



In the event of a conflict between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. Plan documents include but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents.

In the event of a conflict between a Clinical Payment and Coding Policy and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern.

Providers are responsible for accurately, completely, and legibly documenting the services performed including any preoperative workup. The billing office is expected to submit claims for services rendered using valid codes from the Health Insurance Portability and Accountability Act (HIPAA) approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT®), CPT Assistant, Healthcare Common Procedure Coding System (HCPCS), National Drug Codes (NDC), Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (CCI) Policy Manual, CCI table edits, National Council for Prescription Drug Program (NCPDP) and other CMS guidelines. Claims are subject to the code auditing protocols for services/procedures billed.

## **Wasted/Discarded Drugs and Biologicals Guideline**

**Policy Number: CPCP017**

**Version 5.0**

**Clinical Payment and Coding Policy Committee Approval Date: 06/29/2018**

**Effective Date: October 12, 2018 (Blue Cross and Blue Shield of Texas Only)**

### **Description**

The intent of the Wasted/Discarded Drugs and Biologicals Clinical Payment and Coding Policy is to prevent waste and abuse when the dose or combination of appropriate dosage for drugs has not been administered to a patient and therefore may result in incorrect billing practices. **This policy is not intended to impact care decisions or medical practice.**

<b>Definitions/Acronyms:</b>
<b>Multi-use vials/packages:</b> A drug or biologic package that allows more than one (1) dose to be withdrawn for administration by injection or infusion.
<b>Single-use vials/packages:</b> A drug or biologic package that allows only one (1) dose to be withdrawn for administration by injection or infusion.
<b>Drug Waste:</b> The amount of drug or biologic that is discarded and not administered to any patient.



## **Reimbursement Information:**

Reimbursement information provided in this policy for wasted and/or discarded drugs and biologicals may not cover every reimbursement type situation for a patient. Reimbursement and payment are determined by the plan documents under which the member is entitled to covered services. Providers and facilities are urged to administer drugs and biologicals in an efficient manner to prevent waste of the product.

When billing drugs, units of service must be billed in multiples of the dosage specified in the full CPT/HCPCS description. If the amount administered is not a multiple of the CPT/HCPCS code, round to the next highest unit in the CPT/HCPCS description for that code. Administered dose per wasted dose must not exceed the vial amount.

*Example #1: If 750 milligrams (mg) of rituximab is administered, it is appropriate to bill for 8 units J9310, since the CPT/ HCPCS code J9310 defines the unit for rituximab as 100mg. If 800mg total are utilized, but only 750mg are administered, then 50mg is wasted and documented in the medical record. Since the administered amount requires billing 8 units of J9310, no wastage is billed for the 50mg that is not utilized.*

### **JW Modifier Usage**

The actual dosage of drugs or biologicals must be reported with the correct CPT/HCPCS and correct units of service. The amount discarded must also be billed on a separate line with the JW modifier for all non-inpatient places of service. The JW modifier is a CPT/HCPCS Level II modifier that is used to report the amount of drug or biological that is discarded. Hospitals, suppliers, and providers are encouraged to administer and care for patients in a way that drugs and biologicals are used most efficiently to prevent or minimize drug wastage.

Suppliers and providers are required to utilize the JW modifier on claims for discarded drugs and biologicals from single-use vials and or single-use packages when discarded. In addition, suppliers and providers are required to document the amount of the discarded drugs or biologicals in the patient's medical records. The JW modifier will only be applied to the amount of drug or biological that is discarded. The JW modifier should be billed on a separate line than what was administered to the patient. Blue Cross and Blue Shield will provide reimbursement for the discarded amount of a single use dosage drug or biological product that is discarded and administered to the patient up to the amount indicated on the vial or package label that is necessary for the patient's condition.

Blue Cross and Blue Shield will provide reimbursement for drugs and biologicals reported with the JW modifier provided the criteria below are met:

- The dose administered, discarded amount, exact date and time of administration and the reason for wastage are clearly and acceptably documented in the medical record.
- The discarded amount is billed on a separate line than the administered amount with the correct CPT/HCPCS code, units, and JW modifier for all non-inpatient places of service.
- The discarded drugs or biologicals are not administered to another patient.



- The drug or biological administered is only available in a single-use vial or single-use package.
- The drug or biological is administered to the patient appropriately for the patients' medical condition and the unused portion is discarded.
- The units billed correspond with the smallest dose or vial available for purchase from the manufacturer(s) that provides the appropriate dosage for the patient.
- National Drug Codes (NDC) identify drugs using a unique three segment product identifier number. These codes must be included with the CPT/HCPCS code when billing for drugs to receive NDC-based reimbursement. When billing drugs, CPT/HCPCS units of service must be billed in multiples of the dosage specified in the full CPT/HCPCS description. If the amount administered is not a multiple of the CPT/HCPCS code, round to the next highest unit in the CPT/HCPCS description for that code. The NDC units billed should correspond to the CPT/HCPCS units billed.

*Example #2: Trastuzumab is available in a single use, 150mg vial. The CPT/ HCPCS code and description for trastuzumab are J9355, trastuzumab 10mg. If 575mg is administered to the patient, then four 150mg vials (total 600mg) should be utilized. When 600mg are utilized but only 575mg are administered, then 25mg is wasted and documented in the medical record. The correct billing is 58 units J9355 on one line of the claim, and 2 units J9355JW on another line.*

*Example #3: Rituximab is available in single-use vials of 100mg and 500mg. The CPT/HCPCS code and description for rituximab is J9310, rituximab 100mg. If 750mg is administered to the patient, the correct combination of vial sizes is one 500mg vial and three 100mg vials (800mg total). If 800mg total are utilized, but only 750mg is administered, then 50mg is wasted and documented in the medical record. Since the administered amount requires billing 8 units, no wastage is billed for the 50mg not utilized. Billing for two 500mg vials (1000mg total) with 250mg of waste is not reimbursable because it does not minimize the waste.*

### **When Drugs and Biologicals are not Reimbursed**

- ✓ Multi-use vials and multi-use packages will not be reimbursed for discarded amounts of drugs or biologicals.
- ✓ Reimbursement for discarded/wasted drugs must not be billed for use on other patients.
- ✓ A provider will not be reimbursed for purchases of larger packaging of drugs or biologicals when more appropriate packaging can be purchased.
- ✓ Reimbursement will not be given to a provider or hospital due to a patient missing an appointment.
- ✓ The JW modifier is used on claims for hospital inpatient admissions.
- ✓ Volumes or quantities of the drug or biological billed over the manufacturer's labeled package volume or mass ("overfill") will not be reimbursed and must not be billed for use on patients.



### **Whole Vial or Package Waste**

Whole vials or packages billed as waste will not be reimbursed in most circumstances. Whole vial, package or product waste due to manufacturer defect, shipping damage, improper storage, or provider administration error may not be reimbursed. Some scenarios of a non-reimbursable whole vial or package waste include, but are not limited to:

- ✓ A Neulasta OnPro® (J2505) that is administered but fails to deliver the drug.
- ✓ Drugs or biologicals that have been administered after being recalled by the manufacturer.
- ✓ The patient mishandles or damages the drug, requiring a replacement dose.
- ✓ The drug is accidentally stored outside the refrigerator after dispensing.
- ✓ The shipping company damages the drug en route to the patient.
- ✓ The provider mishandles, damages, or does not appropriately reconstitute the drug.
- ✓ Theft from provider or shipping company.

In some limited circumstances, whole vials or packages billed as waste may be reimbursed. Some scenarios of a reimbursable whole vial or package waste include, but are not limited to:

- ✓ Intrauterine Device (IUD) insertion billed on the same date of service.
- ✓ Patient death, hospitalization, or incapacitation after the drug has been shipped (for home delivery providers only).
- ✓ Replacement drug after dispensing due to disasters such as hurricanes, earthquakes, flooding, fires, etc.
- ✓ Theft from a patient.

The whole vial or package waste will be evaluated on a case-by-case basis.

### **Billing information section**

Please see the Provider section of our website, and your provider contract, for the most up to date billing guidelines.

### **References:**

Medicare Claims Processing Manual Chapter 17-Drugs and Biologicals -

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf>

American Medical Association. Current Procedural Terminology (CPT) -

<https://www.ama-assn.org/practice-management/cpt>



**Policy Update History:**

Approval Date	Description
06/29/2018	New policy