Zenith Insurance Company
ZNAT Insurance Company
21255 Califa Street
Woodland Hills, CA 91367

Kentucky
Utilization Review Plan

4/6/2021

Table of Contents

Table of Contents

I. DEFINITIONS

All capitalized terms in this Utilization Review Plan shall have the following definitions, unless otherwise defined in this document:

1. "Appeal" means a request to reconsider a determination not to approve an admission, procedure, and extension of stay or other health care service.

2. "Approve" means to approve services under the injured workers plan of coverage.

3. "Authorization" means assurance that appropriate reimbursement will be made for an approved or authorized specific course of proposed medical treatment to cure or relieve the effects of an accepted compensable industrial injury or illness.

4. "Claims Examiner" means staff trained to process claims.

5. "Concurrent Review" means utilization review conducted during an inpatient stay.

6. "Criteria" as defined by Zenith means the use of Official Disability Guidelines (ODG), and other evidence based medicine guidelines to evaluate Treatment Plans.

7. "Denial" means a determination by the utilization reviewer that the medical treatment or service under review is not medically necessary or appropriate and, therefore, payment is not recommended.

8. "Discharge Planning" means the process of assessing a patient's need for treatment after hospitalization to facilitate the necessary services and resources for an appropriate and timely discharge.

9. "DWC" means the Kentucky Department of Workers' Claims.

10. "Emergency Health Care Services" means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy.

11. "Health Care Provider" means any attending health care provider, facility or practitioner, authorized under state or federal law to bill for health care services rendered.

12. "Immediately" means within 24 hours after learning the circumstances that would require an extension of the timeframe for review decisions in accordance with utilization review standards set forth in this Plan.

13. "Initial Review" means any utilization review conducted, except for utilization review conducted during an inpatient stay, prior to the delivery of the requested medical services.

14. "Medical Director" means a physician licensed by a state Medical Board or Osteopathic Board who holds an unrestricted license to practice medicine in the State in which the physician resides and is responsible for oversight of all Zenith Utilization Review programs. The term Medical Director

includes but is not necessarily limited to physicians holding any of the following Zenith job titles or a variation of these job titles – Medical Director, National Medical Director, Medical Officer, Chief Medical Officer and Assistant Medical Officer.

15. “MMN” means a registered nurse employed by Zenith’s medical management department.

16. “Other Party Designated” means any person or entity designated by the injured worker to receive notice of approval or denials thereof. This term shall presumptively include the primary attending health care provider and any other affected health care provider of record.

17. “Physician” means a medical director, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the reviewer’s practice.

18. "Preauthorization" means the process whereby payment for a medical service or course of treatment is assured in advance by a carrier.

19. “Retrospective Review” means utilization review conducted after medical services have been provided and for which approval has not already been given. Retrospective reviews shall be based solely on the medical information available to the attending physician or ordering provider at the time the health care services were provided. Retrospective Reviews of approvals may be conducted only for purposes of internal quality assurance, procedural compliance with Workers Compensation rules and regulations and auditing of the appropriateness of health care services approved and provided. Once approval is issued, then except for fraud committed by the injured worker or medical provider, Retrospective Review of that approval must not result in any additional cost to the injured worker or medical provider.

20. “Specialty Reviewer” means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the individual’s scope of practice, who has been consulted by the reviewer or the Medical Director to provide specialized review of medical information.

21. “The Act” or the “Statute” means the Kentucky Workers Compensation Act found under applicable sections of KRS Chapter 342.

22. “Treatment Plan” and “Request for Authorization” means a written plan that:

    a) May consist of copies of charts, consultation reports or other written documents maintained by the injured employee’s Designated Physician discussing symptoms, clinical findings, results of diagnostic studies, diagnosis, prognosis, and the objectives, modalities, frequency, and duration of treatment;
    b) Shall include, as appropriate, details of the course of ongoing and recommended treatment and the projected results; and
    c) May be amended, supplemented or changed as conditions warrant.

23. "Utilization review" means a review of the medical necessity and appropriateness of medical care and services for purposes of recommending payments for a compensable injury or disease.

24. "Utilization Review and medical bill audit plan" means the written plan submitted to the executive director by each carrier describing the procedures governing utilization review and medical bill audit activities and which sets forth Zenith's policies and procedures and a description of the Utilization Review Process.

25. "Utilization Review Process" means utilization management functions that initially, retrospectively or concurrently review and approve, modify, delay or deny, based in whole or in part on medical necessity and appropriateness of medical care and services to cure or relieve, treatment recommendations by physicians, prior to, retrospectively, or concurrent with the provisions of medical treatment services. The UR process will result in the treatment being either "certified" (approved) of "non-certified" (denied). Utilization review does not include determinations of the work-relatedness of injury or disease, or bill review for the purposes of determining whether the medical services were accurately billed.

26. "Written" includes a facsimile as well as communication in paper form.

27. "Zenith" means Zenith Insurance Company acting as the bill review and/or utilization review agent on behalf of itself, its wholly owned subsidiaries, sister companies, and other customers.

KENTUCKY UTILIZATION REVIEW PLAN

The following overview, description of processes, policies and procedures constitute Zenith's Utilization Review Plan. Capitalized terms used in this Utilization Review Plan have the meanings ascribed to them in the Definitions section of this Plan. As a Kentucky Claims Administrator, Zenith has established and maintains this Utilization Review Plan and its Utilization Review Process in compliance with 803 KAR 25:190. and applicable regulations.

II. OVERVIEW OF UTILIZATION REVIEW PROCESSES, POLICIES & PROCEDURES

The purpose of the Zenith Utilization Review Process is to provide an assessment of clinical appropriateness and Medical Necessity of medical care and services provided pursuant to 803 KAR 25:190. Zenith strives to work collaboratively with Health Care Providers in order to approve care that is consistent with Official Disability Guidelines or other evidence-based medicine guidelines utilized by Zenith and to provide consistent education and information to all other stakeholders. Each injured worker's medical treatment is evaluated on an individual basis related to their diagnosis and the receipt of a Treatment Request outlining proposed treatment and medical care with appropriate supporting documentation.

Preauthorization: Prior to providing treatment to the injured worker, the provider is required to submit a Treatment Plan to Zenith for Preauthorization in compliance with 803 KAR 25:096 §5 (c) (2):

A Treatment Plan is required when:

(a) Long-term medical care is required as a result of a work-related injury or occupational disease;

(b) The injured employee has received treatment with passive modalities, including electronic stimulation, heat or cold packs, massage, ultrasound, diathermy, whirlpool, or similar

(c) Procedures for a period exceeding sixty (60) days. The Treatment Plan shall detail the need for the passive treatment, the benefits, if any, derived from the treatment, the risks attendant with termination of the treatment, and the projected period of future treatment; or

(d) Seven days in advance of an elective surgical procedure or placement into a resident work hardening, pain management, or medical rehabilitation program is recommended. The Treatment Plan shall set forth specific and measurable performance goals for the injured employee through the surgery, work hardening, or medical rehabilitation program.

- The Designated Physician shall provide a copy of the treatment plan to Zenith seven (7) days in advance of an elective surgical procedure or placement into a resident work hardening, pain management, or medical rehabilitation program. In all other instances when a treatment plan is required, a copy of the treatment plan shall be provided within fifteen (15) days following a request by Zenith. An amendment, supplement, or change to a Treatment Plan shall be furnished within fifteen (15) days following a request.
- Preparation of a Treatment Plan shall be a necessary part of the care to be rendered and is included in the fee authorized in the medical fee schedule for the underlying services. An additional fee may not be charged for the preparation of a Treatment Plan or progress report, except for the reasonable cost of photocopying and mailing the records.

Additionally, per KRS § 342.035 medical providers shall charge only their customary fee for photocopying requested documents. The photocopying fee of a medical provider or photocopying service shall not exceed fifty cents ($0.50) per page. In addition, a medical provider shall not charge a fee when the initial copy of medical records is provided to the injured worker or his or her attorney in response to a written request pursuant to KRS 422.317. Also, there shall be no charge for reviewing any records of a medical

provider, during regular business hours, by any party who is authorized to review the records and who requests a review pursuant to Chapter 342 of the code.

Case Review Selection Criteria: Utilization review will be performed on cases selected by defined criteria. Pursuant to 803 KAR 25:190 §5 (a-e), focused reviews will begin when any of the following occur:

a) Upon a medical provider's request for Preauthorization;
b) Upon notification of a surgical procedure, or residential placement/treatment plan is received;
c) When total medical costs cumulatively exceed $3,000;
d) When total lost workdays cumulatively exceed 30; or
e) An arbitrator or administrative law judge orders a review.

Physician Designation Process: In accordance with 803 KAR 25:096, Treatment Plans should be obtained when required and rendered only by physician designated on physician card or a specialist referred by the designated physician.

Zenith follows the process set forth by 803 KAR 25:096 §§2 & 3(1-3) which allows injured workers to choose a designated physician. Except for emergency care, treatment for a work-related injury or occupational disease shall be rendered under the coordination of a single physician selected by the employee. Within ten (10) days following receipt of notice of a work injury or occupational disease causing lost work time or necessitating continuing medical treatment, the Zenith claims examiner shall mail a Form 113 to the injured employee, including a self-addressed, postage prepaid envelope for returning the Form 113. The injured worker must complete, sign and return the Form 113, identifying the Designated Physician to Zenith within 10 days. The physician must also sign the Form 113 agreeing to act as the Designated Physician. Within ten (10) days following receipt of a Form 113 designating a treating physician, the Zenith Claims Examiner must send a Designated Physician card to the injured employee. The claims examiner is responsible for assuring that the form is received timely and a copy of the fully completed form is uploaded into Documentum and notes placed in Athena.

Change of Designated Physician:
Following initial selection of a designated physician, the employee may change designated physicians once without authorization of the employer or Zenith. Referral by a designated physician to a specialist shall not constitute a change of designated physician unless the latter physician is specifically selected by the employee as the second designated physician.

Within ten (10) days of a decision to change the designated physician, the employee shall complete the back of the first designated physician card and return the card with the name of the second designated physician, including a written acceptance by the second designated physician, to Zenith. Zenith must issue a second card to the employee within ten (10) days.

The card shall bear the legend "Second Designated Physician-Workers' Compensation" and shall contain the information required on the first designated physician card. The reverse side of the card shall contain a notice that:

- Treatment shall be performed by or on referral from the second designated physician; and
- A further change of designated physician shall require the written consent of the employer, its medical payment obligor, arbitrator, or the administrative law judge.

Failure of Zenith to timely mail the "Second Designated Physician" card shall waive an objection to treatment by other than a designated physician prior to receipt by the employee of the card.

If an employee's two (2) choices of designated physician have been exhausted, the employee may not, except as required by medical emergency, make an additional selection of a physician without the written consent of the employer, Zenith, arbitrator, or the administrative law judge.

Medical Treatment Guidelines: Pursuant to KRS 342.035(8) (a), Zenith and its contracted URO have incorporated the Official Disability Guidelines (ODG) as published by MCG Health for use by medical providers in the treatment of work related injuries and occupational diseases. . When the ODG does not provide applicable guidelines, Zenith relies on other peer reviewed evidence-based medicine guidelines.

If the Treatment Plan does not meet the ODG Guidelines, the MMN may contact the requesting physician for an agreement to voluntarily amend or withdrawal the original Treatment Plan. If agreement is reached on an amendment of the original Treatment Plan, the MMN will request that the provider sign a written agreement confirming the modification. Upon receipt of the signed modification agreement, the MMN may approve the Treatment Plan. If agreement is not reached or if agreement was reached but the physician fails to sign and return the agreement; the MMN will refer the Treatment Plan to a Physician Reviewer or Zenith Medical Director.

In the event the MMN believes the Treatment Plan was not accompanied with appropriate information to allow Zenith to render a decision, the MMN will forward the Treatment Plan to Zenith's third party review vendor. The third party review vendor will have the Treatment Plan reviewed by a Physician Reviewer. If necessary, the Physician Reviewer may contact the requesting physician to obtain appropriate additional Information necessary to render a decision. Requests for additional information must be made within 5 business days of the date the Treatment Plan was originally received. Upon receipt of the appropriate additional information, the Treatment Plan will be reviewed by the Physician Reviewer.

A Physician Reviewer may Approve or Deny Treatment Plans based on their evaluation of the Treatment Plan or may request additional information. Therefore, if the MMN is unable to approve a Treatment Plan based on submitted information, the Treatment Plan is sent for external review by Zenith's contracted utilization review organization. Only a Physician Reviewer who is competent to evaluate the specific clinical issues involved in the Treatment Plan, and where the Requested Plan is within the reviewer's scope of practice may Deny Treatment Plans.

Zenith requires that denials be rendered by physicians with an appropriate specialty. Zenith's methodology for updating its review Criteria consists of regular reviews by appropriate staff evaluation of internal processes, review outcomes and compliance with policies and procedures.

Zenith's review criteria also consists of monitoring whether services are being performed in compliance with 803 KAR 25:190 Section 2 including that reviewers are appropriately qualified, medically necessary and appropriate treatment is rendered to injured workers and medically necessary services are not withheld or unreasonably delayed.

Additionally, only a Zenith Medical Director may override (or attempt to override by additional opinions) a decision for approval or denial made by another Zenith Medical Director or external Physician.

Oral Treatment Plans: Zenith requires Treatment Plans to be submitted in writing. However, at the discretion of the MMN, oral requests that are deemed time-sensitive (e.g. the patient is in the emergency room or there is a life-threatening condition) or for requests for which appropriate information has already been provided will be handled by the MMN in accordance with Zenith's Utilization Review Process. Zenith will advise the provider that Preauthorization is not required for emergency services and that failure to obtain Preauthorization for emergency health care services will not be used to as a basis to refuse reimbursement for services provided to treat and stabilize an injured worker presenting for emergency health care services. However, emergency health care services are subject to retrospective review for medical necessity. If the MMN has received the appropriate information, review will be completed and an approval rendered or the request will be forwarded for immediate review to Zenith's third party vendor. The third party vendor will have the treatment request reviewed by a Physician Reviewer. As part of the review process, the third party Physician Reviewer may contact the requesting provider for additional appropriate information or clarification. The Physician Reviewer will render a decision to Approve or Deny the Treatment Plan. The URO is responsible for notifying Zenith, the requesting physician, the injured worker, and, if the injured worker is represented by counsel, the injured worker's attorney of the utilization review decision. The URO notifications are generated by the URO and comply with regulatory requirements. The provider letter includes the URO's contact information and availability in the event the provider wants to talk to the reviewer.

Decision Review Tracking: All activities are tracked on appropriate systems to record in compliance with KRS342:035(5)(b):and 803 KAR 25:190§4 (9):

1. Each instance of utilization review;
2. Each instance of medical bill audit;
3. The name of the reviewer;
4. The extent of the review;
5. The conclusions of the reviewer; and
6. The action taken, if any, as a result of the review.

Records related to utilization and bill review audit activities are maintained for a period of two (2) years or more from the date the underlying workers' compensation claim was closed pursuant to Zenith's records retention requirements.

Reviewer Contact Information: In compliance with 803 KAR 25:190 §4 (10), Zenith maintains toll-free telephone access for employees and medical providers forty hours per week during normal business hours, which are Mon-Friday, 8AM -5PM CST. That toll free number is 800-440-5020.

Additionally, Zenith maintains facsimile numbers available for Health Care Providers to submit Treatment Plans via fax. Zenith accepts Treatment Plans after normal business hours via either voice-mail and/or facsimile transmission.

Third Party Utilization Review Organization: Zenith has contracted with a third party vendor utilization review organization ("URO") to coordinate and conduct a Physician Review of Treatment Plans and provide information when Zenith staff is unable to approve the Treatment Plan (see "Attachment "B"-Third Party Utilization Review Organization.". The URO is required to comply with all Kentucky statutory and regulatory requirements, including maintaining a properly filed utilization review plan. All services performed by the URO on behalf of Zenith are performed in compliance with the URO's filed utilization review plan.

As part of the review process, the third party Physician Reviewer may contact the requesting provider for additional appropriate information or clarification. The Physician Reviewer will render a decision to Approve or Deny the Treatment Plan. The URO is responsible for notifying Zenith, the requesting physician, the injured

worker, and, if the injured worker is represented by counsel, the injured worker's attorney of the utilization review decision. The URO notifications are generated by the URO and comply with regulatory requirements. The provider letter includes the URO's contact information and availability in the event the provider wants to talk to the reviewer.

Contracted MBA/UR Vendors: Zenith Insurance Company performs first level review of treatment requests for utilization review. If Zenith cannot approve the treatment request, Zenith sends the treatment request to Mitchell for review. Zenith performs all levels of bill review internally unless a retrospective review is needed for medical necessity. Those reviews are conducted by Mitchell. Zenith provides utilization review, bill review and other services for itself and the following entities:

a) ZNAT Insurance Company, a wholly owned subsidiary of Zenith Insurance Company;
b) The RiverStone Group ("RiverStone"), a sister company of Zenith under FairFax Financial Holdings Limited ("FairFax") which includes administration for runoff business for the following entities which all merged into TIG Insurance Company under RiverStone:
   i. TIG Insurance Company
   ii. International Insurance Company
   iii. Old Lyme Insurance Company of Rhode Island, Inc.
   iv. Fairmont Specialty Insurance Company, f/k/a Ranger Insurance Company
   v. Fairmont Premier Insurance Company
   vi. Fairmont Insurance Company
   vii. General Fidelity Insurance Company
   viii. American Safety Indemnity Company
   ix. American Safety Casualty Insurance Company
c) Seneca Insurance Company, wholly owned subsidiary of Crum & Forster which is a sister company of Zenith under FairFax.
d) Tokio Marine America Insurance Company
e) Trans Pacific Insurance
f) TNUS Insurance Company

III. TREATMENT REQUEST TRACKING PROCESS

A Written Treatment Request shall be deemed to have been received by Zenith as follows:

1. Where a Treatment Request is received by mail and a proof of service by mail exists, the request is deemed to have been received 5 calendar days after the date indicated on the proof of service unless:
   - Zenith mailroom date stamp is before the 5 calendar days, then the date stamp will control.
   - Zenith mailroom date stamp is after the 5 calendar days, the proof of service will control.

2. Where the Treatment Request is received via certified mail with return receipt, the request is deemed received on the receipt date entered on the return receipt. If no proof of service or dated return receipt exists, the request is deemed received on the date stamped by Zenith's mail room.

3. Where the Treatment Request is received by mail and no proof of service exists, no dated return receipt exists, or no Zenith mailroom date stamp exists, the date of receipt is considered received 5 calendar days after the latest date indicated on the Treatment Request.

4. Where the Treatment Request is received by facsimile the received date is considered as follows:
    - If Zenith's electronic receive date stamp is present, this is considered the received date. Verbal Treatment Requests will be entered into the system the date received. Pursuant to Zenith requirements, Verbal Treatment Requests must also be followed up with a written request. Verbal Treatment Requests will be tracked from the date the verbal request was originally received and entered into the system.
    - If no Zenith Electronic receive date stamp is present, the date of the fax transmission from the requesting sender is considered the received date.
    - If there is no fax transmission date or an erroneous date as the fax transmission date, the received date is considered the latest date indicated on the Treatment Request.

5. When the Treatment Request is received by telephone, the received date is considered as follows:
    - If the telephonic request is received after 3:00 p.m. the received date for the Treatment Plan will be considered the following business day; and the determination will be rendered with two business days of receipt of the necessary information.
    - If the telephonic request is received prior to 3:00 p.m., the received date for the Treatment Plan will be considered that business day.

Mail and facsimiles received after 4:30 PM (Eastern Time) are considered received the following business day. Mail and facsimiles received on a holiday or weekend are deemed received the next business day.

IV. MEDICAL DIRECTOR & STAFF QUALIFICATIONS

Medical Director: Zenith employs a designated Medical Director to oversee its Utilization Review Process. The designated Medical Director holds an unrestricted license to practice medicine. The Zenith Medical Director oversees and evaluates that process by which Zenith reviews, approves or denies requests by physicians prior to, retrospectively or concurrent with the provision of Medical Services. The Medical Director is responsible for all decisions rendered through Zenith's utilization review program.

Zenith's designated Medical Director holds an unrestricted license to practice medicine in the states of Florida, Texas and California and is Board Certified in Occupational Medicine. See Attachment "A" for more information. Additionally, per the Commissioner's request, the Curriculum Vitae for Zenith's Medical Director are included in the Plan as "Attachment A-Designated Medical Director Curriculum Vitae."

Staff Qualifications: Zenith hires qualified staff to implement the Utilization Review Plan in an honest and ethical manner pursuant to 803 KAR 25:190, §6 (1), (2) & (3). At the time of hire, credentials, including designations, licensure, degrees or certifications, must be verified. Staff is required to maintain appropriate licensure and certifications throughout their course of employment with Zenith. The Utilization Review Process is managed by a team that includes the Medical Management Nurse (MMN), Claims Examiner, and administrative support staff. Utilization Review Process has multiple levels and denials can only be rendered by an appropriate Physician Reviewer. Zenith's multi-level Utilization Review Process includes:

a) Zenith Claims Examiners may review Treatment Plans for the purpose of rendering coverage determinations or application of prior determinations. Claims Examiners may not make Medical Necessity determinations including decisions to Approve or Deny, a Treatment Plan. Claims Examiners may apply a Medical Necessity determination that was previously made by an appropriate reviewer or apply administrative decisions or guidelines that do not require a Medical Necessity

determination. Zenith Claims Examiners are provided both tutorial training as well as reference materials to facilitate their understanding and ensure compliance with Zenith's policies and procedures. If Medical Necessity is an issue, the Claims examiner will refer the review to a MMN for further review.

b) MMNs are registered nurses who, at a minimum: (1) have undergone formal training in nursing and/or a health care field, or hold an associate or higher degree in nursing; (2) hold a valid nursing license, and (3) have professional experience providing direct patient care. The MMN can review a Treatment Plan for approval or referral to a Physician Reviewer or a Zenith Medical Officer. The MMN is not permitted to deny a Treatment Plan. The MMN refers Treatment Plans that cannot be approved for further review by a physician. The MMN may seek review by either an internal Medical Officer or an external physician reviewer. The MMN may discuss Criteria or guidelines with the requesting physician if the Treatment Plan appears to be inconsistent with or exceeds applicable guidelines. If the requesting physician voluntarily amends a Treatment Plan and confirms the amendment in writing, the MMN reviewer may approve the amended Treatment Plan.

c) Zenith Medical Officers may review Treatment Plans for approval or peer to peer discussion for voluntary modifications. Zenith Medical Officers are not permitted to issue denials based on Medical Necessity. If Zenith Medical Officers are unable to approve a Treatment Plan, the Treatment Plan is sent for external physician review.

d) If a Treatment Plan cannot be approved through internal review processes, the Treatment Plan will be sent to Zenith's external certified URO for review by a Physician Reviewer. The Physician Reviewer will issue a decision to Approve or Deny.

V. LEVELS OF UTILIZATION REVIEW

Zenith's Utilization Review Process provides for Prospective Reviews, Concurrent Reviews, and Retrospective Reviews. Compensable claims are subject to utilization review when any of the following occur:

- A medical provider requests Preauthorization of a medical treatment or procedure;
- Notification of a surgical procedure or resident placement pursuant to an 803 KAR 25:096 treatment plan is received;
- When total medical costs exceed $3,000;
- When total lost workdays exceed 30; or
- An administrative law judge (ALJ) orders a review

Initial Utilization Review pursuant to 803 KAR 25:190 §5 (e) (2) (a) (1-3)

If applicable, utilization review shall commence when the carrier has notice that a claims selection criteria (above) has been met. If Preauthorization has been requested, the initial utilization review decision shall be communicated to the designated medical provider and employee within two (2) working days of the initiation of the utilization review process, unless additional information is required. If additional information is required, tender of a single request shall be made within two (2) additional working days. The Requested information shall be tendered by the medical provider within ten (10) working days. The initial utilization review decision shall be rendered within two (2) working days following receipt of the requested information.

Retrospective Utilization Review pursuant to 803 KAR 25:190 §5 (e) (2) (b) (1-3)

If retrospective utilization review occurs, the initial utilization review decision shall be communicated in writing to the medical provider and employee within ten (10) days of the initiation of the utilization review process, unless additional information is required. If additional information is required, tender of a single request shall be made within two (2) additional working days. The requested information shall be tendered by

the medical provider within ten (10) working days. The initial utilization review decision shall be rendered within two (2) working days following receipt of the requested information.

Expedited Utilization Review pursuant to 803 KAR 25:190 §5 (e) (3)

A medical provider may request an expedited utilization review determination for proposed medical treatment or services, the lack of which could reasonably be expected to lead to serious physical or mental disability or death. The expedited utilization review determination shall be provided within twenty-four (24) hours following a request for expedited review. Emergency Health Care Services may be subject to Retrospective Review however, failure to obtain prior Authorization for Emergency Health Care Services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for Emergency Health Care Services. Emergency Health Care Services cannot be denied because of a failure to obtain prior Authorization of a Treatment Request. Zenith will not refuse to cover medical services provided to treat and stabilize an injured worker presenting for Emergency Health Services solely on the basis of a failure to obtain prior authorization.

Written Notice of Denial

(1) Pursuant to 803 KAR 25:190. §7 (1), following initial review, a written notice of denial shall:

(a) Be issued to both the medical provider and the employee in a timely manner but no more than ten (10) days from the initiation of the utilization review process;

(b) Be clearly entitled "UTILIZATION REVIEW - NOTICE OF DENIAL"; and

(c) Contain:

1. A statement of the medical reasons for denial;
2. The name, state of licensure and medical license number of the reviewer;
3. An explanation of utilization review reconsideration rights; and
4. A toll free number for the medical provider to contact the utilization reviewer during normal business hours.

(2) Payment for medical services shall not be denied on the basis of lack of information absent documentation of a good faith effort to obtain the necessary information.

30 Day Toll

30 Day Toll pursuant to 803 KAR 25:190 §5 (e) (4)- Initiation of utilization review shall toll the thirty (30) day period for challenging or paying medical expenses pursuant to KRS 342.020(1). The thirty (30) day period shall commence on the date of the final utilization review decision.

VI. RECONSIDERATION PROCESS

Reconsideration: If the aggrieved party disagrees with the utilization review determination, they may request a reconsideration process to appeal within fourteen (14) days of receipt of a written notice of denial. Reconsideration of the initial utilization review decision shall be conducted by a different reviewer of at least the same qualifications as the initial reviewer. A written reconsideration decision shall be rendered within ten (10) days of receipt of a request for reconsideration. The written decision shall be clearly entitled "UTILIZATION REVIEW - RECONSIDERATION DECISION".

Specialty or Sub-Specialty Review: If a utilization review denial is upheld upon reconsideration and a board eligible or certified physician in the appropriate specialty or subspecialty area, or a chiropractor qualified pursuant to KRS 312.200(3) and 201 KAR 21:095 has not previously reviewed the matter, an aggrieved party may request further review by:

1. A board eligible or certified physician in the appropriate specialty or subspecialty; or

2. A chiropractor qualified pursuant to KRS 312.200(3) and 201 KAR 21:095. A written decision shall be rendered within ten (10) days of the request for specialty reconsideration. The specialty decision shall be clearly entitled "FINAL UTILIZATION REVIEW".

In the event Zenith materially changes either its Utilization Review Process or resources, including material changes in the approved plan or vendors that support the Utilization Review Process, Zenith will notify the commissioner by filing a material modification and updating this Utilization Review Plan pursuant to 803 KAR 25:190. §3 (4) and (5) (b).

The Commissioner was most recently notified that Zenith uses Mitchell International, Inc. (Mitchell) for utilization review services by email dated May 23, 2018.

Zenith will update its review Criteria and other relevant data on a regular basis, as required, to ensure that it is using the most up-to-date Criteria when it reviews Treatment Plans. Zenith's methodology for updating its review Criteria consists of regular reviews by the Medical Director and other appropriate medical management staff to evaluate internal processes, review outcomes and compliance with policies and procedures, and to ensure that Zenith and any of its vendors are utilizing the most current and up-to-date Official Disability Guidelines and other peer reviewed evidence-based guidelines. Reviews occur no less frequently than annually.

Pharmacy Formulary Requirements:

Pursuant to 803 KAR 25:270, Pharmaceutical Formulary, Zenith is liable for payment of up to a seven (7)-day supply of a "Y" drug dispensed to or prescribed for an injured employee within seven (7) days of a work-related injury in treatment of that work-related injury even if the Zenith ultimately denies liability for the claim. Payment by Zenith pursuant to this subsection does not waive the right to contest its liability for the claim or benefits to be provided.

Requests for Preauthorization/Reconsideration:

As per §4 (3) (a-c), requests for Preauthorization shall be subject to utilization review unless the employer waives utilization review. If as a result of utilization review the carrier denies a request for Preauthorization, the medical provider may request reconsideration of the denial to include a peer-to-peer conference with a utilization review physician. The request for a peer-to-peer conference shall be made by electronic communication and shall provide:

(a) A telephone number for the reviewing physician to call;
(b) A date for the conference not less than two (2) business days after the date of the request; and
(c) A one (1) - hour period during which the requesting medical provider (or its designee) will be available to participate in the conference between the hours of 8:00 a.m. and 6:00 p.m. (Eastern Time), Monday through Friday.

The peer-to-peer conference must be conducted by a physician of the same specialty as the medical provider requesting reconsideration.

Failure of the reviewing physician to participate in the peer-to-peer conference during the date and time specified shall result in the approval of the request for Preauthorization and approval of the requested prescription. Failure of the requesting medical provider or its designee to participate in the peer-to-peer

conference during the time he or she specified availability may result in denial of the request for reconsideration.

Pursuant to 803 KAR 25:190 Section 8(1)(c), a written reconsideration decision shall be rendered within ten (10) days of date of the peer-to-peer conference. The written decision shall be entitled "FINAL UTILIZATION REVIEW DECISION".

Utilization review shall not be required for a "Y" drug but may be conducted retrospectively to determine medical reasonableness and necessity. A denial of a "Y" drug based on retrospective utilization review shall apply only to refill prescriptions of that drug after the date of the utilization review.

Treatment Guideline Requirements:

Preauthorization:
Pursuant to 803 KAR 25:260, For treatment designated as "Recommended" in the ODG guidelines, preauthorization is not required. For Treatment designated as "Not Recommended," preauthorization is required. When a request is made for preauthorization for treatment designated as "Conditionally Recommended," Zenith must consider any sound medical reasoning submitted by the medical provider and may not deny preauthorization based solely on the basis that conditions precedent have not been met.

Reconsideration:
If Zenith denies preauthorization following utilization review, it shall issue a written notice of denial as required by 803 KAR 25:190, Section 7. The medical provider whose recommendation for treatment is denied may request reconsideration, and may require the reconsideration include a peer-to-peer conference with a second utilization review physician. The request for a peer-to-peer conference shall be made by electronic communication and shall provide:

- A telephone number for the reviewing physician to call;
- A date or dates for the conference not less than five (5) business days after the date of the request; and
- A one (1)-hour period during the date or dates specified during which the requesting medical provider, or a designee, will be available to participate in the conference between the hours of 8:00 a.m. and 6:00 p.m. (Eastern Time), Monday through Friday.

- The reviewing physician participating in the peer-to-peer conference shall be of the same specialty as the medical provider requesting reconsideration.
- Failure of the reviewing physician to participate during the date and time specified shall result in the approval of the request for preauthorization and approval of the recommended treatment unless good cause exists for the failure to participate. In the event of good cause for failure to participate in the peer-to-peer conference, the reviewing physician shall contact the requesting medical provider to reschedule the peer-to-peer conference. The rescheduled peer-to-peer conference shall be held no later than two (2) business days following the original conference date. Failure of the requesting medical provider or its designee to participate in the peer-to-peer conference during the time he or she specified availability may result in denial of the request for reconsideration.
- A written reconsideration decision shall be rendered within five (5) business days of date of the peer-to-peer conference. The written decision shall be entitled "FINAL UTILIZATION REVIEW DECISION."

ATTACHMENT "D"

ZENITH INSURANCE COMPANY

APPLICABLE CONFIDENTIALITY AND PRIVACY POLICIES AND GUIDELINES

Zenith's policy is to protect the confidentiality of medical health information as well as all other company documents. To accomplish this, Zenith utilizes several policies including the Zenith Code of Business Conduct which includes the following statement:

Confidentiality / Use of Confidential Information

To protect Zenith and our clients, we are committed to preserving the right of privacy and the confidentiality and security of information. The following information is confidential:

- Business information such as financial and actuarial information and projections, computer records and programs, contracts, customer files and lists, investments, investment strategies, marketing plans, bid proposals and contract negotiations;
- Medical, financial and other information concerning injured workers, including diagnosis and treatments, personal data and billing and contact information; and
- Employee information, including personnel files, salary and bonus information (except where disclosures are required), evaluations, disciplinary matters and psychological assessments.

It is a violation of this Code for any employee, both during and after such person's employment with the Company, to use or disclose outside the Company any confidential information to any entity or person without authorization or in accordance with Company policies. When using or sharing confidential information, you must secure all data, electronic or otherwise. The concepts of "minimum necessary" and "need to know" always apply to the use and disclosure of confidential information. Detailed privacy and information security policies exist to help employees meet Company expectations *(refer to Zenith's Protection of Personal Information and Business Confidential and Proprietary Information, Information and Facilities Security, and Acceptable Use of Resources policies for more detail).* Version: 6-20-2012

Other polices developed and implemented to help protect the confidentiality of information include Zenith's:

1. Information and Facilities Security Policy
2. Acceptable Use of Resources Policy with Safeguards Attachment A; and
3. Email Security Policy

Copies of these policies will be made available to regulatory agencies upon request with the provision that the policies not be made available to the public.

ATTACHMENT "E"

Template letters and Explanation of Benefits are on file with the Commonwealth of Kentucky, Department of Workers' Claims.