Part B Discarded Drug Units Report
Methodology
November 2020

Background

As of January 1, 2017, the Centers for Medicare and Medicaid Services (CMS) requires all physicians, hospitals, and other providers submitting Medicare Part B drugs claims to report any discarded amount of a single use vial or other single use package drug on its claim for reimbursement. Providers must use the "JW" modifier, a Healthcare Common Procedure Coding System (HCPCS) Level II modifier, to separately identify on the claim the exact discarded drug amount. In addition to paying for the amount of drug that has been administered to a beneficiary, Medicare Part B also pays for the amount of drug that has been discarded, up to the amount that is indicated on the vial or package label.

The Part B Discarded Drug Units report is a set of summary tables that present spending information for Medicare Part B drugs claims that were identified, using the "JW" modifier, as having discarded amounts of a drug. The tables allow users to identify single-use vial drugs with Medicare spending for discarded units in 2017 through 2019. The data provided can be used to highlight drugs where packaging changes and/or payment policy updates may result in savings to the Medicare program and the beneficiary.

These drugs were administered in doctors' offices and other outpatient settings and paid through the Medicare Part B program. Analyses of Part B drugs are possible for all Part B fee-for-service Medicare beneficiaries, but exclude any beneficiaries in the Medicare Advantage program (which represents over 35% of the Medicare population).

Medicare Part B claims were summarized by Healthcare Common Procedure Coding System (HCPCS) codes and limited to HCPCS codes listed in in the publicly available Medicare Average Sales Price (ASP) quarterly files for the year reported. The following Part B claims were excluded: claims billed using "Not Otherwise Classified" (NOC) codes (e.g. J3490, J3590, or J9999) and claims where Medicare was not the primary payer. Drugs with fewer than 11 Part B claims were excluded entirely. Additionally, any information based on fewer than 11 claims was redacted.

Drug Metrics

Drug spending metrics for Part B drugs are based on total spending, which is derived from summing the three revenue center payment fields on the claim referring to Medicare payment, deductible, and coinsurance. This represents the full value of the product, including the Medicare payment and beneficiary liability. All Part B drug spending metrics are calculated at the HCPCS level.

Drug Metric Definitions

- Total Allowed Amount: Total Medicare allowed amount for a given Part B Drug.
- Total Allowed Amount for Units Administered: Total Medicare allowed amount paid for claim lines billed without the modifier "JW", signifying portion of drug that was administered to beneficiary.
- Total Allowed Amount for Units Discarded: Total Medicare allowed amount paid for lines billed with the modifier "JW", signifying portion of drug that was not administered to beneficiary.
- Administered Units as % of Total Allowed Amount: Percentage of Medicare spending that Medicare paid for a given drug that was administered to a beneficiary.
- Discarded Units as % of total allowed amount: Percentage of Medicare spending that Medicare paid for a given drug that was identified as discarded.