**Jyoti Ghale**

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**Summary:**

* 6+ years of experience in Software FACETS Configuration, clinical edits, corrected claims, claim processing and billing procedures and Quality 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.
* Experienced with end to end testing.
* 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 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.
* Experience in Manual for Executing Tests Manually, Defect Logging, Defect Reporting
* Expertise in Test Case Design, Test Tool Usage, Test Execution, and Defect Management
* Experience in all phases of Software Development life cycle such as Agile, Scrum and Waterfall.
* Experience in HealthCare applications for writing SQL statements to validate the database systems and for backend database testing.
* Experience in writing Test Plan and Test Strategies and performing ETL testing for Data Warehousing Applications.
* 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.
* Good team player and good team player with excellent Communication skills (Verbal and Technical), Presentation and reporting.

**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 2000/7/08/10, DOS, Unix, Mac OS |
| Defect Tracking Tools | Quality Center, Rational Clear Quest, Jira |
| Languages/Standards | SQL, XML, HTTP, HIPPA 4010/5010, ICD9/10, ANSIX12 |
| Methodologies | Agile, Waterfall |
| Healthcare Technology | Memb Membership & Billing Group Enrollment, Benefits Auditing, Facets, Configuration, EDI – 834/835/837/270 |

**Professional Experience:**

**Client: Independence Blue Cross, Philadelphia, PA March 2016 - Present**

### Position: QA Analyst

As an analyst, I was responsible for conducting the overall System Testing to verify operations of key Facets modules involved in the processing of claims (including benefits), providers and members. Also worked with FACET pended claims resolution and implementation of FACETS 5.3 and FACETS 5.4

**Responsibilities:**

* Tested new enrollment codes for the projects and releases to ensure the claims application engine produced the expected edits
* Wrote SQL procedures and Batch Processes.
* Wrote Test Plans, Test Scenarios, Test Cases and the Test Matrix.
* Analyzed and worked with MS SQL Server Test databases.
* 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
* 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.
* Worked on Premium Payment for enrolled health plan members, 834-Enrollment /Dis-enrollment to a health plan, 837- Health Care Claims and 278 Authorizations.)
* Recommend ways and workarounds for HIPAA 5010 (EDI X12 837,834,278,270) upgrades.
* Wrote Test scenarios and test cases for testing the 5010 and the processing of member enrollment and benefits, (834) batch jobs corresponding to the claims (837)
* 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.
* Executed FACETS Implementation, involved end to end testing of FACETS Billing, Claim Processing and Subscriber/Member module.
* 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, Guiding Care, Facets, Excel, SQL, DB2, Crystal Report, Quality Center.

**Client: CIGNA Healthcare, Raleigh NC**

**Position: QA /Facets Tester**

**April 2014 – Feb 2016**

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.
* Prepared Test Cases and Test Plans for the mappings developed through the ETL tool from the requirements.
* Validated the translated HIPAA files with the proprietary Common Claim Record implementations.
* Experiences working in ANSI x12 834/837/835 EDI Transaction.
* Was involved in testing the HIPPA EDI 834, 270/271, 837/835 transactions according to test scenarios and verify the data on different modules.
* 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 FACETS Implementation, involved end to end testing of FACETS Billing, Claim Processing and Subscriber/Member module.
* 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.
* Verified session logs to identify the errors occurred during the ETL execution.
* 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:** Agile,Oracle, HIPPA, EDI 5010, XML, QTP, Quality Center, Facets.

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

**Position: QA Analyst Duration:**

**Dec 2012 – March 2014**

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.
* 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
* Provided 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
* Executed Test cases manually by composing 834, 270, 276,837 EDI files and dropped inbound and check response 271,277,835 using interleaves and outbound.
* 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.
* Worked on Electronic health record system as a CRM web based application.
* Working Experience in Electronic Submissions in standard format.
* 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, Clear Quest, Excel, SQL, Crystal Report, Quality Center, MS Project, MS Office, IBM **DB2, Oracle on UNIX**, Enterprise Data Warehouse.

**Client: Florida Blue, Jacksonville**

**Position: QA Tester**

**Jan 2011 – Nov 2012**

Florida Blue’s vision—to be a leading innovator enabling healthy communities . It is the largest health care insurer in the Southeast region. Florida Blue has approximately 4 million health care members and serves 15.5 million people in 16 states. I worked on claim processing application such as diamond to process/adjudicate claims. The project responsibility involved working on 834/835/837 and 27X and formed the E2E process for all EDI transactions like 837 and 835.

**Responsibilities:**

* Developed Test Scenarios and Test Cases based on Business requirement document and functional requirement.
* Extensive knowledge and tested on different types of claims: Institutional and Professional.
* Tested HIPAA EDI Transactions such as 837(Institutional and Professional), 835, 834, 270, 271, 276, and 277 in various claims validation processes.
* Involved in applications analysis and testing which included claims processing as per EDI/ANSI-X12 transactions Standards.
* Performed Integration/System/Regression testing of enrollment and benefits with Diamond.
* Exposure and Knowledge to 834 benefits claims files testing in enrollment.
* Maintained and supported 834, 835 and 837 HIPAA EDI transactions.
* Responsible for testing EOB in accordance to business rules for claims processing.
* Involved in testing Claims, Providers, & Contracts and worked with Claims attributes, Provider attributes, enabling EOB.
* Utilized Quality Center to write and execute test cases.
* Involved in Integration Testing, Functional Testing, and UAT.
* Used quality center for logging defects and defect Tracking.
* Performed User Acceptance Testing (UAT), documented in details the defects using Quality Center.
* Perform back end testing writing SQL queries and extracted data.
* Skilled in executing SQL queries to validate and update database and retrieve data for testing.
* Involved in validating XML Files.

**Environment:** Agile**,** SQL Server 2005, Oracle, Quality Center, UML, MS Office, MS Excel, Toad, Clear Quest, UNIX.

**Education:**

University of South Alabama

Bachelors in Business Administration

Major: Management