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California Utilization Review Plan

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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 LC §4600, subject to the provisions of LC §5402, set forth on a completed "Request for Authorization" as defined under CCR 9792.6.1 and set forth below that has been transmitted by the treating physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of 8 CCR §§9792.9.1 through 9792.12.
3. "Certify" means to Approve services under the Injured Employees' plan of coverage.
4. "Claims Administrator" is a self-administered workers' compensation insurer of an insured employer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator or other entity subject to Labor Code §4610, the California Insurance Guarantee Association, and the director of the Department of Industrial Relations as administrator for the Uninsured Employers Benefits Trust Fund (UEBTF). "Claims Administrator" includes any utilization review organization under contract to provide or conduct the claims administrator's utilization review responsibilities.
5. "Claims Examiner" means staff employed by a Claims Administrator to process claims.
6. "Concurrent Review" means utilization review conducted during an inpatient stay.
7. "Course of Treatment" means the course of medical treatment set forth in the treatment plan contained on the "Doctor's First Report of Occupational Injury or Illness," DIR Form 5021, found at 8 CCR §14006.1, or on the applicable §physician reporting forms authorized by §9785.
8. "Criteria" 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 evidence-based guidelines is set forth in Attachment "C" and are hereby incorporated into and made a part of this Plan.
9. "Denial", "Deny", "Non-Certify" or "Adverse Determination" means a decision by a Physician Reviewer that the requested treatment or service is not Authorized.
10. "Dispute Liability" means an assertion by a Claims Administrator that a factual, medical or legal basis exists, other than Medical Necessity, that precludes compensability for an occupational injury, a claimed injury to any part or parts of

the body, or a requested medical treatment.

11. "DWC" means the California Division of Workers' Compensation.
12. "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.
13. "Expedited Review" means utilization review or Independent Medical Review conducted when the Injured Employee's condition is such that the Injured Employee 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 Employee's life or health or could jeopardize the Injured Employee's permanent ability to regain maximum function.
14. "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, whose consultation for a specialized review has been requested by the claims administrator or utilization review organization, necessitating an extension of time, under §9792.9.6, prior to the determination of medical necessity.
15. "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.
16. "Immediately" means within one (1) business day.
17. "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**.**
18. "LC" means the California Labor Code.
19. "Material modification" means when the Claims Administrator changes utilization review vendor, makes a change to the utilization review standards as specified in §9792.7, or changes in its medical director, address, company name or corporate structure.
20. "Medical Director" means the physician and surgeon 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. The Medical Director is responsible for all decisions rendered through Zenith's utilization review process.
21. "Medically Necessary" and "Medical Necessity" mean medical treatment reasonably required to cure or relieve the Injured Employee 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 / MTUS Drug Formulary / ODG 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 Employee for conditions for which other treatments are not clinically efficacious.

22. "Medical Officer" means physicians employed by Zenith or a Claims Administrator 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.
23. "Medical Services" means those goods and services provided pursuant to Article 2 (commencing with LC §4600) of Chapter 2 Part 2 of Division 4 of the LC.
24. "Medical Treatment Utilization Schedule" and "MTUS" means the most current version of guidelines adopted by the Administrative Director pursuant to LC §5307.27 and set forth in Article 5.5.2 of the Regulations beginning with 8 CCR §9792.20.
25. "Medical Treatment Utilization Schedule ("MTUS") Drug Formulary" or "MTUS Drug Formulary" means the drug formulary adopted by the Administrative Director under LC §5307.27 and defined in 8 CCR §9792.27.1(m). The MTUS Drug Formulary contains the MTUS Drug List, which is set forth in §9792.27.15.
26. "Modification" or "Modify" means a decision by a Physician Reviewer that part of the requested treatment or service is Medically Necessary and part of the requested treatment is not Medically Necessary.
27. "Non-physician Reviewer" means an individual who may assist in utilization review functions but may not modify or deny a request for authorization. Physician reviewers must operate under the supervision of a Physician Reviewer.
28. "Normal Business Day" or "Business Day", or "Working Day" means any day excluding Saturdays, Sundays, and days declared by the Governor to be an official state holiday or a holiday listed on the Department of Human Resources internet website.
29. "NC" and "Nurse Consultant" means a registered nurse employed by Zenith's medical management department or employed by a Claims Administrator.
30. "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 or Physician Reviewer's practice. A NC or Nurse Consultant is considered a Non-Physician Reviewer as that term is defined above.
31. "Primary Treating Physician" means the physician who is primarily responsible for managing the care of an employee, and who has examined the employee at least once for the purpose of rendering or prescribing treatment and has monitored the effect of the treatment thereafter.
32. "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.

33. “Regulations” means Title 8 of the California Code of Regulations.

34. "Request for Authorization” or “Treatment Request” means a written request for a specific course of proposed medical treatment that meets all of the following criteria:

    (1) Unless accepted by a claims administrator under §9792.9.1(b), a request for authorization must be set forth on a “Request for Authorization (DWC Form RFA)” as contained in 8 CCR §9785.5, completed by a treating physician and as further outlined in this subdivision and in §9785(h).

    (2) “Completed,” for the purpose of this section and for purposes of investigations and penalties, means that the request for authorization identifies both the employee and the requesting provider; identifies with specificity all the recommended treatments in the designated section for requests for authorization if a form is used, or, on the first page if a narrative report is used; and is accompanied by documentation, issued or created no earlier than 30 days before the date of submission of the request for authorization, that substantiates the need for the requested treatment. A request for authorization shall be deemed completed following receipt of information, test results, or a specialized consultation requested under §9792.9.6.

    (3) The request for authorization must be signed by the treating physician and may be mailed, faxed, or, if available, sent electronically through the use of an encrypted email system or via electronic data interchange (EDI) to the address, fax number, e-mail address, or clearinghouse designated by the claims administrator under §9781(d)(5) for this purpose. By agreement of the parties, the treating physician may submit the request for authorization with an electronic signature.

35. “Retrospective Review” means utilization review conducted after Medical Services have been provided and for which approval has not already been given.

36. “Secondary Physician” means any physician other than the primary treating physician who examines or provides treatment to the employee, but is not primarily responsible for continuing management of the care of the employee. For injuries on or after January 1, 2004, a chiropractor shall not be a secondary treating physician after the employee has received 24 chiropractic visits, unless the employer has authorized, in writing, additional visits.

37. “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 §9792.9.6 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 Employee 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.

38. "Tracking Tool" means a computerized system utilized to manage utilization review activity.

39. "URAC" means the Utilization Review Accreditation Commission, Workers' Compensation Utilization Management Accreditation Program.

40. "Utilization review decision" means a decision pursuant to LC §4610 to approve, modify, or deny, a treatment recommendation or recommendations by a physician prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to LC §4600 or LC §5402(c).

41. "Utilization Review Plan" or "Plan", means this Written plan, which is filed with the DWC Administrative Director pursuant to LC §4610 and sets forth 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 LC §3209.3, prior to, retrospectively or concurrent with the provision of medical treatment services pursuant to LC §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 a completed request for authorization, or a request for authorization accepted as complete under §9792.9.1(b) 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.

42. "Written" includes a communication transmitted by facsimile or in paper form. Electronic mail or electronic data interchange (EDI) may be used by agreement of the parties although an employee's health records shall not be transmitted via electronic mail or by EDI, unless sent through the use of an encrypted electronic mail or EDI system.

43. "Zenith" means Zenith Insurance Company and/or ZNAT Insurance Company, and its affiliates.

44. "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 LC §§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 and to provide consistent education and information to all other stakeholders. Each Injured Employee'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 such as changes in its medical director, address, company name or corporate structure (and including any vendors that support the Utilization Review Process), Zenith will file a material modification and update this Utilization Review Plan pursuant to 8 CCR §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 public 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 LC §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 Professions 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 LC §4610 and corresponding regulations. The Medical Director is responsible for all decisions rendered through Zenith's Utilization Review Process. 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) including the MTUS Drug Formulary (collectively "MTUS"). When MTUS does not provide applicable guidelines, Zenith relies on the medical evidence search sequence specified as part of the MTUS, including other peer reviewed evidence-based medicine guidelines such as the Official Disability 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 Employee from the effects of the injury.

Treatment will not be denied on the sole basis that MTUS does not include specific criteria for the requested treatment, nor will inapplicable studies be used as the sole source to Authorize, Deny, delay, or Modify a Request for Authorization**.** For all conditions or injuries not addressed by MTUS, review decisions are made using the following guidelines and resources as set forth in §9792.21.1:

a. Search the most current version of ACOEM or ODG to find a recommendation applicable to the Injured Employee's medical condition or injury. Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence set forth in §9792.25.1. If no applicable recommendation is found, or if the treating physician or reviewing physician believes there is another recommendation supported by a higher quality and strength of evidence, then; nationally recognized professional standards;
b. Search the most current version of other evidence-based medical treatment guidelines that are recognized by the national medical community and are scientifically based to find a recommendation applicable to the Injured Employee's medical condition or injury. Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence set forth in §9792.25.1. Medical treatment guidelines can be found in the National Guideline Clearinghouse that is accessible at the following

website address: www.guideline.gov/. If no applicable recommendation is found, or if the treating physician or reviewing physician believes there is another recommendation supported by a higher quality and strength of evidence, then;

c. Treatments Search for current studies that are scientifically-based, peer-reviewed, and published in journals that are nationally recognized by the medical community to find a recommendation applicable to the Injured Employee's medical condition or injury. Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence set forth in §9792.25.1. A search for peer-reviewed published studies may be conducted by accessing the U.S. National Library of Medicine's database of biomedical citations and abstracts that is searchable at the following website: www.ncbi.nlm.nih.gov/pubmed. Other searchable databases may also be used.

Nothing precludes authorization of medical treatment beyond what is covered in the MTUS or supported by the best available medical evidence in order to account for medical circumstances warranting an exception in accordance with §9792.21.1(e).

Prospective Review and Retrospective Review: A Request for Authorization must be submitted for medical services as well as drugs that are not listed as Exempt on the MTUS Drug Formulary. If services are performed without authorization, Zenith may perform Retrospective Review of the treatment or service, including office visits. If the treatment or service is found not to be Medically Necessary, reimbursement for the service will be denied. Prospective review does not apply to treatment rendered within the first thirty (30) days after the date of injury provided that:

a. The treatment or service is for a body part or condition that has been accepted as compensable by the Claims Administrator.

b. The treatment or service is consistent with the recommendations set forth in the applicable guideline of the medical treatment utilization schedule adopted by the administrative director under §5307.27.

c. The initial treating physician timely submits the "Doctor's First Report of Occupational Injury or Illness," DIR Form 5021, to the Claims Administrator as required by §9785, subdivision (e), setting forth in detail the anticipated treatment plan for the injured worker.

d. All treatment or services anticipated to be provided to the injured worker in the first 30 days after the date of injury, including the exempt drugs prescribed to the injured worker under the MTUS Drug Formulary, are set forth in a request for authorization provided to the Claims Administrator in accordance with §9785(h). The form shall be submitted to the Claims Administrator concurrent with the Doctor's First Report of Occupational Injury or Illness. Subsequent treating physicians during the 30-day period shall submit a request for authorization following their first visit with the injured worker indicating all treatment being rendered.

e. The treating physician's medical treatment bill for the non-emergency treatment rendered or services provided under this section is submitted to the Claims

Administrator within thirty (30) days of the date the service was provided. Medical treatment bills for emergency treatment services shall be submitted within 180 days of the date that the treatment was provided.

Services rendered within the first thirty (30) days that are exempt from Prospective Review, remain subject to Retrospective Review.

If a provider has requested Prospective Review for a medical service which is Authorized, but performs services beyond the scope of the Authorized services, the services beyond the scope of the Authorization may be denied if the services are not Medically Necessary. Such services are subject to Retrospective Review. The physician performing the service must 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; or
c. a medical service 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. Those services will be reviewed for Medical Necessity through Retrospective Review. Failure to provide appropriate documentation of Medical Necessity may result in denial of reimbursement for the services.

Pursuant to LC §4610, a Claims Administrator may, at its option, initiate either Prospective or Retrospective Review of medical services of which the Claims Administrator becomes aware if the provider failed to submit a Treatment Request for the service.

Treatment Rendered by ZMPN Provider within 30 Days of Initial Date of Injury

Zenith and its customers may provide medical treatment to Injured Employees through the ZMPN and Zenith Pharmacy Network ("ZPN"). ZMPN providers may provide treatment to Injured Employees for certain medical conditions within the first thirty (30) days following the date of initial injury pursuant to LC §4610(b). All treatment must be in compliance with MTUS, MTUS Drug Formulary and applicable ZMPN requirements. A Claims Administrator may, at its option, request Retrospective Review of the treatment for the purpose of determining compliance with MTUS. If Retrospective Review shows that treatment was not within MTUS guidelines, including the MTUS Drug Formulary, Zenith may:

a. upon notice to the provider, require the provider to obtain Prospective Review for all treatment if there is a pattern and practice of failing to treat consistent within MTUS guidelines, including the MTUS Drug Formulary;
b. petition for a change of physician or provider pursuant to LC §4603; and/or
c. remove the provider from the ZMPN for failure to comply with ZMPN requirements and per LC §4610(f)(2).

The ZMPN provider must submit the "Doctor's First Report of Occupational Injury or Illness," DIR Form 5021, report required under LC §6409 within five (5) days of the initial visit along with a complete request for authorization on DWC Form RFA including documentation substantiating the medical necessity of the treatment. If the provider fails to submit the report and accompanying DWC Form RFA within five (5) days of the initial visit and evaluation, Zenith may revoke the provider's ability to provide further treatment without Prospective Review within the first thirty (30) days following the initial date of injury.

Pursuant to LC §4610(d), all medical services provided under this section, except emergency medical services, must be billed within thirty (30) days of the date of service. Emergency medical services provided within the first thirty (30) days of the initial date of injury must be billed within one hundred eighty (180) days of the date of service.

Pursuant to LC §4610(b) and CCR §9792.9.7, ZMPN providers must continue to request authorization through Prospective Review for the following medical services within the first thirty (30) days following the initial date of injury:

a. Pharmaceuticals, to the extent they are neither expressly exempted from Prospective Review nor authorized by the drug formulary adopted pursuant to §5307.27.
b. Nonemergency inpatient and outpatient surgery, including all presurgical and postsurgical services.
c. Psychological treatment services.
d. Home health care services.
e. Imaging and radiology services, excluding X-rays.
f. All durable medical equipment, whose combined total value exceeds two hundred fifty dollars ($250), as determined by the official medical fee schedule.
g. Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies.
h. Spinal injections including therapeutic medial branch nerve block injections; facet joint injections; intradiscal injections; epidural injections; and sacroiliac joint injections.
i. Any other service designated and defined through rules adopted by the administrative director.

Providers that do not participate in the ZMPN are not eligible to treat without obtaining authorization for treatment rendered within the first thirty (30) days following the initial date of injury, with the exception of providers who are predesignated or who are selected by the employer as per LC §4610(b).

A pattern and practice of failing to render treatment consistent with MTUS, including the MTUS Drug Formulary, may result in Zenith removing the ZMPN provider's ability to render treatment without Prospective Review within the first thirty (30) days following the initial date of injury. Additionally, failure to treat within MTUS guidelines may constitute a showing of good cause to petition for a change in provider and may be grounds for removal from the ZMPN.

Requirements Related to Medications

Zenith and its customers provide pharmaceutical treatment to Injured Employees through the ZPN. Unless exempt by law, Prospective Review of treatment is required to help ensure compliance with MTUS and the appropriate timely delivery of care to Injured Employees. The ZPN does not allow office dispensing of medications. The ZPN requires medications to be provided through a pharmacy participating in the ZPN unless the drug is an antibiotic, antiviral or an intrathecal pain pump, including refills. The Claims Administrator will not reimburse either the provider or Injured Employee for office dispensed drugs except as previously stated.

The MTUS Drug List must be used when prescribing medications. The MTUS Drug list must be used in conjunction with 1) the MTUS Guidelines, which contain specific treatment recommendations based on condition and phase of treatment and 2) the drug formulary rules. (See 8 CCR §9792.20 - §9792.27.23.) The MTUS Drug List includes a column labeled "Reference in Guidelines" indicating guideline topic(s) which discuss the drug. In each guideline there may be conditions for which the drug is Recommended (✓), Not Recommended (×), or No Recommendation (⃠). Users must consult the guideline to determine the recommendation for the condition to be treated and to assure proper phase of care use.

The MTUS Drug List includes Exempt, Non-Exempt and Unlisted Drugs. All three categories of drugs are permitted to be used to treat Injured Employees so long as the usage is within MTUS guidelines and appropriate approval is obtained. If a generic drug is available for treatment of the Injured Employee's medical condition, then generic is given preference over brand name. Brand name drugs must be submitted on an RFA for Prospective Review, unless specifically exempted by law. If a prescription for a Brand name drug is submitted to a participating pharmacy Zenith or the Claims Administrator may, at its discretion, stop the dispense and request an RFA with supporting documentation including patient specific factors be submitted for Medical Necessity review. Lower cost drugs are also preferred over higher cost therapeutic equivalent drugs. The following sections provide additional information on the MTUS Drug List categories.

Exempt Drugs: "Exempt" indicates the drug may be prescribed/dispensed without seeking authorization through Prospective Review if in accordance with MTUS.

MTUS states that physician dispensed "Exempt" drugs are limited to a one (1) seven (7) day supply at initial visit within seven (7) days of the date of injury without Prospective Review. However, as noted above, Zenith does not allow any physician dispensed drug unless it is an antibiotic, antiviral or intrathecal pain pump. Therefore, under Zenith's program, Exempt drugs may not be dispensed for any period of time unless it is an antibiotic, antiviral or intrathecal pain pump. The insertion of an intrathecal pain pump would still be subject to Prospective Review even if it is used in conjunction with an Exempt drug. Prescription/dispensing of Brand name "Exempt" drugs where a generic drug is available requires authorization through Prospective Review. Prospective Review is also required for Exempt drugs when the usage is outside of MTUS guidelines, including conditions for which the Exempt drug is not recommended.

Non-Exempt and Unlisted Drugs: "Non-Exempt" or "Unlisted" drugs require authorization through Prospective Review prior to prescribing or dispensing. (See 8 CCR §9792.27.1 through §9792.27.23 for complete rules.) Zenith will block dispensing of drugs that are not submitted for Prospective Review as required. To avoid delay, it is important that providers submit drugs for Prospective Review in a timely fashion.

Special Fill Drugs: Under the MTUS Drug List, Special Fill indicates the Non-Exempt drug may be prescribed/dispensed without Prospective Review under the following conditions: 1) the drug is prescribed at the initial visit within seven (7) days of injury, and 2) the supply does not exceed the day limit indicated in the MTUS Drug List, and 3) the drug is a generic or single source brand, or brand where physician substantiates Medical Necessity, and 4) the drug is being prescribed in accord with MTUS. (See 8 CCR §9792.27.12.)

Perioperative Fill Drugs: Under the MTUS Drug List, Perioperative Fill indicates the Non-Exempt drug may be prescribed/dispensed without Prospective Review under the following conditions: 1) the prescription is issued during the perioperative period (four (4) days before through four (4) days after surgery), and 2) the drug supply does not exceed the day limit indicated in the MTUS Drug List, and 3) the drug is a generic or single source brand, or brand where physician substantiates Medical Necessity, and 4) the drug is being prescribed in accord with MTUS. (See 8 CCR §9792.27.13.)

The following prescription types require Prospective Review through submission of an RFA accompanied with documentation of patient specific factors supporting Medical Necessity of the drug or compound for treatment of the Injured Employee's medical condition:

1. Brand name drugs when a generic drug is available, unless the brand name drug is listed as Exempt for the specified medical condition;
2. Special Fills, Perioperative drugs beyond the day limit specified by the MTUS Drug List;
3. Compounds. The RFA must include documentation of patient specific factors that support the Medical Necessity of the compounded drug instead of an FDA approved drug for treatment of the Injured Employee's medical condition.
4. Drugs prescribed for an Off Label Use.

Staffing: Qualified staff are used to implement the Utilization Review Plan in an honest and ethical manner pursuant to applicable LC 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. The Utilization Review Process is managed by a team that includes the Nurse Consultant, Claims Examiner, and administrative support staff. The Utilization Review Process has multiple levels, and non-certifications and modifications can only be rendered by an appropriate Physician Reviewer. The multi-level Utilization Review Process includes:

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

b. NCs 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 NC can review a Treatment Request for certification or referral to a Physician Reviewer or a Medical Officer. The NC is not permitted to Deny a Treatment Request. The NC refers Treatment Requests that cannot be certified for further review by a physician. The NC may seek review by either an internal Medical Officer or an external physician reviewer. The NC 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 NC reviewer may Certify the amended Treatment Request.
c. Medical Officers may review Treatment Requests for certification or peer to peer discussion for voluntary modifications and are available to providers, at least four (4) hours per week during normal business hours, 9:00 AM to 5:30 PM., Pacific Time. Medical Officers are not permitted to issue denials based on Medical Necessity. If 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 Treatment Request that has been referred into the Utilization Review Process. Treatment Requests must be submitted by facsimile, mail, electronic mail, or by electronic data interchange on a Request for Authorization (DWC Form RFA) unless Zenith accepts a request in another format. The Request for Authorization form must be correctly and completely filled out and submitted with documentation substantiating the medical necessity of the treatment. The Request for Authorization must be mailed or faxed to the Claims Administrator to the address provided by the Claims Administrator.

Zenith and/or the Claims Administrator has implemented internal processes to identify a misdirected Request for Authorization to help avoid delays in processing Treatment Requests. In the event a Request for Authorization is submitted via a non-designated route, once discovered, the misdirected Request for Authorization is immediately forwarded to the UR intake department. However, requests for treatment and bills for services should be submitted separately. Failure to submit documentation substantiating medical necessity may result in the Request for Authorization being rejected as "not complete". Zenith or the Claims

Administrator 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 or treatments, goods or items are listed on the first page of the document; and
3. the Treatment Request is accompanied by documentation issued or created no earlier than 30 days before the date of submission of the request for authorization, that substantiates the need for the requested treatment. A request for authorization shall be deemed complete following receipt of information, test results, or a specialized consultation requested under §9792.9.6.
4. The request for authorization must be signed by the treating physician and may be mailed, faxed, or, if available, sent electronically through the use of an encrypted email system or via electronic data interchange (EDI) to the address, fax number, ~~or~~ e-mail address, or clearinghouse designated by the claims administrator under §9781(d)(5) for this purpose. By agreement of the parties, the treating physician may submit the request for authorization with an electronic signature.

Even if these requirements are met, Zenith or the Claims Administrator 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 the Treatment Request may be rejected only if the DWC Form RFA is "not complete". If Zenith, the Claims Administrator, Non-physician reviewer or physician reviewer 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 five (5) business days of receipt of the Treatment Request, the Treatment Request must be returned 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 or the Claims Administrator 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.

Review Process: Telephone access is maintained at 800-440-5020 from 9:00 AM to 5:30 PM, Pacific Time, on business days for Health Care Providers requesting authorization for medical services. Additionally, facsimile numbers are available for Health Care Providers to submit Treatment Requests and to receive communications during and after normal business hours via fax at 818-227-3057.

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 LC §4610 and 8 CCR §9792.9.1 and 9792.9.6 addressing the timeframe, procedures and notice requirements and well as 8 CCR §9792.10.1 et seq. addressing dispute resolution.

Compensability decisions are not made through the utilization review process and will be handled through 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, the Claims Administrator 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 NC for review. The Claims Examiner may also defer utilization review as set forth below under Deferral of Utilization Review.

In the event the NC believes the Treatment Request was not accompanied with appropriate information to allow Zenith to render a decision, the NC may contact the requesting physician to obtain appropriate additional information necessary to render a decision. Requests for additional information must be made within five (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 NC 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 NC will request that the provider sign a written agreement confirming the modification. Upon receipt of the signed modification agreement, NC 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 NC 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. 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 or Modify Treatment Requests without consent of the requesting physician.

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 using DWC Form RFA. At the discretion of the NC, 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 NC 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 authorization for emergency health care services will not be used as a basis to refuse reimbursement for services provided to treat and stabilize an Injured Employee presenting for emergency health care services. However, emergency health care services are subject to Retrospective Review for Medical Necessity. If the provider wants to

request authorization 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 URAC certified 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. However, decision letters are issued using Zenith custom letters and on Zenith letterhead.

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 Employee and, if the Injured Employee is represented by counsel, the Injured Employees' attorney of the utilization review decision. The URO decision letters are generated by the URO on Zenith letterhead 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.

The URO also maintains a comprehensive Quality Assurance and Quality Control ("QAQC") Program designed to ensure all utilization review activities are conducted in accordance with the highest standards of clinical quality, accuracy, consistency, and regulatory compliance. The program supports continuous quality improvement through ongoing monitoring, measurement, evaluation, and corrective action processes. (The QAQC Program is aligned with applicable URAC Workers' Compensation Utilization Management (WCUM) standards.)

Financial Incentive Policy: Zenith provides reasonable compensation to its URO for utilization review and other administrative services. Zenith requires compliance with LC §4610(g) including the requirements prohibiting financial incentives to physicians and other providers conducting utilization reviews. This includes, but is not limited to, financial

incentives or consideration based on the decision outcome or number of modifications or denials made by a physician by or on behalf of Zenith. Zenith also requires its URO to maintain a policy for prevention of financial incentives to physicians and other providers based on utilization review as required by LC §4610(g)(4).

Deferral of Utilization Review: Pursuant to 8 CCR §9792.9.2, 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.

A request for authorization of treatment for which UR would otherwise be precluded under LC §4610(k) cannot be deferred if the requesting physician expressly and unequivocally indicates or opines in the request for treatment that there has been a change in facts material to the basis of the prior denial of such same treatment and includes documentation of such change. Such a request must be reviewed by a physician reviewer and any modification or denial of the request must comply with applicable requirements as set forth at §9792.9.5.

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 Employee, and if the Injured Employee is represented by counsel, the Injured Employee'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 §9792.9.2(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 Employee 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 on DWC Form RFA after the determination of liability as required by 8 CCR §9792.9.2(c).

Applicability of Utilization Review Decision: Pursuant to CCR §9792.9.5(g), a utilization review decision to Modify or Deny a treatment recommendation shall remain effective for twelve (12) months from the date of the decision without further action by the Claims Administrator with regard to any further recommendation by the same physician or another physician within the requesting physician's practice group, 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 LC §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 Request for Authorization is received by mail and a proof of service by mail exists, the request is deemed to have been received five (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 five (5) calendar days, then the date stamp will control; or
b. the Zenith mailroom date stamp is after the five (5) calendar days, then the proof of service will control.

When the Request for Authorization 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 Request for Authorization 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 five (5) calendar days after the latest date indicated on the

Treatment Request.

When the Request for Authorization is received by facsimile or secure electronic mail, electronic data interchange, or clearinghouse, 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.

Requests for Authorization received by facsimile transmission, electronic mail, or electronic data interchange after 5:30 PM (Pacific 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 Physician 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 Employee's condition is such that the Injured Employee faces 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 Employee's life or health or could jeopardize the Injured Employee'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 Employee's condition, but not to exceed seventy-two (72) hours after receipt of the Written 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 Employee is hospitalized.

   Decisions to Certify, Modify, Deny, or request additional information for non-formulary medical treatment must be made in a timely fashion that is appropriate for the Injured Employee's condition, not to exceed five (5) business days from the date of receipt of the Request for Authorization including supporting information reasonably necessary to make the determination.

   If appropriate information which is necessary to render a decision was not provided with the Treatment Request, a Written request for appropriate additional information shall be sent within 5 business days from the date of receipt of the Written Treatment Request to the requesting physician, the injured worker, and the injured worker's attorney, if applicable. Requests for additional information, notifications of Time Extensions and utilization reviews conducted upon receipt of the requested information shall comply with 8 CCR §9792.9.6. Further detail of this process is set forth below under the Request for Time Extension section. If additional information is requested, non-formulary medical treatment decision must be made no more than fourteen (14) days from the date of the medical treatment recommendation by the physician. Prospective decisions regarding requests for treatment covered by the formulary shall be made no more than five (5) business days from the date of receipt of the request for authorization for medical treatment.

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 five (5) business days from the date of receipt of the Request for Authorization including supporting information reasonably necessary to make the determination, but in no event more than fourteen (14) days from the date of the medical treatment recommendation by the physician.

   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 Employee and consistent with Medical Treatment Utilization Schedule, and/or other evidence-based medicine guidelines utilized by Zenith, as allowed by the LC and Regulations. Zenith will be liable only for those services determined medically necessary to cure and relieve. If Zenith disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute will be resolved pursuant to §4610.5, if applicable, or otherwise pursuant to §4062. Any compromise between the parties that Zenith believes may result in payment for services that were not medically necessary to cure and relieve must be reported by Zenith to the licensing board of the provider or providers who

received the payments, in a manner set forth by the respective board and in such a way as to minimize reporting costs both to the board and Zenith, for evaluation of possible violations of the statutes governing appropriate professional practices.

If appropriate information which is necessary to render a decision was not provided with the Treatment Request, a Written request for appropriate additional information shall be sent within five (5) business days from the date of receipt of the Written Treatment Request to the requesting physician, the injured worker, and the injured worker's attorney, if applicable. Requests for additional information, notifications of Time Extensions and utilization reviews conducted upon receipt of the requested information shall comply with 8 CCR §9792.9.6. Further detail of this process is set forth below under the Request for Time Extension section.

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 thirty (30) calendar days of receipt of the request for authorization and medical information that is reasonably necessary to make a determination. When payment for the service is made within the time prescribed by §4603.2, a Retrospective Review decision to approve the service need not be otherwise communicated.

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 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 Employee presenting for Emergency Health Care Services solely on the basis of a failure to obtain 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 five (5) business days from receipt of the Written Treatment Request to the requesting physician, the injured worker, and the injured worker's attorney, if applicable. The reviewer or non-physician reviewer shall request the information from the treating physician within four (4) business days from the date of receipt of the request for authorization for drugs listed on the MTUS Drug List. 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 specified in §9792.9.3 and 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 information is sent to the requesting provider, a decision on the Treatment Request must be made no later than fourteen (14) calendar days from the receipt of the original Treatment Request for Prospective and Concurrent Reviews, except as otherwise stated for formulary, or within thirty (30) days from receipt of a request for Retrospective Review regardless of whether or not the information is received. The extension of time as set forth in section 9792.9.6 is not applicable to a request for authorization of a drug listed on the MTUS Drug List. If the additional information is not received, the Physician Reviewer shall Deny the Treatment Request and the denial letter will include a statement that the Treatment Request will be reconsidered upon receipt of all information reasonably necessary and 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 shall 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 Physician 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, if agreed to by the parties, encrypted electronic mail within twenty-four (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 §§9792.9.4 and 9792.9.5, 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 seventy-two (72) hours of receipt of the information. The requesting physician shall be notified by telephone, facsimile or electronic mail within twenty-four (24) hours of making the decision. The Written decision shall include the date the requested information was received and be communicated as required by 8 CCR §§9792.9.4 and 9792.9.5, 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) days of receipt of the request and information regarding rendered medical treatment that is sufficient for a reviewer to make a determination as to whether the treatment was medically necessary. The Written decision shall include the date it was made and be communicated as required by 8 CCR

§9792.9.4 and 9792.9.5 whichever is applicable.

The calculation of time as outlined under §9792.9.3 applies to all utilization review decisions insofar as they do not contravene the timeframes relating to MTUS formulary disputes, which are subject to the requirements of §9792.9.8.

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 the attempt by Zenith or the Reviewer to obtain the necessary information from the requesting physician either by facsimile, mail or encrypted e-mail.

Notification of Utilization Review Decisions: Decisions for approval of a Request for Authorization shall be initially communicated to the requesting provider. Decisions for modifications and denials shall be communicated in writing to the requesting provider, Injured Employee and if the Injured Employee is represented by counsel, the Injured Employee'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.

Decisions to Approve Request for Authorization

For prospective, concurrent, or expedited review, approvals shall be initially communicated to the requesting physician within twenty-four (24) hours of the decision, by telephone, facsimile, or, if agreed upon by the parties, encrypted electronic mail. If the initial communication is by telephone, Written communication shall be issued to the requesting physician within twenty-four (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 thirty (30) days of the request for authorization and information that is reasonably necessary to make a determination.

Written decisions to approve treatment must meet the requirements of 8 CCR §9792.9.4 and shall specify the date the complete, or accepted as complete, request for authorization was first received, the medical treatment service requested, the specific medical treatment service approved, and the date of the decision.

If applicable, the written decision shall also include the date the request for information, exam, or consultation under §9792.9.6, subdivision (a)(1)(A), (B), or (C) was requested, and the date the information was received.

(2) For approvals of a request for authorization of a drug where the request for authorization did not indicate "Do Not Substitute" or "Dispense as Written," the written decision approving the request in generic form shall indicate, "generic substitute authorized" or words to that effect and meaning.

(3) For approvals of a request for authorization of a drug that is exempt on the Drug Formulary,

the written decision approving the request shall indicate, "Exempt per MTUS Drug Formulary" or words to that effect and meaning.

(4) For approvals of a request for authorization of non-drug treatment that are exempt under §9792.9.7 (i.e., the 30-day exemption), the written decision approving the request shall identify the exempt treatment as, "30-day exemption" or words to that effect and meaning.

Decisions to Modify or Deny Request for Authorization

For prospective, concurrent, or expedited review, a decision to modify~~,~~ or deny a request for authorization of treatment shall be initially communicated to the requesting physician within 24 hours of the decision by telephone, facsimile, or, if agreed to by the parties, encrypted electronic mail. Written communication of the decision shall issue to the injured worker, and, if applicable, to the injured worker's representative within 24 hours of the decision for concurrent review,~~ and~~ within two (2) business days for prospective review, and, for expedited review, within 72 hours of receipt of the request. Written communication in accordance with this paragraph shall also issue to the requesting physician where the initial communication of the decision to the physician was by telephone.

For retrospective review, a written decision to deny part or all of the requested medical treatment based on medical necessity 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 receipt of the request for authorization and information that is sufficient for a reviewer to make a determination as to whether the treatment was medically necessary.

Written decisions to Modify or Deny treatment must meet the requirements of 8 CCR §9792.9.5. The Written decision to Modify or Deny treatment must be sent to the requesting physician, Injured Employee and, if applicable, the Injured Employee's representative and/or attorney. Pursuant to 8 CCR §9792.9.5(e), the Written decision to Modify or Deny a Treatment Request shall be signed by either the claims administrator or the Physician Reviewer, and shall only contain the following information specific to the request:

1. The date on which the DWC Form RFA or the completed or accepted Treatment Request was first received;
2. If the timeframe for decision was extended under §9792.9.6, a specific description of the information needed to make a medical necessity determination of the Treatment Request; the date(s) and time(s) the request(s) for information, exam, or consultation under subdivision (a)(1)(A), (B), or (C) of §9792.9.6 were requested; the manner in which the requests were made; and the date the information was first received.
3. The date the decision was made;
4. A description of the specific course of medical treatment set forth on the Request for Authorization;
5. A list of all medical records reviewed, including the date of the medical record;
6. A specific description of the medical treatment service approved, if any.
7. A clear, concise and appropriate explanation, in plain language where possible of the reasons for the Physician Reviewers decision, including the clinical reasons regarding Medical Necessity or; if applicable, that the requesting physician did not provide sufficient information with the request in order to reasonably make a medical

necessity determination, and, if so, identification of the missing information, and a statement that the requested treatment will be reconsidered upon receipt of a new Request for Authorization containing the additional information, exam or test, or specialized consultation. Where the requesting physician has expressly opined that prerequisite treatment or criteria, as recommended under applicable treatment guidelines, should be overlooked or is irrelevant to the requested treatment, the reviewing physician shall provide an explanation for why the requesting physician's explanation is insufficient.

8. For decisions based on medical necessity, a citation to, and a description of the relevant medical criteria or guidelines used to reach the decision pursuant to section 9792.8 and §9792.25.1. Zenith will not charge an Injured Employee, the Injured Employee'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(a)(3));
9. Identification of the URAC accredited entity, approved by the Division of Workers' Compensation, that is liable for the utilization review decision.
10. The Application for Independent Medical Review, DWC Form IMR. All fields of the form, except for the signature of the employee must be completed by Zenith or its utilization review vendor. The Written decision provided to the Injured Employee, shall include an addressed envelope, which may be postage-paid for mailing to the Administrative Director or his or her designee.
11. A clear statement that any dispute will be resolved in accordance with the Independent Medical Review process established by LC §4610.5 and §4610.6 and that an objection to the decision must be communicated by the Injured Employee, their representative or applicant attorney using the Application for Independent Medical Review, DWC Form IMR, within the timeframe indicated on the last page of the application (ten (10) calendar days from the mailing date of the utilization review decision to the Injured Employee that only pertain to drug formulary disputes, and thirty (30) calendar days from the mailing date of the utilization review decision to the Injured Employee for all other medical treatment disputes). 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 Employee must also include an addressed envelope, which may be postage paid, for mailing to the Administrative Director or the Administrative Director's designee; and
12. The mandatory paragraphs required by §§9792.9.5(b)(12) and 9792.9.2(b)(5) advising the Injured Employee that:

    "You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision. (See attached application.) If you have questions about the information in this notice, please call me (insert claims adjuster's or appropriate contact'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."

13. Details about the Claims Administrator's internal utilization review appeals process for the requesting physician, if any, and a clear statement that the internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of LC §4610.5 and §4610.6 but may be pursued on an optional basis.
14. The Written decision Modifying or Denying treatment Authorization provided to the requesting physician shall also include the name, specialty of the reviewer or, if applicable, expert reviewer, and the telephone phone number in the United States of the Reviewer or Expert Reviewer, and disclose the available hours of either the Reviewer, the Expert Reviewer or the Medical Director for the treating physician to discuss the written decision which shall be, at the 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 to discuss the decision with the requesting physician. In the event the Physician Reviewer is unavailable, the requesting physician may discuss the written decision with another Physician Reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

Prior Authorization Without Submission of Request for Authorization: Although all providers are required to submit requests for authorization to Zenith (using the DWC Form RFA), 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 treatment of an Injured Employee without first submitting a request for authorization for each specific medical treatment and procedure to be utilized in treatment of the Injured Employee. 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.

Electronic Reporting to State:
Zenith shall provide electronic documents for every utilization review performed by Zenith as required under LC §4610(o) in the format prescribed by the DWC.

V. Dispute Resolution - Independent Medical Review

Zenith does not offer a voluntary appeal process.

If the Injured Employee disagrees with the utilization review decision and wishes to dispute it, the Injured Employee has the right to request an Independent Medical Review. All utilization review disputes will be resolved in accordance with the independent medical review provisions of LC§4610.5 and §4610.6. An objection to the utilization review decision must be submitted by the Injured Employee, the Injured Employee's representative, or the Injured Employee's attorney on behalf of the Injured Employee on an enclosed Application for Independent

Medical Review, DWC Form within the following applicable time frame:

1. **For Medical Treatment Disputes that Involve Only a Drug or Drug Listed on the MTUS Drug Formulary:** within ten (10) calendar days after the service of the utilization review decision to the Injured Employee; and
2. **For All Other Medical Treatment Disputes:** within thirty (30) calendar days after service of the decision to the Injured Employee.

Failure of the Injured Employee to request an independent medical review timely will result in the loss of the right.

The Injured Employee has a right to disagree with decisions affecting their claim. If the Injured Employee has questions about the information in this notice, the Injured Employee should call Zenith at 1-800-440-5020. However, if the injured employee is represented by an attorney, the Injured Employee should contact their attorney.

For information about the workers' compensation claims process and Injured Employees' 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.

VI. Privacy, Security and Records Retention

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.

The files and other records, whether electronic or paper, that pertain to the Utilization Review Process shall be retained for at least three (3) years following either: (1) the most recent utilization review decision for each injured employee, or (2) the date on which any appeal from the assessment of penalties for violations of LC §4610 or §§9792.6 through 9792.12 is final, whichever date is later. Claims administrators shall retain their claim files as set forth in 8 CCR §10102.

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 Affiliated Entities	
Policy Number: IP01.1	**Issued: January 22, 2008**
Updated:	As most recently revised 7-27-2020 As most recently reviewed 4-1-2026
Approved By: Dr. Jill Rosenthal, SVP & Medical Officer; Jackie Hilston, VP - Claims	

POLICY STATEMENT

It is the policy of Zenith that all U tilization 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. Zenith Medical Officers may not overturn a Clinical Peer Reviewer's decision to authorize treatment but may overturn a decision to Modify or Deny treatment in order to authorize the requested treatment based on information available to the Medical Officer. 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 a Zenith Medical Officer or Clinical Peer Review except as set forth in this policy.

PURPOSE

To establish consistent enterprise- w i d e 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 Employee that is subject to Utilization Review.

4. "*Utilization Review Process*" means the utilization management functions that prospectively, retrospectively, or concurrently review and Certify, 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 to authorize made by a Zenith Medical Officer or a decision to authorize, modify or deny made by an 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).

4. The Zenith employee should schedule the interdepartmental file review staffing meeting to address the concerns or issues arising from the Utilization Review determination within 48 hours of determining a concern exists and the meeting must take place as soon as reasonably possible but no later than thirty (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, Nurse Manager 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 Certify denied care or deny Certified care without Written approval by a Zenith Medical Officer.

1. 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.

2. There may be occasions when other medical reviews must be considered such as an Independent Medical Examination performed by either a Qualified Medical Evaluator or, Agreed Medical Evaluator. Under those circumstances, you should consult your local Medical Officers 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

Telephone Number: (925) 416-5210
Email: rdas@thezenith.com

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:

Genex Services, LLC

California Plan #005
URAC Certified

Genex Services, LLC holds a Workers' Compensation Utilization Management Accreditation administered by URAC and complies with the requirements of its filed utilization review plan when performing services on behalf of Zenith.

ATTACHMENT “C”
ZENITH CALIFORNIA UTILIZATION REVIEW GUIDELINES

Available to the public upon request.

ATTACHMENT "D"
UTILIZATION REVIEW LETTERS

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