myMatrixx monitor

by Steven MacDonald, CEO

Ten Years!

It's hard to believe it has been ten years since my friend, Mike Bunkley, called and told me about a friend of his (now our client) that needed a web enabled PBM. At that time, no such thing even existed. The pharmacy market seemed crowded and uncertain. People had barely become accustomed to email. Most of our very first customers didn't even know how to access the Internet and smart phones hadn't even been conceived. Wow, a lot has happened since then!

This year myMatrixx celebrates its ten year anniversary. The early days held a lot of excitement and a lot of challenges. We incorporated in April of 2001 and launched our first customer, Amerisys, in August of that year. One of my favorite stories is how Mike would show up to work every day in our tiny office in Ybor City (Tampa) and call prospects

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good medicine for business

In This Issue

SPRING/SUMMER 2011

by Steven MacDonald, CEO

Ten Years!

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around the country. The funny part is, we didn't have the money to pay him, but he would show up anyway and start working . . . for free. And he never missed a day. I finally felt so guilty, I took out a loan so we could pay him.

Lindsay Rios, now our VP of Customer Service and Client Services, was still in college. She would become so nervous, she would tremble every time I asked her to speak in front of more than 2 people. She now speaks to hundreds.

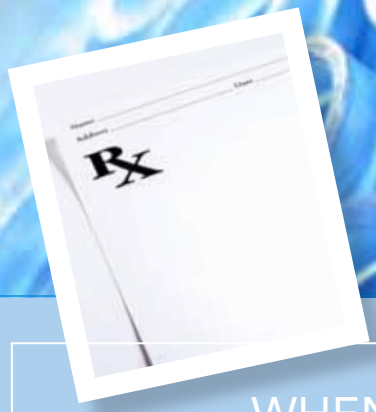
Stuart Kime and I met walking our dogs. One Monday morning, I frantically called him because we couldn't print our invoices. He helped out that day, now he runs our entire IT organization.

There are so many wonderful experiences. Chaz who left but couldn't stay away so she joined our team AGAIN. Lindsay, not taking no for an answer when she offered Gene a job. Gene is now our AR Manager. Tina and Jeanine who rescued our accounting system. Phil, who's office was the top of a filing cabinet for 3 months. There are so many stories and people to thank we don't have enough room here. There are at least 120 stories to share and each one is unique and special.

Over the last decade we have launched a half dozen new products, strengthened our infrastructure, built a world class team and are now opening another office in Austin TX. We are consistently ranked as one of the fastest growing companies in Tampa, and across the country. We have learned a lot, made plenty of mistakes, but most proudly, we have matured as people, as a team and as a company.

None of this would have been possible without the trust and dedication of our employees and our customers. The last ten years have been a thrill to serve you, but the next ten will be even greater! Thank you to all of you who have grown with us and continued to believe in our vision to deliver an unimaginably great customer experience.

Mike Bunkley in Ybor Office



Clinical

CLINICAL CORNER

WHEN IS A NARCOTIC NOT A NARCOTIC?

by Phil Walls, R.Ph.

The answer to this question may depend on who you ask. And it is related to a topic we have addressed previously, which is "what is the difference between a narcotic and an opioid?" Let's refresh the answer to that question first: To a health professional, a narcotic is any drug derived from the opium poppy plant and includes many of the drugs that are so problematic in workers' compensation. However, to a law enforcement officer, a narcotic is any controlled substance, which includes not only the narcotics defined above but also amphetamines, benzodiazepines and other drugs with a high potential for abuse and addiction. The term narcotic is so entrenched in law enforcement with phrases like narcotics officers, that the health community has adopted the term Opioid to refer to drugs derived from the poppy, and more specifically the term opiate to refer to synthetic derivatives.

So back to the original question, When is a narcotic not a narcotic, and why is that important? The importance of that question lies in the fact that I have seen so many reports recently both from competitors and workers comp organizations that are reporting some very specific categories such as Narcotics Utilization, Opioid Utilization, Schedule 2 Opioid Utilization, Schedule II Narcotics Report, etc. So why so many categories? Well, let's make an assumption that in workers' compensation, narcotics equal opioids, but going forward we will adopt the term Opioid exclusively.

With that assumption, it would seem that an Opioid Utilization report would be a good tool to monitor the use of these very dangerous drugs, and it is – as long as it is interpreted correctly. By definition, an Opioid Utilization report should include all opioids – even the ones that are not controlled substances. Yet not all opioids are controlled substances because they do not all have the same risk for abuse and misuse. One is even available over-the-counter as the DM (dextromethorphan) component in most cough syrups (although I must add that if intentionally misused, these products may be very dangerous). Therefore an Opioid Utilization

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"What is the **difference** between a narcotic and an opiod?"

NARCOTIC continued from page 3

report will include the drug tramadol which is an Opioid but not a controlled substance, and will include all levels of controlled substances which ranges from 2 to 5 with the lower number representing the greatest potential for abuse and addiction. There's certainly nothing wrong with reporting all opioids together as long as the reader keeps this in mind when comparing different reports.

Next, let's look at a Schedule 2 Opioid Utilization report. As the title implies, this report will only include the most dangerous and addictive opioids and includes many of the drugs we are so concerned with controlling such as OxyContin, Opana, Kadian, Duragesic, Actiq, Fentora, morphine sulfate and many others – perhaps too many others. This is certainly a good report format to track these particular drugs but the Percent of Schedule II Opioids should never be compared to the Opioid utilization number in the report described above or one may draw incorrect conclusions about the use of these drugs when comparing different state reports and benchmarks. Also, the Schedule 2 Opioid report will not include opioids listed in other schedules where drugs like hydrocodone with acetaminophen, Vicodin, Lortab, Lorcet, Norco and others are found.

So a narcotic is not a narcotic, or perhaps an Opioid is not an Opioid, when it does not measure what is intended. If the intent is to monitor the use of opioids and track overall changes as well as movement within the category and identify injured patients at risk, I recommend a comprehensive Opioid Utilization report that allows the investigator to drill down on specific drugs as well as specific patients.

Recommended Comprehensive Opioid Utilization Report

(will include and identify the following:)

- Total Opioid use with a breakdown of schedule 2,3,4 and 5;
- Non-controlled Opioids;

This would make it very easy to compare to other published reports.

- Next, drill down by category on specific drugs as well as specific patients for detailed information on all the drugs your injured patients are receiving within each category.
- Then drill down on the total Opioid use to identify all patients taking opioids, which ones, how often and potential risk.

Log into myMatrixx today and check out our new Opioid Utilization report, or expect a review at your next stewardship meeting.

DOES THE MARKET REALLY NEED A NEW OPIOD?

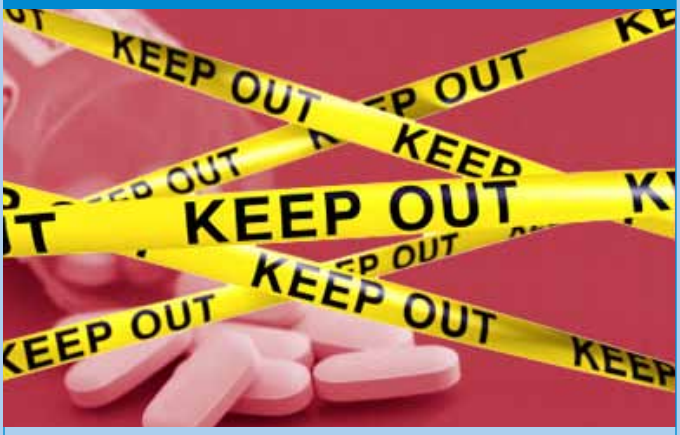
by Phil Walls, R.Ph.

If the market is Workers' Compensation, then my answer is definitely not! However, if the market is Oncology, then I would simply say that cancer patients should be allowed access to whatever pain relief is necessary and appropriate. The quandary then becomes *"How do we keep opioids intended for cancer pain out of the Workers' Compensation market?"*

Obviously, the biggest disaster in this regard was the introduction of Actiq® (oral transmucosal fentanyl citrate) by Cephalon for end-stage cancer pain. This was soon followed by Fentora™. At that time, there were no limitations - other than the DEA regulations for schedule 2 controlled substances - on the prescribing and dispensing of this drug. As a result, the various forms of oral transmucosal fentanyl citrate had a significant impact on drug expense in the workers' comp system. Although myMatrixx successfully slowed and then virtually eliminated the use of this drug among our clients, it seems it was a fight that should not have been necessary in the first place.

So that brings us to the latest "brand name only" version of fentanyl citrate: Abstral®. Abstral® is a sublingual tablet form of fentanyl citrate, and like Actiq®and Fentora™, it is indicated for cancer patients currently taking opioids. The latter part of that statement is crucial because the use of any of the products mentioned so far in an Opioid naïve patient may lead to respiratory depression and death. Because of this danger, these products are covered by the FDA's REMS program – Risk Evaluation and Mitigation Strategy. For the most part, REMS has consisted of educational programs, which in spite of the best of intentions, has not had significant impact on opioid prescribing in my opinion. The REMS program for Abstral® seems a little more stringent in that prescribers and pharmacists must enroll in the Abstral® REMS program, and they are not allowed to do this until they have completed the educational program and obtained an assessment code. Once the assessment code is obtained, enrollment is allowed. With enrollment comes certain requirements of the physician: a Patient-Prescriber Agreement must be completed and signed before writing the patient's first prescription. The educational program is very clear that the only patients who qualify for treatment with Abstral® are patients that are Opioid tolerant, at least 18 years of age, and that have a diagnosis of cancer. A copy of the Patient-Prescriber agreement must be provided to the FDA's REMS program within 10 days. ProStrakan, the manufacturer of Abstral®, is responsible for assessing compliance with the program and has the duty to inactivate non-compliant prescribers.

How do we keep opioids intended for cancer pain out of the Workers' Compensation market?



Similar restrictions are placed on enrolled pharmacies, with one very striking disqualification for the patient: "patients remain active until a trigger for inactivation occurs. Triggers for patient inactivation include: . . . the patient receives prescriptions for Abstral® from multiple prescribers within an overlapping time frame that is suggestive of misuse, abuse or addiction."

In my opinion, that latter statement should apply to every REMS program in existence and should be part of every opioid management program.

THIS JUST IN . . .

This just in . . . the FDA has just given approval to Pfizer Pharmaceuticals to market yet another brand name only opioid. Oxecta® is an immediate release form of oxycodone. Unfortunately the media is comparing Oxecta to OxyContin®. This is not a true comparison since OxyContin is a long acting version of oxycodone. Oxecta is intended to be an abuse deterrent form of oxycodone (you may recall this was the original intent of Oxycontin as well). Oxecta contains niacin in addition to oxycodone with the thought that the flushing and redness casued by high doses of niacin will prevent intentional or accidental misuse. Oxecta will probably be available by third or fourth quarter this year.

PAM WOODY

CUSTOMER SERVICE REPRESENTATIVE

Building and Maintaining Solid Customer Relationships

Pam demonstrates the myMatrixx core value Serves with Passion in her role as Customer Service Representative. Pam's dedication to providing excellent customer service, and her work schedule truly speaks to her commitment. In addition to working two days during the week, Pam also covers the weekend shift on Saturday and Sunday working almost 12 hours each day. Pam is relied upon to be the eyes and ears of the Customer Service department on the weekend shifts.

On more than one occasion, Pam has had to step in and assist the IT Department offering her support. The most recent IT issue occurred when our phone lines were down on a Sunday morning. Pam worked closely with IT department members Carlos and Tina when it was discovered that a power surge had knocked out the power. The team walked her through what needed to be done, and Pam got the phones lines up and running in no time.

Prior to working at myMatrixx, Pam worked as a manager at Chevron. Pam's role there encompassed operations, marketing, purchasing, sales and reporting. Pam also has 10 years of experience as a Pharmacy Technician, furnishing patients with information on drugs, labeling and packaging various prescriptions, providing essential support for pharmacists, and understanding patient-privacy issues and pharmacy procedures. These various skills assist Pam in her role as a Customer Service Representative where she builds and maintains solid customer relationships by handling client questions and concerns with speed and professionalism.

Pam is someone who exudes a driven, "can do attitude." She is respected and well liked by her team. Pam is considered to be one of the "go to employees" in Customer Service.

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REGULATORY UPDATES

HOW STATES ARE TACKLING THIS ISSUE:

Repackaged and Physician Dispensed Drugs

by Joshua Webster, *Regulatory Analyst*

In a regulatory update recently sent out in April, myMatrixx informed clients of a change in the Georgia state pharmacy fee schedule which targeted the high price of repackaged and physician dispensed drugs. As compared to a drug traditionally dispensed through a pharmacy, a repackaged or physician dispensed drug can be three to four times higher in cost. Because of this, myMatrixx decided to do additional research nationwide to see how other states were handling this controversial issue. As it turns out, there has been a lot of reaction to this cost driver.

Alabama, Arizona, Georgia and Mississippi have all amended their state fee schedules requiring reimbursement for repackaged/relabeled drugs based off of the original manufacturers National Drug Code (NDC). Florida and Hawaii both introduced similar bills during their legislative sessions, and Florida also introduced a bill to address the physician dispensing issue. The states of Maryland and Minnesota are trying a more unusual approach by researching the concept of using pricing benchmarks to create a more even playing field.

Arizona first made the change to their 2009–2010 fee schedule (effective 10/01/2009 – 09/30/2010). The language then, and as it is now, states that for a repackaged drug, the Average Wholesale Price (AWP) "would be the AWP of the underlying drug product used in the repackaging…" It continues, clarifying that if information pertaining to the original manufacturer is not provided, it is at the discretion of the payer to select the most closely matched AWP. The only difference between the 2009 fee schedule and the current 2010 fee schedule is that the state of Arizona now selects the publishing source used in determining AWP.

As compared to a drug traditionally dispensed through a pharmacy, a repackaged or physician dispensed drug can be three to four times **higher in cost.**

Mississippi also made the change to reimbursement for repackaged drugs in the release of their 2009 fee schedule. Somewhat differently from the way Arizona handled it, Mississippi established "lesser of" language in their fee schedule. Reimbursement for a repackaged drug is now based on the "lesser of" the AWP as established by the NDC of the "original labeler" or the therapeutic equivalent AWP from "original labeler NDC."

Alabama, which recently implemented language this past April, also went with a "lesser of" approach. They pitted pricing of the repackagers against the original manufacturers as opposed to brand vs. generic, like Mississippi. Alabama is also requiring that repacks include the NDC or other identifying information from the original manufacturer. However, when it comes to reimbursing those drugs, it is based on the "lesser of" the AWP of the original manufacture's NDC or the repackaged/relabled NDC. This method guarantees that the payer will only be responsible for the lowest cost, in the off-chance that a repackaged drug is actually cheaper than one traditionally dispensed through a pharmacy.

Georgia's change now requires that all repackaged/relabeled drugs include the NDC of the original manufacturer. Reimbursement is based on the most current AWP

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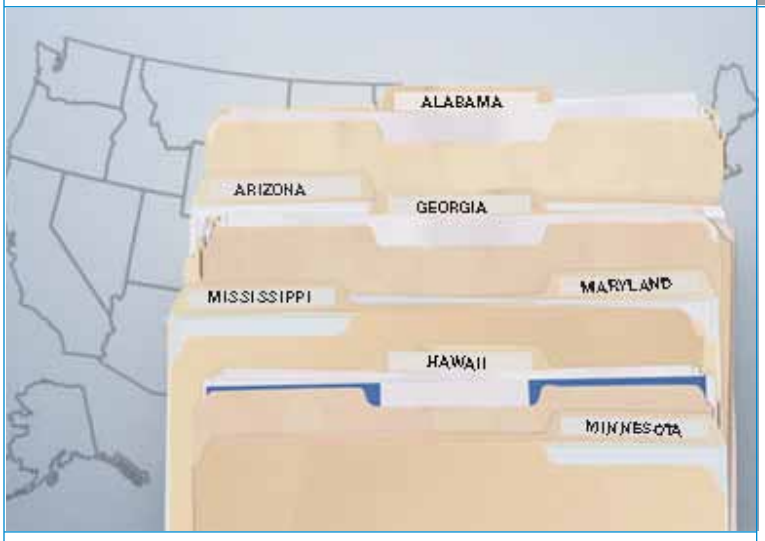
REPACKAGED continued from page 7

published according to the original NDC.

Hawaii's House Bill 1243 and Florida's Senate Bill 2132 both carried similar language. They both required that a repackaged or relabeled drug price not exceed the amount payable (had it not been repackaged or relabeled), and they both require, by statute, that reimbursement for a repackaged drug be based on the AWP as set by the original manufacturer of the underlying drug. The difference between the two is that this language, unfortunately, got amended out of Florida's SB2132, while Hawaii's HB1243, though not passing this session, looks like it will be carried over

myMatrixx decided to do additional research **nationwide** to see how other **states** were handling this controversial issue



to the next session for further discussion and debate. Florida successfully, and at the very last minute, passed a bill that prevents doctors in the state from dispensing schedule II and schedule III controlled substances. This will not have the kind of cost savings that eliminating physician dispensing would. In fact, the price gap between repackaged and traditionally dispensed drugs will remain as an obstacle and, over time, we believe this will be addressed.

The Maryland Workers' Compensation Commission (WCC) held hearings in April to discuss the possible implementation of a pharmacy fee schedule based on the Generic Equivalent Average Price (GEAP). According to the WCC the use of GEAP is "designed to eliminate the existing disparity in reimbursement rates between physician-dispensed and pharmacy-dispensed prescriptions…"

Minnesota believes that a different reimbursement methodology might be the answer, and they have introduced HB1362 and SB1159 to address this. These companion bills would adopt recommendations by the state Workers' Compensation Advisory Council that advocates for, among other things, the use of Wholesale Acquisition Cost (WAC) as the pricing benchmark for their pharmacy fee schedule. Because both GEAP and WAC are based on the average cost of a drug type, they could effectively reduce the cost to payers when reimbursing a repackaged drug, but they both have a few issues that need to be considered.

First, neither GEAP nor WAC are broad enough to have a published price for every drug accepted by the FDA. That leaves a hole in the reimbursement methodology. GEAP has another issue as well. It is currently only published by only one source. This could lead to confusion among providers that cannot afford multiple publishing sources. Straying from the national standard (AWP) is not a recommended method if you want to maintain ease of use or access to everyone in the system.

The working methodology that seems to be the most prevalent is: Go for the original manufacturers NDC and eliminate the repackaging issue no matter what your pricing benchmark. As other states look to adopt these and other methods, myMatrixx will strive to keep all clients informed and current on any changes.

References:

Alabama fee schedule: Click Here

Arizona fee schedule: Click Here

Georgia fee schedule: Click Here

Florida Fee Schedule: HB7095 & SB2132

Hawaii Fee Schedule: HB1243

Maryland: Fee schedule hearing

Minnesota: HB1362 & SB1159

Mississippi fee schedule: Click Here

myMatrixx Cares

Get Involved and Give Back to the Pharmacy Community!

by Erin Kueker, Doctor of Pharmacy Candidate 2012, University of Florida College of Pharmacy

Dr. Michael Nguyen, Manager of Pharmacy Innovation at myMatrixx, volunteers his time to teach pharmacy students about real-world pharmacy opportunities. Pharmacy students spend their final year of school in clinical rotations, attending different pharmacy practice settings for four to eight weeks at a time. One of those practice settings is the pharmacy department at myMatrixx. Students are supervised by Dr. Nguyen and perform many of the daily activities of a pharmacist.

Dr. Nguyen has been **recognized by** the University of Florida College of Pharmacy for his **excellence** as a preceptor faculty member.

As a preceptor, Dr. Nguyen goes beyond the traditional role of a pharmacist. A pharmacy student in a four-week rotation at myMatrixx said, "As pharmacy students, we need more than just learning in a classroom. We need guidance from pharmacists who practice in our field every day. Being a preceptor is optional. Without people like Dr. Nguyen, who choose to give up their time for our benefit, we wouldn't get very far outside of the classroom." Preceptors give back to the pharmacy community in a way that is unmatched by other pharmacy educators.

Dr. Nguyen has been recognized by the University of Florida College of Pharmacy for his excellence as a preceptor faculty member. He has been elected to the Professional Experience Programs Advisory Panel, comprised of only 20 preceptor faculty members throughout the state of Florida. Advisory Panel members serve for two years and meet periodically to guide the UF College of Pharmacy's Office of Experiential Programs on existing preceptor or student needs and emerging issues. The overall goal of this Advisory Panel is to provide continuous quality improvement of the clinical rotations program, which is an essential part of the College of Pharmacy curriculum.

This position is an honor within the UF College of Pharmacy. We are proud to have Dr. Nguyen, a leader in the pharmacy field, as part of the myMatrixx team.

CORE VALUES OF myMATRIXX

Do the Right Thing

by Stacey Dion and Jeannine Guay

Do the Right Thing is an expression, a movie title and a book, but here at myMatrixx it is also a way of life. Our philosophy of Do the Right Thing means to *be* the customer (internal or external) and do what is best for them. If you focus on the customer, everything else will fall into place.

In the Accounting Department, Do the Right Thing is extremely important. Our function is to present financial information in a timely and accurate manner. We have multiple lines of business that need to be accounted for.

If you focus on the **customer**,
everything else will **fall into place.**

All income and expenses must be separated properly and coded to each department. We detail out every expense to make sure that the right department is charged for each expense appropriately. We check and re-check each income report for integrity and accuracy before reporting the numbers. Ensuring that this is done correctly is the only way to figure out what the bottom line is for each line of business. Getting this done accurately and timely allows this growing company to make quick and meaningful decisions on what is working and what isn't.

All of our lines of business are designed to save our customers money. We pass on pharmacy savings to our customer in retail business. We re-price invoices to lower the cost to customers in our Bill Pay department. We shop to get the best pricing to pass on to our customers in our Mail Order Pharmacy, our Compound Pharmacy and our Ancillary Services.

People rely on the numbers we produce. myMatrixx, its employees and their families depend on the decisions that are made using these numbers. Do the Right Thing means taking the extra time to get those figures correct. It also means thinking about the customer's needs. What format would the information work best for them? How can I get the data to the customer in a timely manner? We also take the time to further investigate issues that are unusual or unexpected in order to give our customers reliable explanations.

Do the Right Thing also means that we must be flexible and ready to move quickly to the next situation. Through careful planning, we are prepared for any surprises that may arise. With a dynamic, growing company like myMatrixx, changes occur at a fast pace. New lines of business, system updates and new personnel are all part of that. With proper planning, we are better prepared to serve our customers.

Do the Right Thing is an instinct. Here at myMatrixx, we are encouraged to make things happen. There is no waiting around to make that decision. By Doing the Right Thing in every situation, our customers, our co-workers and our organization all win.

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GOVERNMENT RELATIONS

Texas House Bill 528: The PBM Bill

by Josh Webster

On Friday, June 17, 2011, Governor Rick Perry of Texas signed house bill 528 into law. HB 528, also known as the PBM bill, allows PBMs and other informal networks to continue to process workers' compensation pharmacy claims at rates below the state fee schedule.

However, in order to do this, each informal network must meet certain state required obligations. Among other requirements, each informal network must be registered with the Texas Division of Workers' Compensation, and they must have contracts established with both their insurer clients and the healthcare providers in their networks. These contracts must clearly state what the network reimbursement levels will be for all parties involved. Additionally, should the Division of Workers' Compensation request them , these contracts must be readily available to settle fee disputes. Non-compliance with any of these issues can result in a maximum fine of $25,000 per day per occurrence.

What does this mean to you? myMatrixx's clients will be pleased to know that last year we completed all necessary steps to both register and establish the correct contracting information in anticipation of this bill. We will continue to monitor its status and enforcement policies as regulatory bodies begin to implement it into the already existing worker's compensation system. If any changes or updates occur, myMatrixx will notify our clients as soon as possible in order to take all necessary actions.

Sonya

SONYA KLAVER

CUSTOMER SERVICE REPRESENTATIVE

Warmth, Genuineness and Caring are an Asset

Sonya's role as a Customer Service Representative allows her to build strong relationships using her interpersonal and communication skills. Sonya characterizes myMatrixx core value **Respond with Care** by sharing her warmth, genuineness and caring with both clients and co-workers. She is well versed in managing customer issues, and handles customer concerns and questions with ease and confidence. Sonya's calm demeanor and professionalism make her an asset to the myMatrixx team.

Before joining myMatrixx, Sonya spent 17 years with PMSI working in Pharmacy Operations Customer Service. She was responsible for any issues that a patient, adjuster/NCM had with their medications. She was also in charge of processing scripts for overnight deliveries to patients that were in need of their medications, receiving in-bound calls and making outbound calls to patients, adjusters and doctors.

Sonya's industry knowledge and experience gained at PMSI now enables her to apply the same skills to her role as Customer Service Representative on the Inbound Team. She is the liaison between several parties including patients, patient family members, pharmacies, adjusters, nurse case managers, attorneys and doctor's offices. In addition, Sonya is also part of our ODG Team. These team members were handpicked to manage the authorization requests that concern our Texas clients.

Sonya has earned respect and gratitude from her associates for her professionalism, work ethic and "team first attitude," which makes Sonya a valuable part of this Customer Service team.

Upcoming Events myMatrixx will be attending:

American Association of State Compensation Insurance Funds (AASCIF) Annual
Isle of Palms, SC
June 19th-23rd, 2011
www.aascif.org

SEAK
Hyannis, MA
July 19th-21st, 2011
www.seak.com

Florida Association of Self Insureds (FASI)
Naples, FL
July 24th-27th, 2011
www.fasi-fl.org

Southern Association of Workers' Compensation Administrators (SAWCA)
Biloxi, MS
July 25th-29th, 2011
www.sawca.com

Louisiana Association of Occupational Health Nurses (LAOHN)
New Orleans, LA
August 11th-13th, 2011
www.laohn.org

Florida Workers' Compensation Institute (FWCI)
Orlando, FL
August 15th-18th, 2011
www.fwciweb.org

Georgia Workers' Compensation
Atlanta, GA
August 28th-31st, 2011
www.sbwc.georgia.gov

Maine Work Comp Summit
Northport, ME
September 11-13, 2011
http:// www.mainehr.com/wc/

Texas Workers' Compensation Educational Conference
Austin, TX
September 13th-14th, 2011
http://www.tdi.state.tx.us/wc/

Maryland Workers' Compensation Educational Association (MWCEA)
Ocean City, MD
September 18th-21th, 2011

Montana Governor's Conference TBA
www.mt.gov

California Workers' Compensation Conference
Dana Point, CA
September 27th-29th, 2011

National Workers' Compensation and Disability Conference
Las Vegas, NV
November 9th-11th, 2011
www.wcconference.com

Contact Us:

P.O. Box 274070
Tampa, FL 33688

Questions? Feedback?

We are always looking to better our programs and services. If you have a question or comment, please send your valued feedback via **this email:** accountmanagement@mymatrixx.com

phone:
877-804-4900
web: mymatrixx.com

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