**IKENNA EMEH**

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**Experience summary:**

* 6+ years experience as a Software Quality Analyst / Business Analyst in Healthcare industry.
* Thorough understanding of Software Development Life Cycle (SDLC) and Software Test Life Cycle (STLC).
* Excellent skills in designing Test Plan, Test Cases and Test Scripts.
* Maintained Test Matrix and Requirement Traceability Matrix.
* Experienced in all aspects of testing processes includes planning, Preparation, Execution and Completion.
* Performs Gap and Impact Analysis for HIPAA 4010 837P and 835 transactions and HIPAA 5010 837P and 835 transactions
* Works on requirements of the 835 HIPAA projects, 276/277, 278, 837, and HIPAA EDI Transactions across enterprise
* Thoroughly understands healthcare industry including Enrollment, Benefits, Claims, Medicare, and implementation of HIPAA key EDI (ANSI X12) transactions
* Extensive experience in all EDI transactions like 834, 837 P, 835, 27x and conversion of 4010 to 5010
* Strong analytical skills in performing gap analysis and writing documentation
* Writes and prepares business requirements documents (BRDs), system requirements specifications (SRS), system design specification (SDS), functional specifications, defining project plan and change request
* Conducts JAD sessions, Gap analysis, and prioritizes requirements using interviews, document analysis, and requirements workshops
* Extensively involved in verification and validation for both Web based on Client server applications. Having very good Experience in Unit Testing, Integration Testing, Regression Testing, System Testing, and UAT.
* Having Experience in design and execution of test plans, Test Scenarios and test cases based on the requirements for the applications.
* Proficient in bug tracking/test management tools like team track, Quality Center and Clear Quest.
* Extensively involved in testing Trizetto’s Facets and mainly involved in Enrollment and Eligibility modules.
* Excellent in understanding Business Requirements, Functional Specifications and Technical Specifications.
* Knowledge of Rational Unified Process (RUP) methodology, UML, QA Validations to ensure the Quality standards, Quality Assurance Life Cycle (QALC) and QA Methodologies.
* Expertise in testing Enrollment, Billing and claims processing in FACETS.
* Experience in defect reporting and tracking using HP Quality Center.
* Experience in using the automation tool QTP for both data driven and keyword driven testing.
* Experience in web services testing using SoapUI.
* A self starter with excellent verbal, written and analytical skills; a self motivator who can work collaboratively
* Excellent knowledge of HIPAA standards, EDI (Electronic data interchange), Implementation and Knowledge of HIPAA Transaction sets, ICD-9, ICD-10.
* Worked on pre authorization of claims in Meditech5.66, Meditech 6.00. Knowledge of ICD-9/ICD-10, CPT codes.
* Having very good understanding of software Development lifecycle, QA methodologies and strategies.
* Interacted with developers in fixing the defects by verifying the logs and database in a lot of occasions.
* Very good team player and also have ability to work independently in time sensitive environment.

**Technical Skills:**

Operating System: MS Windows XP Professional, Vista & 7, Mac, MS Word, Excel

Language: VBScript, TSL, HTML, SQL, Java, J2EE, C++, PHP, CSS, ASP.NET, .NET, AJAX

Business Methodology:Agile, Waterfall, RUP, RAD

Office tools: MS Word, MS Access, MS Excel, MS Project, MS Power point, MS Outlook, Ms Visio, Paint

Testing Tools: HP Quality Center, JIRA, BugZilla, SoapUI, HP Quick Test Professional (QTP)/UFT

Browsers & Databases: Oracle, MS SQL Server, Internet Explorer, Firefox, Safari, Chrome, HTTP, FTP

**Work Experience:**

**Catholic Health Initiatives ICD 10** – **Implementation,** **Englewood, CO Jan 2014 – Present**

**Sr.QA Analyst / Business Analyst**

The ICD-10 implementation program is designed to prepare CHI for the ICD-10. The transition to ICD-10 codes has a large impact on policies, business operations, clinical processes, and IT systems across the CHI enterprise. The program is intended to identify activities, risks, solutions and education associated with the planning and implementation of ICD-10 for business operations, infrastructure and applications which would include both clinical and administrative areas, as applicable.

The objective of this program is the successful implementation of the ICD-10 mandate with minimal disruption to business operations, coding, reimbursement, clinical programs, research programs and patient care work flow.

**Responsibilities**:

* Involved in preparing Test plan, Test script and its execution using application lifecycle management (ALM).
* Extensively worked on HP Application lifecycle Management to Write Test Cases, Execute Test Cases, Log Defects, Track Defects and Prioritize Defects.
* Created system models for the “As-Is” Systems and for the “to-Be” system using Unified Modeling Language.
* Worked on EDW gaps which came into existence after small group migration for EDW client on subject areas like product & group.
* Used requirement elicitation techniques like interviews and JAD sessions to gather and document information regarding upcoming changes
* Conducted JAD sessions with the management, users and other stakeholders for open and pending issues to develop specifications. Analyzed and evaluated User Interface Designs, Technical Design Documents and Quality Assurance Test Conditions to test the performance of the application from various dimensions.
* Helped create the 'Business Glossary' to facilitate efficient understanding of the business process amongst the other teams. Assisted in creation of the Functional Design Document from the Business Requirements Document which was used as the reference by the development team while preparing the design and held the responsibility of the required data setup for unit testing.
* Worked in RDBMS tools like oracle (TOAD) and MS SQL Server with SQL skills (writing queries and verifying data). Solid understanding of databases, data ware house, OLTP, OLAP, and Data Modeling.
* Prepared and created Test cases/ Test data for ICD 10.
* Conducting Validations for different FACETS modules Providers, Claims, Subscriber/Family, Products, Class, and Plans etc.
* Wrote and enhanced test cases and test scripts to meet new functional requirements as per the new business requirements for ETL process verifications as well.
* Experience with designing, developing and the execution of reusable and maintainable Automated Scripts using QTP for Java user-Interface and API testing.
* Conduct walkthrough of the Test Cases and Test Data with Developers and Business Analyst.
* Validated ICD 9 and 10 HIPAA Compliance.
* Identify processes and systems to enable to trade files with non ICD-10 complaint trading partner. Monitor and resolve testing issues.
* Validated the code changes for the ICD-10 with in the Facets system
* Involved in the full HIPAA compliance lifecycle from GAP analysis, mapping, implementation, and testing for processing of Eligibility. Worked on HIPAA Standard/EDI standard 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.
* Tested the ANSI X12 Version 5010 / EDI transactions (HIPAA) like 270, 271, 276, 277, 278,820, 837P, 837I, 837D, 835 remittances).
* Validating elements of CHIP/MMC plan data, creating.
* Verifying whether the data is loaded in appropriate tables and columns in database.
* Preformed positive and negative testing of the application for identification of bugs.
* Performed with different aspects of Meditech 5.0 implementation lifecycle.
* Performed System testing, Integration Testing.
* Performed End to End Testing.
* Review requirements and Logical and physical designs.
* Involved in creation of Requirement Traceability matrix and Defect report.
* Participate in Defect triage meeting for defect review.
* Involved in writing SQL queries for backend testing.
* Involved in creating Defect report, test execution report and test completion report.
* Obtain daily task from the manager and distribute among the team and plan for its approach.

**Client: Aetna Health Services, Nashville, TN**  **Aug 2012 – Dec 2013**

**QA Analyst**

Working with Nashville, TN EDI Corporation, which is upgrading an existing EDI system, to use for dual purposes: First, this system is used as a National HIPAA 5010 EDI testing tool and for 5010 test-data generating, typically for Medicare, Medicaid or Commercial Payer HIPAA 5010 Projects or HIPAA Training. The second use is for an affordable 5010 desktop solution for Providers. Involved in the Forward Mapping and Backward Mapping analysis of ICD 9 – ICD 10 Conversion for CM (Diagnosis Codes) and PCS (Procedure Codes); Involved in GEM (General Equivalence Mapping) tools for forward mapping of ICD 9 – ICD 10 codes.

**Responsibilities:**

* Acted as a primary contact in all the phases of Software Development Life Cycle SDLC including Quality Assurance Testing, Performance & User Acceptance testing.
* Performed GAP analysis for ICD - 10 and EDI 5010 X12 Message Structure with the 4010 Structure.
* Developed End-to-End Quality Process Flows for HIPAA 5010 EDI transactions including 834 (Benefit Enrollment and Maintenance), 835 (ERN-Electronic Remittance Notification) and 837 (Claims Submission) Transactions.
* Performed Application Readiness/Business Acceptance testing in Facets into Subscriber/Member and Billing module for the rate plan testing in the front-end facets and data model back-end table.
* Acting as liaison between end user and Facets for user problems, outstanding issues, training needs and new software releases.
* Responsible for creating the test plan and designing test cases for the EDI 834 members’ enrollment file loading process into Facets through HIPAA Gateway.
* Involved in FACETS Implementation, involved.
* Worked on ICD 9 codes and gathered future requirements based on ICD 10 codes. Managed creation of sample mappings for the conversion of EDI X12 transactions code sets version 4010 to 5010 and translation of ICD 9 codes into ICD 10 codes.
* Set claim processing data for different Facets Module.
* Created the “AS-IS” as Current Quality Process Model and the “TO-BE” as the Intended Model, to analyze and improve the Quality processes.
* User Acceptance Testing (UAT) – Performed UAT tests using the MORAE Usability Testing Tool using the Observer and the Manager Mode.
* Performed manual Back-End testing on the application by writing complex SQL queries.
* Wrote INNER, OUTER JOINS to retrieve desired or expected data from tables of database with and without comparison operators to perform Backend testing in QTP.
* Recorded the Test cases using Quick Test Professional (QTP) for web based application and performed regression testing of the application for every release.
* Prepared Data including raw and XML data, SOAP UI messages that satisfies all the business conditions and real world scenarios.
* Worked with Teradata, Mainframes (DB2, Copy book, VSAM files, Sequential files), SQL Server and Oracle.
* Worked on UNIX Platform and experienced in back end testing by executing SQL Queries.
* Checked the data flow through the frontend to backend and used SQL Queries to extract the data from the database.
* Involved in writing extensive SQL Queries for back end testing oracle database.
* Retrieved files using SQL statements and UNIX commands.
* Created and maintained SQL Queries for back-end testing.
* Used Rational Clear Quest to track and report system defects and bug fixes
* Analyzed and evaluated User Interface Designs, Technical Design Documents and Quality Assurance Test Conditions the performance of the application from various dimensions.

**Health Net Inc., Tempe, AZ Oct 2011 - July 2012**

**Business Analyst**

Health Net Inc., is a company that services HMO, POS and PPO, and provides health plans through Medicaid, Medicare and the Health Insurance Marketplace and other Health Solutions. As a consulting BA, I was involved on ICD 9 to ICD 10 conversion project and was working on the full integration of forward and backward mapping and efficiency of the crosswalk in the context of meeting government mandated and business process requirements.

**Responsibilities:**

* Reviewed government and business process requirements and drafted business and functional requirement documents that clarifies requirements across team members /Developers, QAs/ through Joint Application Development (JAD) Sessions
* Performed requirements elicitation, gap analysis by conducting “AS IS” and “TO BE” scenarios, designed the new process flows and documented the business process
* Produced BRDs and FRDs that reflects business requirements accompanied with Wireframe/Mockups, Use Case Documents, and Activity and Sequence Diagrams
* Follow up the effectiveness of the project by serving as a liaison between SMEs, developers and testers
* Ensured full understanding of the concept and keep uniform cadence of effort to meet project objective by conducting walkthroughs and meetings involving various leads/members from BA, Development, QA and Technical Support teams
* Worked closely with Developers, SMEs, User Representatives and participated in the product design process including specifications and other document reviews.
* Written test strategies, plans, scenario and test cases that meets the pre-RTM details
* Participated in the UAT to test forward and backward mapping analysis of ICD 9 (CM/PCS) – ICD 10 (CM/PCS) conversion through checking the consistency of the crosswalk results
* Made all necessary documentation
* Escalates scope creeps, appropriate issues to my manager for appropriate intervention
* Conducted successful JAD session that brought all parties on same level of understanding
* Reviewed test scenarios and test cases against compliance guidelines applicable to the healthcare industry
* Assist/overlook manual testing of Forward and Backward Mapping analysis of ICD 9 (CM/PCS) – ICD 10 (CM/PCS) Conversion
* Loading test cases from excel file onto QC/ALM
* Analyzed EDI X12 - 837I/P, 835 and 834 transactions consistency related to providers, payers, subscribers and other related entities
* Checked consistency of EDI 835 X12 files for containing the correct EOB detail using Facets
* Wrote SQL queries to check proper data population in application tables
* Assisted in the preparation of Test plans and created test scenario and test cases against the requirements for the clinical aberrancy rules

**Affinity Health Plan, Bronx, NY    Oct 2008-Aug 2010**

**Business Analyst**

Affinity Health Plan is an independent, non-profit managed care plan that serves the needs of over 210,000 residents of the New York Area and provides healthcare coverage through its plans and through Medicare & Medicaid programs. Affinity Health Plan implemented TirZetto’s Facets Enterprise Administrative System to allow for more efficient claims processing, membership enrollment and provider data maintenance, and access to customer records. Followed X12 EDI and HIPAA standards throughout the project.

**Responsibilities:**

* Performed GAP analysis as pertains to membership management and claims processing to evaluate the adaptability of the new application with the existing process
* Gathered and prioritized requirements using 1 to 1 interviews, job shadowing, brainstorming & developing questionnaires
* Translated business requirements into functional specifications and documented the work processes and information flows of the organization
* Created detailed use cases, use case diagrams, and activity diagrams using MS Visio
* Conducted requirement feasibility analysis with the developers to ensure the project was in scope with the timeline defined in the project plan
* Created data structures by using SQL in Teradata & TOAD.
* Developed SQLs for Extracting data from database and built data structures, reports
* Designed and developed various Ad hoc, Daily, Weekly, Monthly and year-end reports for the Business Analyst using SQL, Ms Excel, Ms Access and Teradata
* Understood EMEVS, the NY state's electronic Medicaid eligibility verification system & the Medicaid & Medicare intermediary along with their roles in claim processing
* Produced Activity diagrams with defined swim lanes as part of claims process analysis
* Developed prototype of new information processing application. Facilitated collection of functional requirements from system users and preparation of business requirement documents using Rational Requisite Pro.
* Used HIPAA Gateway to comply with HIPAA standards (270/271, 276/277 & 837) for EDI transactions
* Worked with FACETS, eBilling and EDI HIPAA Claims (837/835/834) processing.
* Coordinated with the developers and IT architects to design the interface of the new system according to the X12 (270, 276, 278, 834, 835, 837 (I,P,D) and 820) standards
* Contributed in the build and design of organizational Wiki that provided comprehensive knowledge of workflows, policies and procedures, patient care objectives, regulatory requirements, and industry best practices for membership management
* Took part in the meeting held for the analysis of migration to HIPAA 5010 from 4010 and migration of ICD9 codes to ICD10
* Worked on analysis of FACETS claims processing system and to gathered requirements to comply with HIPAA 5010 requirements
* Owned the business rules document which documented the business rules across different systems
* Involved with various aspects of the project's needs such as the logging, tracking, and resolution of issues, current state workflow assessments, assist with integration and script testing, downtime activities/testing
* The process included importing claims into Facets that had been adjudicated and setting them in a “PAY” status so that a payment cycle could be run to create checks on Facets.
* Created test plan, test data and conducted manual testing to validate functionality and performed regression testing
* Clarified to claims personnel the new Affinity payments and Explanation for payments (EOPs) for same claim processing cycle
* Designed and implemented complex SQL queries for QA testing and data validation
* Conducted user training pertaining to old and new Affinity Provider ID appearing on documents providers receive from Affinity (mainly occur with EOPs, capitation rosters, PCP membership rosters, provider directory listings and some system generated letters)