ConnectiCare

Reimbursement Policy:

Discarded Drugs/Biologicals – Modifiers JW & JZ (Commercial)

POLICY NUMBER	EFFECTIVE DATE:	APPROVED BY
RPC20230047	1/1/2021	**RPC (Reimbursement Policy Committee)**

Reimbursement Guideline Disclaimer: We have policies in place that reflect billing or claims payment processes unique to our health plans. Current billing and claims payment policies apply to all our products, unless otherwise noted. We will inform you of new policies or changes in policies through postings to the Reimbursement Policies webpage on connecticare.com. Further, we may announce additions and changes in our provider manual and/or provider newsletters which are available online and emailed to those with a current and accurate email address on file. The information presented in this policy is accurate and current as of the date of this publication.

The information provided in our policies is intended to serve only as a general reference resource for services described and is not intended to address every aspect of a reimbursement situation. 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, physician or other provider contracts, the member's benefit coverage documents and/or other reimbursement, and medical or drug policies. Finally, this policy may not be implemented the same way on the different electronic claims processing systems in use due to programming or other constraints; however, we strive to minimize these variations.

We follow coding edits that are based on industry sources, including, but not limited to, CPT® guidelines from the American Medical Association, specialty organizations, and CMS including NCCI and MUE. In coding scenarios where there appears to be conflicts between sources, we will apply the edits we determine are appropriate. We use industry-standard claims editing software products when making decisions about appropriate claim editing practices. Upon request, we will provide an explanation of how we handle specific coding issues. If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may deny the claim and/or recoup claim payment.

Overview:

ConnectiCare has based this reimbursement policy on the guidelines established by the Centers of Medicare and Medicaid Services (CMS) regarding reimbursement and appropriate reporting of discarded drugs and biologicals.

The intent of this policy is to serve as a general reference guide for the appropriate use of modifier JW when appended to CPT®/HCPCS codes submitted on professional and/or facility claims for discarded drugs and biologicals administered from single use vials, single use packages, and multi-use vials.

Policy Statement:

When a physician, hospital or other provider/supplier must discard the remainder of a single use/dose vial or other single use/dose package after administering a dose of the drug or biological, ConnectiCare will reimburse the amount of drug or biological discarded as well as the dose administered, up to the amount of the drug or biological as indicated on the vial or package label provided the criteria below are met.

Note: ConnectiCare does not reimburse for discarded or wasted amounts of drug from multi-dose vials/multi-use packages.

All services described in this policy may be subject to additional ConnectiCare reimbursement policies including, but not limited to, Maximum Frequency per Day.

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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
Single-Dose Vial	A vial of medication intended for administration by injection or infusion that is meant for use in a single patient for a single procedure. These vials are labeled as single-dose or single-vial by the manufacturer
Multi-Dose Vial	A vial of medication intended for administration by injection or infusion that contains more than one dose of medication. These vials are labeled as multi-dose by the manufacturer and typically contain an antimicrobial preservative to help prevent the growth of bacteria.

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

Reimbursement Guidelines:

Modifier JZ (No Discarded Amount/Waste):

- **Effective 4/1/2024**, ConnectiCare has aligned with CMS and JZ modifier is required on all claims that bill for drugs from single-dose containers when there are no discarded amounts.
- For the administered drug amount, the claim line should include the billing and payment code (such as HCPCS code) describing the given drug, the JZ modifier (attesting that there were no discarded amounts), and the number of units administered in the units field.

Example of Appropriate Use of Modifier JZ:

Modifier JZ for reporting drugs from single-dose containers with no wastage, submit one complete claim line:

- **Claim line #1:**

  HCPCS code for drug given with JZ modifier appended, the number of units given to the patient, and calculated price for the administered amount

  Example: J1234 JZ

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Modifier JW (Reporting Discarded Amount/Waste):

- A valid National Drug Code (NDC) number is required in addition to, the applicable revenue, HCPCS or CPT code.
- When billing drugs, units of service must be billed in multiples of the dosage specified in the full CPT/HCPCS descriptor. This descriptor does not always match the dose given.
- To minimize waste, 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.
    - For Example: The CPT/HCPCS code for Drug A indicates 1 unit = 30 mg. Drug A is available from the manufacturer in 60mg and 90 mg vials. 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 submit 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.
- Any excess discarded/wasted amount (submitted with modifier JW but greater than the minimum wasted amount possible as described above) will be denied as bundled or included in the reimbursement for the drug administered.
- Modifier JW must be appended to a claim in order to obtain payment for unused or discarded amount of drug/biological in single dose vial or single use packaging only.
    - Report the drug amount administered on one claim line *and*
    - On a separate line, report the discarded or unused drug/biological with modifier JW appended.
- Do not append modifier JW if no discarded drug/biological is being billed.
- The unused amount the drug/biological must actually be discarded and may not be used for another patient
- Use of modifier JW is not appropriate for drugs/biologicals that are from multi-dose vials or multi-use packages.
- Use of modifier JW is not appropriate when the actual dose of the drug/biological administered is less than the billing unit
    - For Example: One billing unit for a drug is equal to 10mg of the drug in a single use vial. A 7 mg dose is administered to a patient while 3 mg of the remaining drug is discarded. The 7 mg dose is billed using one billing unit that represents 10mg on a single line item. The single line item of 1 unit would be processed for payment of the total 10 mg of 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 of an overpayment.*
- To avoid an overpayment, providers and facilities must always roll the amount administered UP to the next bill unit, then roll DOWN to the previous bill unit when reporting the amount of drug discarded.

Example of Appropriate Use of Modifier JW:

Modifier JW for reporting waste for drugs from single-dose containers, submit two complete claim lines:

- **Claim line #1:**

  HCPCS code for drug administered with no modifier appended

  Claim line #2:

  HCPCS code for drug given with JW modifier appended (number of units wasted)

  Example: J1234 JW **OR** J1234
  J1234 J1234W

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Documentation Requirements:

The patient's medical record documentation must include the following:

- Physician's orders for the drug
- The amount of the drug administered including the discarded drug/biological
  - The total amount the vial is labeled to contain
  - The date and time the drug was discarded,
  - The amount discarded,
  - The name, licensure, and signature of the person who wasted the drug.
- The discarded drug/biological amount must be documented in the same location as the administration of the drug/biological
- A charge capture report is not considered part of the medical record and is not acceptable documentation to support drug wastage charges.

ConnectiCare may request medical records for review. These reviews can be internal or external (also known as vendor reviews). When records are received in response to the records request, the items received are considered to be the complete documentation needed to support the services billed; any items later received are deemed not to have existed at the time the claim was submitted. It is the responsibility of the billing provider to ensure that their responses to records requests are both prompt and complete.

- *Neither additional records nor amended records will be accepted once the audit review is complete*
- *If the physician's order, drug administered, and amount discarded/wasted are not clearly, completely, and properly documented in the medical records submitted for review, any excess billed amounts will be denied for insufficient documentation; and the member may not be billed.*

A provider may dispute denials of drug amounts following a claim review by submitting a written appeal. The documentation submitted for appeal reconsideration should include a written explanation of how the records submitted for the original review support the items and quantities billed. The explanation should also include how the number of billed units was calculated based on the physician's orders and medical records.

Note: Additional records that were not submitted for the original review cannot be considered in the appeal process.

References:

1. American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services.
2. Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
3. Centers for Medicare and Medicaid Services, CMS Manual System or other CMS publications and services
4. Centers for Medicare and Medicaid Services, Medicare-Fee-For-Service, Hospital Outpatient PPS, Discarded Drugs and Biologicals – JW Modifier and JZ Modifier Policy, https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/jw-modifier-faqs.pdf

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Revision History

Company(ies)	DATE	REVISION
ConnectiCare	2/26/2025	• Policy title updated to include Modifier JZ • Addition of requirement of modifier JZ, **effective 4/1/2024** • Added examples of appropriate use of modifiers JW & JZ for clarity
ConnectiCare	2/26/2025	• Transferred policy content to individual company-branded template. No changes to policy title or policy number.
EmblemHealth **ConnectiCare**	1/1/2021	• EH: New Policy • CCI: New Policy