**Mohamed Aly**

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Over 6 years of diverse experience as a Sr. QA Analyst in developing and implementing innovative business processes in Healthcare domain.

**Summary:**

* 6+ years of experience in Software FACETS Configuration, clinical edits, corrected claims, claim processing and billing procedures and Business Systems Analysis.
* Experience in HIPAA EDI Transactions and code sets: 835, 270/271, and 276/277.
* Clear understanding of FACETS Claim Processing, Billing, Membership and Enrollment, provider modules
* Capable of writing complex SQL queries FACETS support systems were used to enable inbound/outbound HIPAA EDI transaction in support of HIPAA 834, 835, 837 270/271 transactions.
* Hands on experience with Member and Family Accumulators and the process those claims deductibles and coinsurance, as well as benefits will get aggregated to accumulator buckets.
* Expertise in creating prototypes and mock-ups for user interface designs for FACETS accumulators.
* Research behavioral health accumulator errors to ensure member deductibles and out of pocket accumulations are not over plan limits.
* Experience with AMISYS Advance.
* Experience of FACETS in Billing Entity, Premium Rates, Product Billing Component, Billing Group, Fees and Discounts, Adjustments, Claims, Provider, Member.
* FACETS UI Extensions, Inbound batch interfaces and reports.
* Research a wide range of moderately complex activities and claims issues in relation to the setup and administration of accumulators in our own system, as well as Facets
* 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 of Facets accumulator’s structures and configuration.

**Technical Skills:**

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| Microsoft Technologies: | MS Project, Visio, Excel, Word, Outlook, PowerPoint |
| Requirements Management Tools | Rational Requisite Pro, Rational Rose, MS Visio |
| Operating System | Windows 2000/7/XP, DOS, Unix |
| Defect Tracking Tools | Quality Center, Rational ClearQuest |
| Languages/Standards | SQL, XML, HTTP, HIPPA 4010/5010, ICD9/10, ANSIX12 |
| Methodologies | Rational Unified Process (RUP), Agile, Waterfall |
| Healthcare Technology | Membership & Billing Group Enrollment, Benefits Auditing, Facets, Configuration, Accumulator, EDI – 834/835/837/270 |

**Professional Experience:**

**Client: Independence Blue Cross, Philadelphia, PA**

### Position: Sr. Facet Tester

### Duration: Nov 2015 - Present

As a QA Analyst, I was involved in various kinds of requirements gathering and creating project artifacts for the Facets application modules like Enrollment, Membership and Claims and accumulator. Also worked with FACET pended claims resolution and implementation of FACETS 5.0.

**Responsibilities:**

* Responsible for testing UI parameters in various testing environments alongside the release of newer diagnosis and procedural codes of ICD 10
* Tested new enrollment codes for the projects and releases to ensure the claims application engine produced the expected edits
* Worked with claim approvals, denials, and pends while also keying in claim details and retrieving them accordingly.
* Primarily worked testing of Utilization Management/Case Management cases in Trizetto FACETS, and Medical Management Platform, Clinical Care Advance as well as with patient care management.
* Involved directly in maintaining logs of test scripts and defects in ALM accordingly
* Maintained automation scripts and ALM collateral during systems testing
* Worked comprehensively with plan inquiries with proper analysis and technical feedback support through SRTS application.
* Tested on advanced patient care management systems including GuidingCare™ Care Management System Demos for Potential Clients: Onsite and WebEx.
* Tested and implemented Altruista Health’s GuidingCare Care Management System for advanced care management.
* Presented the test scenarios to the Plans via Town Hall Meeting Conference and provided pertinent clarifications on the raised issues
* Involved in daily touch base meetings with Business Analysts, Project Managers, Team Leads, Testing Managers with respect to the progress on the ongoing project and defect tracking
* Performed both manual and automation testing of the pre written scripts whether they are according to the functional specifications or not
* Responsible for creating complex scenarios according to the provided specifications and requirements and further test execution before UAT and production
* Involved with presenting the scenarios in the user-friendly manner to the business users during the UAT process before the update is signed off to the production
* Involved in FACETS Implementation, involved end-to-end testing of FACETS Billing, Claim Processing and Subscriber/Member module.
* Gathered requirements and create documentation for HIPPA EDI 834, 270/271, 837/835 transactions according to test scenarios and verify the data on different modules.
* Experiences working in ANSI x12 837-835 EDI Transactions.
* Implemented claim processing and adjustments within FACETS.
* Assisted with the Requirement Study, Test Plan Preparation, Test Cases Creation using Facets.
* Work on coordination of benefits (COB) in a claim processing.
* Performed Back-End Testing to check database integrity by writing SQL queries.
* Extensively used SQL statements to query the Oracle Database for Data Validation and Data Integrity.
* Set claim processing data for different Facets Modules.
* Extensively worked on any requirement upgrade and/or change request while doing UAT.

### Environment: Agile/Waterfall, HP UML, RUP, GuidingCare, Rational Requisite Pro, Rational Rose, Facets, Rational ClearQuest, Excel, SQL, DB2, Crystal Report, Quality Center.

**Client: Health Plus of Michigan, Flint, MI**

**Position: QA Analyst**

**Duration: June 2014- Oct 2015**

Health Plus uses Amisys Advance, a fully integrated, intelligent data processing and management information system for managed healthcare. Involved in an application where I can enroll members, check eligibility and process end to end claims with downstream processing of it.

**Responsibilities:**

* Attended daily touch point calls and set targets for the day and met them on daily basis
* Performed extensive analysis of the tracked issues and works on them accordingly
* Worked with 834 resolution and reconciliation, in addition to 1095A generation
* Tested web services by generating XML SOAP requests and validated the corresponding XML SOAP responses
* Carried out Web Service testing by generating SOAP requests and verifying the corresponding SOAP responses
* Analyzed the x12 errors in the source file and made amends for output file generation accordingly.
* Coordinating with Business Analysts and IT Technical Delivery Leads to complete testing specifications and release requirements.
* Developed a plan and built the team responsible for enhancing data and processing interfaces into and from the claims payment system, Amisys.
* Tested requirements and designed multiple custom interfaces to migrate the provider data from Amisys to Facets.
* Assisting in the creation of Test Plans including UAT, SIT, E2E, and Regression
* Coordinating with IT Technical Delivery Leads on project test planning and test execution schedule
* Design, develop and execute test strategies/plans; debug and troubleshoot; collaborate with test resources on proper and testing procedures
* Performing QA status reporting to the Manager of Business Analysis & Quality Assurance
* Providing assistance in the coordinate of defect tracking, defect triage activities, and issue resolution for all assigned projects.
* Responsible for configuring Benefits, Pricing, Security, Authorization, Reference and Control table Requirements for Amisys Platform as per the Affordable Care Act (ACA).
* Performing QA status reporting to the Manager of Business Analysis & Quality Assurance
* Assist in the coordinate of defect tracking, defect triage activities, and issue resolution for all assigned projects.
* Analyzed SIT and UAT environment processing issues as needed to keep the AMISYS testing on schedule.
* Ensuring that all system tests are successfully completed and documented and all problems are resolved prior to any production releases
* Supporting all quality initiatives that are implemented during each phase of the system development life cycle.
* Performed the backend analysis with use of SQL queries to resolve and reconcile the 834 EDI
* Worked on Electronic health record system as a CRM web based application.
* Working Experience in Electronic Submissions in standard format.
* Experience with ICD-10 conditions to benefit from tailored diseases.
* Provided weekly project status report to project manager and project presentation to the high level management on monthly basis.
* Assisted project manager for planning and organizing the project activities, and in communicating with other business center managers and stakeholders of the project.

**Environment:** UML, RUP, Rational Requisite Pro, Amisys, Rational Rose, Rational ClearQuest, Excel, SQL, DB2, Crystal Report, Quality Center, MS Project, MS Office, IBM **DB2,  Oracle on UNIX**, Enterprise Data Warehouse.

**Client: United Health Group, Hartford, CT**

**Position: QAAnalyst**

**Duration: Nov 2012 - April 2014**

I was involved in an incentive program and directly responsible for multiple clients’ business processes and responsible for documenting and analyzing business requirements.

**Responsibilities:**

* Authored test scenarios and test cases based in both the QC/ALM and MS Excel spreadsheets for the assigned projects
* Created x12 837 files according to the base templates and the WellCare companion guides
* Dropped the claims into the drop location, extracted the WCNs, executed queries in the SQL Server and the SQL Developer, and further validated the member/provider level details according to the warning codes and error codes
* Executed test scripts and maintained defect logs for defect tracking in the QC
* Created extensive SQL queries to prepare test data for test execution
* Design, analyze and performed Integration and wrote System requirements on different leading health care software’s such as FACETS.
* Analyzed the system requirements specification and developed appropriate test plans, test cases, test scripts and executed testing
* Worked on claim processing module which involved Receipt, Enrolment (834), Verification of Claims Form (837) and Claims Adjudication, Health Claim Payment/Advice (835) as per HIPAA guidelines.
* Coordinate with reforms operations group to build new marketing strategies for exchange products on portals; designing exchange products with addition of exchange specific attributes to SBCs
* Performed Health Care Reform audit for multiple Health Care Reform provisions. Provided recommendations for systems being developed to support the audit.
* Conducted interviews and workshops for soliciting customer requirements
* Interacted with the technical team for the 837 claims transactions design
* Manage the Requirements (Business as well as System requirements), performed requirements analysis along with the creation of Test Scenarios.
* Worked with the development team to make sure that they understood the user requirements and that the system developed met those requirements.
* Worked with the Project Manager on various Project Management activities like keeping track of Project Status and Deadlines/Milestones.

**Environment:** Oracle E-Business (Oracle Federal Financial), MS Access, MS Visio, MS Office, MS Project, Quality Center, SQL, Facets, Agile, Jira

**Client: CIGNA Healthcare, Raleigh NC**

**Position: QA Software Engineer/UAT Tester**

**Duration: June 2011 - Oct 2012**

CIGNA Healthcare provides quality health insurance at affordable prices. I worked particularly on analyzing **Facets** interfaces. My duties included working with claims module and processing them for various scenarios. As an analyst, worked on **ETL** projects to construct and verify data requirements. Experiences working in ANSI x12 270-271 EDI transaction . Involved in EDIs according to HIPPA code set 834 enrolment and disenrollment in a health plan using QTP . Involved in Documenting **EDIs according to code set X12 835 Claim Payment & Remittance Advice Claims processing and 837 Claim transactions .**

**Responsibilities:**

* Extensive work as a claims adjuster and configuration professional, cleaning up errors with claims, benefits, provider contracts, and making modifications in a cleanup effort.
* Validated the translated HIPAA files with the proprietary Common Claim Record implementations.
* Performed Use-Case analysis using UML to capture the dynamic aspect of the application
* Perform Gap Analysis, develop & implement maps for translating inbound and outbound transactions into respective standards.
* Create maps to transform data from EDI to standard XML business documents, provided assessment of business and technical needs.
* Set-up, co-ordinate & conduct system & UAT testing
* Analyzed current data stores and generated UML diagrams of logical and physical data.
* Developed system and defined metrics to evaluate performance in innovation, customer satisfaction &employee participation.
* Analyzed resource utilization using workload parameterization for improving performance of application under development.
* Analyzed existing procedures and reported them to management to improve productivity.
* Performed Business Process Modeling using Visio.
* Worked on different modules of Facets such as Members/subscriber, commissions, provider, billing.
* Identified, analyzed, and documented defects, errors, and inconsistencies in the application using Mercury Quality Center.
* Reported defects according to Defect Life Cycle.
* Membership/enrollment and billing-entered information on **Facets** to ensure correct eligibility, etc

**Environment:** Oracle, HIPPA, EDI 5010, XML, QTP, Mercury Quality Center, **Facets.**

**Wellcare Group, Tampa, FL**

**Oct 2010 - May 2011**

**QA Analyst**

This project dealt with the development of a Medical claim capture system. The system helped to accelerate document input process and eliminate manual entry. Overall the system was meant for the administration team to have a faster and easier way to access to patient's electronic health records. The project also involved implementation of Claims processing module which involved Receipt and Verification of Claim Forms (837), Enrollment Implementation Format (834), and Claims Attachments (275), Claims Enquiry and Response (276/277C), Adjudication, Healthcare Claim Payment/Advice (835) as per HIPAA guidelines.

**Responsibilities:**

* Monitoring and conducting non-supervisory support role will include coordinating team schedules, monitoring event attendance and outcomes, reporting to manager, escalating issues and conduct process improvement.
* Ensured that the MMIS upgrades are able to handle the new HIPPA transaction.
* Validated the following Transaction Processing: 837 (Health Care Claims or Encounters), 835 (Health Care Claims payment/ Remittance), 270/271 (Eligibility request/Response), 834 (Enrollment/Dis-enrollment to a health plan)
* Experience using Agile Scrum Methodology.
* Set claim processing data for different Facets Modules.
* Tested HIPAA regulations in Facets HIPAA privacy module.
* Worked on Enrollment and Billing Module through both 834 EDI transactions as well as Facets Online/enrolling members in Facets from Facets front end screens, web portal application and EDI 834 transactions.
* Also made appropriate changes to records by resolving enrollment system rejects. Reconciling our various EDI transactions sets such as 834 enrollment files, 820 payment remittance files, ID card files, and Group XML files.
* Involved in the testing of web portal of New MMIS system.
* Created transaction sets requirements, usually with Microsoft Excel, for transactions such as: HIPAA 270/271, 276/277, 278/278, 820, 834, 271U, 835, 837-(I, P, &D), 835 Remittances and others.
* Ran SQL queries to obtain various data including deductible, copayment and accumulators.
* Implemented and provide support for HIPAA ANSI X12 standard transactions 270, 271, 276, 277 and 278. Maintain and support 834, 835 and 837 HIPAA EDI transactions.
* Created SQL scripts for different frames of testing.
* Developed/Modified Test Cases, Test Scenarios and Test Data using JIRA, Version1 and Quality Centre tools.
* Checked the data flow through the front end to backend and used SQL Queries to extract the data from database
* Involved in testing Encounter submission and error reconciliation.
* Performed analysis on various project types and solutions including but not limited to: EDI analysis supporting standard and non-standard transaction, Data analysis, trading partner analysis and mapping, etc.
* Performed the Gap analysis on the earlier systems, generated a detailed Requirements document describing new system architecture through Use Cases and Activity diagrams.
* Developed and executed Test Cases and Test Plan Documents in Quality Center based on the requirement and design.

**Environment:** Agile/Waterfall, MS Office Tools, Windows XP, Quality Center, Facets, MS SQL, UNIX.

**Environment:** SQL Server 2000, Oracle, Quality Center, UML, MS Office, Toad, Clear Quest, UNIX.