



**Manual:** Reimbursement Policy

**Policy Title:** **Drugs and Biologicals, Wastage and/or Discarded Amounts (Modifier JW)**

**Section:** Medicine

**Subsection:** None

**Date of Origin:** 12/1/2006                      **Policy Number:** RPM015

**Last Updated:** 5/3/2018                      **Last Reviewed:** 8/10/2018

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### **Scope**

This policy applies to all Commercial medical plans, Medicare Advantage plans, and Oregon Medicaid/EOCCO plans.

### **Reimbursement Guidelines**

#### NDC Numbers

Please include NDC numbers in addition to the HCPCS code when billing for drugs, to facilitate accurate pricing of the drug supply.

#### Correct Reporting of Units

Units of service must be reported correctly.

Each HCPCS/CPT code has a defined unit of service for reporting purposes. A physician or facility should not report units of service for a HCPCS/CPT code using a criterion that differs from the code's defined unit of service. (*NCCI Policy Manual*<sup>3</sup>)

#### Discarded or Wasted Amounts

Moda Health does not reimburse for discarded or wasted amounts of drug from multi-dose vials or multi-use packages.

Moda Health will reimburse for discarded or wasted amounts of drug **only** when all of the following requirements are met:

- The drug is only supplied in single-use vials or single-use packages.
- The physician's orders for the drug must be clearly and completely documented in the medical record. When the physician order for the drug is written in terms of patient specific factors (weight, body surface area, etc.), records documenting current measurements of those specific factors must also be included with the records provided for review.

- The amount of drug administered must be clearly and completely documented in the medical record.
- The discarded or wasted drug must be clearly documented as discarded or wasted in the medical records supplied to Moda Health for review. The documentation must include the date and time the drug was discarded, the amount discarded, the reason for wastage, and the name, licensure, and signature of the person who wasted the drug.
- The amount of drug that is actually administered to the member is billed on one line on the claim.
- The amount of drug that was wasted or discarded is billed separately on a second line item, with modifier JW attached. (CMS<sup>1</sup>)
- Moda Health will only reimburse for the minimum amount of drug above what was actually ordered to arrive at the nearest whole vial using the vial size and dose that result in the least amount of wastage.

For example:

If the physician orders for the patient to receive 180 mg of the drug in question, and the drug is manufactured in both a 100 mg single-use vial and a 150 mg single-use vial, then Moda Health will only reimburse for 20 mg of wastage (the result of using two 100 mg vials).

If the provider only has 150 mg single-use vials on hand on the date of service in question and two 150 mg vials are used for the 180 mg dose, 120 mg will be wasted. In this instance, Moda Health will still only reimburse for 20 mg of wastage. The remaining 100 mg of wasted drug is excess wastage that is not eligible for reimbursement, and becomes a business expense or loss incurred by the billing provider due to not having the 100 mg vials available when needed.

Any excess drug above what is ordered or documented that is billed without modifier JW will be denied to provider write off as not documented or supported in the medical record.

Any excess wastage amount (billed with modifier JW but greater than the minimum wastage amount possible as described above) will be denied to provider write off as bundled or included in the reimbursement for the drug administered.

Moda Health staff and/or Moda Health business associates (contracted claim review vendors) conduct claim reviews and audits for this and other concerns. When records are received in response to the records request, the items received are deemed to be the total documentation needed to support the services billed; any items later received are deemed not to have existed at the time the claim was submitted. Neither additional records nor amended records will be accepted once the audit review is complete. Therefore, it is the responsibility of the billing provider to ensure that their responses to records requests are both prompt and complete. If the physician's order, drug administered, and amount wasted or discarded are not clearly, completely, and properly documented in the medical records supplied for review, any excess billed amounts will be denied to provider write-off due to the insufficient documentation.

Denials of drug amounts following a claim review/audit may be disputed by submitting a written appeal. The documentation submitted for appeal consideration should include a written explanation of how the records provided for the original review support the items and quantities billed, and how the number of billed units was calculated from those physician's orders and records. Additional records not submitted for the original review cannot be considered in the appeal process.

### **Background Information**

A large majority of drugs and biologicals are issued in multi-dose vials. However, some drugs and biologicals do not have the stability needed for multi-dose vials and are packaged in single-use vials. The package insert for each individual drug or biological will specify the dosing and administration instructions, stability of the product, and time frames when the substance may be safely administered and after which it must be discarded.

CMS encourages physicians, hospitals and other providers to schedule patients in such a way that they can use drugs or biologicals most efficiently, in a clinically appropriate manner. For instance, some chemotherapy drugs are both highly effective and highly expensive. Oncology and chemotherapy clinics commonly schedule multiple patients to receive treatments of the same drug concurrently. However, there may be occasions when the remainder of a single dose vial or single use package must be discarded after administering a dose/quantity of the drug or biological to a member.

For the remainder of this policy, both drugs and biological will be collectively referred to with the generic terms "drug" or "drugs."

### **Codes and Definitions**

Modifier JW                      Drug amount discarded/not administered to any patient

### **Coding Guidelines**

Modifier JW is a HCPCS Level II modifier similar to modifiers AS, LT, RT, finger modifiers F1-FA, toe modifiers T1-TA, etc. While modifier JW was created by CMS, and CMS contractors may or may not require its use, the use of modifier JW is not limited exclusively to CMS members or plans.

"When processing claims for drugs and biologicals (except those provided under the Competitive Acquisition Program for Part B drugs and biologicals (CAP)), local contractors may require the use of the modifier JW to identify unused drug or biologicals from single use vials or single use packages that are appropriately discarded. This modifier, billed on a separate line, will provide payment for the amount of discarded drug or biological. For example, a single use vial that is labeled to contain 100 units of a drug has 95 units administered to the patient and 5 units discarded. The 95 unit dose

is billed on one line, while the discarded 5 units may be billed on another line by using the JW modifier. Both line items would be processed for payment.

The JW modifier is only applied to the amount of drug or biological that is discarded. A situation in which the JW modifier is not permitted is when the actual dose of the drug or biological administered is less than the billing unit.” (CMS<sup>1</sup>)

“Physicians must report units of service correctly. Each HCPCS/CPT code has a defined unit of service for reporting purposes. A physician should not report units of service for a HCPCS/CPT code using a criterion that differs from the code’s defined unit of service.” (NCCI Policy Manual<sup>3</sup>)

### **Cross References**

None.

### **References & Resources**

1. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 17 – Drugs and Biologicals, § 40.
2. Verhovshek, G. John, MA, CPC. “Drug Waste = Money.” AAPC. August 20, 2010. April 7, 2011 < <http://news.aapc.com/index.php/2010/08/drug-waste-money/>>.
3. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § A.

### **IMPORTANT STATEMENT**

The purpose of Moda Health Reimbursement Policy is to document payment policy for covered medical and surgical services and supplies. Health care providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. The billing office is expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS’ National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the applicable member contract language. To the extent there are any conflicts between the Moda Health Reimbursement Policy and the member contract language, the member contract language will prevail, to the extent of any inconsistency. Fee

determinations will be based on the applicable provider contract language and Moda Health reimbursement policy. To the extent there are any conflicts between Reimbursement Policy and the provider contract language, the provider contract language will prevail.