, IBM DB2, Sybase, Trizetto Facets4.71, MS Word and MS Excel

**Meridian Health Plan, Detroit, MI Jan 2013-Jun 2014**

**Business System Analyst**

Meridian Health Plan is the largest **Medicaid HMO** in the State of Michigan, providing health care to Medicaid enrollees through a contract with the Michigan Department of Community Health (MDCH).

The project was to upgrade their system from HIPAA 4010 to HIPAA 5010. **Gap** Analysis was performed and changes were identified so as to assist in the upgrade of **Medicaid Management information System (MMIS)** to comply with the new standards mandated by HIPAA.

**Responsibilities:**

* Responsible for the requirement-gathering phase and project plan.
* Responsible for requirements analysis, design and developing technical requirements.
* Responsible for the full HIPAA compliance lifecycle from gap analysis, mapping, implementation and testing for processing of Medicaid Claims.
* Responsible for gap analysis in changing old MMIS and Involved in testing new MMIS
* Was  instrumental  in  writing  the  Requirement  documents  for  Facets  Claim  Module for  MMIS  Claims  and enrollment process.
* Created Simulations and wrote requirements using iRise studio.
* Used  HIPAA  4010  transactions  to  support  the  analysis of  current  business  processes  and  work  with management  to improve  and  implement  enterprise  solutions  to  ensure  compliance  and  got  involved  in designing future state processes for HIPAA 5010 transaction processing EDIs 837, 835, and 834 and ICD-10 code sets.
* Validating the Log Files (999, x12,) for 834/820,277CA, 837IB and 835 Transactions in UNIX and HTM (Healthcare Transaction Manager).
* Profound understanding of insurance policies like HMO, PPO, EPO and POS with proven experience in HIPPA 4010 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).
* Assisted in upgrading HMO Medicare EDI and reporting.
* Assisted in managing and billing Medicare, Commercial HMO/PPO claims on a daily basis.
* Involved in creating BRD and FRD for Medicaid managed care requirements and documenting them.
* Acted as a SME for the application team and the Infrastructure team.
* Gathered managed care specific business requirements from several different managed care programs.
* Used RequisitePro for writing/analyzing project vision, goals, specifications and requirements.
* Involved in the testing of web portal of New MMIS system.
* Performed Back-end Testing using PL/SQL for Database Validation.
* Performed gap analysis by matching the requirements for managed care programs.
* Matched the requirements for programs such as Medicare and Medicaid, which are part of the Social Security Act.
* Held regular JAD meetings with the system architects, developers, database developers, quality testers during the entire project to assure that the critical as well as the minute details of the project were discussed and issues were resolved beforehand.
* Worked With HIPAA compliant ANSI X12 837 formats for both professional claims and institutional claims.

**Environments:** UML,RUP, Rational Requisite Pro, Rational Rose, Facets, Rational Clear Quest, Excel, SQL, DB2, Crystal report, HP Quality Center

[**NEDHHS, L**](http://americansforprosperity.org/nebraska/article/ne-dhhs-obamacare-medicaid-expansion-unaffordable/)**incoln, NE Jan 2012-Dec 2012**

**Business System Analyst / EDI Analyst**

The DHHS need to comply with the U.S. Department of Health and Human Services (HHS) published implementation date of the 10th revision for the International Classification of Diseases (ICD-10) Worked on ICD 9 to ICD 10 conversion project.

**Responsibilities:**

* Analyzed Business Requirements and segregated them in to high level and low level Use Cases, Activity and Sequence using MS Visio according to UML Methodology.
* Prepared Crosswalk documents for ICD 9 and ICD 10 Procedure and Diagnosis codes.
* Conducted JAD sessions with project's stakeholders such as users, QAs and project management team  to identify and resolve issues.
* Involved in analysis of HIPAA compliance and EDI Transactions sets and took part in discussions for designing the EDI transactions
* Conducted Claims and HIPAA Compliance Training to run the test cases. Also worked with NPI
* Experienced in X12 transactions 835/837/834/820/271 of medical claims/underwriting for support and point of reference for the vendor in business issues.
* Designed and developed Use Cases, Activity Diagrams, Sequence Diagrams, OOD (Object oriented Design) using UML.
* Manage RTM (Requirement Traceability Matrix) to track the project flow.
* Prepared BRD and Derived Functional Requirement Specifications (FRS) based on User Requirement specifications and delivered to the project team. Understand and articulate business requirements from user interviews and then convert requirements in to technical specifications
* Worked extensively on 837I, 837P, 837D, 835, NCPDP and NCPDP response files.
* Facilitated User Acceptance Testing (UAT) with stakeholders and the business users.
* Frequently updated the requirements and defect status as per the current status of the Testing project in the Clear Quest.
* Project Management and Controlling to ensure on time delivery using MS Project.
* Used guidelines and artifacts of RUP to strategize the implementation of the Rational Unified Process effort in different iterations and phases of the Software Development Life Cycle (SDLC).
* Used HIPAA 4010 transactions to support the analysis of current business processes and work with management to improve and implement enterprise solutions to ensure compliance and got involved in designing future state processes for HIPAA 5010 transaction processing EDI’s 837, 835, and 834 and ICD-10 Code sets.
* Worked on Health care Eligibility and Benefit, Claim Status transactions 270/271, 276/277, 835, 837 based on the HIPAA compliant ANSI X12 version 4010/5010
* Documented the Use Cases and prepared the Use Case and Activity Views using MS Visio and Rational Rose for a clear understanding of the requirements by the development team.
* Developed timelines for project delivery, and managed projects and resources to successful completion.
* Involved in writing Data Mapping Documents for the system and involved in documenting the ETL process and writing SQL Queries for the retrieval of the data
* Performed Data Analysis on the extracted data, data cleansing and scrubbing.
* Validated the database by applying business rules using SQL queries

**Environment:** Rational Rose, HP Quality Center 10.0, BizTalk, Putty for UNIX, SQL Developer, Power Point Comparison Tools (Visual Studio), \ BI, ETL, Crystal   Reports, Microsoft Project, Quality Assurance, Testing Life Cycle, Promotion Processes.

**Mutual of Omaha, Omaha, NE Feb 2009–Dec 2011**

**Business Analyst / EDI Analyst**

Founded in 1909, Mutual of Omaha is a solid, family-oriented company that is reliable, trustworthy, and knowledgeable. It is a full-service, multi-line provider of insurance and financial services products for individuals, businesses and groups throughout the United States.

The project was about implementation of a new processing system for Benefit Enrollment files (834) and Payer and Claims (837) along with review, design and reconfigure of the following **FACETS** functional areas: Enrollment, Claim, Billing, Provider and Member Information.

**Responsibilities:**

* Participated in creating Facets data model.
* Worked on the EDI 834-file load to Facets through MMS (Membership Maintenance Sub-system)
* Performed requirement gathering by interacting with business users and documented the requirements
* Worked with business users and solution engineers to solve the capture defects in the MMS system and to effectively solve them.
* Performed Data Mapping to map the EDI 834 data to XML.
* Worked on solving the errors of EDI 834 load to Facets through MMS.
* Conducted JAD Sessions, Peer Review sessions with the SMEs, Solution Engineers, developers, Business users.
* Analyzed  the  scope  of  the  project  to  review  it  with  the  customers  for  different  review  sessions  of  the application.
* Experienced in X12 transactions 835/837/834/820/271 of medical claims/underwriting for support and point of reference for the vendor in business issues.
* Intensively involved in project testing efforts by helping testers perform System Integration Testing, Regression Testing and by helping UAT team in User Acceptance Testing (UAT)
* Used to execute test cases for several transactions such as 837, 835, 820, 834, 277, 278, 270/271
* Created SQL queries to read data from databases.
* Performed GAP analysis for EDI transactions such as 837, 834 to support state specified X12 5010 file formats.
* Executed Test cases manually by composing 270, 276,837 EDI files and dropped inbound and check response 271,277,835 using interleaves and outbound.
* Performed Data Mapping to map the EDI 834 data to XML.
* Worked on EDI 834, 835,837 as per HIPPA guidelines.
* Requirements Gathering & Analysis always ensured HIPAA Compliance Auditing
* Worked with the Testing team to test the system extensively and log defects.
* Defined the maps from the existing BizTalk solution and validated it with the client for any changes.
* Performed data mapping and tracing data from system to system in order to solve a given business or system problem.

**Environment:** Ms Office Tools, MS Project, MS-PowerPoint, SQL Server 2005, XML, Mercury Quality Center, Agile framework.

**Anthem Blue Shield, San Francisco, CA                                                                                                      Apr 2008 – Jan 2009**

**Business Analyst**

As a member of BA team for Claims processing applications, assisted in the UML Diagrams, collecting business requirements and writing detail level documentation for design of Plan view generated reports and data validation efforts of several Healthcare Membership, Eligibility, and Claims Processing Systems.

**Responsibilities:**

* Involved  in  gathering  user  requirements  and  preparing  following  documents:     Functional  requirement Specification  (FRS),  System  Requirement  Specification  (SRS),  Business  Requirement  document  (BRD)  and Product Configuration Specifications
* Translated business requirement to technical staff to ensure the requirement are incorporated into system design
* Participated in multiple team JAD sessions
* Used MS Visio and UML for generating class diagrams and activity diagrams
* Used standard Business Analysis methodology centered on RUP (Rational Unified Process)
* Involved  in  the  development  of  processes  and  systems  to  support  HIPPA  compliance  and  administrative procedures
* Experience   with   developing   HIPAA   Companion   Guides   for   835   Claim   Payment   /   Advice  to   support reimbursement processing for health care products and services
* Experience in 834, 270/271, 276/277 & 835 processes of medical claims/underwriting for support and point of reference for the vendor in business issues
* Reviewed and executed feature test cases and ensure that feature testing validated the business technical requirements for system implementation
* Assisted in development of training materials for new technology and process improvements
* Involved in writing Data Mapping Documents for the system and involved in documenting the ETL process and writing SQL Queries for the retrieval of the data
* Performed Data Analysis on the extracted data, data cleansing and scrubbing.
* Validated the database by applying business rules using SQL queries

**Environment:** Cogon’s BI (Framework Manager, Report Studio, DMR), Informatica Visio, Oracle PL/SQL, HP-UNIX, Java, Windows XP.

**EDUCATION:**

B.S. Biology, George Mason University