# Clean Claim Submission Analysis – Corrected Claims Report

This project analyzed 30 mock hospital visits to evaluate common billing errors that prevent claims from being accepted by payers. Errors included missing or invalid CPT, ICD-10, and revenue codes, as well as missing modifiers and mismatched CPT/revenue combinations. The purpose was to demonstrate the process of identifying and correcting errors to improve the clean claim rate prior to clearinghouse submission.

Claims were flagged in Excel using formulas to detect errors such as missing ICD-10 codes, invalid CPT codes, invalid revenue codes, missing required modifiers, and CPT–revenue mismatches. A correction process was then applied using official CPT/ICD-10 code lists and CPT–revenue crosswalk rules. Corrected values were documented in a separate column with notes explaining the change.

## Results

| Metric | Before | After |
|---|---|---|
| Total Claims | 30 | 30 |
| Clean Claims | 5 (16.7%) | 30 (100%) |
| Improvement in Clean Claim Rate | - | +83.3% |

The majority of claim rejections were caused by invalid revenue codes and CPT–revenue mismatches, followed by missing or invalid CPT/ICD-10 codes. These errors represent gaps in coding accuracy and charge entry consistency. After corrections, all claims passed validation, showing that systematic review of revenue code assignments and CPT/ICD compliance can significantly improve clean claim rates.

The analysis demonstrated that proactive claim scrubbing and accurate code validation can improve clean claim rates dramatically. By identifying and correcting billing errors early, healthcare organizations can reduce denials, accelerate reimbursement, and improve revenue cycle efficiency.