

NCPDP Work Group 16 Guidance for the Property & Casualty and Workers' Compensation Industry

VERSION 1.0

This document offers guidance to the Property & Casualty and Workers' Compensation industry on the use of NCPDP standards.

February 2010

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The writers of this paper will review and possibly update their recommendations should any significant changes occur.

This document is for Education and Awareness Use Only.

I. PURPOSE AND SCOPE

NCPDP Property & Casualty and Workers' Compensation Work Group 16 (WG16) has created this document as a resource to the industry on the use and application of NCPDP standards to meet the business requirements of the Property & Casualty and Workers' Compensation Insurance environment. The document will contain two sets of information: Frequently Asked Questions (FAQ) and Detailed Guidance. Periodic additions and modifications are anticipated as new issues and business needs are brought forward. Questions and issues needing industry guidance should be submitted to the WG16 Co-Chairs or the assigned NCPDP staff liaison.

In the Workers' Compensation arena there is a growing trend among the states to move to the standard transactions and code sets adopted under HIPAA for the healthcare industry for the billing and reporting of services. The providers of the healthcare services are familiar with these transactions and code sets which makes the move advantageous both in terms of efficient work flow and administrative costs. The states derive benefit by having a greater ability to do comparative analysis of their services and costs with those in the general healthcare arena. Utilization of the electronic standards also saves the system administrative costs as electronic claims processing and adjudication is more cost effective than the processing of paper claims.

Definitions

Adjuster – the individual who handles the claims process for the insurance carrier (payer).

Apportion - is the process the Workers' Compensation Appeals Board uses to determine what portion of an employee's injuries are legally attributable to the worker's industrial injuries and, consequently, to the employer.

Bill Review – Also referred to as bill screening or bill audit. It is the evaluation and adjudication of a provider bill for appropriateness of reimbursement relative to medical necessity and prevailing rates of reimbursement, duplicate charges, unbundling of charges, medical relativity of services to injury or illness, necessity of assistant surgeons, adjudication of multiple procedures, number of modalities, global procedures, and any other prevailing adjudication issues that may apply.

Claim Number - A number assigned by the insurance carrier or self-insured employer to identify a specific claim for an injury.

Claimant - Injured worker/employee (injured while at work) who has filed a workers' compensation claim.

Compensability - Eligible for or subject to compensation, especially for a bodily injury or illness.

Controverted - A disputed claim.

Date of Injury (DOI) – The date the employee was injured or sustained an illness while on the job as identified in reports and confirmed by the insurer.

Denied Claim - A claim in which the insurance company believes the injury or illness is not covered by workers' compensation.

Division/Department of Worker's Compensation (DWC) – State government entities that monitor and enforce the administration of workers' compensation claims, and provides administrative and judicial services to assist in resolving disputes that arise in connection with claims for workers' compensation benefits.

Eligibility - Validity of an individual's claim for payment or for the health care services provided to the injured worker.

Explanation of Benefits (EOB/EOR/EOBR) - A summary statement (paper or electronic) that explains claim payment and/or the reason for denial of specific charges.

Fee Schedule - Is promulgated by the State Division of Workers' Compensation. It is used as a key for payment of medical services required to treat work related injuries and illnesses.

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FROI - First Report of Injury

Medical Necessity - Refers to what is medically necessary for a particular patient, and hence entails an individual assessment rather than a general determination of what works in the ordinary case.

Payer - An entity that assumes the risk of paying for medical treatments. This can be an uninsured patient, a self-insured employer, or a health care plan or health maintenance organization (HMO).

Pharmacy Benefit Manager (PBM) - A person or corporation, other than a pharmacy or pharmacist, who acts as an administrator in connection with pharmacy benefits. PBMs generally contract with both the pharmacy and the insurer (Payer).

Return to Work (RTW) - Phrase used in relation to an injured or ill employee who has reached substantial medical improvement to be able to return to the employee's position with either no workplace modifications or restrictions, or with permanent workplace modifications or restrictions that are not essential to the job function for which the employee was hired.

Statement of Medical Necessity - A written statement and supporting documentation from the prescribing physician to establish the need for treatments and services.

Timely Filing - Specific time frame set forth by the state(s) to submit a bill for services rendered.

Third Party Administrator (TPA) - A third party administrator (TPA) is an organization that processes insurance claims or certain aspects of employee benefit plans for a separate entity. This can be viewed as "outsourcing" the administration of the claims processing, since the TPA is performing a task traditionally handled by the company providing the insurance or the company itself. Often, in the case of insurance claims, a TPA handles the claims processing for an employer that self-insures its employees. Thus, the employer is acting as an insurance company and underwrites the risk. The risk of loss remains with the employer, and not with the TPA.

Treatment Guidelines - Established and effective treatment protocol intended to assist in the provision of medical treatment by offering an analytical framework for the evaluation and treatment of an injured worker, by providing the best medical outcome.

Utilization Review (UR) - The determination of medical necessity for medical and surgical in-hospital, outpatient, and alternative setting treatments for acute and rehabilitation care. It includes pre-certification for elective treatments. Concurrent review and, if necessary, retrospective review are required for emergency cases.

Utilization Review Entity - A private utilization review vendor, a carrier or its affiliate, a self-insured employer, a third-party administrator, or a group fund that provides utilization review.

Workers' Compensation Coverage - A form of "no-fault insurance" that most states require employers to carry to cover employees for on-the-job injuries. Employers purchase workers' compensation insurance policies to transfer their potential losses (financial consequences) to a third party in exchange for a small periodic payment.

II. FREQUENTLY ASKED QUESTIONS

At the present time no questions have been brought forward for work group review and response.

III. DETAILED GUIDANCE

I. Workers' Compensation – Brand/Generic Selection and Invoicing when both the Brand and Generic NDC and Cost Must Be Present

1. Background

In workers' compensation the rules promulgated in the various state jurisdictions dictate how pharmacy services/prescriptions should be fulfilled. Some of these regulations have not taken into consideration the real-time process or other complexities of pharmacy services/prescription processing.

More specifically, some jurisdictions have passed generic only dispensing for workers' compensation claims unless the physician specifically writes "brand medically necessary" (DAW1) upon the prescription. Taking into consideration, some rights of the injured worker (patient), a number of these same jurisdictions (see table below), have allowed for the injured worker to select the brand name drug, when not specified medically necessary (DAW2), and have advised that the injured worker must pay the cost difference between the brand dispensed and the generic that would have been dispensed. Additionally, not all billing rules in these particular states are specific in detailing how the billing for these types of transactions should be completed. Some state rules detail that the pharmacy must invoice showing the brand NDC that was dispensed and cost, the generic NDC that would have been dispensed and cost, the amount paid by the injured worker, leaving the amount due from the payer. The payer could be a third party entity (biller or PBM) or the insurance carrier directly.

The intent of this document presented by NCPDP Work Group 16 – Billing Task Group, is to provide some guidance to the pharmacy services industry on how to bill for this scenario both electronically and through paper invoicing.

2. Rules Specific to Patient Brand Selection

The following table depicts the WC rules currently in effect in states allowing the patient to select the branded drug when a generic is available and the brand is not deemed to be medically necessary by the physician.

State	Rule or Document	Mandated AWP Source	State Directive
Florida	<p>Three total 69L-7.602 – Medical Billing and Reporting Rule</p> <p>Health Care Provider Reimbursement Manual</p> <p>FL Statute 465.025 Substitution of drugs.--(2)A pharmacist who receives a prescription for a brand name drug shall, unless requested otherwise by the purchaser, substitute a less expensive, generically equivalent drug product that is:</p> <p>(a) Distributed by a business entity doing business, and subject to suit and service of legal process, in the</p>	None	<ul style="list-style-type: none"> - DWC10 Form required to bill for retail pharmacy services - No electronic billing mandate - No directive on how to complete the transaction -Details that the pharmacy shall establish a formulary to select the brand/generic equivalency

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State	Rule or Document	Mandated AWP Source	State Directive
	<p>United States; and (b) Listed in the formulary of generic and brand name drug products as provided in subsection (5) for the brand name drug prescribed.</p> <p>(5) Each community pharmacy shall establish a formulary of generic and brand name drug products which, if selected as the drug product of choice, would not pose a threat to the health and safety of patients receiving prescription medication. In compiling the list of generic and brand name drug products for inclusion in the formulary, the pharmacist shall rely on drug product research, testing, information, and formularies compiled by other pharmacies, by states, by the United States Department of Health, Education, and Welfare, by the United States Department of Health and Human Services, or by any other source which the pharmacist deems reliable. Each community pharmacy shall make such formulary available to the public, the Board of Pharmacy, or any physician requesting same. This formulary shall be revised following each addition, deletion, or modification of said formulary.</p>		
<p>Kansas</p>	<p>Prescription Services Ground Rules and Fees</p>	<p>Any recognized AWP files e.g., the PriceAlert of Medi-Span,</p>	<ul style="list-style-type: none"> - CMS1500 required for billing pharmacy services - No electronic billing mandate - No directive on how to complete the transaction and invoice for the brand dispensed and the generic which would have been dispensed
<p>Kentucky</p>	<p>803 KAR 25:092 Section 2. Payment for Pharmaceuticals. (1) Unless the prescribing practitioner has indicated that an equivalent drug product should not be substituted, an employee who requests a brand name drug shall be responsible for payment of the difference between the equivalent drug product wholesale price of the lowest priced therapeutically equivalent drug the dispensing pharmacist has in stock and the brand name drug wholesale price at the time of dispensing.</p> <p>(2) Any duly licensed pharmacist</p>	<p>No mandate</p>	<ul style="list-style-type: none"> -No specific billing form - No electronic billing mandate - No directive on how to complete the transaction and invoice for the brand dispensed and the generic which would have been dispensed

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State	Rule or Document	Mandated AWP Source	State Directive
	<p>dispensing pharmaceuticals pursuant to KRS Chapter 342 shall be entitled to be reimbursed in the amount of the equivalent drug product wholesale price of the lowest priced therapeutically equivalent drug the dispensing pharmacist has in stock, at the time of dispensing, plus a five (5) dollar dispensing fee plus any applicable federal or state tax or assessment.</p>		
Maine	<p>Title 39A Part 1, Chapter 5, 206 Providers shall prescribe generic drugs whenever medically acceptable for the treatment of an injury or disease for which compensation is claimed. An employee shall purchase generic drugs for the treatment of an injury or disease for which compensation is claimed if the prescribing provider indicates that generic drugs may be used and if generic drugs are available at the time and place of purchase. If an employee purchases a non-generic drug when the prescribing provider has indicated that a generic drug may be used and a generic drug is available at the time and place of purchase, the insurer or self-insurer is required to reimburse the employee for the cost of the generic drug only. For purposes of this section, "generic drug" has the same meaning found in Title 32, section 13702-A, subsection 14:</p> <p>14. Generic and therapeutically equivalent drug. "Generic" and "therapeutically equivalent drug" means any drug that has identical amounts of the same active ingredients in the same dosage form and the same concentration that, when administered in the same amounts, will produce or can be expected to have the same therapeutic effect as the drug prescribed.</p>	No mandate	<ul style="list-style-type: none"> -No specific billing form - No electronic billing mandate - No directive on how to complete the transaction and invoice for the brand dispensed and the generic which would have been dispensed
Montana	<p>Montana Code Annotated 2007 39-71-727(2) If an injured worker prefers a brand-name drug, the worker may pay directly to the pharmacist the difference in the reimbursement rate between the brand-name drug and the generic-name product, and the pharmacist</p>	No mandate	<p>(1) For payment of prescription drugs, an insurer is liable only for the purchase of generic-name drugs if the generic-name product is the therapeutic equivalent of the brand-name drug prescribed by the physician, unless the generic-name drug is unavailable.</p>

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State	Rule or Document	Mandated AWP Source	State Directive
	<p>may bill the insurer only for the reimbursement rate of the generic-name drug.</p>		<p>(2) If an injured worker prefers a brand-name drug, the worker may pay directly to the pharmacist the difference in the reimbursement rate between the brand-name drug and the generic-name product, and the pharmacist may bill the insurer only for the reimbursement rate of the generic-name drug.</p> <p>(3) The pharmacist may bill only for the cost of the generic-name product on a signed itemized billing, except if purchase of the brand-name drug is allowed as provided in subsection (1).</p> <p>(4) When billing for a brand-name drug, the pharmacist shall certify that the generic-name drug was unavailable.</p> <p>(5) Reimbursement rates payable by an insurer are limited to the average wholesale price of the product at the time of dispensing, plus a dispensing fee not to exceed \$5.50 per product.</p> <p>(6) The pharmacist may not dispense more than a 30-day supply at any one time.</p> <p>(7) For purposes of this section, average wholesale prices must be updated weekly.</p> <p>(8) For purposes of this section, the terms "brand name", "drug product", and "generic name" have the same meaning as provided in 37-7-502.</p>
North Dakota	<p>Fee Schedule Guideline / Medical Services Rules 2004 Section 202 When an Rx is listed either by generic or brand, the Pharmacist shall select the lowest priced drug from such list which is chemically and therapeutically equivalent, unless otherwise instructed by the prescriber, or by the purchaser if the purchaser agrees to pay any additional cost in excess of the benefits provided by the purchaser's health benefit plan if allowed under legal requirements applicable to the plan, otherwise to pay the full cost of the higher priced drug.</p>	<p>First DataBank</p>	<ul style="list-style-type: none"> -No specific billing form -Product selection limitations -Fee Schedule Guideline / Medical Services Rules 2004 Section 202 - Any pharmacist substituting a generically equivalent drug shall charge no more than the UC retail price for that selected drug; charge shall not exceed the UC retail price of the prescribed brand.
Ohio	<p>4123-6-21 Payment for medication. (F) Claimants who request a brand name drug or whose physician specifies a brand name drug designated by "dispense as written"</p>	<p>Bluebook</p>	<ul style="list-style-type: none"> - POS system - Formulary driven - WC specific billing form adopted - NDC -Enter an eleven-digit National Drug Code (NDC) from the stock

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	<p>on the prescription for a medication which has an applicable maximum allowable cost price shall be liable for the product cost difference between the established maximum allowable cost price of the drug product and the average wholesale price plus or minus the bureau established percentage of the dispensed brand name drug, if prior authorization for the brand name drug is not obtained by the prescriber.</p> <p>Billing Reimbursement Manual Chpt 3 Generic and Brand Name Drugs Effective October 1, 2005, for all claims, regardless of date of injury, BWC will no longer reimburse any brand-name drugs when a generically equivalent drug is available.</p> <p>If a physician prescribes a brand name drug, the following options are available.</p> <ul style="list-style-type: none"> • The physician agrees that a generic drug may be dispensed • The physician prescribes a different drug • The brand name drug is dispensed and the injured worker pays the difference in price between the generic and the brand name even if the physician writes dispense as written (DAW) on the prescription. <p>Even if the physician writes dispense as written or DAW on the prescription, the injured worker will be responsible for the cost difference between the generic and brand name medication.</p>		<p>bottle from which the dispensed drug was obtained, or if dispensed in a unit-of-use container, the NDC obtained from the unit-of-use container.</p> <p>- Special notes/remarks field on billing form: This field should be utilized whenever an item billed is a compounded prescription or if any of the items billed were written "dispense as written" or "DAW" by the prescribing physician. If an item is a compounded prescription, the ingredients of the compounded prescription should be listed using the NDC of each ingredient, and the metric quantity of each ingredient. Reimbursement will be based on the total documented cost of the prescription.</p> <p>Chapter 3 Billing - Submitting drug bills for a new claim</p> <p>Pharmacy providers are expected to submit electronic bills for new injuries online through BWC's pharmacy benefit manager even before the injured worker has a BWC claim number by using the injured worker social security number and date of injury. The PBM will inform the pharmacist that this is a "new claim" and will notify the pharmacist the amount that BWC will reimburse for the prescription. The amount is usually indicated in the "co-payment" area on the prescription receipt. The pharmacist can elect to collect this amount from the newly injured worker or choose to "accept assignment". If the pharmacist wants to accept assignment, he/she should reverse the previously submitted bill, and then submit the bill to ACS with the Prior Authorization code of "999000000". The injured worker's co-pay field will default to \$0.00, and the PBM will automatically reimburse the pharmacy the fee schedule amount for the prescription plus an additional dispensing fee of \$2.50 once BWC allows the claim. If a pharmacy does not accept assignment, the injured worker is asked to pay the BWC fee schedule amount for the prescribed medication at the point of sale. The PBM will automatically reimburse the injured worker once BWC allows the</p>

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State	Rule or Document	Mandated AWP Source	State Directive
			claim. In either case, if BWC disallows the claim, the bill becomes the injured worker's responsibility. Pharmacy providers should not submit any portion of a bill for a medication used to treat a work-related injury to a private health insurance carrier.
Tennessee	(Rule 0800-2-18-.12,(vi) If a workers' compensation claimant chooses a brand-name medicine when a generic medicine is available and allowed by the prescriber, the claimant shall pay the difference in price between the brand-name and generic medicine and shall not be eligible to subsequently recover this difference in cost from the employer or carrier.	PriceAlert from Medispan. If not found, then Redbook	-Billing Form - CMS 1500 -Rule 0800-2-18-12 (i) A bill or receipt for a prescription drug shall include all of the following: (I) When a brand name drug with a generic equivalent is dispensed, the brand name and the generic name shall be included unless the prescriber indicates "do not label." (II) If the drug has no brand name, the generic name, and the manufacturer's name or the supplier's name, shall be included, unless the prescriber indicates "do not label."
Texas	Section 134.503(2)(A)(B) (2) when an injured employee chooses to receive a brand name drug instead of the prescribed generic drug, the pharmacist shall dispense the brand name drug as requested and shall be reimbursed: (A) by the insurance carrier, the fee established for the prescribed generic drug in accordance with subsection (a) of this section; and (B) by the employee, the cost difference between the fee established for the generic drug and the fee established for the brand name drug in accordance with §134.503(a)(2) of this title.	Medispan or Redbook	-DWC 66 mandated billing form -NDC of both brand and generic drug must be present when a brand medication is dispensed -Electronic billing (with 10/10 exception) regulated as of January 1, 2007 (NCPDP 5.1) §134.504. Pharmaceutical Expenses Incurred by the Injured Employee. (2) The pharmacist shall: (A) determine the costs of both the brand name and generic drugs by using the reimbursement formulas stated in §134.503(a)(2), and notify the injured employee of the cost difference amount; (B) collect the cost difference amount from the injured employee in a form and manner that is acceptable to both parties; (C) submit a bill to the insurance carrier for the generic drug that was prescribed by the doctor; and (D) not bill the injured employee for the cost of the generic drug if the insurance carrier reduces or denies the bill.
Vermont	Vermont F/S Update - 2006 When an Rx is listed either by generic or brand, the Pharmacist shall select the lowest priced drug from such list which is chemically and therapeutically equivalent, unless otherwise instructed by the prescriber, or by the purchaser if the	Redbook or equivalent	-CMS 1500 billing form -§ 4605. Alternative drug selection (a) When a pharmacist receives a prescription for a drug which is listed either by generic name or brand name in the most recent edition of the federal Food and Drug Administration's "Orange Book" of

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State	Rule or Document	Mandated AWP Source	State Directive
	<p>purchaser agrees to pay any additional cost in excess of the benefits provided by the purchaser's health benefit plan if allowed under legal requirements applicable to the plan, otherwise to pay the full cost of the higher priced drug.</p>		<p>approved drug products, the pharmacist shall select the lowest priced drug from such list which is chemically and therapeutically equivalent, unless otherwise instructed by the prescriber, or by the purchaser if the purchaser agrees to pay any additional cost in excess of the benefits provided by the purchaser's health benefit plan if allowed under the legal requirements applicable to the plan, otherwise to pay the full cost for the higher priced drug.</p>
West Virginia	<p>CHAPTER 23. WORKERS' COMPENSATION. ARTICLE 1. GENERAL ADMINISTRATIVE PROVISIONS. §23-4-3. 3) Any pharmacist filling a prescription for medication for a workers' compensation claimant shall dispense a generic brand of the prescribed medication if a generic brand exists. If a generic brand does not exist, the pharmacist may dispense the name brand. In the event that a claimant wishes to receive the name brand medication in lieu of the generic brand, the claimant may receive the name brand medication but, in that event, the claimant is personally liable for the difference in costs between the generic brand medication and the brand name medication..</p>	No mandate	<p>--Preferred Drug list - POS system (electronic) - No directive on how to complete the transaction and invoice for the brand dispensed and the generic which would have been dispensed</p>
Wisconsin	<p>Workers' Compensation Act 172.425(2)(c) (c) Unless par. (b) applies, if an injured employee requests that a specific brand name drug be used to treat the employee's injury, the pharmacist or practitioner dispensing the prescription shall dispense the specific brand name drug as requested. If a specific brand name drug is dispensed under this paragraph, the employer or insurer and the employee shall share the cost of the prescription</p>	Drug Topics Red Book, published by Medical Economics Company, Inc. or its successor.	<p>(c) Unless par. (b) applies, if an injured employee requests that a specific brand name drug be used to treat the employee's injury, the pharmacist or practitioner dispensing the prescription shall dispense the specific brand name drug as requested. If a specific brand name drug is dispensed under this paragraph, the employer or insurer and the employee shall share the cost of the prescription as follows: 1. The employer or insurer shall be liable in an amount equal to the average wholesale price, as determined under sub. (3) (a) 1., of the lowest-priced drug product equivalent that the pharmacist or practitioner has in stock on the day on which the brand name drug is dispensed, plus the dispensing fee under sub. (3) (a) 2. and any</p>

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State	Rule or Document	Mandated AWP Source	State Directive
			applicable taxes under sub. (3) (a) 3. that would be payable for that drug product equivalent. 2. The employee shall be liable in an amount equal to the difference between the amount for which the employer or insurer is liable under subd. 1. and an amount equal to the average wholesale price, as determined under sub. (3) (a) 1., of the brand name drug on the day on which the brand name drug is dispensed, plus any applicable taxes under sub. (3) (a) 3. that are payable for that brand name drug.
Wyoming	Ch. 10 Section 23(a) An injured worker may choose to pay the difference between the generic and the name brand product, in which case the Division shall pay only the wholesale generic price or substitute equivalent plus a professional fee.	Redbook	-Billing form WSCD 10 -No electronic billing mandate -Ch. 10 Section 23(a) An injured worker may choose to pay the difference between the generic and the name brand product, in which case the Division shall pay only the wholesale generic price or substitute equivalent plus a professional fee.

3. Pricing the Patient Selected Branded Drug

There is an underlying theme of selecting the lowest-priced therapeutically equivalent generic for pricing purposes when the patient opts for the brand name drug vs. the generic. For electronic transactions, NCPDP Work Group 16 recommends the following to complete the transaction:

Scenario #1 Generic medication prescribed – Brand medication dispensed

Using either NCPDP Telecommunication Standard 5.1 or D.Ø, the pharmacist should submit the following data (Valium and Diazepam are being used within the example. Additionally, the dollar values detailed below are also only being used as examples and do not necessarily represent true market data):

Transaction

Claim Segment			General Notation about Field(s)
407-D7	Product/Service ID	00140-0006-35	Brand drug dispensed – Valium
408-D8	Dispensed as Written	2	DAW2 – Patient Selected Brand
445-EA	Originally Prescribed Product/Service Code	00228-2053-10	Generic prescribed drug - Diazepam
Pricing Segment			General Notation about Field(s)
409-D9	Ingredient cost submitted	.55	Cost of 1 tablet of Valium
412-DC	Dispensing fee submitted	4.00	
433-	Patient paid amount submitted	.50	Cost difference between valium and

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DX			diazepam
430- DU	Gross amount due	4.55	

Since the instructions within the telecommunication standard do not permit the gross amount due to be reflective of a subtraction of the patient paid amount, Payer Sheets or other agreement documents will need to advise the payer of the claim, when making restitution, to subtract the patient paid amount from the gross amount due when responding and submitting payment for the claim.