Priority Health	BILLING POLICY No. 188
JW, JZ: DRUG DOSING MODIFIERS	
Date of origin: 4/2026	**Review dates: 10/2026**

POLICY OVERVIEW

This policy provides guidelines for billing, coding, and documentation associated with JW and JZ modifiers, ensuring claims are processed according to contractual agreements and industry standards. This policy applies to all products.

DEFINITION

The JW and JZ modifier policy applies to all drugs separately payable that are described as being supplied in a “single-dose” container or “single-use” package based on FDA-approved labeling.

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

Modifier JW - Drug amount discarded

The JW modifier is used to identify discarded doses or quantities of the drug or biological from a single-use vial or single-use packaging. We’ve adopted the CMS guideline requiring JW be appended to obtain payment for the discarded amounts effective January 1, 2017. Dosage or quantity reported as waste should be discarded and not administered to another member, with documentation in the medical record to support.

Units reported must correspond with the smallest dose (vial) available from drug manufacturer or pharmacy for purchase. This allows for minimal waste or discarded drug or biological.

Modifier JZ - Zero drug amount discarded

The JZ modifier is used to identify that no amount of drug was discarded and eligible for payment. To align with the CMS modifier policy effective July 1, 2023, the JZ modifier is required when there are no discarded amounts.

MEDICAL POLICY

- No related PH medical policy

FOR MEDICARE

For indications that don’t meet criteria of NCD, local LCD, or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient’s medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

Documentation requirements and Coding Specifics

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect modifier reporting

Modifier JW and/or JZ appended to a claim that is supplied in a multi-dose container will deny for inappropriate modifier use.

Appending both modifier JZ and JW to one claim line is not an appropriate modifier combination and will cause the claim line to be denied.

Both modifiers JW and JZ do not apply to drugs that are not separately payable, such as packaged OPPS or ASC drugs, or drugs administered in the FQHC or RHC setting.

Claim examples of JW and JZ modifiers

JW modifier reporting
Report the drug code on two claim lines (see below)

Claim line 1:
- HCPCS code for drug given
- No modifier
- Number of units given to the patient
- Calculated submitted price for only the amount of drug given

Claim line 2:
- HCPCS code for drug wasted
- JW modifier to indicate waste
- Number of units wasted
- Calculated submitted price for only the amount of drug wasted

JZ modifier reporting
To submit claims for a non-discarded drug, submit one complete claim line:
- HCPCS code for drug given
- JZ modifier to indicate no waste
- Number of units given to the patient
- Calculated submitted price for the amount given

Resources

Modifier JW fact sheet *(cms.gov)*
Modifier JZ fact sheet *(cms.gov)*
Medicare Claims Processing Manual, Chapter 17 on Drugs and Biologicals *(cms.gov)*
JW Modifier and JZ Modifier policy FAQs *(cms.gov)*
MM13056 - New JZ Claims Modifier for Certain Medicare Part B Drugs *(cms.gov)*

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
April 2026	New policy
October 2026	Policy overview added, Definition section updated