



CLINICAL REIMBURSEMENT POLICY	
Policy Name:	Convenience Kits, Drug and Biological Waste
Policy Number:	HWC-RP-1150
Responsible Department(s):	Medical Management
Provider Notice/Issue Date:	09/28/2026
Effective Date:	12/01/2026
Next Annual Review:	12/2027
Revision Date:	09/2026
Products:	Highmark Wholecare SM Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1 of 3

Policy History

Date	Action
12/01/2026	Provider Effective date
07/27/2026	Policy initially developed

Disclaimer

Highmark WholecareSM medical policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

Policy Statement

Highmark WholecareSM may provide coverage under the medical (medical-surgical, DME, therapy etc.) benefits of the Company's Medicaid products for medically necessary. This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

(Current applicable Pennsylvania HealthChoices Agreement Section V. Program Requirements, B. Prior Authorization of Services, 1. General Prior Authorization Requirements.)

Definitions

Prior Authorization Review Panel (PARP) – A panel of representatives from within the PA Department of Human Services who have been assigned organizational responsibility for the review, approval and denial of all PH-MCO Prior Authorization policies and procedures.

Procedures

Drug Wastage

When the total vial of a drug or biological cannot be administered to one or more patients and is discarded (i.e., wastage), the appropriate drug or biological code along with the JW modifier should be reported on a separate line and is eligible for reimbursement.

The Plan will reimburse for discarded or wasted amounts of drug when all of the following requirements are met:

1. The drug is being supplied from a “single-use” vial or “single-use” package.
2. The physician’s orders for the drug must be clearly and completely documented in the medical record.
 - a. 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 provided to The Plan.
 - ✓ 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 as a separate or second line item, with modifier JW attached.

The Plan will only reimburse for the minimum amount of drug above what was actually ordered to arrive at the nearest whole vial using the smallest commercially available vial size and dose that result in the least amount of wastage.

The Plan does not reimburse discarded contrast material when billed with modifier JW. Providers should bill the appropriate contrast material code and report only the units administered.

The Plan does not reimburse for discarded or wasted amounts of drug from multi-dose vials or multi-use packages. It is inappropriate to report the JW modifier for wastage from a multi-dose vial or package.

Every attempt should be made to utilize the drug or biological in a responsible manner to avoid wastage.

Effective July 1, 2023, claim line(s) for drugs from single-dose or single use containers MUST append either the JZ modifier to report that there were no discarded amounts or append the JW modifier to report there was a discarded amount. On October 1, 2023, claims for drugs from single-dose or single

use containers that do not append one of these two modifiers on the claim line(s) may be rejected as unprocessable until claims are accurately resubmitted.

Convenience Kits

Convenience Kits are considered part of the provider's supply allowance used to administer the drug or biological; therefore, convenience kits are not reimbursed by the Plan. These charges are non-billable and a participating or network provider cannot bill the member for the denied service.

1. Post-payment Audit Statement

The medical record must include documentation that reflects the medical necessity criteria and is subject to audit by Highmark WholecareSM at any time pursuant to the terms of your provider agreement.

2. Place of Service

The proper place of service for Convenience kits, drugs and biological waste is outpatient.

Coding Requirements

Modifiers

Modifier	Description
JW	Drug/biological amount discarded/not administered to any patient
JZ	Zero drug amount discarded/not administered to any patient

Reimbursement

Participating facilities will be reimbursed per their Highmark WholecareSM contract.

Reference Sources

Centers For Medicare and Medicaid Services (CMS); Competitive Acquisition Program (CAP) for Part B drugs and biologicals.

Centers For Medicare and Medicaid Services (CMS); Claims Processing Manual Chapter 17: Drugs and Biologicals; section 100.2.9, and section 40.

Centers For Medicare and Medicaid Services (CMS); Medicare Coverage Database: L35041, Article ID 54117: Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds.