Zenith Insurance Company
ZNAT Insurance Company

21255 Califa Street
Woodland Hills, CA 91367

California Utilization Review Plan

May 5, 2017

Table of Contents

Definitions

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

The following definitions apply regardless of the date of injury or service:

1. "Approval" or "Approve" means a decision that the requested treatment or service is Authorized as Medically Appropriate to cure or relieve the effects of a compensable industrial injury.
2. "Authorization" or "Authorized" means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, based on a completed "Request for Authorization for Medical Treatment, " DWC Form RFA, as contained in California Code of Regulations, title 8, section 9785.5, that has been transmitted by the treating physician to Zenith or its designee. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, section 9792.9.1, and may be provided by utilizing the indicated response section of the "Request for Medical Treatment," DWC Form RFA.
3. "Certify" means to Approve services under the injured workers' plan of coverage.
4. "Claims Administrator" means Zenith as a self-administered workers' compensation insurer. The Claims Administrator may utilize an entity contracted to conduct its utilization review responsibilities.
5. "Claims Examiner" means staff employed by Zenith to process claims.
6. "Criteria" as defined by Zenith means the use of the California Medical Treatment Utilization Schedule, and/or other evidenced base medicine guidelines to evaluate Treatment Requests. The current list of Zenith evidence based guidelines is set forth in Attachment "C" and are hereby incorporated into and made a part of this Plan.
7. "Concurrent Review" means utilization review conducted during an inpatient stay.
8. "Deny", "Non-Certify" or "Adverse Determination" means a decision by a Physician Reviewer that the requested treatment or service is not Approved as Medically Necessary.
9. "Dispute Liability" means an assertion by Zenith that a factual or legal basis exists that precludes compensability for an occupational injury, a claimed injury to any part or parts of the body, or a requested medical treatment.
10. "DWC" means the California Division of Workers' Compensation.
11. "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.
12. "Expedited Review" means utilization review or Independent Medical Review conducted when the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health,

including, but not limited to, the potential loss of life, limb or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function.

13. "Expert 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 Physician Reviewer to provide specialized review of medical information.
14. "Health Care Provider" means a provider of Medical Services as well as related services or goods, including but not limited to an individual provider or facility, a health care service plan, a health care organization, a member of a preferred provider organization or medical provider network as provided in LC §4616.
15. "Immediately" means within one business day.
16. "Injured Employee" means an employee or former employee whose Employer has ongoing workers' compensation obligations and selected the Zenith Medical Provider Network (ZMPN) for the provision of medical treatment to its employees**.**
17. "LC" means the California Labor Code.
18. "MMN" means a registered nurse employed by Zenith's medical management department.
19. "Medical Director" means the physician licensed by the Medical Board of California or the Osteopathic Board of California who holds an unrestricted license to practice medicine in the State of California and is responsible for oversight of all Zenith Utilization Review programs. The Medical Director is responsible for all decisions rendered through Zenith's utilization review program.
20. "Medical Officer" means physicians employed by Zenith who hold unrestricted licenses to practice medicine in any state or the District of Columbia. Zenith's designated Medical Director is also a Medical Officer for purposes of this Plan.
21. "Medically Necessary" and "Medical Necessity" mean medical treatment reasonably required to cure or relieve the injured worker of the effects of his or her injury and based on the following standards, which will be applied in the order listed, allowing reliance on a lower ranked standard only if every higher ranked standard is inapplicable to the employee's medical condition:
    (A) The MTUS guidelines;
    (B) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service;
    (C) Nationally recognized professional standards;
    (D) Expert opinion;
    (E) Generally accepted standards of medical practice; and
    (F) Treatments that are likely to provide a benefit to the injured worker for conditions for which other treatments are not clinically efficacious.
22. "Medical Services" means those goods and services provided pursuant to Article 2 (commencing with Labor Code section 4600) of Chapter 2 Part 2 of

Division 4 of the Labor Code.

23. "Medical Treatment Utilization Schedule" and "MTUS" means the most current version of guidelines developed and adopted by the Administrative Director pursuant to LC §5307.27 and set forth in CCR Title 8, sections 9792.20 et seq.
24. "Modification" or "Modify" means a decision by a Physician Reviewer that part of the requested treatment or service is Medically Necessary.
25. "Physician Reviewer" or "Reviewer" 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.
26. "Pre-service Evaluation" means a medical evaluation performed by a medical provider in the Zenith Medical Provider Network to evaluate whether the Injured Employee is eligible to receive the requested services. Pre-Service Evaluation does not include a pre-op clearance review once a requested surgery has been found to be Medically Necessary.
27. "Prospective Review" means any utilization review conducted, except for utilization review conducted during an inpatient stay, prior to the delivery of the requested Medical Services.
28. "Regulations" means Title 8 of the California Code of Regulations.
29. "Retrospective Review" means utilization review conducted after Medical Services have been provided and for which approval has not already been given.
30. "Time Extension" means a decision by a Physician Reviewer that no determination based on Medical Necessity can be made within the time frames required by section 9792.9.1(c) for one or more of the following reasons:
    a. The Reviewer is not in receipt of all the information reasonably necessary to make a determination;
    b. The Reviewer has asked that an additional examination or test be performed upon the injured worker that is reasonable and consistent with professionally recognized standards of medical practice;
    c. The Reviewer needs a specialized consultation and review of the medical information by an expert reviewer.
31. "Tracking Tool" means a computerized system utilized to manage utilization review activity.
32. "Treatment Request" and "Request for Authorization" means a written request for a specific course of proposed medical treatment. The term "Treatment Request", as used in this Utilization Review Plan, is synonymous with a "Request for Authorization", as such term is used in the relevant sections of the Labor Code and 8 CCR §9792.6.1(t).
33. "Utilization Review Plan" means this Written plan, which is filed with the DWC Administrative Director pursuant to LC §4610 and sets forth Zenith's policies and procedures and a description of the Utilization Review Process. Utilization Review Process" means utilization management functions that prospectively, retrospectively, or concurrently review and approve, Modify, or Deny, based in whole or in part on Medical Necessity to cure or relieve,

treatment recommendations by physicians, as defined in Labor Code section 3209.3, prior to, retrospectively or concurrent with the provision of medical treatment services pursuant to Labor Codes section 4600. Utilization Review does not include determinations of the work-relatedness of injury or disease, or bill review for the purpose of determining whether the Medical Services were accurately billed. The Utilization Review Process begins when the completed DWC Form RFA is first received, whether by Zenith or its designated utilization review agent, or in the case of prior authorization, when the requesting physician satisfies the conditions described in the Utilization Review Plan for prior authorization.

34. "Written" includes a facsimile as well as communication in paper form. Electronic mail may be used by agreement of Zenith and the other party although an employee's health records shall not be transmitted via electronic mail.

35. "Zenith" means Zenith Insurance Company and/or ZNAT Insurance Company.

36. "Zenith Medical Provider Network" (ZMPN) means an entity or group of providers approved as a Medical Provider Network by the Administrative Director of the Division of Workers' Compensation pursuant to Labor Code section 4616 to 4616.7.

Utilization Review Plan Administrative Overview

The following overview, description and 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 California Claims Administrator, Zenith has established and maintains this Utilization Review Plan and its Utilization Review Process in compliance with LC §4610 et seq and applicable regulations.

California Utilization Review Process Description

I. Overview

The purpose of the Zenith Utilization Review Process is to provide an assessment of clinical appropriateness and Medical Necessity of Treatment Requests and goods provided pursuant to Article 2 (commencing with LC §4600) of Chapter 2 of Part 2 of Division 4 of the LC for accepted and delayed claims. The Utilization Review Process does not include determinations of the work relatedness of the injury or disease or bill review for the purpose of determining whether the Medical Services were accurately billed.

Zenith strives to work collaboratively with Health Care Providers in order to Certify care that is consistent with Medical Treatment Utilization Schedule 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.

In the event Zenith materially changes either its Utilization Review Process or resources, including any vendors that support the Utilization Review Process, Zenith will file a material modification and update this Utilization Review Plan pursuant to Regulations §9792.7(c). 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 Requests. 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 Medical Treatment Utilization Schedule and other peer reviewed evidence based guidelines. Reviews occur no less frequently than annually.

This Utilization Review Plan includes both administrative procedure and process descriptions that govern Zenith's Utilization Review Process. Zenith makes this Utilization Review Plan available to the publice by posting it on www.thezenith.com. Zenith's Utilization Review Plan may be made available through electronic means or via hard copy for a reasonable copying and postage fee that shall not exceed $0.25 per page plus actual postage costs.

II. Utilization Review

Medical Director: In compliance with Labor Code §4610(d), Zenith employs a designated Medical Director to oversee its Utilization Review Process. The designated Medical Director holds an unrestricted license to practice medicine in the State of California, issued pursuant to section 2450 of the Business and Professional Code. The Zenith Medical Director oversees and evaluates that process by which Zenith reviews, certifies, modifies, or Non-Certifies requests by physicians prior to, retrospectively or concurrent with the provision of Medical Services in compliance with Labor Code 4610 and corresponding regulations. The Medical Director is responsible for all decisions rendered through Zenith's utilization review program. The designated Medical Director's name, address, phone number and license number are set forth in Attachment "A".

Treatment Guidelines: Zenith's utilization review decisions are made using the Medical Treatment Utilization Schedule (MTUS) adopted by the Administrative Director pursuant to CCR Article 5, §9792.20 et seq. When MTUS does not provide applicable guidelines, Zenith relies on other peer reviewed evidence based medicine guidelines. A complete listing of the current peer reviewed guidelines adopted and utilized by Zenith is attached to this Plan as "Attachment "C" – Utilization Review Guidelines." The MTUS guidelines are considered presumptively correct on the issue of extent and scope of medical treatment. The presumption is rebuttable and may be controverted by a preponderance of the scientific medical evidence establishing that a variance from the guidelines is reasonably required to cure or relieve the injured worker from the effects of the injury.

Treatment will not be denied and authorization for treatment is not automatically precluded on the sole basis that MTUS does not include specific criteria for the requested treatment. For all conditions or injuries not addressed by MTUS, review decisions are made using the following guidelines and resources in order of use:

(A) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service;
(B) Nationally recognized professional standards;
(C) Expert opinion;
(D) Generally accepted standards of medical practice; and
(E) Treatments that are likely to provide a benefit to the injured worker for conditions for which other treatments are not clinically efficacious.

Preauthorization and Retrospective Review: Zenith requires medical services to be preauthorized. If services are performed without authorization, Zenith may require retrospective review of the treatment. If the treatment is found not to be Medically Necessary, reimbursement for the service will be denied.

If a provider has requested preauthorization for a medical service, but performs services beyond the scope of what was authorized, the services beyond the scope of the authorization may be denied if the services were previously found not to be Medically Necessary or the physician does not provide documentation showing that treatment was for:

a. an Emergency Health Care Service;
b. a medical condition discovered during the course of providing the authorized treatment and it was Medically Necessary to treat the newly discovered

condition;

c. medical services or durable medical equipment identified as Medically Necessary during a medical examination and the treatment is rendered during the same office visit as the medical examination.

Providers must submit medical documentation to support the Medical Necessity of any services rendered outside the scope of authorized services. Failure to provide appropriate documentation of Medical Necessity may result in denial of reimbursement for the services.

Pre-Service Evaluations: Zenith requires that a Pre-Service Evaluation be performed before certain services are performed or authorized. This includes services that require the Injured Employee to have medical clearance or be eligible for services before the service can be performed. This includes but is not limited to certain psychological clearance for surgical procedures when required by Zenith, weight loss reduction programs including surgery, Functional Restoration Programs and inpatient detoxification programs. Zenith requires that Pre-Service Evaluations be performed by a ZMPN physician that has no financial or personal conflict of interest that would potentially impact the appearance of impartiality of the Pre-Service Evaluation. Zenith expects Pre-Service Evaluations to be free from bias caused by the Pre-Service Evaluator's own financial interests or the financial interests of persons or entities with whom the reviewer is affiliated or related. Conflicts can arise due to financial interests in medical groups and practices and through personal relationships. Pre-Service Evaluations by family members of either the requesting provider or provider performing the medical service will not be permitted.

Staffing: Zenith shall hire qualified staff to implement the Utilization Review Plan in an honest and ethical manner pursuant to applicable Labor Code and regulatory requirements. At the time of hire, credentials, including designations, licensure, degrees or certifications, must be verified. Staff are 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. The Utilization Review Process has multiple levels and non-certifications can only be rendered by an appropriate Physician Reviewer. Zenith's multi-level Utilization Review Process includes:

a. Zenith Claims Examiners may review Treatment Requests for the purpose of rendering coverage determinations or application of prior determinations. Claims Examiners may not make Medical Necessity determinations including decisions to Certify, Non-Certify, or Modify a Treatment Request. 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 in the state of California, and (3) have professional experience providing direct patient care. The MMN can review a Treatment Request for certification or referral to a Physician Reviewer or a Zenith Medical Officer. The MMN is not permitted to Deny a Treatment Request. The MMN refers Treatment Requests that cannot be certified 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 Request appears to be inconsistent with or exceeds applicable guidelines. If the requesting physician voluntarily amends a Treatment Request and confirms the amendment in writing, the MMN reviewer may Certify the amended Treatment Request.

c. Zenith Medical Officers may review Treatment Requests for certification 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 Certify a Treatment Request, the Treatment Request is sent for external physician review.
d. If a Treatment Request cannot be certified through internal review processes, the Treatment Request will be sent to Zenith's external URO for review by a Physician Reviewer. The Physician Reviewer will issue a decision to Certify, Modify or Deny.

Submission of a Treatment Request: Utilization review begins with the receipt of a Written Treatment Request that has been referred into the Utilization Review Process. Treatment Requests must be submitted in writing on a Request for Authorization DWC form RFA unless Zenith accepts a request in another format. At Zenith's discretion, Zenith may accept a Treatment Request that is not submitted on the DWC Form RFA if:

1. the first page of the document containing the Treatment Request clearly includes the words "Request for Authorization" at the top of the first page;
2. all requested Medical Services, goods or items are listed on the first page of the document; and
3. the Treatment Request is accompanied by documentation substantiating the Medical Necessity of the requested treatment, including a Pre-Service Evaluation when required.

Even if these requirements are met, Zenith may, at its discretion, either accept or reject a Treatment Request that is not submitted on the DWC Form RFA. If the Treatment Request is submitted on a DWC Form RFA, then Zenith may only reject the Treatment Request if the DWC Form RFA is "not complete". If Zenith elects to reject either a DWC Form RFA as "not complete" or reject a Treatment Request not submitted on a DWC Form RFA for any reason, within 5 business days of receipt of the Treatment Request, Zenith must return the Treatment Request to the requesting physician marked "not complete" and specify the reasons for the return. The timeframe for a decision on a returned Treatment Request will begin anew upon receipt of a completed DWC Form RFA or the completed Treatment Request that was submitted without a DWC Form RFA if Zenith is agreeing to accept the submission so long as it is "completed". For purposes of this section Completed means the Treatment Request must identify both the employee

and the provider, identify with specificity a recommended treatment or treatments, and be accompanied by documentation substantiating the need for the requested treatment. A Treatment Request that requires a Pre-Service Evaluation will be returned as incomplete if the Pre-Service Evaluation is not included with the Treatment Request. The Treatment Request must be signed by the Requesting physician and may be mailed, faxed or emailed to the address, fax number or email address designated by Zenith for submission of Treatment Requests. Zenith will not review or respond to Treatment Requests that are not submitted to the address, fax number, or email address designated by Zenith, including Treatment Requests submitted through an electronic billing system. Treatment Requests should never be submitted as part of a medical bill submission. Zenith will accept Treatment Requests that have an electronic signature affixed to the request.

Review Process: Zenith maintains telephone access from 9:00 AM to 5:30 PM (California time) on normal business days for Health Care Providers to submit Treatment Requests. Additionally, Zenith maintains facsimile numbers available for Health Care Providers to submit Treatment Requests via fax. For after-hours operations, Zenith maintains the capability for Health Care Providers to submit Treatment Requests through a voice-mail system and/or a facsimile number.

Proper notifications will be provided for any actions taken by internal staff or by the external Peer Review vendor. Telephonic, facsimile, and Written notifications for all utilization review outcomes are made in accordance with applicable codes and regulations including Labor Code §4610 and 8 C.C.R. §9792.9.1 addressing the timeframe, procedures and notice requirements and well as 8 C.C.R. §9792.10.1 et seq. addressing dispute resolution.

Compensability decisions are not made through the utilization review process and will be handled through Zenith's claims processes. Therefore, any Treatment Request subject to the Utilization Review Process shall be evaluated by a Claims Examiner to determine coverage given the scope of decision-making authority of the Claims Examiner. In the event that a claim has not yet been accepted and a Treatment Request is received, Zenith will follow normal utilization review processes to address Medical Necessity. If the Claims Examiner determines coverage is available, the Treatment Request is forwarded to a MMN for review. The Claims Examiner may also defer Utilization Review as set forth below under Deferral of Utilization Review.

In the event the MMN believes the Treatment Request was not accompanied with appropriate information to allow Zenith to render a decision, the MMN will forward the Treatment Request to Zenith's third party review vendor. The third party review vendor will have the Treatment Request 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 Request was originally received. Upon receipt of the appropriate additional information, the Treatment Request will be reviewed by the Physician Reviewer.

If the Treatment Request does not meet the MTUS Guidelines or other evidence-based medicine guidelines, as allowed by the LC and Regulations, the MMN may contact the requesting physician for an agreement to voluntarily amend or withdrawal the original

Treatment Request. If agreement is reached on an amendment of the original Treatment Request, the MMN will request that the provider sign a written agreement confirming the modification. Upon receipt of the signed modification agreement, the MMN may Certify the Treatment Request. 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 Request to a Physician Reviewer or Zenith Medical Officer.

A Physician Reviewer may Certify, Deny or Modify Treatment Requests based on their evaluation of the Treatment Request or may request additional information. Therefore, if the MMN is unable to approve a Treatment Request based on submitted information, the Treatment Request 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 Request, and where the Requested Treatment is within the reviewer's scope of practice may Deny Treatment Requests.

Additionally, only a Zenith Medical Officer may override (or attempt to override by additional opinions) a decision for certification, modification or denial made by another Zenith Medical Officer or external Clinical Peer Review.

Oral Treatment Requests: Zenith requires Treatment Requests to be submitted in writing. 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) will be handled by the MMN in accordance with Zenith's Utilization Review Process in an expedited manner. 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 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 provider still wants precertification and Zenith has the information necessary to render a certification decision, a letter of certification will be issued to the provider that states the Authorization is based on an oral request. The provider will be advised that they must follow up with a written request in order to comply with CCR §9792.9.1(a). If Zenith cannot Certify the request based on the available information, the provider will be advised that they need to submit a written Treatment Request and ask for an expedited review.

For oral Treatment Requests that are not deemed time sensitive, the requesting physician will be advised that according to CCR §9792.9.1(a), the request must be submitted in writing.

Review of Treatment Requests by Third Party Utilization Review Organization: Zenith has contracted with a third party utilization review organization "(URO") to coordinate and conduct a Physician Review of Treatment Requests and provided information when Zenith staff is unable to approve the Treatment Request (see Attachment B, Third Party Utilization Review Organization). The URO is required to comply with all California 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 Certify, Deny or Modify the Treatment Request. The URO is responsible for notifying Zenith, the requesting physician, the injured worker and, if the injured worker is represented by counsel, the injured workers' attorney of the utilization review decision. The URO notifications are generated directly 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.

Zenith requires the URO to verify compliance with licensing requirements of Physician Reviewers at least annually. The vendor is required to submit a list of Physician Reviewers to Zenith with proof of licensing during this review. The URO has previously filed its utilization review plan with the California Division of Workers' Compensation and therefore the URO plan and accompanying materials are not being filed as part of the Zenith Utilization Review Plan.

Deferral of Utilization Review: Pursuant to 8 CCR §9792.9.1(b), Utilization Review may be deferred if Zenith as the claims administrator is disputing liability for either the occupational injury for which the treatment is recommended or the recommended treatment itself on grounds other than Medical Necessity. If Zenith is disputing liability for the requested medical treatment, Zenith will issue a written decision no later than five (5) business days from receipt of the Treatment Request and include notification that Zenith is deferring utilization review. The decision letter will be sent to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney. In these situations, the Zenith claims examiner is responsible for sending Zenith's non-4610 form letter and including the utilization review deferral language in the letter. No notice is required if the requesting physician has been previously notified of a dispute over liability and an explanation of the deferral of utilization review was already sent to the provider for a specific course of treatment pursuant to 8 CCR §9792.9.1(b).

The written deferral decision will include the following:

a. The date on which the Treatment Request was first received;
b. A description of the specific course of proposed medical treatment for which authorization was requested;
c. A clear, concise, and appropriate explanation of the reason for Zenith's dispute of liability for either the injury, claimed body part or parts, or the recommended treatment;
d. A plain language statement advising the injured worker that any dispute shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board; and
e. The following mandatory language:

> "You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster's name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me.

and

"For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401."

If Utilization Review is deferred and it is finally determined that Zenith is liable for treatment of the condition for which treatment is recommended, the time to conduct Retrospective Review begins on the date the determination of liability becomes final, and the time to conduct Prospective Review begins from the date Zenith receives a Treatment Request after the determination of liability.

Applicability of Utilization Review Decision: Pursuant to Labor Code 4610(g)(6), a utilization review decision to Modify or Deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

Neither the employee nor the employer shall have any liability for medical treatment furnished without authorization if the treatment is Modified, or Denied by a utilization review decision unless the utilization review decision is overturned by independent medical review pursuant to Labor Code §§ 4610.5 and 4610.6.

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

When a Treatment Request is received by mail and a proof of service by mail exists, the request is deemed to have been received 5 business days after the date indicated on the proof of service or after deposit in the mail at a facility regularly maintained by the United States Postal Service unless:

a) the Zenith mailroom date stamp is before the 5 calendar days, then the date stamp will control; or
b) the Zenith mailroom date stamp is after the 5 calendar days, then the proof of service will control.

When 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.

When 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.

When the Treatment Request is received by facsimile or secure electronic mail the received date is considered as follows:

a) If Zenith's electronic receive date stamp is present, this is considered the received date

b) If no Zenith electronic or email receive date stamp is present, the date of the fax transmission from the requesting sender is considered the received date

c) If there is no fax transmission date or an erroneous date as the fax transmission date, the received date is the date the fax was transmitted to Zenith pursuant to Title 8 CCR § 9792.9.1. An erroneous fax date occurs when the sender of the fax has failed to set up the time stamp on the sender's fax machine and the date on the fax reflects a date far in the past.

Mail and facsimiles received after 5:30 PM (California 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. Types of Treatment Request Reviews

Zenith's Utilization Review Process provides for Expedited Reviews, Prospective Reviews, Concurrent Reviews, and Retrospective Reviews. The review and decision to Deny- or Modify a request for medical treatment must be conducted by a Reviewer, who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the individual's practice. The first day in counting any timeframe requirement is the day after receipt of the Treatment Request, except when the timeline is measured in hours. When the timeframe in which to respond is in hours, the time for compliance is counted in hours from the actual time the request is received.

The reviews are as follows:

1. Expedited Review is a utilization review conducted when the injured worker's condition is such that the injured worker faces imminent and serious threat to his/her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the injured worker's life or health or could jeopardize the injured worker's ability to regain maximum function. The requesting provider must clearly state the need for an Expedited Review upon submission of the Treatment Request.

   Decisions to Certify, Deny or Modify Treatment Requests must be made in a timely fashion that is appropriate for the nature of the injured worker's condition, but not to exceed 72 hours after receipt of the information reasonably necessary to make the determination. The requesting physician must Certify the need for an expedited review upon submission of the request when using the DWC Form

RFA. For requests not required to be on the DWC Form RFA, the provider must document the need for an expedited review upon submission of the request.

2. Prospective Review is any utilization review conducted prior to the delivery of requested Medical Services, unless the injured worker is hospitalized.

   Decisions to Certify, Modify, Deny, or request additional information must be made within 5 business days from receipt of the Treatment Request.

3. Concurrent Review is a utilization review conducted during an inpatient stay.

   Decisions to Certify, Modify, Deny, or request additional information must be made within 5 business days from receipt of the Treatment Request.

   Medical care shall not be discontinued nor denied until the requesting physician has been notified of the decision and a care plan has been agreed upon by the requesting physician. The care plan must be appropriate for the medical needs of the injured worker and consistent with Medical Treatment Utilization Schedule, and/or other evidence based medicine guidelines utilized by Zenith, as allowed by the LC and Regulations.

   If appropriate information which is necessary to render a decision was not provided with the Treatment Request, a Written request for appropriate additional information must be sent within 5 business days from receipt of the Written Treatment Request to the requesting provider.

   If a request for appropriate additional information is sent to the requesting provider, then the timeframe for a decision is no later than 14 calendar days from the receipt of the original Treatment Request.

   If the appropriate additional information requested is not received, a Physician Reviewer shall Deny the request with the stated condition that the request will be reconsidered upon receipt of the information.

   If the appropriate additional information requested is received, then upon receipt of such information a decision must be made within 5 business days of receipt of the additional information, but no later than 14 calendar days as stated above.

4. Retrospective Review is a utilization review conducted after Medical Services have been provided and for which certification has not already been given. Decisions to Certify, Modify or Deny must be completed within 30 calendar days of receipt of the request for authorization and medical information that is reasonably necessary to make a determination.

5. Requests for authorization of Emergency Health Care Services will be completed immediately. However, Emergency Health Care Services are not required to be authorized prior to the services being rendered. If a physician requests authorization of Emergency Health Care Services, Zenith will inform the physician that authorization is not required and that Emergency Health Care

Services cannot be denied because of a failure to obtain prior Authorization of a Treatment Request. If the provider continues to request authorization, Zenith will expedite the Treatment Request.

Zenith will not refuse to cover Medical Services provided to treat and stabilize an injured worker presenting for Emergency Health Care Services solely on the basis of a failure to obtain prior Authorization. Such services may, however, be subjected to Retrospective Review. Documentation for Emergency Health Care Services shall be made available to Zenith upon request.

Request for Time Extension: If appropriate information which is necessary to render a decision was not provided with the Treatment Request, a Written request for appropriate additional information must be sent within 5 business days from receipt of the Written Treatment Request to the requesting provider. The timeframe for decisions may only be extended with a Written notice by the Reviewer that a Time Extension is needed to complete the review under one or more of the circumstances set forth below and decisions must be made within the applicable timeframe:

(1) If the Reviewer is not in receipt of all of the necessary medical information reasonably requested a Time Extension may be requested. When a request for additional medical information is sent to the requesting provider, a decision on the Treatment Request must be made no later than 14 calendar days from the receipt of the original Treatment Request for Prospective and Concurrent Reviews or within thirty (30) days from receipt of a request for Retrospective Review regardless of whether or not the information is received. If the additional information is not received, the Reviewer will Deny the Treatment Request and the denial letter will include a statement that the Treatment Request will be reconsidered upon receipt of the information requested.

(2) A Time Extension may be requested, if the Reviewer requests that either:

(a) an additional examination, or medical test, be performed upon the Injured Employee that is reasonable and consistent with professionally recognized standards of medical practice; or

(b) a specialized consultation and review of medical information by an expert reviewer be provided.

If an examination, medical test, or specialized consultation was required and the results from the requested service is not received within thirty(30) days from the date of the request for authorization, the Reviewer will Deny the Treatment Request and the denial letter will include a statement that the Treatment Request will be reconsidered upon receipt of the results of the requested additional examination, medical test, or specialized consultation.

Upon receipt of the information requested, the Reviewer, for Prospective or Concurrent review, shall make the decision to approve, Modify, or Deny the request for authorization within five (5) business days of receipt of the information. The requesting physician shall be notified by telephone, facsimile or electronic mail within 24 hours of making the decision The Written decision shall include the date the information was received and the decision

shall be communicated in the manner required by 8 CCR §9792.9.1(d) or (e), whichever is applicable.

Upon receipt of the information requested, the Reviewer, for decisions related to an Expedited Review, shall make the decision to approve, Modify, or Deny the request for authorization within 72 hours of receipt of the information. The requesting physician shall be notified by telephone, facsimile or electronic mail within 24 hours of making the decision. The written notice of decision shall include the date the requested information was received and be communicated as required by 8 CCR §9792.9.1(d)(2) or (e)(3), whichever is applicable.

Upon receipt of the information requested, the reviewer, for Retrospective Review, shall make the decision to approve, Modify, or Deny the request for authorization within thirty (30) calendar days of receipt of the request and medical information that is reasonably necessary to make a determination. The decision shall include the date it was made and be communicated as required by 8 CCR 9792.9.1(d)(3) or (e)(4), whichever is applicable.

Documentation of File for Lack of Information Denials: Whenever a Reviewer denies a Treatment Request for lack of medical information necessary to make a determination, Zenith will document that attempt by Zenith or the Reviewer to obtain the necessary medical information from the requesting physician either by facsimile, mail or e-mail.

Notification of Utilization Review Decisions: Decisions for all types of reviews shall be communicated in writing to the requesting provider, injured worker and if the injured worker is represented by counsel, the injured worker's attorney. Notification of outcomes, requests for additional information, certifications, non-certifications, or modifications, must be communicated in compliance with 8 CCR§9792.9.1. All decisions to approve a request for authorization set forth in a DWC Form RFA shall specify the specific medical treatment service requested, the specific medical treatment service approved, and the date of the decision. For prospective, concurrent, or expedited review, approvals shall be communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail. The communication by telephone shall be followed by written notice to the requesting physician within 24 hours of the decision for concurrent review and within two (2) business days for prospective review. For retrospective review, a written decision to approve shall be communicated to the requesting physician who provided the Medical Services and to the individual who received the Medical Services, and his or her attorney/designee, if applicable, within 30 days of the request for authorization and medical information that is reasonably necessary to make a determination.

Written decisions to approve, Modify or Deny treatment must meet the requirements of 8 CCR §9792.9.1(d) and (e), whichever is applicable. The Written decision to Modify or Deny treatment must be sent to the requesting physician, injured worker and the injured worker's representative and if applicable the applicant attorney. The Written decision to Modify or Deny a Treatment Request must include:

1. The date on which the DWC Form RFA or accepted Treatment Request was first received;
2. The date the decision was made;
3. A description of the specific course of proposed medical treatment for which Authorization was requested;

4. A list of all medical records reviewed, including the date of the medical record;
5. A clear, concise and appropriate explanation of the reasons for the Physician Reviewers decision, including the clinical reasons regarding Medical Necessity and a description of the relevant medical criteria or guidelines used to reach the decision. If a decision is due to insufficient information, the decision shall specify the reason for the decision and specify the information that is needed. Zenith will not charge an injured worker, the injured worker's attorney or the requesting physician for a copy of the relevant portion of the criteria or guidelines relied upon to Modify or Deny the Treatment Request. (See Title 8 CCR §9792.8(3));
6. A specific description of any medical treatment service that is approved;
7. The Application for Independent Medical Review, DWC Form IMR. All fields of the form, except the signature of the employee must be completed by Zenith or its utilization review vendor. An envelope addressed to Maximus will be included with the IMR form.
8. A clear statement that any dispute will be resolved in accordance with the Independent Medical Review process established by Labor Code section 4610 and 4610.6 and that an objection to the decision must be communicated by the injured worker, their representative or applicant attorney using the Application for Independent Medical Review, DWC For IMR, within 30 calendar days after service of the decision. The Application for Independent Medical Review, DWC Form IMR must be included with the decision letter. All fields of the DWC Form IMR, except for the signature of the Injured Worker, must be completed by Zenith or its designee. The decision letter sent to the injured worker must also include an addressed envelope, which may be postage paid, for mailing to the Administrative Director or the Administrative Director's designee; and
9. The mandatory paragraphs required by §9792.9.1(e)(5)(I).

The Written decision to the provider will also include the name, specialty and phone number of the reviewer/expert reviewer, and disclose the available hours for the reviewer/ expert reviewer or the medical director for the treating physician to discuss the written decision. These available hours will be at a minimum, four (4) hours per week during normal business hours, 9:00 AM to 5:30 PM., Pacific Time or an agreed upon scheduled time.

Prior Authorization Without Submission of Request for Authorization: Pursuant to Title 8 CCR 9792.7(a)(5), Zenith may, based upon provider performance and pursuant to Zenith's filed and approved Zenith Provider Evaluation Policy, pre- authorize select providers to proceed with continuing care for an injured worker without submission of a request for authorization for each specific medical treatment and procedure to be utilized in treatment of the injured worker. Zenith will periodically review provider's performance and determine the level of utilization review and authorization to be required from the provider based on performance history. Zenith will notify the provider of any changes in status for that provider and the reasons for the change in status.

V. Dispute Resolution - Independent Medical Review

Zenith does not offer a voluntary appeal process. If the Injured Worker disagrees with the utilization review decision, any dispute will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6. An objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on an Application for Independent Medical Review, DWC Form IMR, within thirty (30) calendar days of receipt of the decision. Zenith's third party utilization review vendor will assist in the management of independent medical review. Specifically, the vendor will provide Zenith copies of all documents submitted to the physician reviewer with the Treatment Request, any information concerning peer to peer interactions and copies of the final determination letters. If more detail is needed concerning the guidelines utilized for review, the vendor will provide those to Zenith. Zenith will transmit the materials along with any other applicable medical records to the state within the required time frame. The IMR review is conducted by an independent medical review organization selected by the DWC. Zenith will comply with the requirements of LC 4610.5 and 4610.6.

VI. Privacy and Security

Zenith requires staff to protect the privacy of the information used, maintained or accessed by Zenith in the normal course of the business. To help ensure compliance with privacy and confidentially, Zenith has implemented the following policies:

- Code of Business Conduct and Ethics
- Protection of Personal Information and Business Confidential and Proprietary Information
- Information and Facility Security
- Acceptable use of Resources and Safeguards Attachment A
- E-mail Security Policy

Zenith requires any suspected breach to be reported immediately to Zenith's Privacy and Security Officer.

Policies and Procedures

The following attached policy describes Zenith's National Utilization Review policy and how Zenith maintains the Utilization Review Process. This policy and procedure is incorporated in whole as part of this Utilization Review Plan.

C O M P A N Y P O L I C Y	
Title: Zenith Insurance Company National Utilization Review Policy	
Application: Zenith Insurance Company, ZNAT Insurance Company, ZIMS and	
Policy Number: IP01.1	**Issued: January 22, 2008**
Updated:	As most recently revised 08-04-2015
Approved By: Dr. Jill Rosenthal, SVP & Medical Officer; Mike Gillikin, VP-Claims; Jackie Hilston, VP - Claims	

POLICY STATEMENT

It is the policy of Zenith that all utilization review denials be rendered by external Clinical Peer Review. Decisions to overturn or modify a Clinical Peer Review decision may only be made by a Zenith Medical Officer or external Clinical Peer Reviewer. It is further the policy of Zenith that utilization review determinations (coverage, modification or denials) made by either a Zenith Medical Officer or the Clinical Peer Review process be followed and implemented without delay. No individual employee may override, modify or delay implementation of a treatment determination made by either a Zenith Medical Officer or Clinical Peer Review except as set forth in this policy.

PURPOSE

To establish consistent enterprise wide processes for the denial or modification of a request for Medical Services after compensability of a claim has been accepted and for services denied prior to the acceptance of compensability of the claim.

DEFINITIONS

1. "*Clinical peer review*" means a licensed physician competent to evaluate specific clinical issues related to medical treatment and Medical Services where the services under review are within the individual physician's scope of practice.

2. *"Medical Officer"* means physicians employed by Zenith who hold unrestricted licenses to practice medicine in any state or the District of Columbia. Zenith's designated Medical Director is also a Medical Officer for purposes of this Plan.

3. "*Treatment Request*" is a request for Medical Services or treatment for an injured

worker that is subject to utilization review.

4. "*Utilization Review Process*" means the utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify or deny based in whole or in part on Medical Necessity to cure or relieve, treatment recommendations by physicians prior to, retrospectively, or concurrent with the provision of medical treatment.

PROCEDURES FOR POLICY COMPLIANCE

Policies:

1. Treatment Requests can be modified or denied only by a physician. At the Zenith, we utilize external Clinical Peer Review for denials and either external Peer Review or an internal Zenith Medical Officer for modifications. No Zenith employee may override (or attempt to override by additional opinions) a decision for coverage, modification or denial made by a Zenith Medical Officer or external Clinical Peer Review.

If compensability has not yet been determined and the basis for denial is Medical Necessity, the denial must be rendered by external Clinical Peer Review. If the denial is based on compensability still being undetermined, then the denial must be approved by a Zenith Medical Officer. If the denial is procedural (e.g. treatment outside of the network, Treatment Request not made by a party authorized to treat under the law, or other reasons not based in causation or Medical Necessity) the underlying request for authorization does not meet the definition of a Treatment Request and is not subject to this policy, therefore the claim handler is authorized to respond to these requests in compliance with the law.

2. Determinations and recommendations made by a Zenith Medical Officer or external Clinical Peer Review must be followed and implemented in a timely manner subject to the Internal Review Process set out in (3) below.

3. **Internal Review Process:** In the event a Zenith employee disagrees with or has legal process or other concerns regarding a utilization review determination made by a Zenith Medical Officer, or external Clinical Peer Review, the determination **must be escalated** for an interdepartmental branch staffing (with representation from claims, legal and medical management).

The Zenith employee must schedule the interdepartmental file review staffing meeting to address the concerns or issues arising from the utilization review determination within 48 hours and the meeting must take place as soon as reasonably possible but no later than 30 calendar days from the date the concern became known. The review staffing meeting must include the appropriate departmental AVP, any Zenith Medical Officer involved in the determination and if none, a Zenith Medical Officer and other appropriate Medical Management, Claims Manager, Claims Examiner, Medical Management Nurse Supervisor and Legal staff given the issues or concerns. The Zenith Medical Officer(s) may choose to include the external Clinical Peer Review physician and/or the medical director of the external Clinical Peer Review company.

No referral for a second or third opinion may be made in lieu of this interdepartmental staffing. The Medical Officer shall have final authority in consultation with the staffing team set out above for authorization, modification or denial of Treatment Requests subject to the Utilization Review Process.

No individual employee may approve denied care or deny approved care without written approval by a Zenith Medical Officer.

4. Nothing in this policy modifies or alters non-clinical staff's ability to deny requests of care on files in which Zenith has:

    a. officially rejected compensability of the underlying claim for workers compensation. In these situations, all denials must be for lack of compensability and not on the basis of utilization review criteria; or

    b. determined that certain body parts or medical conditions are not part of or related to the accepted compensable claim and therefore, requests for care related to those conditions or body parts should be denied.

5. There may be occasions when other medical reviews must be considered such as a QME or IME. Under those circumstances, you should consult your local Medical Officer and legal staff to determine which medical decision should be followed.

ATTACHMENT "A"
DESIGNATED MEDICAL DIRECTOR INFORMATION

Zenith's designated Medical Director who holds an unrestricted license to practice medicine in the State of California is responsible for the oversight of and decisions rendered by Zenith's utilization review program. Zenith's designated Medical Director is:

Name: Rupali Das, M.D.
Job Title: Senior Vice President and California Medical Director
Address:
Zenith Insurance Company
21255 Califa Street
Woodland Hills, CA 91367
California License Number: G-65098
Original Issue Date: 02/14/1989

ATTACHMENT "B"
THIRD PARTY UTILIZATION REVIEW ORGANIZATION

Zenith has contracted with the following utilization review organization to perform utilization review on behalf of Zenith when Zenith is unable to approve a Treatment Request for Medical Necessity based on information submitted with the Treatment Request:

UniMed Direct (UMD)
5068 W. Plano Parkway, Suite 122
Plano, Texas 75093

California Plan # 078

UniMed Direct complies with the requirements of its filed utilization review plan when performing services on behalf of Zenith.

NOTE: Treatment requests should be submitted to Zenith Insurance Company, not UniMed.

ATTACHMENT "C"
ZENITH CALIFORNIA UTILIZATION REVIEW GUIDELINES

To support the Utilization Review process, Zenith and its contracted URO utilize the following evidence-based guidelines:

General Guidelines

- MTUS
- ACOEM/Medical Disability Guidelines (MDA)
- ODG
- National Guideline Clearinghouse
- Cochrane Collaboration (Free Abstracts)

By Specialty

Orthopedic

- Wheeless' Textbook of Orthopaedics
- Journal of Bone and Joint Surgery (JBJS)
- American Academy of Orthopedic Surgeons Clinical Practice Guidelines
- North American Spine Society Evidence Based Guidelines

Pain/Psych

- American Psychiatric Association Clinical Practice Guidelines
- Clinical Journal of Pain
- American Pain Society Clinical Practice Guidelines
- AAPM&R Practice Guidelines

PT/Chiro

- Chiro - Guidelines from Around the World
- Chiro - Guidelines for Acute and Chronic Spine Related Pain
- PT - Clinical Practice Guidelines (CPG's)
- PT - APTA-Practice Guidelines
- PT - APTA-Orthopedic Clinical Guidelines
- Chiropractic Standards of Practice and Utilization Guidelines in the Care and Treatment of Injured Workers
- Philadelphia Panel

Radiology

- American College of Radiology (ACR) - Appropriateness Criteria
- American College of Radiology: Musculoskeletal Imaging Guidelines

Other Resources

- CMS: Alphabetical List of LMRPs/LCDs
- Milliman Care Guidelines (Surgery: Inpatient/Outpatient)
- Aetna Clinical Policy Bulletins
- Cigna Coverage Positions/Criteria Medical and Pharmacy Index
- Current studies that are scientifically-based, peer-reviewed and published in journals that are nationally recognized by the medical community (i.e. U.S. National Library of Medicine's database of biomedical citations and abstracts)

ATTACHMENT "D"
UTILIZATION REVIEW LETTERS

Zenith Internal Certification Letters/Fax
UniMed Letters/Fax

(Letters are submitted with the Plan but not attached to the Plan due to volume.)