REIMBURSEMENT POLICY STATEMENT
Marketplace

Policy Name		Policy Number	Effective Date
Single Dose Vial – Claims Modifiers		PY-PHARM-0104	01-01-2025
Policy Type			
Medical	Administrative	Pharmacy	**REIMBURSEMENT**

Reimbursement Policy Statement: Reimbursement Policies prepared by CareSource and its affiliates are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, indust ry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable re ferral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service (s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

This policy provides guidance for claims billing documentation and reimbursement of single dose injectable vials.

B. Background

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS/ICD-10 code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

This policy describes documentation requirements and reimbursement guidelines for billing of the administered and discarded portion(s) of drugs and biologicals. Providers shall bill and receive reimbursement for both the dose administered and the unused portion of weight-based or variable dosing injectable drugs that are manufactured and supplied only in single dose or single use format.

The JW modifier is required to be reported on a claim to report the amount of drug that is discarded and eligible for payment and should be used only for claims that bill single-dose container drugs. The discarded portion of single use or single dose vials must be identified with the JW Modifier as a separate line item from the dose or administered portion. Providers may be reimbursed for the discarded portions of drugs and biologicals in single-dose vials (otherwise known as drug waste) only when appropriately reported based on the policy reimbursement guidelines.

As of July 1, 2023, providers and suppliers are required to report the JZ modifier on all claims that bill for drugs from single-dose containers when there are no discarded amounts. The JZ modifier is reported on a claim to attest that no amount of drug was discarded and should only be used for claims that bill for single-dose container drugs. Claims containing drug administered from multi-dose vials are not subject to this requirement.

Under this policy, all claims for separately payable single dose format injectable drugs must include either a JW modifier or a JZ modifier after 7-1-2023 in order to be reimbursed

MODIFIER	SHORT DESCRIPTOR	LONG DESCRIPTOR
JW	Discarded portion of drug not administered	Drug amount discarded/not administered to any patient
JZ	All drug administered – none discarded	Zero drug amount discarded/not administered to any patient

C. Definitions

Modifier JW refers to the drug amount discarded (wasted)/not administered to any patient.

Modifer JZ refers to zero drug amount discarded/not administered to any patient.

Discarded Wastage or Unused Portion is defined as 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 is defined as 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 and typically do not contain a preservative.

Multi-Dose Vial is defined as 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.

D. Policy

Modifier JW should be billed on the detail line that denotes the discarded portion of the drug or biological. The amount administered to the patient should be billed on a separate detail line without modifier JW. Both details are reimbursable.

- Caresource will consider reimbursement for:
  - I. A single-dose or single-use vial drug that is wasted, when Modifier JW is appended.
  - II. The wasted amount when billed with the amount of the drug that was administered to the member.
  - III. The wasted amount billed that is not administered to another patient.

- CareSource will NOT consider reimbursement for:
  - I. The wasted amount of a multi-dose vial drug.
  - II. Any drug wasted that is billed when none of the drug was administered to the patient.
  - III. Any drug wasted that is billed without using the most appropriate size vial, or combination of vials, to deliver the administered dose.

NOTE: The JZ modifier is required when there are no discarded amounts of a single - dose container drug for which the JW modifier would be required if there were discarded

amounts. The JZ modifier is required to attest that there were no discarded amounts, and no JW modifier amount is reported.

E. Conditions of Coverage

- Providers must not use the JW modifier for medications manufactured in a multi-dose vial format.
- Providers must choose the most appropriate vial size(s) required to prepare a dose to minimize waste of the discarded portion of the injectable vials.
- Claims considered for reimbursement must not exceed the package size of the vial used for preparation of the dose. Providers must not bill for vial contents overfill.
- Providers must not use the JW modifier when the actual dose of the drug or biological administered is less than the billing unit.
- The JW Modifer is only applied to the amount of drug or biological that is discarded (wasted). The discarded (wasted) drug should be billed on a separate line with the JW modifier.
    1. Claim Line #1 – HCPCS code for drug administered and the amount admistered to the patient.
    2. Claim Line #2 – HCPCS code for drug discarded (wasted) with JW modifier appended to indicate waste and the amount discarded (wasted).
- The JZ Modifier is applied when zero amounts of a single-dose container drug is discarded.

F. Related Policies/Rules

- Chapter 17, Section 40.1 of CMS Medicare Claims Processing Manual

G. Review/Revision History

	DATE	ACTION
Date Issued	01-22-2023	Original effective date
Date Revised	08-25-2023	Updated policy to include JZ modifier. Updated policy name and references.
	10-11-2024	Annual review. No changes.
Date Effective	01-01-2025	
Date Archived		

H. References

1. Billing and Coding: JW and JZ Modifier Billing Guidelines Article - Billing and Coding: JW and JZ Modifier Billing Guidelines (A55932) (cms.gov)
2. New JZ Claims Modifer for Certain Medicare Part B Drugs https://www.cms.gov/files/document/mm13056-new-jz-claims-modifier-certain-medicare-part-b-drugs.pdf
3. Discarded Drugs and Biologicals – JW Modifier and JZ Modifier Policy FAQs. jw-modifier-faqs.pdf (cms.gov)

The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.