

Pharmacy Revenue Integrity Compendia

Developed by the 2024-2025 Infusion Services Strategy Committee

Pharmacy revenue integrity (PRI) ensures all pharmacy-related services and medications are meeting medical necessity, accurately charged and billed, appropriately reimbursed, and fully compliant with regulatory requirements. Medical necessity is also a legal doctrine that guides what insurers, including Medicare, will cover. Services must be “reasonable and necessary” for the diagnosis or treatment of illness or injury, or to improve functioning. Insurers use established guidelines from national organizations to determine what is considered medically necessary for coverage decisions. PRI fosters collaboration between pharmacy, revenue cycle, payer administration and finance teams, breaking down departmental silos and streamlining revenue-related workflows.

Incorporating pharmacists and pharmacy technicians into pharmacy revenue integrity workflows delivers significant value by leveraging their clinical expertise, operational knowledge, and specialized training to optimize both financial and patient care outcomes. Pharmacists contribute enhanced accuracy and compliance through their clinical expertise, which is essential for accurate coding, documentation, and billing-especially when appealing denials or ensuring claims meet payer requirements. Pharmacy technicians complement these efforts by handling tasks such as charge capture, billing, inventory management, and 340B coordination, ensuring that processes are completed efficiently and in compliance with regulations.

This collaborative approach has been shown to significantly reduce claim denials and increase successful appeal rates, with pharmacists analyzing and resolving complex cases while technicians gather necessary documentation and manage billing workflows. Furthermore, by minimizing billing errors, capturing all eligible charges, and ensuring compliance, pharmacists and technicians help maximize revenue capture and minimize revenue leakage, directly supporting the financial health of the institution. Their involvement in regular audits and process improvements also helps identify and rectify sources of revenue loss before they impact the bottom line. The combined clinical insight of pharmacists and the operational skills of technicians foster effective collaboration with revenue cycle, compliance, and IT teams, ensuring a cohesive approach to revenue integrity. Ultimately, optimized revenue integrity supports reinvestment in patient care, technology, and staff, leading to sustained quality and better healthcare outcomes.

Validating these medical necessity parameters ensures that the treatment is not only clinically appropriate but also meets payer requirements for coverage, reducing the risk of denials and supporting high-quality patient care.

Core Components of Pharmacy Revenue Integrity		
Pillar	Objective	Key Activities
Minimize Revenue Loss	Reduce denials and recover lost revenue	Medical necessity validation, denials management, root cause analysis, appeals, continuous quality improvement
Optimize Revenue Capture	Ensure all billable opportunities are realized	Charge/reimbursement audits, focus on high-value drugs, automation
Ensure Billing Compliance	Prevent errors and maintain regulatory compliance	Charge Description Master (CDM) ownership, EHR medication list maintenance, daily monitoring

Below is a standardized template and checklist to evaluate and document medical necessity, synthesizing best practices and requirements from CMS, major insurers, and clinical guidelines. This tool can be used for any service, medication, or equipment and is adaptable for letters, forms, or internal reviews.

Prior Authorization Overview

A centralized prior authorization (PA) model offers numerous benefits for health systems, providers, staff, and patients. By consolidating PA processes into a dedicated team, the administrative burden is significantly reduced, allowing clinical staff to focus more on direct patient care rather than paperwork. This centralization streamlines workflows and standardizes procedures, often leveraging technology and automation to speed up processing times and minimize errors. As a result, patients experience faster access to necessary treatments, which can lead to improved health outcomes and greater satisfaction.

Financially, a centralized PA model helps reduce claim denials and delays, improving reimbursement rates and strengthening overall revenue cycle management. Accurate and timely submissions prevent lost revenue and accelerate cash flow. Additionally, having a specialized, cross-trained team ensures consistency and quality in handling PA requests, reducing preventable denials and rework while maintaining compliance with payer requirements. This model also supports better staff engagement through comprehensive training and cross-training opportunities, which enhances flexibility and morale.

Ultimately, a centralized prior authorization approach not only improves operational efficiency and financial performance but also enhances the patient experience by providing clearer communication and faster access to therapies and financial assistance. This integrated and focused process benefits all stakeholders by promoting smoother, more reliable healthcare delivery.

Medical Necessity Overview

Medical necessity is a concept used by health insurance providers to determine which treatments and services are eligible for coverage under a specific benefit plan. The definition of medical necessity used in each health plan directly affects which medical services and treatments the insurer will pay for. Most insurance policies will include a specific definition of “medical necessity” or “medically necessary services.” Sometimes, state laws also provide their own definitions. Generally, services are considered medically necessary if they:

- Are provided to diagnose, treat, cure, or alleviate a health condition, illness, injury, or disease (excluding experimental, investigational, or cosmetic procedures unless otherwise specified in the policy)
- Are appropriate and required for the diagnosis, treatment, cure, or relief of a health issue or its symptoms
- Align with the accepted standards of medical practice within the community (i.e. national guidelines)
- Are not provided solely for the convenience of the patient, their family, or the health care provider

Some policies may also consider:

- The cost-effectiveness of the proposed treatment
- The availability of alternative treatments or supplies
- The setting in which the medically necessary service is provided

Medical Necessity in Different Plans

Plans that are self-funded and not regulated by state insurance authorities often use Third Party Administrators (TPAs) to manage benefits. The Summary Plan Description, which is given to employees, will typically outline what is considered medically necessary.

For example, Medicare defines medically necessary services as those needed to diagnose or treat an illness, injury, condition, or disease (or its symptoms) and that meet accepted standards of medical practice. Medicaid programs may have their own state-specific definitions.

Traditional Medicare and some Medicaid programs do not offer prior authorizations. In these cases, Medicare or Medicaid will pay for the drug if one of the following is met: (1) Use is according to FDA labeled indication (2) Use is supported by Medicare approved compendium or (3) Use is supported by local coverage determinations (LCDs) and national coverage determinations (NCDs).

Commercial payers sometimes do not require prior authorizations. In these cases, a pre-determination should be completed for high cost drugs. If prior authorization and pre-determination is not offered, then the medical policy should be reviewed. If the medication doesn't meet the policy requirements, then it should be assumed the claim will be denied. If the medication meets the policy requirements, then all policy criteria should be documented in the patient's chart prior to initiating therapy. If there is

no policy available, but the drug is used according to FDA approved labeling, then the drug can be assumed to be covered. Denial trends should be monitored and any trends noted should be addressed.

How Is Medical Necessity Determined?

A doctor's recommendation that a service is medically necessary is an important factor, but insurers often require additional documentation. Your provider might need to submit a "Letter of Medical Necessity" as part of a certification or utilization review process. This process allows the insurer to review the requested service and decide if it meets their criteria for coverage. Reviews can occur:

- **Before treatment** (precertification review): The insurer decides if the service meets their requirements for medical necessity by reviewing documentation such as the Letter of Medical Necessity and relevant medical records.
- **During treatment** (concurrent review): The insurer evaluates whether ongoing care continues to be medically necessary.
- **After treatment** (retrospective review): The insurer determines if the services provided were medically necessary, and whether they were experimental, cosmetic, or required in an emergency.

Decision-Making Process

- **National Coverage Determinations (NCDs):** CMS issues NCDs that set national standards for what Medicare will cover, based on evidence and public input.
- **Local Coverage Determinations (LCDs):** Medicare Administrative Contractors (MACs) can issue LCDs to address services not covered by NCDs, reflecting local medical practice and standards.
- **Diagnosis Codes:** Claims are evaluated based on diagnosis codes submitted by providers, which must align with the services rendered to demonstrate medical necessity.
- **Prior Authorization and Reviews:** Some services require prior authorization, where providers submit documentation (such as a letter of medical necessity and medical records) for review before, during, or after the service is provided to ensure it meets CMS criteria.

What Is a Medical Policy?

A health plan's definition of medical necessity includes the requirement that care aligns with accepted medical standards. These standards are detailed in the insurer's medical policy. If a health plan uses its medical policy to deny coverage, it must make that policy available to you upon request.

Validating medical necessity in situations where prior authorization is not required remains critically important for several reasons. First, it ensures that healthcare services provided are appropriate, evidence-based, and tailored to the patient's specific clinical needs, which helps maintain high standards of quality and patient safety. Even without the external checkpoint of prior authorization, confirming medical necessity prevents unnecessary or potentially harmful procedures, reducing the risk of adverse events and complications for patients.

From a financial and operational perspective, proper validation and documentation of medical necessity are essential for accurate billing and timely reimbursement. Insurance companies and payers often review claims retrospectively, and services lacking clear evidence of medical necessity may be denied or result in payment delays, even if authorization was not initially required. This can lead to lost revenue, increased administrative burden, and potential compliance issues for providers.

Additionally, validating medical necessity supports efficient resource allocation and cost control within the healthcare system by ensuring that only necessary interventions are performed, thereby avoiding wasteful spending. It also fosters trust and collaborative decision-making between patients and providers, as care decisions are grounded in transparent, evidence-based guidelines and tailored to individual patient needs.

In summary, validating medical necessity-even when authorization is not needed-protects patient safety, supports quality care, ensures proper reimbursement, and promotes efficient, cost-effective healthcare delivery.

Clinical Parameters for Validating Medical Necessity	
Parameter	What to Validate
Diagnosis & Clinical Indicators	Clearly documented, supported by objective evidence
Clinical Criteria	Meets accepted guidelines and community standards
Rationale for Treatment	Appropriateness and necessity for the patient's condition
Prior Treatments/Alternatives	Alternatives tried or contraindicated
Supporting Clinical Evidence	Labs, imaging, notes, and other objective data
Documentation Consistency	Complete, legible, and non-contradictory records
Provider Clinical Judgment	Clear, prudent reasoning and justification

Always reference the specific insurance policy, CMS guidance, or clinical guideline relevant to the service and patient population for the most accurate validation. This checklist helps ensure consistent, thorough, and compliant validation of medical necessity, reducing risk of denials and supporting appropriate patient care.

Sample Checklist for Validating Medical Necessity	
Section	Checklist Items
1. Patient and Service Identification	- Patient's full name, date of birth, and insurance ID - Provider's name and credentials - Service/treatment/procedure requested (with CPT/HCPCS code) - Date(s) of service
2. Diagnosis and Clinical Background	- Primary diagnosis and ICD-10 code(s) - Relevant comorbidities and medical history - Documented symptoms and severity
3. Clinical Rationale and Justification	- Clear explanation of why the service is medically necessary for this patient - How the service will: • Diagnose, treat, or prevent a specific illness, injury, or condition • Improve or maintain patient function - Supporting clinical evidence (exam findings, test results, imaging, labs) - Reference to evidence-based guidelines or accepted standards of care
4. Prior Treatments and Alternatives	- List of previous treatments/interventions tried, duration, and outcomes - Explanation for why alternatives were ineffective, inappropriate, or not tolerated
5. Appropriateness and Compliance	- Service is safe and effective for the patient's condition - Not experimental or investigational - Ordered and provided by qualified personnel - Performed in a setting appropriate to the patient's medical needs - Meets, but does not exceed, the patient's medical needs - No less costly, equally effective alternative available
6. Documentation Review	- Medical record is complete and supports the diagnosis, care, and need for service - All entries are signed, dated, and legible - Documentation includes: • Progress notes • Treatment plans • Test results • Letters of medical necessity (if required) - Cross-check with payer's specific medical necessity policy or LCD/NCD
7. Final Validation	- Service aligns with payer's definition of "reasonable and necessary" - All required documentation is present and attached - Any required pre-authorization or prior approval is obtained and documented

American Academy of Family Physicians. "A Refresher on Medical Necessity." *AAFP*, July 2006. www.aafp.org/pubs/fpm/issues/2006/0700/p28.html. Accessed 14 May 2025.

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