Wellpoint

Massachusetts | Commercial

Commercial Reimbursement Policy	
Subject: **Pharmaceutical Waste – Professional and Facility**	
Policy Number: **C-11031**	Policy Section: **Drugs**
Last Approval Date: **08/14/2024**	Effective Date: **08/14/2024**

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a Wellpoint member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Wellpoint may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

Wellpoint allows reimbursement for single-dose vial (SDV) pharmaceutical waste reported by a provider using the appropriate claim form. Wellpoint requires that any non-self-administered drug/biologic dosage prepared from an SDV, procured by the provider and administered to the member, be medically appropriate for treating the member's condition, and calculated in the most efficient manner to optimize utilization and minimize pharmaceutical waste unless provider, state, federal contracts and/or mandates indicate otherwise.

Non-self-administered drug/biologic dosage prepared from a SDV not administered to a member because they are deemed contaminated, expired, or discarded due to spillage, damage, or breakage are not eligible for reimbursement.

Modifier JW is not permitted when the actual dose of a covered drug/biologic administered from a single dose vial is *less than* the billing unit defined by a specific Healthcare Common Procedure Coding System Level II (HCPCS) code. The provider may bill Wellpoint and that drug/biologic administered will be eligible for reimbursement and the remaining amount will be discarded.

- For example, the descriptor text for HCPCS code J2175 is "injection, meperidine hydrochloride, per 100 mg." If the administered dose of this drug is 97 mg and 3 mg are discarded, J2175 is reported with one unit on one line and the allowance for J2175 is eligible for reimbursement. Billing for one unit on a separate claim line with modifier JW for 3 mg of discarded drug would result in overpayment.

Wellpoint expects that a provider will have a pharmaceutical waste management system in place. Wellpoint also requires the provider to utilize the most cost-effective vial or combination of vials of pharmaceutical when procuring and preparing a dose for administration to avoid pharmaceutical wastage.

- For example, when a pharmaceutical is available in 20 units and 100 units and the member only requires 40 units, the expectation is the provider will use two 20-unit vials rather than using a 100-unit vial, administering only 40 units, and wasting 60 units.

Modifier JW must be appended to a specific HCPCS code when the actual dose of a covered drug/biologic administered from a single dose vial is *more than* the billing unit represented by the HCPCS code. The unused portion of the drug/biologic not administered is considered pharmaceutical waste and may be eligible for separate reimbursement. In this scenario, the provider should report the HCPCS code for the drug/biologic on one line with the actual units administered indicated and the amount discarded/wasted should be reported on a separate line of the same claim with the modifier JW appended to the specific HCPCS code being reported.

- When the dosage required to minimize waste is unavailable, the provider should use the next efficient and medically appropriate unit(s) to ensure minimization of pharmaceutical waste and the additional units may be eligible for reimbursement.
  - For example, if a SDV contains 100 units, the HCPCS code indicates 10 units, and 95 units are administered to a member, the provider would report the HCPCS code with 10 units and the 5-unit wastage is eligible for reimbursement within the reported units and not reported separately.
- By contrast, if a SDV contains 100 units, the HCPCS code indicates 1 unit, and 40 units are administered to a member, then the pharmaceutical should be reported on two lines with the first line indicating the 40 units administered and the second line with 60 units and modifier JW to indicate the wasted units and both lines are eligible for reimbursement.
- The number of units reported for a specific HCPCS pharmaceutical code is based on the dosage indicated in the code description, not necessarily the number of milligrams actually given to the member.
  - For example, J2505, pegfilgrastin (Neulasta) 6 mg – when a dose of 6 mg is administered to a member, 1 unit is reported since the descriptor text includes 6 mg.

In addition to documenting the amount of the drug/biologic administered to the member, the date, time, amount discarded, and the reason for the wasted amount should also be documented in the member's medical record.

Note: The JZ modifier should be appended to HCPCS that are single-use vials that have zero waste.

Policy does not apply to facility providers.

Related Coding

Modifier	Description	Comments
JW	Drug amount discarded/not administered to any patient	Unused portion of the drug/biologic not administered may be eligible for reimbursement
JZ	Zero drug amount discarded/not administered to any patient.	N/A

Policy History

08/14/2024	Review approved and effective: added language for non-self-administered drug/biologic dosage; updated Definitions
09/13/2023	Review approved: added Modifier JZ and removed language on waste due to spillage
05/24/2019	Review: policy language updated; removed a sentence from the third paragraph, removed the word maximum; updated definitions; new policy template
05/02/2017	Review: updated disclaimer
05/03/2016	Revised: policy language updated
02/02/2016	Review with no changes
02/03/2015	Revised: policy language updated
04/01/2014	Review: policy language updated
04/02/2013	Review: minor updates to language and punctuation
04/03/2012	Review: updated header, added new effective date; updated policy history table; no changes to content
04/05/2011	Initial approval and effective for professional providers

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Centers for Disease Control and Prevention (CDC)
- Optum EncoderPro 2023

Definitions

Pharmaceutical Waste	The discarded amount not administered to any patient
Single-Dose Vial	A drug or biologic vial/ package that allows only one dose to be withdrawn for administration.
General Reimbursement Policy Definitions	

Related Policies and Materials

None

Use of Reimbursement Policy

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.

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