**Samay Singh**

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**PROFESSIONAL SUMMARY**:

* Over 6 years of diversified experience in Information Technology with strong emphasis on manual and automated testing tools, Web based and Client/Server applications
* Extensive experience in various Software Development Life Cycle (SDLC) Phases and Quality Assurance Life Cycle (QALC)
* Strong knowledge of software development methodologies including Agile, Waterfall, and Rational Unified Process (RUP) Methodology
* Good knowledge in Functional, System, Integration, End-to-End, Unit, System, Integration, Regression and Performance testing
* Experience in testing Health care Insurance applications on different environments
* Proficient in designing, reviewing and documenting system test plans, defining test procedures and creating test cases on the basis of product release features, client’s requirements and related technical documents
* Expertise in preparing test scenarios, test cases and designing test strategies.
* Knowledge in Business Process Testing using HP Quality Center/ ALM.
* Extensive hands on experience in using relational databases like MS-SQL Server and Oracle.
* Strong experience working with HIPAA ANSI X12 Transactions(837/835/834/ 270/271/276/277)
* Excellent Knowledge in Iterative Testing, Agile Methodology (SCRUM).
* Good knowledge of ICD-9/ICD-10 and HIPAA 4010/5010 Transaction requirements.
* Experience in preparing a Quality Assessment Report at the end of the release highlighting the vulnerable areas of the product.
* Expert in usage of Defect tracking and reporting using Quality Center/ HP ALM, Test Director.
* Extensive experience in Back-end Testing on distributed databases using SQL queries.
* Experience in performing functional testing using Quick Test Pro (QTP)
* Proficient in working with FACETS, claim-processing systems
* Extensive experience in Web services testing using SOAP UI
* Ability to work closely with developers and project managers to analyze the new features of the software application.
* Self-Motivated team player with good communication, problem-solving skills, analytical and strong presentation skills.

**TECHNICAL SKILLS:**

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| **Testing Tools:** | QTP/ UFT, Facets, SOAP UI, Selenium, TOAD |
| **Defect/TestManagement Tools:** | HP Quality Center/ ALM, Clear Quest, JIRA |
| **RDBMS:** | Oracle, DB2, SQL Server, MS Access |
| **Languages:** | C, C++, Pl/SQL, Oracle SQL, Java |
| **Operating Systems:** | Microsoft Windows, Unix, Linux |
| **Web Technologies:** | HTML, XML, CSS, VBScript, JavaScript |
| **Packages:** | MS Office, Rational Rose |

**WORK EXPERIENCE:**

**Client: CMS / Cognosante, McLean, VA**

**Position: QA Analyst**

**Duration: September 2015 – Present**

This is a CMS Federal Government project. Once a year, consumers who applied for health insurance through the Marketplace would get 1095A Forms. Consumers then use those forms to file their taxes. If consumers think their 1095A Forms are not correct, they can contact the Marketplace to get them fixed. They will open a case for the consumer. Cognosante and CMS will work the case. As an EDI Analyst, I investigated and made determination on the cases using data from different sources.

**Responsibilities:**

* Responsible for trouble shooting and resolving errors in 834 and 820 transactions for health insurance exchanges and performing root cause analysis
* Responsible for analysis of discrepancies in the eligibility reconciliation process for multiple stakeholders and continuous process improvement of the reconciliation process
* First, consumer calls Marketplace regarding his/her issue on the 1095A Form. The agent opens a case in HICS - Health Insurance Casework System - System used by CCO (Contact Center Operation) to manage cases
* Cognosante uses SharePoint Portal – E1095A Issue Tracking system – to keep track of HICS cases with different status, disposition, assigned EDI analyst, assigned outreach agent, etc.
* As an EDI Analyst, I created an Excel Workbook for each case. I searched for data from the Share Drive and gather them into one single workbook. These data will be used later on to either approve or deny the consumer’s request
* Each insurance policy has one 1095A form with Start Date, End Date, APTC amount, Premium amount, Application ID, Tax Year, Subscriber’s information, Issuer’s information
* The data from MIDAS - Multidimensional Insurance Data Analytics System – reflects what is presented on consumer’s current 1095A Form, how many forms he has, and how many individuals in one form
* The data from EDBO – Enrollment DB Output – reflects what Marketplace and Issuer have in their Databases about the consumer’s policy. There are two types of EDBO

1. EDBO FFM – Federal Facilitated Marketplace
2. EDBO Issuer

* The Pre-Audit data is the raw data
* The Issuer Outreach data is obtained after Cognosante reaches out to Issuer to confirm consumer’s coverage
* If all the data agrees with each other on the information in consumer’ current 1095A Form, consumer’s request is denied. Consumer has the right to escalate the case to CMS Regional Caseworker. Cognosante handles the escalation process as well
* If the data mismatches and agrees with consumer’s request, the case is approved. Analyst updates Opera BUU – Batch Update Utility – the program used to submit updates to the FFM. A corrected 1095A Form will be issued to consumer

**Environment:** SharePoint Portal, HICS, MIDAS, EDBO, Pre-Audit, BUU, and Microsoft Office Word/Excel.

**Client: Blue Cross Blue Shield of Michigan – Blue Care Network, Southfield, MI**

**Position: QA Analyst**

**Duration: August 2014 – July 2016**

BCN was building Health Care Reform (Obama Care) products. They modified the existing products instead of building everything from scratch. They modified Riders, which were used to make changes in the original Certificates. A Product has many Riders. If one of the Riders was changed, that Product had to be tested. As a tester in the Business Configuration Unit, I received and processed Products with Change Requests.

**Responsibilities:**

* Experienced working with Medical, Visual and Drug claims
* Manually keyed claims into Facets and recorded the claims in database
* Collaborated with colleagues on receiving and testing Change Request (CR)
* Looked up current CR in the back-end Test Case Database (TCDB)
* Reviewed and chose an eligible member from the member list for the test. This could be a Commercial, Blue Care Advantage or Medicaid member.
* In TCDB database, chose the appropriate Test Scenarios according to the changes in the Riders
* In Developer/Configuration Facets, under Subscriber/Family module, entered the member chosen previously
* Changed the Plan/Product of this member into the testing Product
* Under Medical Claims Processing and Hospital Claims Processing Modules, keyed the member into appropriate Test Scenarios
* Performed configuration and regression test to check if the new Plan is showing correct payments with this member
* Saved and pasted the new claims into TCDB database
* Worked with Product, Benefit Summary and Service Payment modules in Facets to validate the new Rider String, Product ID, Benefit Summary, Service Payment, Limit, Deductible, Explanation of Benefit
* Performed Validation Report on tested CR
* Knowledgeable on error messages in Facets. Often had to override and make changes in order to test the claims
* Triage the tested Change Request after the periodically Database Refresh
* Worked with colleagues in submitting CR before Data Migration / Product Release deadlines
* Coordinated with UAT team to ensure the correct business requirements

**Environment:** FACETS 5.01 / 5.10, SharePoint, Microsoft Office Excel/Access, TCDB database.

**Client: ACS Government HealthCare, Atlanta, GA**

**Position: QA Analyst**

**Duration: March 2013–June 2014**

I was involved in a project to re-engineer a suite of Medicaid management products and create a core application called Enterprise. My team was responsible for receiving, documenting, tracking and addressing the problems encountered by the customers of Flagship software product EPM (Enterprise Practice Management) while generating 837 Professional, Institutional, and Dental claims, Functional Acknowledgement 997, Claim Status Inquiry/Response 276/277 Unsolicited for their destination direct Payers or Clearinghouses such as Proxy Med, WebMD, etc.

Responsibilities:

* Created Test Documentation and Test Plans.
* Involved in HIPAA/EDI Medical Claims Analysis, Design, Implementation and Documentation.
* Entered numerous claims for testing purposes to ensure accurate and quality adjudication and implementation of business and operational requirements.
* Exported test cases from Excel and requirements from MS Word to ALM
* Worked on Data Mapping to map Facets data to outbound eligibility extracts.
* Wrote SQL queries to extract and validate the data from the Facets database.
* Extensively worked with Member/Subscriber and HIPAA Privacy Facets application groups.
* Use Quality Center to create to create Test Plan, Test cases and test scripts as well as steps for manual and automated implementation of test cases in Quality Center.
* Developed and maintained complex SQL queries for MS SQL Server and MS Visual SourceSafe for extensive back end testing purposes.
* For testing purposes, manipulated Members information in the QA environment through Facets front-end application.
* Web testing utilizing HP Quick Test Professional (QTP), Client/Server application manual testing utilizing Windows XP, Oracle 9i, TOAD, and SQL Server. Clear Quest for defect tracking and test cases repository and maintaining RUP documentation.
* Monitoring the performance of the system on a day-to-day basis.
* Performed Black Box Testing. Performed Positive and Negative testing for the system.
* Conducted Back End Testing to test the connection between Store’s system and the database in order to verify data integrity.
* Made sure that the systems complied with the rules of HIPAA
* Used SQL to test various reports and ETL load jobs in development, QA and production environment
* Involved in manually testing the application from the backend to carry out data validation.

Environment: Quality Center, HP ALM, Oracle, ANSI X12, HTML, XML, HIPAA, EDI, and MS Office, Windows.

**Client: Wisconsin Health Insurance, Madison, WI**

**Position: QA Analyst**

**Duration: September 2011– February 2013**

I worked on various EDI transactions to implement HIPAA 5010, the configuration of system between trading partners and transaction manager, the process of migrating the current EDI Gateway to a new Gateway platform, EDI transaction’s inbound and outbound activities through HIPAA gateway.

**Responsibilities:**

* Tested data and processes through running and scripts using IBM’s Rational Test Manager.
* Analyzed the business requirements and functional requirements to identify test scenarios
* Developed and managed the formal Agile Methodology which includes Configuration Management, Requirements Management, Agile Manifesto, Lean Development
* Created 837 I & P X12 files Electronic and Paper claims for test data
* Viewed, edited and modified 837 transactions to fit testing scenarios.
* Requested the batch jobs to load the claims to the Facets
* Worked on FACETS Claims Payment and Adjustments (Up adjusted and down adjusted)
* Experienced in Claim Processing such as Submission, Claims inquiry, Remittance, Explanation of Benefits, Discounts, Adjustment, Accumulators, Interest calculations, Split payment, Finalization, COB.
* Tested ICD 10-Diagnosis and Procedural Codes along with CPT and HCPCS codes in Medicare
* Developed the test cases as per the HIPAA regulations (270, 271, 275, 276, 278, 834, and 837)
* Worked on System Testing (functional Testing) of NYS 837I (Institutional Claims and NYS 820 Medicaid Premium Payment).
* Created new and modified existing jobs (Proc) and JCL for test run of application on Mainframe using TSO/ISPF, DB2, and IMS (DB).
* Created Access cross tab by implementing SQL queries
* Created SQL to test source to target data warehouse transforms, using TOAD.
* Verified and modified subscriber/ member’s plan, product and subgroups for eligibility
* Terminated subscribers/members from Facets front end to match the test scenarios
* Developed Test cases from business use cases, Test data and test scripts for testing
* Worked with Medicaid and Medicare claims
* Tested data migration from MS SQL Server to Oracle database using Informatica and performed Data Mapping on them.
* Tracked and reported defects using HP Quality Center
* Performed backend testing with extensive use of SQL queries by writing Stored Procedures, views, triggers to check the validity of ETL process.

**Environment:** FACETS, HP Quality Center, Informatica, COGNOS, Oracle, SQL, ANSI X12, HTML, XML, HIPAA, EDI, MS Office, In charge of creating complex SQL queries to test the Backend functionality of the application.

* Maintained a Test matrix.
* Investigated software bugs and interacted with developers to resolve technical issues using Test Director.

**Environment:** Windows, Win Runner, Test Director, HTML, SQL, ODBC, Oracle, IIS, MS Office, and ASP.

**Education: Masters of Science**