Auxee

The Ultimate Prompt Cheat Book for RCM

10 ready-to-use prompts that turn RCM pain into pay

General Prompting Tips and Tricks

1. Start with roles: Begin prompts with “Act as a [specific role]” (e.g., Denial Management Specialist, Revenue Integrity Analyst) for more accurate outputs.
2. Structure the response: Add “Step by step” or “Give me a checklist” to get usable workflows.
3. Cut the fluff: Use “No fluff” to keep answers practical.
4. Control length: Say “Summarize in 3 bullets” or “Keep under 200 words.”
5. Choose the format: Ask for tables, checklists, or CSVs for direct use in RCM workflows.
6. Make it actionable: Add “Provide next steps” to convert analysis into tasks.
7. Set timeframes: Example: “Focus on payer policy changes in the last 12 months.”
8. Tailor for audience: Ask, “Simplify this for front desk staff” or “Expand for coder training.”
9. Refine outputs: Use follow-ups like “Have you covered all critical aspects?” or “Rank these fixes by impact.”
10. Highlight exceptions: Request “List the top 5 exceptions or edge cases I should watch for.”
11. Test for accuracy: Ask “Where could this output be wrong?” or “What are the limitations?”
12. Turn into training: Prompt with “Reframe this as a training script for new billing staff.”
13. Scenario testing: Use “If denial rates rise 10%, what’s the projected impact?” to explore what-ifs.

Contents

Mining 835 files for six-figure savings that stick

Prompt

Act as a **Revenue Integrity Specialist** with deep expertise in payer contracts, medical coding, and underpayment detection. Your task is to mine 835 ERA files for underpayments and hidden revenue leakage. Please provide:

- **Discrepancy Detection:** Flag all claims where the *paid amount* is less than the *expected contractual amount*.
- **Dollar Impact:** Calculate the total underpayment dollars across the batch and rank by payer and CPT/HCPCS code.
- **Patterns & Hotspots:** Identify repeat offenders (payers, service lines, codes) where underpayments consistently occur.
- **Root Cause Insights:** Suggest why these underpayments may be happening (e.g., bundling logic, modifier denials, contract misalignment, timely filing misapplied).
- **Action Plan:** Deliver a prioritized roadmap for recovery — which claims to appeal first for the fastest ROI, and which payer issues to escalate for systemic fixes.
- **Stickiness Check:** Recommend process or automation rules that ensure once corrected, these savings *stick* going forward.

My expected output - A summary dashboard with:

- Total underpayment dollars found.
- Top 5 payers by underpayment impact.
- Top 5 CPT/HCPCS codes most affected.
- Quick-hit appeals list (*Claim ID | Expected vs Paid | $ Underpaid | Payer*).
- 3 “make it stick” automation rules to prevent repeat losses.

What you need to provide as a file attachment:

1) **835 ERA file(s) with the following fields:**
    a. Claim ID
    b. CPT/HCPCS code
    c. Paid amount
    d. Allowed/expected amount (per contract or historical benchmark)
    e. Payer name
2) **Contract fee schedule** (to calculate expected reimbursement).
3) **Optional:** Denial reason codes or adjustment codes for deeper root cause analysis.

Sample Output

Summary Dashboard

Total Underpayment Dollars Found: $187,400 across 2,150 claims

Top 5 Payers by Underpayment Impact:

1. UnitedHealthcare – $62,700
2. Aetna – $45,300
3. Cigna – $32,600
4. Blue Cross – $26,800
5. Medicare Advantage Plan X – $20,000

Top 5 CPT/HCPCS Codes Most Affected:

1. 99213 (Office Visit, Est.) – $41,200
2. 27447 (Knee Arthroplasty) – $36,800
3. D4341 (Scaling & Root Planing) – $28,400
4. 93000 (EKG) – $23,600
5. 99285 (ER, Complex) – $20,900

Quick-Hit Appeals List (High-Value Claims)

Claim ID	CPT/HCPCS	Expected	Paid	$ Underpaid	Payer	Reason Code	Appeal Priority
1837264	27447	$12,000	$9,500	$2,500	Aetna	CO-45	HIGH
1987342	99213	$120	$90	$30	UnitedHealthcare	CO-97	MEDIUM
2019833	93000	$150	$80	$70	Blue Cross	CO-29	HIGH
2098733	D4341	$320	$200	$120	Cigna	CO-45	HIGH
2139845	99285	$1,250	$950	$300	Medicare Adv. X	CO-97	HIGH

Root Cause Insights

- Modifier -25 issues: Payers systematically downcoding office visits when billed with procedures.
- Bundling errors: Certain EKGs bundled incorrectly despite contract carve-outs.
- Contract misalignment: Aetna contract update not reflected in system fee schedules.

Make-It-Stick Automation Rules

1. Auto-flag any claim where Paid < Allowed by >5% for audit before posting.
2. Real-time fee schedule match: push claims through a contract validation engine pre-posting.
3. Recurring payer discrepancy tracker: monthly dashboard showing payer underpayment trends.

Clean Claim Readiness Check

Prompt

Act as a **Revenue Integrity Specialist** with expertise in payer requirements, claim scrubbing, and front-end denial prevention. Your task is to analyze a batch of pre-submission claims and ensure they are clean, accurate, and ready for first-pass approval. Please provide:

- **Error Detection:** Flag missing or invalid data such as subscriber ID, member DOB, provider NPI, place of service, or authorization number.
- **Coding Alignment:** Check diagnosis–procedure consistency, modifier sequencing, NCCI edits, frequency limitations, and units validation.
- **Eligibility & Coverage:** Identify eligibility mismatches, inactive coverage on date of service, and out-of-network plan flags.
- **Pre-Authorization Controls:** Detect procedures requiring prior authorization that are missing or expired.
- **Clean Claim Fixes:** Recommend specific corrections for each error category, and note the responsible role (front desk, coder, biller).
- **Quick Wins:** Highlight the 3 most impactful low-effort changes that would improve clean claim rates immediately.
- **Effort vs. Impact:** Rank fixes from highest to lowest based on their ability to prevent rejections and denials.
- **Action Plan:** Deliver a pre-submission checklist my RCM team can run daily to ensure claim readiness.

Expected Output:

- **A dashboard summary** with error counts by category.
- **A table of fixes with** columns: *Error | Correction | Responsible Role | Priority*.
- **A short daily checklist** for staff (4–5 steps).
- **A Quick Wins** list that ties directly to cash flow improvement.

What you need to provide as a file attachment:

- A batch of pending claims with: CDT/CPT code, modifiers (if applicable), ICD-10 codes, demographics, provider NPI, subscriber ID, payer.
- Optional: Eligibility verification files and auth/pre-auth logs.

Sample Output

Summary Dashboard

Total Claims Reviewed: 400
Potential Errors Detected: 68 (17%)

Top 5 Error Categories:

1. Missing subscriber ID or DOB mismatch – 20
2. Invalid or missing ICD-10 code – 15
3. Frequency limitations exceeded (D1110/D1120) – 12
4. Missing or expired prior authorization – 11
5. Modifier sequencing/NCCI edit conflicts – 10

Error Fixes & Responsible Roles

Error	Correction	Responsible Role	Priority
Missing subscriber ID	Verify patient file matches payer enrollment	Front Desk	High
DOB mismatch	Correct date of birth in demographics	Front Desk	High
Invalid ICD-10 linkage	Ensure diagnosis matches procedure per payer policy	Coder	High
Expired pre-authorization	Resubmit with updated authorization number	Biller	Medium
NCCI edit conflict	Re-sequence modifiers (e.g., -25, -59) per CMS rules	Coder	Medium
Frequency violation (prophy)	Confirm service interval compliance before resubmission	Front Desk	Medium

Quick Wins

1. Add auto-validation for subscriber ID/DOB before submission.
2. Require tooth/surface and ICD-10 linkage fields for all restorative and perio codes.
3. Embed frequency limit rules in billing software to flag preventive services billed too soon.

Pre-Submission Daily Checklist

1. Verify patient demographics: subscriber ID, DOB, coverage status.
2. Confirm ICD-10 diagnosis codes align with procedures.
3. Check for active/valid authorizations on all pre-auth procedures.
4. Validate coding edits (modifiers, frequency, NCCI rules).
5. Run final scrub for missing tooth numbers, surfaces, or quadrant details.

Denial Root Cause Analysis

Prompt

Act as a **Denial Management Specialist** with expertise in payer rules, coding, and RCM operations. Your role is to analyze a batch of denied claims and uncover the underlying root causes that are driving denials. Please provide:

- **Denial Categorization:** Group denials by type (e.g., eligibility, coding, documentation, medical necessity, timely filing).
- **Root Cause Analysis:** Explain the true cause behind each category (e.g., front desk data errors, missing attachments, incorrect modifiers, payer misapplication of policy).
- **Dollar Impact:** Quantify the financial impact of each denial category.
- **Prevention Strategies:** Recommend specific fixes and edits that would have prevented the denial (including system rules, staff training, or automation).
- **Effort vs. Impact:** Rank recommendations by effort required vs. dollars recovered.
- **Responsible Role:** Assign ownership for prevention (front desk, coder, biller, provider).
- **Action Plan:** Deliver a step-by-step denial prevention playbook for RCM teams to reduce repeat issues.

Expected Output:

- **A dashboard summary** showing denial categories, counts, and dollars lost.
- **A table with:** *Denial Category | Root Cause | $ Impact | Fix | Responsible Role | Priority.*
- **A ranked list of prevention strategies** (quick wins vs. systemic fixes).
- **A daily/weekly checklist** to ensure lessons learned are applied.

What you need to provide as a file attachment:

A batch of **denied claims** with denial codes (CARC/RARC), payer name, CPT/CDT, dollar amounts, and denial reasons.

Optional: **835/837 files** or payer denial letters for deeper insight.

Sample Output

Summary Dashboard

Total Denied Claims Reviewed: 275
Total Denied Dollars: $82,600

Top 5 Denial Categories:

1. Eligibility/coverage issues – $26,400 (32%)
2. Coding errors (ICD-10/CDT mismatches, modifiers) – $19,800 (24%)
3. Missing or expired prior authorization – $14,200 (17%)
4. Documentation/attachments missing – $12,500 (15%)
5. Timely filing denials – $9,700 (12%)

Denial Root Cause Table

Denial Category	Root Cause	$ Impact	Fix	Responsible Role	Priority
Eligibility issues	Front desk not verifying active coverage on DOS	$26,400	Run real-time eligibility check at check-in	Front Desk	High
Coding errors	Diagnosis code not linked to procedure; incorrect modifier sequencing	$19,800	Coder training + auto-validator for NCCI edits	Coder	High
Missing prior authorization	Authorization expired or not attached	$14,200	Pre-auth tracker with alerts in scheduling system	Biller	Medium
Documentation missing	Required perio chart or radiographs not submitted	$12,500	System prompt to attach documentation before submission	Provider/Front Desk	Medium
Timely filing	Claims not submitted within payer deadline	$9,700	Dashboard to monitor claims aging; automated reminders	Biller	Medium

Ranked Prevention Strategies

1. Implement real-time eligibility checks at scheduling and day-of-service (High impact, low effort).
2. Embed NCCI and modifier validation rules into claim entry workflow (High impact, medium effort).
3. Add pre-auth tracker that alerts staff 7 days before expiration (Medium impact, low effort).
4. Require attachment checklist for perio, oral surgery, and implant claims (Medium impact, medium effort).
5. Automated claims aging report to prevent timely filing issues (Medium impact, low effort).

Denial Prevention Playbook (Weekly Checklist)

1. Run eligibility reports daily and flag inactive coverage before claim submission.
2. Validate ICD-10 linkage and modifier use against payer policies.
3. Confirm active prior authorization on all high-cost procedures.
4. Attach required documentation (perio charts, radiographs, narratives) before submission.
5. Monitor pending claims >20 days old to avoid timely filing risk.

Days in A/R Reduction

Prompt

Act as a **Cash Flow Analyst** with expertise in payer performance and accounts receivable. Your role is to analyze outstanding A/R and design interventions to reduce median days in A/R while freeing up working capital. Please provide:

- **A/R Categorization:** Break down A/R by payer, claim type, and age buckets (0–30, 31–60, 61–90, 90+ days).
- **Root Cause Analysis:** Explain the drivers of aging (e.g., missing attachments, secondary billing delays, payer no-response, eligibility mismatches, untimely follow-up).
- **Dollar Impact:** Quantify the financial exposure tied to each aging bucket and payer segment.
- **Acceleration Strategies:** Recommend fixes to shorten resolution times (e.g., proactive attachment submission, payer-specific escalation workflows, faster secondary billing).
- **Automation Opportunities:** Identify automation rules to prevent delays (auto-flagging aged claims, auto-generating secondary claims, prioritizing high-dollar claims).
- **Effort vs. Impact:** Rank interventions by days removed from median A/R and total dollars accelerated into cash.
- **Responsible Role:** Assign ownership for implementing each fix (front desk, biller, coder, follow-up team).
- **Action Plan:** Deliver a step-by-step "A/R Sprint Playbook" RCM teams can run weekly to continuously lower median days in A/R.

Expected Output:

- **A dashboard summary** showing A/R by age bucket, payer, and dollar amount.
- **A table with:** A/R Driver | Root Cause | $ Impact | Fix | Responsible Role | Priority.
- **A ranked list** of acceleration strategies (quick wins vs. systemic fixes).
- **A weekly A/R Sprint Checklist** to ensure consistent reduction in days outstanding.

What you need to provide as a file attachment:

- An A/R aging report (at least 90 days) segmented by payer, claim type, and dollar value.
- Historical payment lag data by payer (primary vs. secondary).
- Outstanding dollar amounts tied to aged claims.
- Optional: workflow notes on attachment delays, secondary billing, or payer follow-up cadence.

Sample Output

Dashboard Summary:

- 0–30 Days: $1.2M (45%)
- 31–60 Days: $700K (25%)
- 61–90 Days: $450K (15%)
- 90+ Days: $300K (15%)

Payer Breakdown:

- Delta Dental: Avg. 45 days, $600K outstanding
- Aetna: Avg. 38 days, $400K outstanding
- UnitedHealthcare: Avg. 29 days, $350K outstanding

Table Example

A/R Driver	Root Cause	$ Impact	Fix	Responsible Role	Priority
Secondary Billing Delays	Claims not refiled within 24h	$150K	Automate secondary claim generation	Biller	High
Missing Attachments	EOB/clinical notes not attached	$100K	Embed attachment checklist at submission	Coder	Medium
No Payer Response	Follow-up not triggered until 60d	$200K	Auto-flag claims >30d with no response	Follow-up Team	High

Ranked Acceleration Strategies

1. Auto-flag no-response claims >30 days (High impact, low effort)
2. Automate secondary claim filing within 24 hours (High impact, medium effort)
3. Embed attachment checklist to prevent rejections (Medium impact, low effort)
4. Train staff on payer-specific follow-up cadence (Medium impact, medium effort)
5. Implement escalation matrix for payers >45 days (High impact, high effort)

Weekly A/R Sprint Checklist

- Review all claims >30 days by payer and dollar amount
- Escalate high-dollar claims >45 days
- File all secondary claims within 24h of primary payment
- Verify attachments before claim submission
- Generate weekly A/R dashboard for leadership

Work Effort Reducer

Prompt

Act as a **Workflow Optimization Specialist** with expertise in healthcare RCM operations. Your role is to analyze claim workflows and staff activities to identify areas where manual effort can be reduced without sacrificing accuracy or compliance. Please provide:

Task Inventory

- Break down repetitive staff tasks across the claim lifecycle (front-end data entry, eligibility checks, coding edits, follow-ups, secondary billing).

Effort Quantification

- Estimate staff hours currently spent on each task category.

Automation & System Rules

- Recommend automation, batching, or EHR/PM system rules that can reduce touchpoints (e.g., auto-posting, automated eligibility checks, bulk secondary claims).

Low-Value vs. High-Value Work

- Flag tasks that consume effort but don't drive cash acceleration, and reallocate staff to higher-value activities.

Effort vs. Impact

- Rank recommendations by hours saved vs. impact on claim outcomes.

Responsible Role

- Assign ownership for implementing changes (front desk, coder, biller, manager, IT).

Action Plan

- Deliver a 30-day workflow optimization playbook that reduces staff hours spent on avoidable rework and claim touchpoints.

Expected Output

- A time-savings dashboard summarizing effort by task and estimated hours reduced.
- A table with: Task | Current Hours | Automation/Rule | Hours Saved | Responsible Role | Priority.
- A ranked list of quick wins (e.g., eligibility auto-checks) vs. longer-term system changes.
- A 30-day checklist to implement high-impact fixes.

What you need to provide as a file attachment:

- A time-and-task log of staff activities (front desk, billing, coding, follow-up).
- Workflow notes on current EHR/PM system capabilities.
- Optional: Benchmark productivity reports or staffing ratios for context.

Sample Output

Dashboard Summary

Total Staff Hours Saved (Monthly): 120 hours (~0.7 FTE)

Top Contributors: Eligibility auto-checks, auto-secondary claims, bulk claim status checks.

Table Example

Task	Current Hours	Automation/Rule	Hours Saved	Responsible Role	Priority
Eligibility verification	40	Automated nightly eligibility batch	30	Front Desk / IT	High
Secondary claim submission	25	Auto-generate secondary claim within 24 hrs	20	Biller	High
Claim status follow-up	30	Bulk payer portal queries	15	Biller	Medium
Coding validation	20	NCCI edit auto-check	10	Coder	Medium
Manual payment posting	15	ERA auto-posting rules	10	Biller	High

Ranked Recommendations

1. Automate eligibility verification (saves 30 hours/month, immediate impact).
2. Auto-generate secondary claims (saves 20 hours/month).
3. Implement ERA auto-posting rules (saves 10 hours/month, improves accuracy).
4. Bulk claim status checks (saves 15 hours/month).
5. Coding edit automation (saves 10 hours/month, reduces errors).

30-Day Checklist

- Week 1: Enable nightly eligibility auto-checks.
- Week 2: Configure secondary claim automation rules.
- Week 3: Roll out ERA auto-posting for top 5 payers.
- Week 4: Train staff on reduced manual follow-ups and reassign hours to denial prevention.

Payment Variance Spotter

Prompt

Act as a **Contract Compliance Analyst** with expertise in payer reimbursement rules and underpayment detection. Your role is to identify hidden payment variances that erode revenue. Please provide:

- **Variance Detection:** Compare actual payments against contracted rates (allowables by CPT/CDT, modifiers, units). Flag both underpayments and overpayments.
- **Variance Categorization:** Group variances by cause (e.g., fee schedule mismatch, incorrect bundling, missing secondary payment, payer miscalculation).
- **Dollar Impact:** Quantify total dollars lost and highlight the top CPT/CDTs and payers driving the gap.
- **Root Cause Analysis:** Explain whether variances stem from payer error, incorrect claim coding, late secondary filing, or system configuration.
- **Recovery Opportunities:** Provide a prioritized list of claims to appeal or rebill, with dollar amounts at stake.
- **Prevention Strategies:** Recommend contract load checks, system rules, and automation (e.g., auto-flagging claims >2% below contracted rate).
- **Effort vs. Impact:** Rank fixes by potential dollars recovered vs. complexity to implement.
- **Responsible Role:** Assign ownership for recovery and prevention (billing staff, payer relations, revenue integrity).
- **Action Plan:** Deliver a step-by-step playbook for RCM teams to run a monthly payment variance check.

Expected Output:

- **A variance dashboard:** Total variances, payer breakdown, top CPT/CDTs, total $ lost.
- **A table with:** *CPT/CDT | Expected $ | Paid $ | Variance $ | Root Cause | Responsible Role | Recovery Priority*.
- **A ranked list of prevention strategies** (quick wins vs. systemic).
- **A monthly checklist** for variance monitoring and appeals.

What you need to provide as a file attachment:

A batch of 835 files (ERA) or remittance reports with CPT/CDT, units, paid amounts, and payer details.

Optional: Contract fee schedules for validation.

Sample Output

Variance Dashboard Summary

- Total Variances Detected: $124,560
- Underpayments: $112,430
- Overpayments: $12,130

- Top 3 Payers Driving Variances: Delta Dental, Aetna, Cigna
- Top 3 CPTs Impacted: D2740 (Crown, porcelain/ceramic), D4341 (Scaling & root planing, per quadrant), D1110 (Adult prophylaxis)

Variance Table

CPT/CDT	Expected $	Paid $	Variance $	Root Cause	Responsible Role	Recovery Priority
D2740	$850	$720	-$130	Fee schedule mismatch	Payer Relations	High
D4341	$190	$160	-$30	Bundling error	Biller	Medium
D1110	$95	$100	+$5	Overpayment – payer system error	Billing Staff	Low

Ranked Prevention Strategies

1. Load updated payer fee schedules quarterly (Quick Win).
2. Automate variance flagging in PMS/EDI software (Systemic Fix).
3. Train billing staff on top 10 variance-prone procedures (Quick Win).
4. Escalate repeat payer errors via contract compliance team (Systemic Fix).

Monthly Variance Monitoring Checklist

- Run variance report across all payers and CPTs.
- Validate top 10 underpaid CPT/CDTs against contract.
- Appeal underpayments >$50.
- Review and correct system configuration for recurring variances.
- Send variance summary to leadership for accountability.

Authorization & Eligibility Gaps

Prompt

Act as a **Revenue Integrity Specialist** with expertise in eligibility, coverage validation, and payer prior-authorization rules. Your role is to prevent denials and patient balance surprises by identifying missing or invalid eligibility and authorization data before services are rendered. Please provide:

- **Gap Detection:** Identify claims or scheduled procedures with inactive coverage, missing subscriber data, expired prior authorization, or plan exclusions.
- **Root Cause Analysis:** Explain the reasons (e.g., staff skipped eligibility check, wrong payer loaded, auth expired).
- **Dollar Exposure:** Estimate potential lost revenue tied to each gap.
- **Prevention Strategies:** Recommend fixes, such as real-time eligibility ping, prior auth expiration alerts, or EHR rules.
- **Effort vs. Impact:** Rank each prevention strategy by ease vs. dollars protected.
- **Responsible Role:** Assign ownership (front desk, scheduling, auth team, biller).
- **Action Plan:** Deliver a pre-service checklist that RCM teams can run daily to avoid eligibility/auth-related denials.

Expected Output

- **A dashboard summary showing:** Eligibility errors | Auth gaps | Estimated $ at risk.
- **A table:** *Gap Type | Root Cause | $ Impact | Fix | Responsible Role | Priority*.
- **A ranked list of prevention strategies**.
- **A daily checklist** for front-desk/auth staff.

What you need to provide as a file attachment:

Scheduled appointments or pre-submission claims with CPT/CDT, payer info, subscriber/member data, and authorization numbers.

Optional: Eligibility response files (270/271) or prior auth logs for deeper analysis.

Sample Output

Dashboard Summary

Analysis of 1,200 claims flagged 145 cases (12%) with eligibility or prior authorization issues. Total at-risk revenue: $485,000. High-impact categories include missing pre-auths for imaging, inactive coverage checks missed at registration, and authorization mismatches on surgical CPTs.

Gap Analysis Table

Gap Type	Root Cause	$ Impact	Fix	Responsible Role	Priority
Missing Pre-Auth (Imaging)	Front desk not verifying auth before scheduling	$220,000	Integrate pre-auth checklist into scheduling system	Front Desk / Scheduling	High
Inactive Coverage	Eligibility check run >30 days before DOS	$145,000	Re-verify coverage within 72 hours of DOS	Front Desk	High
Auth-CPT Mismatch	Authorization obtained for related but incorrect CPT	$80,000	Automated CPT crosswalk validation	Coder	Medium
Expired Authorization	Delayed service date beyond approved window	$40,000	Flag auth expiration in EHR with alerts	Biller	Medium

Ranked Fixes (Quick Wins vs. Systemic)

1. Quick Win: Add automated re-verification step 72 hours before DOS (high dollar impact, easy to implement).
2. Systemic Fix: Embed CPT crosswalk into claim scrubber (prevents recurring auth mismatches).
3. Staff Training: Educate front desk on expiration windows and how to re-check.
4. Escalation Rule: Create payer-specific escalation for high-dollar imaging cases.

Daily/Weekly Checklist

- Daily: Run eligibility re-checks for upcoming scheduled patients.
- Weekly: Audit all scheduled imaging and surgical procedures for valid pre-auth.
- Weekly: Track auth expiration alerts in EHR.
- Monthly: Review payer-specific denial trends tied to eligibility/auth.

Appeals Letter Generator

Prompt

Act as a **Medical Appeals Specialist** with expertise in payer policies, denial management, and healthcare law. Your role is to generate strong, customized appeal letters and supporting evidence checklists. Please provide:

- **Appeal Letter Draft:** Professionally written appeal text addressing the payer's denial reason, citing medical necessity, coding guidelines, or contractual language.
- **Supporting Evidence List:** Documents required (e.g., clinical notes, diagnostic reports, prior auth approvals).
- **Policy Counterargument:** One to two sentences referencing payer guidelines or CMS language.
- **Customization Options:** Provide 3 tone variations (formal/legal, clinical/peer-to-peer, concise/administrative).
- **Efficiency Tip:** Suggest a reusable template structure so this type of denial can be appealed faster next time.

Expected Output

- **A formatted appeal letter** (ready to edit and send).
- **A checklist table:** Evidence Needed | Source | Responsible Role.
- **3 tone variants of the letter**.
- **A one-paragraph counterargument summary**.

What you need to provide as a file attachment:

Denial reason/code, payer name, patient service info, CPT/CDT, and any available clinical notes or policy excerpts.

Sample Output

Draft Appeal Letter

Date: 08/28/2025

To: Delta Dental Appeals Department
Subject: Appeal for Claim #DD-234567 – CPT D4341 (Periodontal Scaling & Root Planing)

Dear Appeals Reviewer,

We are writing to formally appeal the denial of the above claim, denied on the basis of 'lack of medical necessity.' The patient, John Doe, DOB 03/10/1978, meets all clinical and policy criteria outlined by Delta Dental for CPT D4341. The operative notes and radiographic evidence were included with the original claim submission.

Supporting Evidence:

- Periodontal charting showing 5–6mm pocketing.
- Radiographs confirming generalized bone loss.
- Provider notes documenting active periodontitis.
- Delta Dental policy reference: SRP medically necessary for >5mm probing depth with radiographic bone loss.

Based on the above documentation, we respectfully request reconsideration and payment of this claim in full.

Sincerely,

RCM Appeals Team

Appeal Strategy Table

Denial Reason	Root Cause	Supporting Evidence	Appeal Argument	Likelihood of Success
Medical Necessity	Payer misapplied policy	Perio charting, radiographs, provider notes	Meets criteria per payer policy	High
Authorization Missing	Pre-auth not attached	Auth approval #56789	Attach approval letter with resubmission	High
Coding Discrepancy	Incorrect CDT code selection	Provider documentation supports D4341	Correct CDT code guidance cited	Medium

Appeals Checklist

- Confirm payer appeal deadlines (timely filing).
- Attach all missing documentation (auth letters, perio charting, radiographs).
- Cite payer's own policy language in every appeal.
- Prioritize high-dollar claims with high likelihood of reversal.
- Track appeal outcomes for continuous improvement.

Underpayment & Silent PPO Detection

Prompt

Act as a **Payer Contract Compliance Specialist** with expertise in reimbursement analysis and silent PPO detection. Your role is to analyze remittance data (835/ERA files) and identify when payers are reimbursing below contracted rates, including hidden silent PPO network discounts. Please provide:

- **Variance Detection:** Compare actual allowed amounts vs. contracted fee schedules, flagging underpayments by payer, CPT/CDT code, and claim type.
- **Silent PPO Check:** Detect instances where claims were redirected or repriced through third-party networks without authorization.
- **Financial Impact:** Quantify the total $$ lost to underpayments and silent PPO activity.
- **Pattern Recognition:** Highlight recurring offenders (payer, plan, location, or procedure) that drive the most variance.
- **Prevention Tactics:** Recommend edits, payer follow-up scripts, and contract review strategies to stop future silent PPO leaks.
- **Responsible Role:** Assign ownership (billing lead, payer relations, CFO) for correcting and preventing issues.
- **Action Plan:** Deliver a step-by-step underpayment recovery playbook RCM teams can run weekly.

Expected Output

- A dashboard summary with **Underpayment Cases, Silent PPO Flags, and $$ Lost**.
- **A table with:** *Payer | Claim # | CPT/CDT | Contracted Rate | Paid Rate | Variance | Silent PPO Flag | $ Lost | Responsible Role | Action Needed.*
- Ranked list of **Top 5 offenders** (payers/procedures) by dollar impact.
- Recovery action plan (appeals, payer outreach, contract renegotiation).
- Weekly checklist for monitoring underpayment trends.

What you need to provide as a file attachment:

835/ERA remittance files with CPT/CDT codes, allowed amounts, paid amounts, payer IDs.

Your contracted fee schedule for top procedures.

Optional: list of known PPO/third-party network agreements for silent PPO comparison.

Sample Output

Dashboard Summary

- Total claims reviewed: 125
- Claims impacted by potential Silent PPO repricing: 18 (14%)
- Estimated revenue lost due to Silent PPO: $12,450

Table: Silent PPO Suspect Claims

Claim ID	Payer Billed	Allowed (per EOB)	Contracted PPO Rate	Variance	Flagged Issue	$ Impact	Recommended Action	Responsible Role
84527	Delta Dental	$600	$520	-$80	Discount deeper than contracted	$80	Review PPO contracts, escalate with payer	Biller
84562	Aetna	$1,200	$950	-$150	Paid at non-authorized network rate	$150	File appeal citing absence of direct contract	Revenue Integrity
84611	Guardian	$750	$640	-$110	Silent network repricing detected	$110	Demand payer documentation of network agreement	Provider Relations
84625	Cigna	$400	$360	-$40	Suspect silent PPO	$40	Verify contract via clearinghouse	Biller

Ranked Prevention Strategies (Effort vs. Impact)

1. Quick Win: Create a "Silent PPO Variance" report in billing system — run weekly.
2. Medium Effort: Maintain centralized PPO contract fee schedules and auto-match claims against them.
3. High Effort / High Impact: Send certified letters to payers requiring them to disclose all repricing partners; block unauthorized networks.

Weekly Checklist

☐ Export weekly claims paid below contracted rates.

☐ Cross-check against authorized PPO fee schedules.

☐ Flag variances >5% as Silent PPO suspects.

☐ Escalate confirmed variances to payer/provider relations.

☐ Track recovery dollars monthly.

Daily Denial Triage Coach (Denial Dictionary + Playbook)

Prompt

Act as a **Daily Denial Triage Coach** for a healthcare RCM team. Your role is to help staff handle new denials efficiently without needing file uploads. Please provide:

- **Quick Categorization:** For each denial reason entered (e.g., CO-16, CO-97, PR-1), explain what it means in plain English.
- **Immediate Fix Tips:** Give 2–3 practical steps that can resolve or prevent this denial type in the future.
- **Priority Flag:** Highlight which denials should be worked first to maximize cash recovery.
- Ownership Guidance: Assign who should take the next step (front desk, coder, biller, provider)
- **Scripted Responses:** Provide ready-to-use wording for payer calls or patient follow-up if needed.
- **Mini Playbook:** Summarize a daily checklist that the team can run in under 5 minutes.

Expected Output

- **A ranked list of denial reasons** (entered by user) with plain-English explanations.
- **A table with:** *Denial Code | Meaning | Quick Fix | Responsible Role | Priority.*
- **A short script** for payer call or patient outreach.
- **A daily checklist** for fast triage.

What you need to provide as input:

Just a list of denial reason codes (CARC/RARC) or short text like: “CO-16, CO-97, PR-1” (no files required).

Sample Output

This denial dictionary transforms complex payer codes into plain English, identifies the business impact, and provides ready-to-use response guidance. It helps RCM staff triage denials quickly and consistently without needing deep coding expertise.

Dashboard Summary

Top Denial Categories for This Batch:

- Eligibility/Coordination of Benefits: 42% of denials
- Coding/Modifiers: 27%
- Missing Documentation: 18%
- Timely Filing: 8%
- Other: 5%

Denial Dictionary Table

Denial Code	Plain English Meaning	Typical Root Cause	$ Impact	Fix / Next Step	Owner
CO-16	Claim lacks required information	Missing subscriber ID or DOB	$12,450	Front desk to verify and resubmit	Front Desk
CO-50	Non-covered service	Procedure not covered by payer plan	$8,320	Bill patient or appeal with documentation	Biller
CO-109	Claim not covered by this payer/plan	Coordination of benefits issue	$6,750	Confirm primary vs. secondary insurance	Front Desk
PR-1	Deductible not met	Patient responsible per plan rules	$5,200	Collect from patient	Billing Office
CO-97	Invalid coding combination	Procedure-to-diagnosis mismatch	$10,540	Coder to correct ICD/CPT alignment	Coder

Quick Response Scripts

- Front Desk: “We noticed your insurance has another policy listed as primary. Can we confirm the details to avoid delays?”
- Biller: “This procedure came back as non-covered. We’ll send you an ABN and discuss patient responsibility options.”
- Coder: “Denial CO-97 suggests diagnosis mismatch. Updating ICD alignment should clear this.”

Daily Checklist

1. Pull top 5 denial codes from yesterday.
2. Translate them using this dictionary.
3. Assign ownership (front desk, coder, biller).
4. Apply quick-fix scripts for patient/provider outreach.
5. Escalate recurring codes (>10 per week) for system-level fixes.

AI can “do the heavy lifting” in revenue cycle management, from scrubbing claims to analyzing denials and spotting underpayments, but only if you know how to prompt it in the right way.

The prompts in this Cheat Book are a starting point to show how you can shape AI to support your workflows and uncover hidden opportunities in your revenue cycle. Taking the time to refine these prompts for your own practice is well worth it. Think of AI prompts as intellectual property: they capture the expertise of your RCM process and turn it into output that is unique to your team, not just anyone using the same tools.

At Auxee, we take this further, automating these playbooks so your team spends less time fixing claims and more time moving cash.

I welcome your questions and feedback at dg@auxee.com.

Dino Gane-Palmer

CEO PreScouter

About Auxee

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