# Professional Summary

* IT professional with over Seven years of experience as a Quality Analyst with an emphasis in the **healthcare** industry.
* Hands on experience gathering requirements, interviewing senior level company officials to gather requirements for documenting project functional specification.
* Wrote test scripts, technical specification documents, and worked on application’s input / output data definitions.
* Experienced in customer/client interaction, deep understanding of business systems functionality and technicality.
* Good knowledge of Health Insurance Plans (Medicare, managed care concepts (**Medicaid and Medicare**) and experienced in determining the membership eligibility, billing experience in health plans.
* **Healthcare exchange/Reform (HIX) project** in gathering requirements for enrolling ON Exchange Individual and SHOP group members
* Good Understanding of **HIX and Obama Care. Expertise** in HIPAA based on the rules/regulations of CMS and reflected the same changes in RTM for tracking purpose.
* **Provided healthcare provider problem resolution, including ICD-10, HCPCS; Procedures and diagnosis testing.**
* Used MS Excel spread sheet, PowerPoint, MS Visio, and MS Project.
* Expert in Agile software development and release management.
* Used **MDE Claims Test Pro** to create new suite of **Enrollments, Claims by extracting existing member data** from the **FACETS (Production Environment)**
* Skills in developing use case diagrams, sequence diagrams, state chart diagrams, and class diagrams.
* Expertise in **Claims, Subscriber/Member, Plan/Product, Claims, Provider and Billing Modules of Facets.**
* Worked with EDI X12 5010 as well as ANSI X12 4010 including medical transactions such as 837 (medical claims), 835 (medical claim payments), 270 (eligibility inquiry), 271 (eligibility response), 276 (claim status), 277 (claims status response).
* Experience in developing XML requests for Web Service Testing and validate response XML.
* Prepared unit test cases and performed unit testing.
* Extensive experience in Functional, Integration, Regression, User Acceptance (UAT), System, Load and Black Box testing.
* Good Management, Execution and Documentation skills.
* Expertise in all areas of software development including client interaction, analysis and tele-conferencing with the client during the progress of the project.
* Efficient in MS Project/MS Excel for planning/status reporting/writing test scenarios.

**Technical Skills**

Operating System: Windows Server, Windows, UNIX

Testing Tools: ALM/ Quality Center, Quick Test Professional, Rational Team Test

Bug Tracking Tools: ALM/Quality Center, Rational Clear Quest

Front - End Tools: Adobe Photoshop, MS Office, MS Project, MS Visio

Languages: C, C++, SQL, TSL, Visual Basic.NET, PL/SQL

Web Technologies: HTML, XML, .NET

Database: Oracle, MS SQL Server

**PROFESSIONAL EXPERIENCE**

**WellCare, Tampa, FL Mar 2014 – Present**

**Sr. QA /Facets Tester**

As a QA Analyst, I worked closely with project team to identify and interpret user’s business requirements, create test data for various test scenarios, develop and execute Test cases to validate whether different modules such as Provider, enrollment, claims and customer service are integrated successfully as per business requirements to the latest version of **FACETS**.

I handled here multiple enhancements for **HIX** EOB, plus some minor patches like:

* Multiple file output needed result in identical XML file headers
* Resolving Pharmacy totals not having been added into Subscriber annual totals
* The extract needed to log to database tables, down to the claim level
* Implementing the use of customized explanations for EXCD\_ID values
* Implementing configuration file application settings for included and excluded subscribers

Also I worked extensively on **EDI** files to create, modify, update or mock up the data for the claims in multiple Test Environments and I’ve

* Broader understanding of EDI X12 837 transactions system and routines.
* Been Processing mechanism of 837 (4010 & 5010) transactions, custom mappings, segments and translators etc.
* Familiarity in EDI claims inbound work flow and mapping routines for 837 4010 and 5010 transactions (Medical, Hospital & Dental).
* Proficiency in HIPAA & inbound claim load jobs, 835/837 related outbound jobs.

**Responsibilities**:

* Responsible for testing the Navigation Flow, Functionality Testing, System Testing and User Acceptance Testing.
* Prepare Test Data, Test scenarios, Test Scripts and executed Test Cases from Quality Center/ALM.
* Creating **SQL queries** for data validation.
* Performing manual **Back-end** testing on the application by writing complex **SQL queries**.
* Involved in reviewing complex **SQL queries**, **views**, **functions** and **stored procedures** and spotting issues before/during code migration.
* Validate the date from EDI transaction in the front end as well as back end.
* Testing of EDI 834, 837I ,837D and 835 Transaction sets for claims processing
* Tested 4010/5010 conversion EDI transactions, **834**, **837**, **835** etc.
* Involved in Processing **FACETS** 834 member enrollment EDI X12 Healthcare files in member PORTAL to validate enrolments and COC’s.
* Worked with providers and **Medicare or Medicaid entities to validate EDI transaction sets or Internet web portals**. This includes HIPAA 4010; 837, 835, 270/271, ACHA1104 (Affordable Healthcare Act)
* Involved in coordinating with SMEs to discuss different scenarios at the time of scripting Test Cases.
* Have good exposure to modern **Agile** Methodologies such as **SCRUM** and **TDD**.
* Participating/Facilitating **Defect Triage meetings** with developers and SMEs.
* Extensively involved in **Grooming sessions** within the team to discuss the complexity of the projects and **Sprint planning** to determine the time frame for the accomplishment of each task in that specific sprint.
* Creating several Test Cases and Test Conditions for testing various **Claims**, Enrollment, Billing and Provider reports.
* Worked on **EDI X12** transaction set 837 I/P/D, 276/277 feeds to allow for change in the claim number.
* Worked on **Members, Providers, Claims, Configuration and Payment Modules of FACETS.**
* Analyzed the **FACETS Requirements/BRD’s/Gap analysis**, then prepared test scenarios and test cases.
* Conducted Validations for different **FACETS modules Providers, Claims and Membership**
* Member and Provider Conversion, Created Keyword and EDI File and Modify the Member Data as per the Business Requirement Document and as per the test case.
* Extensively performing manual testing and defect reporting using HP Quality Center/ALM.
* Performing manual testing, considering the base line of developed test pl an and test cases considering both positive and negative scenarios.
* Test scenario identification and alignment of service oriented architecture implemented within the organization.
* Creating different pricing rules and verified whether the adjudication system is using the rules while adjudicating the **Claims.**
* Processed EDI/X12 (834, 820, and 837) test files and verified system is able to validate certified and non-certified trading partners.  Reconciliation calls for 834 files for the discrepancy.
* Involved in System and Regression testing for **278, 837 inbound** and **outbound** process**, 834 and 835** files for **Medical** and **Institutional Claims.**
* Responsible for testing of different Benefit terms and contract terms, according to Configuration library.
* Development of **SQL queries** as per the request of the business team in SQL server.
* Conducting Validations for different **FACETS** modules like **Providers, Claims** and **Enrollment**.
* Extensively involved in managing defects using Clear Quest and interacted with the DEV team in resolving critical and high defects.
* Extensively involved in **UAT support** for their execution and **Defect Triage**.

**Environment**: HP **ALM /Quality Center**, Trizetto **FACETS,** Trizetto **MDE**, Tidal, EncoderPro (OPTUM), SQL Server, SQL Server Reporting Tool, TOAD, **MS-Office,** MS SharePoint**.**

**Premera Blue Cross, Mountlake Terrace, WA Aug 2012 – Feb 2014**

**QA /Facets Tester**

I was working in Obama health insurance Exchange (HIX) project that was implemented by Premera. As per contract between Premera and State/Government, Premera developed this web based application. The project was based on 3 states WA\_HIX, AK\_HiX and OR\_HiX. I worked on Facets Subscriber/Member Enrollment Application system. Worked on **FACETS** claims processing system and worked on its different applications like enroll subscriber/member.

Premera was also enrolling members from Health Exchange as required by the Patient Protection and Affordable Care Act (PPACA). I worked as a Senior Quality Assurance Analyst and tested various systems and processes of this health exchange membership enrollment, account implementation and billing project.

**Responsibilities:**

* Review and analyze Business Requirement Documents (BRDs), Technical Requirement Documents (TRDs), and Conceptual Specification Design Documents (CSDs).
* Write Test Scenarios and Test Cases based on the BRDs, TRDs, CSDs, process flows, architectural diagrams and business needs. This activity included Individual and Group Setup in Members Edge; Health Exchange Payment (820); Health Exchange Enrollment (834), UCSW; IVR; Invoice & Billing activities.
* Create Test Data as required. Test Data was created for Standard Payments **(820) in ASC X12 005010X218** format; Health Insurance Exchange Related Payments **(820) in ASC X12 005010X306** format; Health Insurance Exchange Enrollment (834) in **ASC X12 005010X307** format; Setting up a new Health Exchange Groups /Individuals and perform Billing and Fulfillment activities
* Execute Test Cases for Individual and Group Setup in Health Exchange Enrollment **(834),** Health Exchange Payment **(820);** UCSW; IVR; Invoice & Billing activities.
* Analyzed User stories and developed test case negative and positive scenario and wrote the test cases.
* Involved in performing Functional, integration, and regression testing.
* Validate  **EDI 834** enrollment process according to **HIPAA** compliance
* Created various suites of enrollment process, claim process in Claims Test Pro by creating a keyword file and loading them to FACETS for testing.
* Prepared Test Plans and Test Cases based on the functional requirements and **HIPAA** regulations like 834, **837, etc.**
* Participated in the management of testing project with the help of QTP.
* Performed Manual Testing to check the usability of the application.
* Executed Configuration Testing to check if the application was compatible in different environment for each module of the application.
* Created test cases manually to perform different types of testing such as positive/negative, functional/regression, interface, black box, white box, performance testing, smoke/sanity testing, etc.
* Part of a team for testing **FACETS** Accumulators
* Involved in **FACETS** Implementation, involved end to end testing of **FACETS Billing, Claim Processing and Subscriber/Member module.**
* Set claim processing data for different **FACETS** Module.
* Tested **HIPAA** regulations in **FACETS HIPAA** privacy module.
* Conducted Back-End Testing manually for the purpose of Database Integrity.
* Developed test scripts in SQL to check the data integrity from the databases
* Bug Reporting and Tracking using **Quality Center**
* Performed User Acceptance Testing (UAT)
* Generated defect reports using **Quality Center** and presented using MS Office tools

**Environment: FACETS**, SQL plus, VB Script, MS Visio, XML, MS Outlook, Test Director, **Quality Center**, QTP

**Xerox State Healthcare, West Sacramento, CA Oct 2010 – July 2012**

**QA Tester (Facets)**

DHCS of CA needed to comply with the U.S. Department of Health and Human Services (HHS) published implementation date of the 10th revision for the International Classification of Diseases (ICD-10). The move to ICD-10 version required significant changes across the operations of the enterprise including departments like Pre-Authorization, Claim adjudications and Provider reimbursement. The conversion of ICD-9 to ICD10 codes required rigorous and complex testing execution plan completed prior to the compliance date to ensure that DHCS of CA can operate in a “business as usual” status post October 1st, 2014 (Lately changed to October 1st, 2015) . **FACETS** is used for Membership and Claims Management Information tracking System, Finance and Utilization management System modules.   I was also involved in various kinds of testing of the **FACETS** application modules like Enrollment, Membership, Provider, Subscriber and Claims.

**Responsibilities:**

* Developed Test scenarios, Test Scripts and Test cases based on Requirements, DSD’s and GAP documents.
* Involved in coordinating with SME to discuss different scenarios at the time of scripting Test Cases.
* Involved in End to End testing of **FACETS Billing, Claim Processing and Subscriber/Member module.**
* Extensive experience in testing **FACETS applications** mainly in **Provider, Group, subscriber/Family, membership and billing.**
* Good experience working with **Claims Processing, Subscriber/Member and Provider** applications.
* Created various suites of enrollment process, claim process in Claims Test Pro by creating a keyword file and loading them to **FACETS** for testing.
* Worked on Data Validation and Data Verification for Crosswalk Mapping File on CICS Screens.
* Worked on code validation on ICD9 & ICD10 in UPDATE File for Crosswalk Mapping File.
* Worked on creating specifications for transitioning business from HIPAA 4010A to 5010 and from ICD-9 to ICD-10.
* Tested EDI transactions, 834, 837, 835, etc. for scenarios after ICD-10 implementation.
* Tested claim using DDE and X-12 files through Online Portal.
* Exposed to using ICD 9/ICD 10 coding standards in Medicare and Medicaid domains of the healthcare systems and industry for inpatients, outpatients, reimbursement methodology.
* Created Job Aid for UPDATE Process of Crosswalk Mapping File.
* Organized training sessions for more than 40 Team members to develop the understanding on Update Process of Crosswalk Mapping File.
* Tracked to resolution all UAT environment and data test issues before code is released for test.
* Executed test cases, and test scenarios for **User Acceptance (UAT**), Functional and Regression test cases.
* Used SQL for back end testing and ensured the data is updated accordingly.
* Closely interact with clients for **User Acceptance Testing. (UAT**).
* Gathered and validated inventory of applications, interfaces, and reports that will need to be modified to comply with ICD-10 requirements**.**
* Change requests are made using Quality Center.
* Extensively involved in managing defects using Quality Center and interacted with DEV team in resolving critical and high defects.
* Extensively involved in UAT for execution and Defect Triage.

**Environment: FACETS, Quality Center, Test manager, Clear Quest web,** SQL Server, MS Office

**Unicare, Inc., Chicago IL Mar 2008 to Sep 2010**

**Quality Analyst**

Unicare Health Insurance Company is one of the health insurers in the United States. Worked on Claims management system. Worked particularly on analyzing Facets interfaces. Duties included working with claims module and processing them for various scenarios. As an analyst, worked on various projects to construct and verify data requirements. Experiences working in ANSI x12 270-271 EDI transactions. Involved in EDIs according to HIPAA code set 834 enrollment and disenrollment in a health plan using QTP. Involved in documenting EDIs according to code set X12 835 Claim Payment and Remittance Advice Claims processing and 837 Claim transactions.

* Created testing documentation as needed such as test plan/ test strategy and how to setup manual or automated test cases.
* Worked with both and provide training for any new users using Mercury Quality Center and Quick Test Professional.
* Created Use Case diagrams using UML and Business Process Models using MS-Visio.
* Responsible for Business Process Management (BPM) for development of various projects.
* Participated in providing implementation assessment for Rational RequisitePro, Rational ClearQuest using Unified Modeling Language (UML) and Rational Unified Process (RUP).
* Developed Use Cases, Sequence Diagrams, Activity Diagrams and Class Diagrams.
* Assisting the project manager in creating detailed project plans and scheduling and tracking project timelines.
* Also worked on implementation of Patient Protection and Affordable Care Act for Medicaid.
* Recommended changes for system design, methods, procedures, policies and workflows affecting Medicare/Medicaid claims processing in compliance with government compliant processes like HIPAA/ EDI formats and accredited standards ANSI.
* Involved in **Facets** implementation, involved end to end testing of Facets Billing, Claim Processing and Subscriber/Member module.
* Set claim processing data for different **Facets** modules.
* Worked as the primary liaison between the business user and the developers throughout the project cycle.
* Worked with various Business Intelligence tools for reporting and decision making.
* Performed Gap Analysis to identify the deficiencies of the current system and to identify the requirements for the change in the proposed system.
* Handled changes at each stage of project development.
* Documented Requirement Traceability Matrix in Requisite Pro for traceability of requirements.
* Scheduled meetings with developers, System Analyst's (SA) and Testers to identify resource allocation and project completion using MS Project.
* Assisted the Project Manager in setting realistic project expectations, in evaluating the impact of changes on the organization and plans accordingly, and conducted project related presentations.
* Provided technical assistance in identifying, evaluating, and developing systems and procedures that were cost effective and met business requirements.

**Environment:** Rational Requisite-Pro, **Facets**, Rational Clear-Quest, RUP, MS Office, MS-Project, MS Visio, QTP, Quality Center.