healthfirst
Health Insurance for New Yorkers

# Reimbursement Policy

| | | | |
|---|---|---|---|
| **Subject:** | Discarded Drugs and Biologicals Billing Guidelines | | |
| **Policy Number:** | PO-RE-130v1 | | |
| **Effective Date:** | 01/01/2025 | **Last Approval Date:** | 06/16/2025 |

## I. Policy Description

This policy establishes guidelines for the proper billing and reimbursement of drugs and biologicals supplied in single-dose containers, specifically addressing situations involving wastage and discarding of such drugs. The aim is to ensure compliance with the Centers for Medicare & Medicaid Services (CMS) regulations, promote accurate claim submissions, and prevent improper reimbursements. The policy emphasizes the correct use of modifiers JW and JZ, documentation standards, and billing practices to reflect actual drug waste or full utilization.

The information below applies to the following lines of business:

- Child Health Plus (CHP)
- Medicaid Managed Care (MMC)
- Medicare Advantage
- Personal Wellness Plan (PWP)/Health & Recovery (HARP)
- Qualified Health Plan (QHP)
- Essential Plan (EP)
- Managed Long Term Care Plan (MLTCP – Senior Health Partners)
- Medicaid Advantage Plus/MAP (CompleteCare)
- Medicare PPO

**Policy Scope**

Healthfirst will no longer reimburse for excessive drug wastage that is not supported by proper documentation, as well as proper use of any related modifiers. All claims must comply with CMS guidelines regarding the reporting of discarded drugs and biologicals. The policy is based on CMS established standards for appropriate reporting and reimbursement of wastage, including the correct application of modifiers JW and JZ. Failure to adhere to these guidelines will result in denial of claims for wastage that lack sufficient documentation or proper coding.

**Reimbursement and Billing Guidelines**

Modifier JW and JZ

January 1, 2017, providers and suppliers are required to report the JW modifier on all claims that bill for drugs and biologicals (hereafter, drug) separately payable under Medicare Part B with unused and discarded amounts (hereafter, discarded amounts) from single-dose containers or single- use packages (hereafter, single-dose containers). Also, providers and suppliers must document the amount of discarded drugs in Medicare beneficiaries' medical records. Through subsequent rulemaking, we codified the requirement to use the JW modifier for single-dose container drugs that are separately payable under Part B. We will use the JW and JZ modifiers to calculate discarded drug refunds effective January 1, 2023.

Beginning July 1, 2023, providers and suppliers are required to report the JZ modifier on all claims that bill for drugs from single-dose containers that are separately payable under Medicare Part B when there are no discarded amounts.

CMS encourages physicians, hospitals and other providers and suppliers to care for and administer drugs and biologicals to patients in such a way that they can use drugs or biologicals most efficiently, in a clinically appropriate manner.

1. Modifier Definition:
    - Modifier JW: Indicates the drug amount discarded/not administered to any patient.
    - Modifier JZ: Indicates that there is a zero-drug amount discarded/not administered to any patient.
2. Modifier Usage:
    - Modifier JW:
        - Use a separate claim line to report the quantity of drug that was discarded (wasted) from a single-dose container.
        - Only the discarded amount should be billed with this modifier, calculated to reflect the minimum wastage necessary.
            1. For the administered amount, one claim line shall include the billing and payment code (such as a HCPCS code) describing the given drug, no modifier, and the number of units administered in the unit field.
            2. For the discarded amount, a second claim line shall include the same billing and payment code as used for the administered amount, the JW modifier, and the number of units discarded in the unit field. For example, if a single-use vial contains 100 units of a drug and only 80 units are administered, the remaining 20 units should be reported with the JW modifier.
    - Modifier JZ:
        - Use to indicate that there was zero drug wasted or discarded. It is essential for situations where the entire drug amount was administered to the patient, ensuring transparency and accuracy in reporting. For instance, if a single-use vial contains 100 units and all 100 units are administered, the JZ modifier should be used to indicate no wastage.

**Billing Procedure:**

1. Separate Claim Lines:
    - On CMS-1500 (for outpatient providers and physicians):
        - Line 24D:
            - Enter the drug HCPCS code (or CPT/HCPCS as appropriate).
            - Enter the units administered in Item 24G.
            - Leave Item 24H (unit charge) and 24I (total charge) to be filled automatically or as per usual billing practice.
        - Modifiers:
            - Leave blank for the administered amount.
            - For wastage, add JW to the same line or a separate line as per CMS guidelines, indicating the discarded units.
            - If there is no wastage, add JZ to the line for the full dose.

    - On CMS-1450 (UB-04 for institutional billing):
        - Form Locator 44 (HCPCS/Revenue Code):
            - Enter the specific HCPCS code for the drug.
        - Form Locator 46 (Unit or dosage):
            - Specify the dose per unit.
        - Modifiers:
            - Use JW or JZ in the appropriate modifier field (often in Item 78 or 79, depending on the software interface).
        - Separate lines:
            - For wastage, report the discarded units on a separate line with the same HCPCS code and the JW modifier.

2. Billing for Multiple Units:
    - When multiple units are involved, report units accurately.
    - For wastage, only bill the minimum necessary units with JW, based on the least wastage amount consistent with CMS guidelines.

3. Full Administration:
    - When no wastage occurs, bill only one line with the total units and JZ modifier to indicate zero wastage.

**Reimbursement Calculation**

- Reimbursement is based on the minimum wastage amount, rounded up to the nearest whole vial, considering the vial size and dose administered.
- Any excess wastage billed with the JW modifier beyond this minimum amount will be denied and regarded as part of bundled reimbursement.
- When using the JZ modifier, full reimbursement is provided for the entire dose, with no wastage reported.

**Documentation Requirements:**

- Physician’s orders must specify:

    - The drug name and dose.
    - The total vial contents.
    - The exact amount administered.
    - The amount discarded and the reason for wastage.
    - The date and time of administration.
- The total amount the vial is labeled to contain dose administered, discarded amount, exact time, and date the drug was administered, and the reason for the wastage.
    - The discarded drug/biological amount must be documented in the same location as the administration of the drug/biological.
- Reimbursement will be allowed for only the minimum amount of drug above what was ordered to arrive at the nearest whole vial using the vial size and dose that result in the least amount of wastage.
- Any excess wastage amount (billed with modifier JW but greater than the minimum wastage amount as described above) will be denied to provider write off as bundled or included in the reimbursement for the drug administered.
- The name, licensure, and signature of the professional responsible for administration and wastage must be recorded.
- Medical records must support the claim; a charge capture report is not considered part of the medical record and is not acceptable documentation to support drug wastage charges.

**Adjudication and Appeal Process**

1. Providers are encouraged to administer drugs efficiently to minimize wastage.
2. Proper use of modifiers JW and JZ is critical for compliance and accurate reimbursement.
3. Claims not adhering to these guidelines may be denied or rejected.
4. This policy aligns with CMS regulations and applies to all providers billing for drugs in single-dose containers under Medicare Part B.
5. If the line of business (LOB) is not mentioned in this policy, the services are not covered and not eligible for reimbursement.
6. Reimbursement is subject to member eligibility, program coverage, and medical necessity at the time the service is provided.
7. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst Provider Manual Subsection 17.6, "Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process" in this section.*

## II. Applicable Codes

| Code | Description | Comment |
|---|---|---|
| | | |
| | | |

| | | |
|---|---|---|
| | | |
| | | |

## III. Definitions

| Term | Meaning |
|---|---|
| | |
| | |
| | |

## IV. Related Policies

| Policy Number | Policy Description |
|---|---|
| PO-RE-088 | National Drug Code (NDC) Billing Requirements Reimbursement Policy |
| | |
| | |



*Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.*

## V. Reference Materials

| |
|---|
| CMS Medicare Claims Processing Manual, Chapter 17, Drugs and Biologicals |
| Discarded Drugs and Biologicals – JW Modifier and JZ Modifier Policy |
| Discarded Drugs and Biologicals – JW Modifier and JZ Modifier HCPCS Codes |
| OCE Quarterly Release Files |
| ASC Payment Rates - Addenda |

## VI. Revision History

| Revision Date | Summary of Changes |
|---|---|
| | |

healthfirst
Health Insurance for New Yorkers

**Disclaimer**

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for the services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.