IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies use Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms (CMS 1450). Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy. This information is intended to serve only as a general resource regarding UnitedHealthcare’s reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee’s benefit coverage documents. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations.

UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

*CPT copyright 2010 (or such other date of publication of CPT) American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

Proprietary information of UnitedHealthcare. Copyright 2014 United HealthCare Services, Inc.
Electronic equivalent or its successor form. This policy applies to all products, all network and non-network physicians, and other health care professionals. The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing UnitedHealthcare. It is not enough to link the procedure code to a correct, payable ICD-9-CM diagnosis code. The diagnosis must be present for the procedure to be paid. Compliance with the provisions in this policy is subject to monitoring by pre-payment review and/or post-payment data analysis and subsequent medical review. The effective date of changes/additions/deletions to this policy is the committee meeting date unless otherwise indicated. CPT codes and descriptions are copyright 2010 American Medical Association (or such other date of publication of CPT). All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS/DFARS restrictions apply to Government use. Fee schedules, relative value units, conversion factors, and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Current Dental Terminology (CDT), including procedure codes, nomenclature, descriptors, and other data contained therein, is copyright by the American Dental Association, 2002, 2004. All rights reserved. CDT is a registered trademark of the American Dental Association. Applicable FARS/DFARS apply.

**Summary**

**Overview**

**Drugs and Biologicals**

B3-2049, A3-3112.4.B, HO-230.4.B The Medicare program provides limited benefits for outpatient drugs. The program covers drugs that are furnished "incident to" a physician's service provided that the drugs are not usually self-administered by the patients who take them. Generally, drugs and biologicals are covered only if all of the following requirements are met: They meet the definition of drugs or biologicals (see Sec.50.1); They are of the type that are not usually self-administered. (see Sec.50.2); They meet all the general requirements for coverage of items as incident to a physician's services (see Sec.Sec.50.1 and 50.3); They are reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered according to accepted standards of medical practice (see Sec.50.4); They are not excluded as noncovered immunizations (see Sec.50.4.4.2); and They have not been determined by the FDA to be less than effective. (See Sec.50.4.4). Medicare Part B does generally not cover drugs that can be self-administered, such as those in pill form, or are used for self-injection. However, the statute provides for the coverage of some self-administered drugs. Examples of self-administered drugs that are covered include blood-clotting factors, drugs used in immunosuppressive therapy, erythropoietin for dialysis patients, osteoporosis drugs for certain homebound patients, and certain oral cancer drugs. (See Sec.110.3 for coverage of drugs, which are necessary to the effective use of Durable Medical Equipment (DME) or prosthetic devices.)

**Discarded Drugs and Biologicals**

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. However, if a physician, hospital or other provider must discard the remainder of a single use vial or other single use package after administering a dose/quantity of the drug or biological to a Medicare patient, the program provides payment for the amount of drug or biological discarded along with the amount administered, up to the amount of the drug or biological as indicated on the vial or package label. Medical record documentation must clearly indicate the amount of drug administered and the amount wasted. When billing drugs, units of service must be billed in multiples of the dosage specified in the full HCPCS descriptor. This descriptor does not always match the dose given. The units billed must correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient. The following examples will help illustrate some of these points:

**Example of choice of vial size**

HCPCS for drug A indicates 1 unit = 30 mg.

Drug A doses available from the manufacturer: 60 mg vial and 90 mg vial.

The amount prescribed for the patient is 48 mg. If the provider uses a 90 mg vial to administer the dose, the provider may only bill 2 units (rather than 3 units) as the doses available from the manufacturer allow the prescribed amount to be administered with a 60 mg vial.
Discarded Drugs and Biologicals

Additionally, if after administering the prescribed dosage of any given drug, the provider must discard the remainder of a single-use vial or other package, Medicare may cover the amount of the drug discarded along with the amount administered.

**Examples of wastage of single use vials:**
Currently, onabotulinumtoxinA (Botox) is available only in a 100-unit size and has a short shelf life. Often, a patient receives less than a 100-unit dose. Because this is a very expensive drug, physicians are encouraged to schedule patients in such a way that they can use Botox most efficiently.

HCPCS code J0585 is defined as onabotulinumtoxinA, per unit. The physician schedules three Medicare patients to receive Botox on the same day and administers thirty (30) units to each patient. The remaining ten (10) units are billed to Medicare on the account of the last patient. Therefore, thirty (30) units are billed on behalf of the first two patients. Forty (40) units are billed on behalf of the last patient seen because the physician had to discard ten (10) units at that point due to the limited shelf life of the drug. The documentation for the last patient should indicate thirty (30) units administered to the patient and ten (10) units wasted. If the ten (10) units wasted are not indicated in the medical record, the physician will only be reimbursed for the thirty (30) units administered to the patient.

The first two patients are billed with J0585, thirty (30) units each. The third patient is billed as J0585, forty (40) units on one line. In the record, the documentation for the last patient should indicate thirty (30) units administered to the patient and ten (10) units wasted. If the ten (10) units wasted are not indicated in the medical record, the physician will only be reimbursed for the thirty (30) units administered to the patient.

If a physician must discard the remainder of a vial after administering it to a Medicare patient, the program covers the amount of drug discarded along with the amount administered. The example below from another Contractor would be illustrative of this situation:

**Per Unit Example, Single Patient:**
A physician must administer 15 units of onabotulinumtoxinA to a Medicare patient, and it is not practical to schedule another patient who requires this botulinum toxin, as the physician has only one patient who requires botulinum toxin, or the physician sees the patient for the first time and does not know the patient will be receiving the drug upon scheduling. HCPCS code J0585, onabotulinumtoxinA, per unit, is billed for a total of one hundred (100) units. Again, the record must reflect the wastage.

**Example illustrating the billing of wastage when the waste is included in the units reported:**
"If 2.5 milligrams of Zoledronic Acid is administered, it is appropriate to bill for 3 units, as the HCPCS defines the unit for Zoledronic Acid as 1 milligram.” In this example, the wastage is already considered reimbursed in the billing of the 3 units. (2.5 mg given and 0.5mg wasted). The entire 3mg expense to the provider is covered with one detail line by billing the J code multiplied by three. The medical record must document the 2.5 mg injected and the 0.5mg of wastage.

As a reminder, drug wastage cannot be billed if none of the drug was administered (such as a missed appointment by the patient).

**NOTE:** Multi-use vials are not subject to payment for discarded amounts of drug or biological.

**Reimbursement Guidelines**
The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This information does not take precedence over CCI edits. Please refer to CCI for correct coding guidelines and specific applicable code combinations prior to billing Medicare.

- If the "J" code descriptor can be multiplied to reflect the dosage being administered, use the J-code, with the appropriate number of units which reflect the dosage given.
- It is not appropriate to use the "J" code with a multiplier in the units' field, when there is another "J" code, which more closely describes the amount given.
- It is not appropriate to bill for the full amount of a drug when it has been split between two or more patients. Bill only for the amount given to each beneficiary.
- NOC codes should only be reported for those drugs that do not have a valid HCPCS code which describes the drug being administered.
- When appropriate, the NOC code is selected based upon the therapeutic value of the drug (e.g., J8999 Prescription drug, oral, chemotherapeutic, NOS; J3490 Unclassified drugs, etc.).
Discarded Drugs and Biologicals

- When billing with an NOC code, include on the claim, the narrative description reflective of the agent and the dose administered.
- Where the sole purpose of an office visit was for the patient to receive an injection, (CPT codes 96372, 96373, 96374, and 96379) payment may be made only for the injection service (if it is covered).
- Conversely, injection services (CPT codes 96372, 96373, 96374, and 96379) included in the Medicare Physician Fee Schedule (MPFS) are not paid for separately, if the physician is paid for any other physician fee schedule service furnished at the same time.
- The drug is separately payable. All injection claims must include the specific name of the drug and dosage. Identification of the drug enables proper payment for the services.

JW Modifier

Medicare guidelines state to report the drug amount administered on one line, and on a separate line you may report the amount of drug NOT administered (wasted) with modifier –JW appended to the associated HCPCS code. Modifier –JW is only applicable to the amount of the drug discarded or wasted, and not the amount administered. Further, the amount wasted and identified by the use of modifier –JW, must be at least equal to one billing unit. For example, if the HCPCS code is reportable in 10mg increments and you administered 7mg of a 10mg SDV, report the entire billing unit (1) without a separate line for the amount wasted. If, on the other hand, a HCPCS code is reportable in 10mg increments, and you administered 70mg from a 100mg SDV, you may report 7 bill units as administered, and on a separate line report 3 bill units with modifier –JW appended to the HCPCS to indicate the drug amount discarded.

 Modifier –JW is not permitted to identify discarded amounts from a multi-dose vial (MDV). In order to ensure you do not receive overpayment, remember to always roll the amount administered UP to the next bill unit when reporting the amount of drug discarded. For example, if a HCPCS code is reportable in 10mg increments, and you administered 77mg from a 100mg SDV, you may report 8 bill units as administered, and on a separate line report 2 bill units with modifier –JW appended to the HCPCS to indicate the amount discarded.

As always, Medicare expects the administration of drugs to be scheduled and performed in an efficient manner, minimizing the amount of drug wastage.

Refer to CMS Transmittal 1962, Change Request (CR) 6711, issued April 30, 2010, for full text.

Documentation Information

Documentation is expected to be maintained in the patient’s medical record and to be available to UHC upon request.

Every page of the record is expected to be legible and include both the appropriate patient identification information (e.g., complete name dates of service(s)), and information identifying the physician or non-physician practitioner responsible for and providing the care of the patient.

The submitted medical record should support the use of the selected ICD-9-CM code(s).

The submitted CPT/HCPCS code should describe the service performed.

When a portion of the drug is discarded, the medical record is expected to clearly document the amount administered and the amount wasted.

<table>
<thead>
<tr>
<th>CPT/HCPCS Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Code</strong></td>
</tr>
<tr>
<td>J0120–J9999</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Modifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Code</strong></td>
</tr>
<tr>
<td>JW</td>
</tr>
</tbody>
</table>

Questions and Answers

1. Q: How should medications be billed?
## Discarded Drugs and Biologicals

<table>
<thead>
<tr>
<th>Q</th>
<th>A</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A:</strong> Medications should be billed using the correct Revenue Code and/or Healthcare Common Procedure Coding System (HCPCS) codes for the medication that is being administered and the correct number of units should be entered for the dose that is being administered.</td>
<td></td>
</tr>
<tr>
<td><strong>Q:</strong> How should a Medicare provider correctly bill units for drugs?</td>
<td><strong>A:</strong> The provider should be attentive to the long description of the Healthcare Common Procedure Coding System (HCPCS) code. The definition of the HCPCS code specifies the lowest common denominator of the amount of the dosage. Providers should utilize the unit's field as a multiplier to arrive at the dosage amount. For example, J1756 is described as an injection for iron sucrose, 1 mg. For a total dosage of 100 mg, the provider will show (100) in the units field.</td>
</tr>
<tr>
<td><strong>Q:</strong> Can a provider charge for the 'waste' of a medication when they have used a partial vial of a drug and there is not another patient scheduled who could receive the same drug?</td>
<td><strong>A:</strong> Providers are encouraged to schedule patients in such a way that the provider can use the drug most efficiently. However, if the provider must discard the remainder of a <strong>single use vial</strong> after administering part of it to a Medicare patient, the provider may bill for the amount of drug discarded along with the amount administered. <strong>To clarify,</strong> coverage of discarded drugs applies only to <strong>single use vials.</strong> Multi-use vials are not subject to payment for discarded amounts of drug. An itemized bill or medication administration records should be submitted with the claim to verify how the drug was supplied.</td>
</tr>
<tr>
<td><strong>Q:</strong> What information is needed in the medical record when billing for medications and/or billing for the 'waste'?</td>
<td><strong>A:</strong> It is expected that the medical record will contain the name of the drug, dosage, route of administration, time and date given. When a portion of the drug is discarded, the medical record must clearly document the amount administered and the amount wasted.</td>
</tr>
</tbody>
</table>

### References Included (but not limited to):

**CMS LCD**

**CMS Claims Processing Manual**
Chapter 17; §40 Discarded Drugs and Biologicals

**CMS Transmittals**
Transmittal 1962, Change Request 5120, Dated 07/30/2010 (Discarded Drugs and Biologicals Updates)

**MLN Matters**
Article MM6711, Discarded Drugs and Biologicals Updates
Article MM7095, Discarded Drugs and Biologicals Policy at Contractor Discretion

**Others**
Billing Discarded Drugs and Biologicals, Noridian Administrative Services, LCC

### History

<table>
<thead>
<tr>
<th>Date</th>
<th>Revisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/26/2014</td>
<td>• Policy presented to MRPC</td>
</tr>
<tr>
<td></td>
<td>• Approved</td>
</tr>
<tr>
<td>04/24/2013</td>
<td>• Policy presented to MPRC</td>
</tr>
<tr>
<td></td>
<td>• Approved</td>
</tr>
</tbody>
</table>