MBS
MEDICAL BILLING
SERVICES

PLAYBOOK · 2026 EDITION

# The Clean Claim Playbook

Front-end discipline that holds first-pass resolution where it belongs.

Written for: Practice administrators and billing managers

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# Why clean claims start at the front desk

A clean claim is one the payer accepts and adjudicates on first submission without edits, requests for information, or rework. Most avoidable rejections are not coding mysteries. They are small front-end errors: a wrong subscriber ID, a lapsed authorization, a missing modifier, or a diagnosis that does not support the service billed.

Every claim that bounces costs staff time to fix, delays cash, and risks crossing a timely-filing deadline. The practices with the highest first-pass rates treat claim quality as a front-end process, not a back-office clean-up job.

### What this playbook covers

- The five pre-submission checks behind most avoidable rejections
- Where eligibility and benefit verification should sit in the visit workflow
- A worked example of first-pass resolution rate and what moves it
- A one-page audit you can run against your last 100 claims

# The five pre-submission checks

Build these into your workflow so every claim passes them before it reaches the clearinghouse.

| Check | What to confirm | Common failure |
|---|---|---|
| 1. Patient & subscriber data | Legal name, DOB, member ID, and relationship match the payer card exactly | Nickname used, dependent billed under wrong subscriber |
| 2. Eligibility & coverage | Active coverage on the date of service, correct plan and payer ID | Coverage termed, patient changed plans mid-year |
| 3. Authorization & referral | Auth number on file, covers the CPT codes, units, and dates billed | Auth expired or covers fewer visits than billed |
| 4. Coding accuracy | CPT/HCPCS, modifiers, and ICD-10 codes are valid and support medical necessity | Missing modifier 25 or 59, unspecified diagnosis |
| 5. Provider & place of service | Rendering and billing NPI, taxonomy, and POS are correct and enrolled | Provider not yet credentialed with the payer |

### Make the checks automatic

- Use clearinghouse and practice management scrubber edits for format and code validity.
- Add payer-specific rules for your top payers. They cause the majority of your volume.
- Hold claims that fail any check in a work queue with a named owner, not a shared inbox.
- Review scrubber rules each quarter against your actual rejection reasons.

# Where eligibility belongs in the visit

Verification done at check-in is too late to fix a problem without friction. The strongest workflows verify in three passes:

| When | What to do |
|---|---|
| At scheduling | Capture insurance details, run a real-time eligibility check, and flag services that need authorization. |
| 48–72 hours before the visit | Re-verify coverage and benefits, confirm the authorization is approved, and estimate patient responsibility. |
| At check-in | Scan the current card and ID, confirm demographics, and collect the copay or estimated balance. |

## Benefit details worth recording

- Deductible met and remaining, copay, and coinsurance for the visit type
- Visit limits (for example physical therapy or behavioral health session caps)
- In-network status for the rendering provider, not just the practice
- Coordination of benefits: which plan is primary when two apply

# Worked example: first-pass resolution rate

**First-pass resolution rate** = claims paid or correctly adjudicated on first submission ÷ total claims submitted in the period.

Illustrative figures only.

| Month | Claims submitted | Resolved first pass | Rate |
|---|---|---|---|
| Baseline | 2,000 | 1,780 | 89.0% |
| After eligibility re-verify added | 2,000 | 1,850 | 92.5% |
| After auth tracking added | 2,000 | 1,905 | 95.3% |

In this example, the two fixes cut first-pass failures from 220 to 95 a month. At roughly 15–20 minutes of rework per failed claim, that frees 30–40 staff hours every month and brings cash in weeks sooner.

## What moves the number

- Registration accuracy and eligibility re-verification (largest lever for most practices)
- Authorization tracking tied to scheduled services and units
- Payer-specific scrubber edits for your top five payers
- Coder feedback loops: rejected claims reviewed with the person who coded them

# The 100-claim audit

Pull your last 100 submitted claims (or every rejected claim from the last 30 days). For each one, record whether it passed each check. The pattern tells you where to spend effort first.

| Audit question | Tally |
|---|---|
| Patient/subscriber data exactly matched the payer card? | Yes ___ No ___ |
| Eligibility verified within 72 hours of the visit? | Yes ___ No ___ |
| Required authorization on file and matching services billed? | Yes ___ No ___ N/A ___ |
| Codes and modifiers valid and supported by documentation? | Yes ___ No ___ |
| Rendering provider enrolled with the payer on the DOS? | Yes ___ No ___ |
| Claim submitted within your target days from DOS? | Yes ___ No ___ |
| Accepted on first submission? | Yes ___ No ___ |

## Reading the result

- Any single check failing on more than 5 of 100 claims is your first project.
- Registration and eligibility failures point to front-desk training and timing.
- Coding failures point to documentation templates or coder education.
- Enrollment failures point to credentialing. See *Credentialing Timelines That Hold*.

## Controls that keep the rate high

- ☐ Weekly rejection report reviewed by the billing lead
- ☐ Named owner for every rejection category
- ☐ Quarterly scrubber rule review
- ☐ New-staff registration training with a short sign-off quiz

# Want this run against your own numbers?

MBS can walk through your first-pass resolution, denial categories, and aged A/R with you using your own data. Request a custom billing review at **www.mbsrcm.com/contact**, or try the free A/R & Denial Benchmark at **www.mbsrcm.com/tools/ar-denial-benchmark**.

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