Digital Blocks Testing Assessment

This exam aims to assess candidates ability to understand and review requirements, design High Level Scenarios and write test cases.

❖ Evaluation Criteria

1. Ability to read the requirements and report issues, assumptions, questions.
2. Ability Design HLS (High level Scenarios) & test cases to cover the scope.
3. Ability to work with Excel/GoogleSheets to document the above and provide a requirements traceability matrix RTM.

❖ Expected Deliverables:

This assignment is expected to be delivered in a workbook Excel/GoogleSheets containing:

1. Identified requirements
2. Designed High Level Scenarios HLS
3. Designed Test Cases
4. Identified assumptions and questions
5. Dashboard including graphs that give visibility on the above - optional

❖ Assignment Duration:

4 hours starting from receiving the assignment email.2

If duration extension is required for any reason please reply back to the assignment email.

Are you ready?

System description:

This system functions in the health care and insurance field. The part in this assessment covers the business cycle of submitting patient claims and processing them between service provider portal and payment system.

REQ001: Encounter Registration.

Brief Description:

Upon the beneficiary's visit to the healthcare provider and benefiting from any service(s), the provider starts the process of claiming for the performed service(s).

Encounters are the patient's journey or visits record which can have all the performed activities to them in order to submit it to the payer if needed.

This is where patients' new encounters can be created.

Encounter registration happens on Provider Portal that is used by healthcare providers, by entering beneficiary details, diagnosis details, performed services details, and any other relevant data such as observations.

Use Case:

Use Case	Name: Encounter Registration. Goal: Enter one encounter to Provider Portal with real data.

	Actor(s): Provider Portal user. Actor Type: Human Preconditions: • User should have valid credential for accessing the portal. • Beneficiary data registered in the payer system. • Diagnosis and service data are stored in system and could be used by provider. • Healthcare service given to beneficiary. Flow of events: • Login to Provider Portal. • Navigate to Encounter registration, New Encounter. • Search for an existing member using national ID. • Select member from search results. • Select encounter type from drop-down list. • Select encounter start date. • Select diagnosis. • Select Activity. • Add observations “Optional”. • Save encounter. Post condition: • Encounter saved successfully to Provider Portal. Use Case Diagram

Alternative Flows	▪ Encounter bulk upload: ▪ System has a functionality of uploading multiple encounters as a bulk by using an excel file, using the same data attributes as existing on encounter registration screen.
Trigger	Physician need to create new encounter Related Business Rule(s)
Related Business Rule(s)	• Beneficiary eligibility. • Provider contract validity. • Pricelist validity.
Related Functions	•Claim Submission •Claim Processing in Payer System •Remittance ProcessRemarks
Activity Diagram	Mentioned in Figure 1.

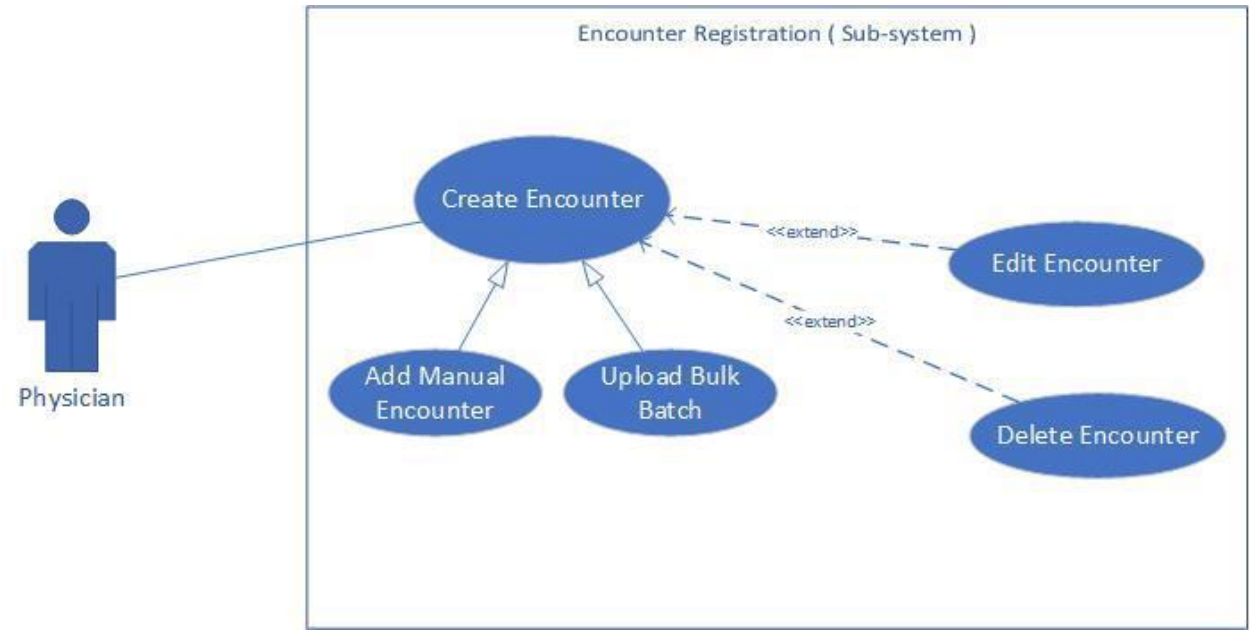

Figure 1.

REQ002: Claim Submission

Brief Description:

System shall be capable of pushing recorded claims from Provider Portal to payer application, in order to claim for the financial values of the performed healthcare services:

• Claim Submission: Transaction for sending the recorded claims data from the Provider to the Payer system

Use Case	Name: Create claims submission and send it to the payer system. Goal: To submit a bulk of performed encounters to payer system as claims, for payer system processing, then issuing remittance advice. Actors: Provider portal user. Actor Type: Human Preconditions: ▪ User should have Valid credentials for accessing the Provider Portal. ▪ Encounter(s) should be created and stored successfully on provider portal. Flow of events: ▪ User login to provider portal. ▪ Navigate to e-claim, add new submission.

	▪ Select transaction type “Encounters”. ▪ Select payer “receiver”. ▪ Users should select encounters that should be submitted to the player. ▪ User should validate the list of encounters that is going to be submitted to the payer system, and to edit any encounter’s details as needed. ▪ User clicks “Save & Send” to send the claims submission to the payer system. Post condition: ▪ Submission code is generated by provider portal indicating that the encounters bulk has been successfully sent to the payer system.
Activity Diagram	Mentioned in Figure 2.

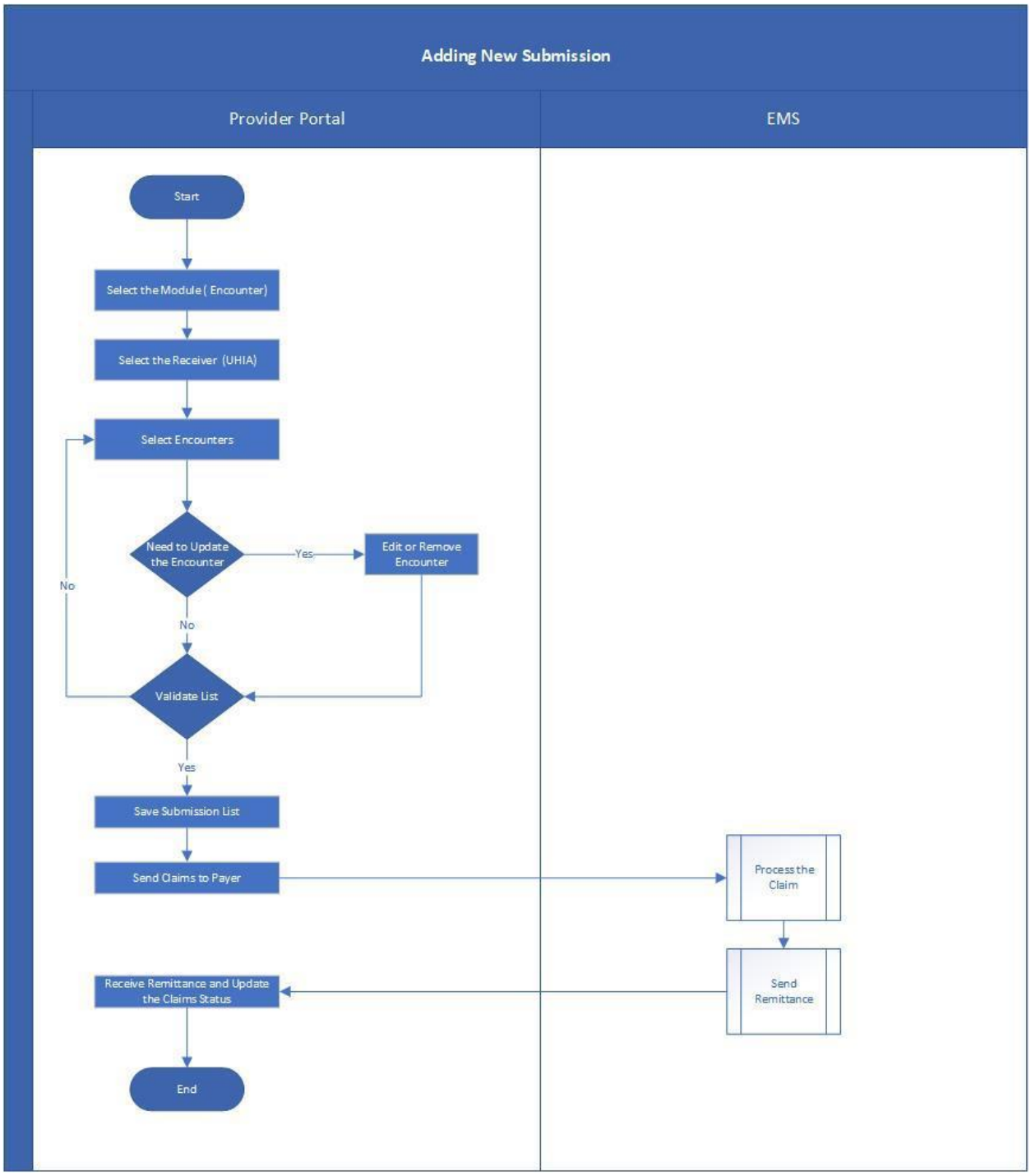
Adding New Submission
Provider Portal
EMS
Start
Select the Module (Encounter)
Select the Receiver (UHIA)
Select Encounters
Need to Update the Encounter
Yes
Edit or Remove Encounter
No
No
Validate List
Yes
Save Submission List
Send Claims to Payer
Process the Claim
Send Remittance
Receive Remittance and Update the Claims Status
End

Figure 2.

REQ003:Claim Processing in Payer System

Use Case	Name: Claims processing on payer system. Goal: To process submitted claims from provider portal on payer system. Actors: Payer system user. Actor Type: Human Preconditions: Payer system users should have valid credentials to access the payer system. Claim submission is sent successfully from Provider Portal and passed successfully through TMB. Claim submission is received successfully by the payer system. Flow of events: User navigates to payer system, Tracking, claims. User searches for the desired claim by using encounter ID/Submission “Batch” ID. User enters to claim details screen. User checks claim calculations: 1- Requested net amount by provider. 2- Gross amount as per payer’s price list. 3- Patient share amount as calculated automatically by system according to beneficiary’s plan configuration, in details of specific patient share percentage for each encounter type, and patient share cap “Maximum Amount”. 4- Net payment amount to be remitted to the provider. User checks the automatic processing results on each activity inside the claim. Users can click “Edit Claim” to enable manual approval/rejection of activities. Once claim is edited by a user, this claim becomes blocked by this same user, so only this user and admin user can edit this claim. Once user finishes claim auditing, user clicks “Stage for remittance”. Claim becomes available for remittance. Post condition: Claim status changes to “staged for remittance” on claims tracking screen. Claim becomes available on batch creation screen on payer system.
Activity Diagram	Mentioned in Figure 3.

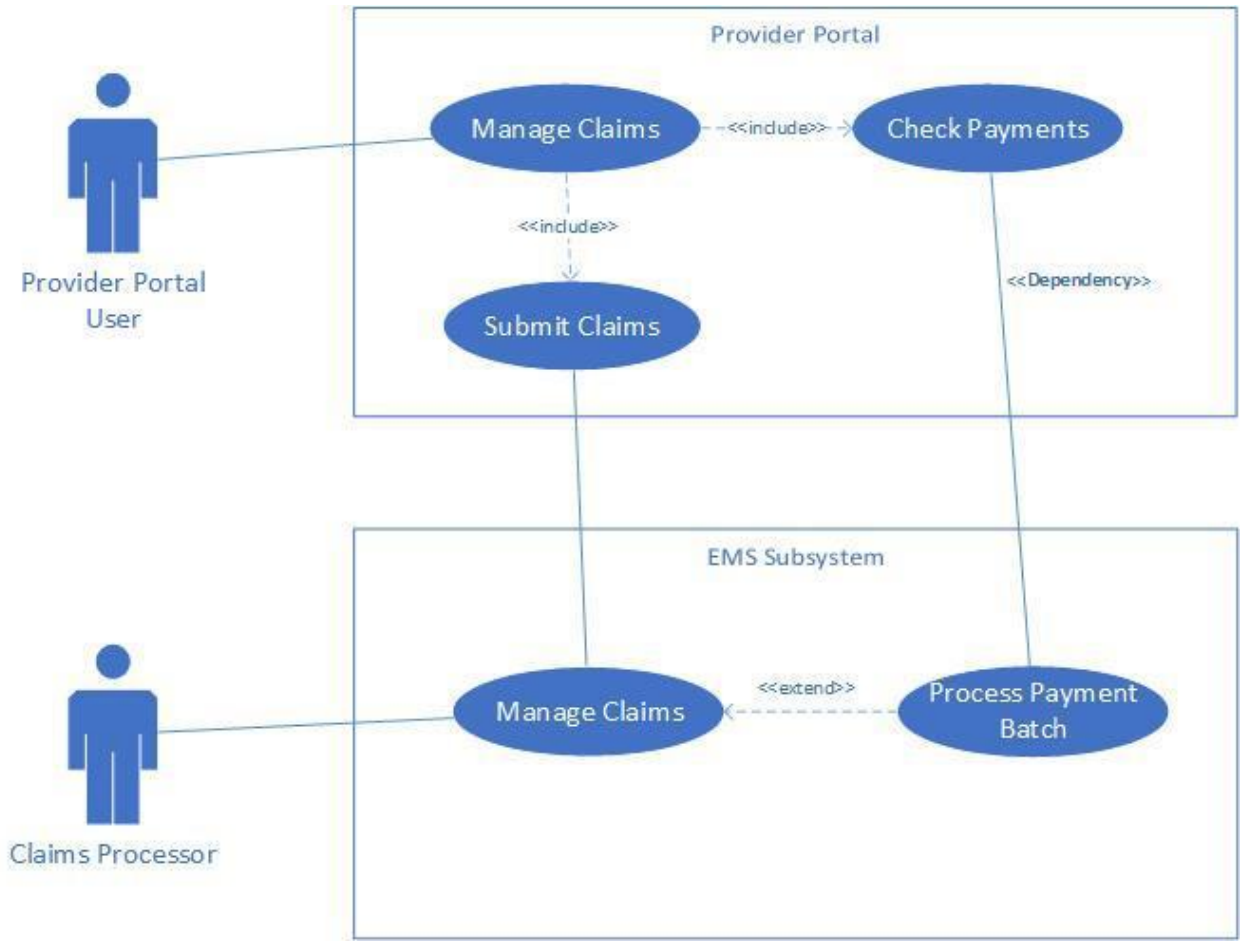
Provider Portal
Manage Claims
<<include>>
Check Payments
<<include>>
<<Dependency>>
Submit Claims
Provider Portal User
EMS Subsystem
Manage Claims
<<extend>>
Process Payment Batch
Claims Processor

Figure 3