Payment Policy CPP_47
Discarded Drugs and Biologicals (Professional and Facility)

BlueCross BlueShield of Vermont
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Last Review: New Policy
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Description

The intent of this policy is to delineate payment guidelines concerning discarded drugs and biologicals, appended by the modifier -JW, administered from single-use vials, single-use packages, and multi-use vials.

This policy describes how Blue Cross and Blue Shield of Vermont (Blue Cross VT) Providers may receive payment for discarded drugs and biologicals when compliant per the payment policy guidelines set forth below. The primary aim of the wasted/discarded drugs and biologicals payment policy is to mitigate potential waste and/or abuse by offering guidance on proper reporting practices for discarded drugs and biologicals. This policy is not intended to influence care decisions or medical practice.

Definitions

Term	Definition
Discarded Drug or Biological	The amount of a single use/dose vial or other single use/dose package that remains after administering a dose/quantity of a Drug or Biological.
-JW Modifier	Drug amount discarded/not administered to any member.
Multi-Use Vials/Packages	A drug or biologic package that allows more than one (1) dose to be withdrawn for administration by injection or infusion. (Note, use of modifier -JW should not be appended to drugs that are from multiple dose vials or packages.)
Overfill	Any excess product (that is, overfill) is provided without charge to the provider. Providers may not bill for overfill harvested from single use containers, including overfill amounts pooled from more than one container, because that overfill does not represent a cost to the provider.
Single-Use Vials/Packages	A drug or biologic package that allows only one (1) dose to be withdrawn for administration by injection or infusion.

Policy & Guidelines

Policy Statement

Blue Cross and Blue Shield of Vermont (Blue Cross VT) will provide benefits for the appropriately amount of discarded drugs and biologicals administered from single use vials/packages, after administering what is reasonable and necessary for the member's condition only when specific reporting guidelines are met.

Guidelines

Blue Cross VT will only pay one claim line of an administered drug or biological per day, per provider or same group Practice. If multiple lines of the same drug /code are billed on the same claim or date of service and one line does not contain the -JW modifier, the Lines(s) with an equal or lower quantity will be denied.

Drugs and biologicals with multiple administration routes must be billed with modifiers (-JA [Administered intravenously (IV)], -JB [Administered subcutaneously] (SQ)) to indicate route of administration.

When a provider or facility must dispose of the remaining contents of a single-use/dose vial or other single-use dose package after administering a drug or biological, payment may be provided for both the administered dose and the amount discarded, up to the quantity indicated on the vial or package label.

When billing for drugs, units of service must be billed in multiples of the dosage specified in the full CPT®/HCPCS descriptor. The descriptor may not always align with the actual dose administered. Ideally, the units billed should correspond to the smallest dose (vial) available for purchase from the manufacturer(s) that can deliver the appropriate dose for the member, while minimizing drug wastage.

Blue Cross VT may conduct a thorough evaluation of any drugs and biologicals billed to ensure they align with the smallest available dose (vial) available from the manufacturer that can effectively deliver the prescribed dosage to the member. Charges that exceed the reporting procedure based on the smallest dose (vial) will not be included in the final claim payment calculation.

For instance, if the CPT®/HCPCS code for drug A specifies 1 unit as 30 mg, and Drug A is available in vials of a 60 mg and 90 mg, with a prescribed dosage of 48 mg, if the provider uses a 90 mg vial, they may only submit 2 units (rather than 3 units), as the doses available from the manufacturer permit the prescribed amount to be administered with a 60 mg vial.

NOTE: The -JW modifier is exclusively permitted to be used to identify discarded amounts from a single vial or single package drug or biological. **It is inappropriate to append -JW modifier to multi-dose vial.**

Blue Cross VT guidelines follow the Centers for Medicare and Medicaid rules for reporting the administered drug amount on one line, and on a separate line report the amount of drug **NOT** administered (discarded) with modifier -JW appended to the associated CPT®/HCPCS code. When more than one vial is administered with different National Drug Codes (NDC's), each NDC should be reported on a separate claim line alone with the appropriate units given from each vial. An additional line is then added indicating the discarded units with modifier -JW, applicable to only the discarded amount, not the administered amount.

The -JW modifier is **NOT** permitted when the actual dose of the drug or biological administered is less than the billing unit.

For example, one billing unit for a drug is equal to 10 mg of the drug in a single use vial. A 7 mg dose is administered to the member while the remaining drug is discarded. The 7 mg dose is billed using 1 billing unit that represents 10 mg on a single line item. The single line item 1 unit would be processed for payment of the total 10 mg of the drug administered and discarded. Billing another unit on a separate line item with the -JW modifier for the discarded 3 mg of drug is not permitted because it would result in over payment.

To prevent overpayment, providers and facilities must always round the administered amount up to the next billing unit and round down when reporting the discarded amount.

For example, if a CPT®/HCPCS code is reportable in 10 mg increments and you administer 77 mg from a 100 mg single dose vial, you may report 8 units as administered on one line and on a separate line report 2 units with modifier -JW to the CPT®/HCPCS to indicate the amount discarded.

Eligible

The following elements must be followed for the discarded amount to be eligible for benefits:

- The dose administered, discarded amount, exact date and time of administration, and reason for wastage are clearly 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 member.
- The drug or biological administered is only available in a single-use vial or single-use package.
- The drug or biological administered to the member appropriately for the members' medical condition and the unused part is discarded.
- The units billed correspond with the smallest dose or vial available for purchase from the manufacturer(s) that supplies the proper dosage for the member.

- National Drug Codes (NDC) show 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.

Whole Vial or Package Waste

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

- Member death, hospitalization, or incapacitation after the drug has been shipped (for home delivery providers only).

Not Eligible

Examples not limited to non-payable drugs and biologicals, including whole vial or package waste, are:

- Blue Cross VT does not reimburse for the wastage of drugs from multi-dose vials or packages.
- Multi-use vials and multi-use packages will not be paid for discarded amounts of drugs or biologicals when billing includes pricing per HCPCS code or NDC units.
- The extra amount for the drug manufacturer provided to account for wastage in syringe hubs. Many manufacturers provide an extra drug in each vial to account for the wastage in the syringe hubs. The extra amount should not be billed because it is not an expense to the provider and it exceeds the amount of the vial or package label.
- The administered plus wasted drug cannot exceed the labeled quantity on the vial.
- Single-use vials which have been reimbursed for discarded/wasted drugs, using the -JW modifier, for one member may not be billed for use on other members.
- Coverage does not apply if the provider chooses to purchase larger packages (for a lower per unit cost) when smaller, more appropriate packaging is available.
- Payment will not be given to a provider or facility due to a member missing an appointment or the member declining administration after the drug is prepared.
- Volumes or quantities of the drug or biological billed over the manufacturer's labeled package volume or mass ("overfill") will not be payable and must not be billed for use on members.
- On-body injector system that has been applied, but the drug does not deliver. Examples include, but are not limited to, Neulasta OnPro® (J2506- Injection, pegfilgrastim, excludes biosimilar, 0.5 mg eff 1/1/2022, J2505- Injection, pegfilgrastim, 6 mg pre 1/1/2022) or UDENYCA (pegfilgrastim-cbqv) co-packaged with on-body injector (Q5111-

Injection, pegfilgrastim-cbqv (udenyca), biosimilar, 0.5 mg eff 1/1/2019).

- Drug stored outside the storage requirements described within the product(s) prescribing information or improperly stored or compounded in accordance with the United States Pharmacopeia General Chapter (797) -Pharmaceutical Compounding.
- Pharmaceuticals that are not administered to a member and/or are deemed contaminated, expired or considered waste due to spillage or breakage.
- The shipping company damages the drug in route to the member or provider.
- The provider mishandles, damages, or does not appropriately reconstitute the drug.
- Theft from provider or shipping company.
- Drug or biologicals for members enrolled in a program which requires drug manufacturers to enter into a National Drug Rebate Agreement (NDRA) and the NDC is not eligible for rebate on the date of service.
- Discarded drugs or biologicals if the NDC code is not present and accurate on the claim.
- The dose was not clearly documented in the member's medical record. If a dose is based on patient specific factors (weight, body surface area), the medical record must document current measurements and actual dose administered to the member.

Whole Vial or Package Waste

Whole vials or packages billed as waste will not be payable in most circumstances. Scenarios of non-payable whole vial or package waste include, but are not limited to:

- Wastage where the drug is not separately payable.
- Multi-dose vials or packages appended with -JW modifier.
- The -JW modifier will not be payable when billed and another claim line for the administered drug is not billed for the same drug and date of service. Claims for whole vial or packages submitted with the- JW modifier will not be paid.

Provider Billing Guidelines and Documentation

The -JW modifier is a CPT®/HCPCS Level II modifier used to report the amount of drug or biological that is discarded. The actual dosage of drugs or biologicals must be reported with the correct CPT®/HCPCS code and the correct units of service. The discarded amount must be billed on a separate line with the -JW modifier for all non-inpatient places of service. Suppliers and providers must append the- JW modifier on claims for discarded drugs and biologicals from any single-use vials and or single-use packages when they are discarded. In addition, suppliers and providers must document the amount of the discarded drugs or biologicals in the member's medical records.

Blue Cross VT reserves the right to request supporting documentation. Claim(s) that do not adhere to coding and billing guidelines may result in a denial or reassigned payment rate. Wasted/discarded drug and biological claim submissions are evaluated on a case-by-case basis that may include a review of applicable medical documentation including documentation of drug product preparation.

Benefit Determination Guidance

Payment for services is determined by the member's benefits. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Eligible services are subject to applicable member cost sharing such as co-payments, co-insurance, and deductible.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information, please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Inter Plan Programs (IPP): In accordance with the Blue Cross and Blue Shield Association's Inter-Plan Programs Policies and Provisions, this payment policy governs billing procedures for goods or services rendered by a Vermont-based provider (Blue Cross VT is the local Plan), including services rendered to out-of-state Blue members. Provider billing practices, payment policy and pricing are a local Plan responsibility that a member's Blue Plan must honor. A member's Blue Plan cannot dictate the type of claim form upon which services must be billed, codes and/or modifiers, place of service or provider type, unless it has its own direct contract with the provider (permitted only in limited situations). A member's Blue Plan cannot apply its local billing practices on claims rendered in another Plan's service area. A member's Blue Plan can only determine whether services rendered to their members are eligible for benefits. To understand if a service is eligible for payment, it is important to verify the member's benefits **prior** to providing services. In certain circumstances, the member may be financially responsible for services beyond the benefit provided for eligible services.

Claims are subject to payment edits that are updated at regular intervals and generally based on Current Procedural Terminology (CPT®), Health Care Procedural Coding System (HCPCS), Internal Classification of Diseases, CMS National Correct Coding Initiative Edits, Specialty Society guidelines, etc.

Eligible Providers

This policy applies to all providers/facilities contracted with the Plan's Network (participating/in- network) and any non-participating/out-of-network providers/facilities.

Audit Information

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure adherence with the guidelines stated in the payment policy. If an audit identifies instances of non-adherence with this payment policy, Blue Cross VT reserves the right to recover all

non-adherence payments.

Legislative and Regulatory Guidelines

(Not Applicable)

Related Policies

(Not Applicable)

References

CMS Medicare Claims Processing Manual, Chapter 17, Drugs and Biologicals
https://www.cms.gov/Regulationsand-uidance/Guidance/Manuals/downloads/clm104c17.pdf

CMS Billing and Coding: -JW Modifier Billing Guidelineshttps://www.cms.gov/medicare-coveragedatabase/view/article.aspx?articleid=53024&ver=12&keyword=JW+Modifier&keywordType=starts&areaId=all&docType=NCA%2cCAL%2cNCD%2cMEDCAC%2cTA%2cMCD%2c6%2c3%2c5%2c1%2cF%2cP&contractOption=all&sortBy=relevance&bc=1

United States Pharmacopeia General Compounding Chapter (797):
https://www.usp.org/compounding/general-chapter-797

Document Precedence

The Blue Cross VT Payment Policy Manual was developed to provide guidance for providers regarding Blue Cross VT payment practices and facilitates the systematic application of Blue Cross VT member contracts and employer benefit documents, provider contracts, Blue Cross VT corporate medical policies, and Plan's claim editing logic. Document precedence is as follows:

1) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the member contracts or employer benefit documents, the member contract or employer benefit document language takes precedence.
2) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and provider contract language, the provider contract language takes precedence.
3) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and corporate medical policy, the corporate medical policy takes precedence.

4) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the Plan's claim editing solutions, the Plan's claim editing solution takes precedence.

Policy Implementation/Update Information

This policy was originally implemented in November 2010

Date of Change	Effective Date	Overview of Change
07/31/2025	11/01/2025	This policy is moving from a Medical Policy to a Payment Policy. Formatting changed and moved to new template.
10/16/2025	01/01/2026	Name changed from "Drug Wastage" to "Discarded Drugs and Biologicals (Professional & Facility)". Policy statements remain unchanged. Additional policy language added to improve, define and clarify intent with specific examples. Update references.

Approved by **Update Approved: 10/16/2025**

Tom Weigel, MD

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