Zenith Insurance Company
ZNAT Insurance Company

21255 Califa Street
Woodland Hills, CA 91367

Illinois
Utilization Review Plan

01/24/2018

Table of Contents

Definitions

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

1. "ACOEM Practice Guidelines" or "ACOEM" means the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, Second Edition.
2. "Authorization" means assurance that appropriate reimbursement will be made for an approved or authorized specific course of proposed medical treatment to cure or relieve the effects of an accepted compensable industrial injury or illness.
3. "Certify" means to approve services under the injured workers plan of coverage.
4. "Claims Administrator" means Zenith as a self-administered workers' compensation insurer. The Claims Administrator may utilize an entity contracted to conduct its Utilization Review responsibilities.
5. "Claims Examiner" means staff employed by Zenith to process claims.
6. "Criteria" as defined by Zenith means the use of ACOEM Practice Guidelines, the Official Disability Guidelines and other evidenced base medicine guidelines to evaluate Treatment Requests.
7. "Concurrent Review" means Utilization Review conducted during an inpatient stay.
8. "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.
9. "Expedited Review" means Utilization Review conducted when the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function.
10. "Expert Reviewer" means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the individual's scope of practice, who has been consulted by the reviewer or the Medical Director to provide specialized review of medical information. Zenith currently utilizes UniMed to conduct these types of reviews.
11. "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.

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

13. "MMN" means a registered nurse employed by Zenith's medical management department.

14. "Medical Director" means a physician licensed by a state Medical Board or Osteopathic Board who holds an unrestricted license to practice medicine in the State in which the physician resides and is responsible for oversight of all Zenith Utilization Review programs. The term Medical Director includes but is not necessarily limited to physicians holding any of the following Zenith job titles or a variation of these job titles – Medical Director, National Medical Director, Medical Officer, Chief Medical Officer and Assistant Medical Officer.

15. "Non-Certify" means to deny services requested on behalf of an injured worker.

16. "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.

17. "Regulations" means and Regulations formulated to implement the Illinois Workers' Compensation Act 820 ILCS 305.

18. "Retrospective Review" means Utilization Review conducted after medical services have been provided and for which approval has not already been given. Retrospective Reviews shall be based solely on the medical information available to the attending physician or ordering provider at the time the health care services were provided.

19. "Peer Reviewer" means a Medical Director, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the reviewer's practice. Zenith currently utilizes Intracorp to conduct these types of reviews.

20. "The Act" or the "Statute" means the Illinois Workers Compensation Act found under 820 ILCS 305.

21. "Treatment Request" is a Written confirmation of an oral request for a specific course of proposed medical treatment or a Written request for a specific course of proposed medical treatment. An oral Treatment Request must be followed by a Written confirmation of the request within seventy-two (72) hours. The term "Treatment Request", as used in this Utilization Review Plan, is synonymous with a "Request for Authorization".

22. "Utilization Review" means the evaluation of proposed or provided health care services to determine the appropriateness of both the level of health care services medically necessary and the quality of health care services provided to a patient, including evaluation of their efficiency, efficacy, and appropriateness of treatment, hospitalization, or office visits based on medically accepted standards. The evaluation will be accomplished by means of a system that identifies the utilization of health care services based on standards of care of nationally recognized peer review guidelines as well as nationally recognized treatment guidelines and evidence based medicine based upon standards as provided in the Illinois

Workers Compensation Act. Utilization techniques may include Prospective Review, second opinions, Concurrent Review, discharge planning, peer review, independent medical examinations, and Retrospective Review (for purposes of this sentence, Retrospective Review shall be applicable to services rendered on or after July 20, 2005). Utilization Review does not include determinations of the work-relatedness of injury or disease, or bill review for the purposes of determining whether the medical services were accurately billed.

23. "Utilization Review Plan" means this Written plan, which is filed as part of the utilization registration with the Department of Financial and Professional Regulation pursuant to the Illinois Workers Compensation Act, Section 8.7 and which sets forth Zenith's policies and procedures and a description of the Utilization Review Process.

24. "Utilization Review Process" means utilization management functions that prospectively, retrospectively or concurrently review and approve, modify, delay 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 provisions of medical treatment services. Utilization Review does not include determinations of the work-relatedness of injury or disease, or bill review for the purposes of determining whether the medical services were accurately billed.

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

26. "Zenith" means Zenith Insurance Company acting on behalf of itself, its subsidiary ZNAT Insurance Company or a sister company.

Zenith
Illinois Utilization Review Plan Administrative Overview

The following overview, description and policies and procedures constitute Zenith's Utilization Review Plan (Plan). Capitalized terms used herein shall have the meanings ascribed to them in the Definition section of the Plan. As an Illinois Claims Administrator, Zenith has established and maintains this Utilization Review Plan and its Utilization Review Process compliant with 820 ILCS 305/8.7 and Department of Financial and Professional Regulation, Title 50 Ins. Chap. 1, Subchapter hh, Part 2905 et seq.

Zenith employs a designated Medical Director to oversee its Utilization Review Process on a national basis and also designates a Medical Director to be responsible for Illinois. The national designated Medical Director is responsible for oversight of all Zenith Utilization Review programs and holds an unrestricted license to practice medicine. The Illinois designated Medical Director is responsible for Illinois specific programs. The designated Medical Directors' names, addresses, phone numbers and license numbers are set forth in Attachment "A".

Zenith will update its review Criteria and other relevant data on a regular basis 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 appropriate staff including to evaluate internal processes, review outcomes and compliance with policies and procedures, and to help ensure that Zenith and any of its vendors are utilizing the most current and up-to-date evidence based guidelines such as the American College of Occupational and Environmental Medicine ("ACOEM") or the Official Disability Guidelines ("ODG").

This Utilization Review Plan includes both administrative and departmental policies, procedures, and process descriptions that govern Zenith's Utilization Review Process.

Zenith will make the Utilization Review Plan available to the public upon request. The Plan will be made available through either 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.

Illinois 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 to injured workers 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 ODG, ACOEM or other evidence-based medicine guidelines and to provide consistent education and information to all other stakeholders. To meet this objective Zenith employs a Medical Director who is qualified in the area of occupational disease and disorders.

Staff Qualifications

Additionally, Zenith shall hire qualified staff to implement the Utilization Review Plan in an honest and ethical manner pursuant to the following standards, the LC and Regulations:

1. All staff shall hold valid and current licensure as required by the state.

2. All staff shall complete training on nationally recognized evidence based medicine guidelines to utilize in their review of Treatment Requests. In addition, all staff shall complete continued training in the application of treatment strategies and Utilization Review practices.

3. Zenith Claims Examiners may review Treatment Requests for the purpose of rendering coverage determinations or application of prior determinations. Claims Examiners may not make medical necessity determinations including decisions to Certify, Non-Certify, delay or modify a Treatment Request.

4. MMNs are registered nurses who, at a minimum: (1) have undergone formal training in nursing and/or a health care field, or hold an associate or higher degree in nursing; (2) hold a valid nursing license in the state of Illinois and (3) have professional experience providing direct patient care.

5. Medical assistants provide clerical support for the Utilization Review Process and have a minimum of a high school diploma or equivalent and undergo internal training courses.

Each injured worker's medical treatment is evaluated on an individual basis related to their diagnosis and the receipt of a Treatment Request outlining proposed treatment and medical care.

Zenith's Utilization Review decisions are made using the standards set forth in the ODG, ACOEM and/or other evidence based medicine guidelines.

Treatment Requests that are subject to Zenith's Utilization Review Process are supported by a team that includes MMN, Claims Examiners, and administrative support staff. Claims Examiners review Treatment Request for the purpose of determining coverage but may not make medical necessity determinations. Claims Examiners may Certify certain Treatment Requests based on prior determinations or when a medical necessity review is not required. The Utilization Review Process has multiple levels and non-certifications can only be rendered by an appropriate Peer Reviewer (as provided below). Zenith's multi-level Utilization Review Process includes:

- Claims Examiner review for coverage determinations and referral to the MMN;
- MMN review for certification or referral to a Peer Reviewer or Medical Director;
- Peer Reviewer and/or Zenith Medical Director review for certification or referral to an Expert Reviewer;
- Expert Reviewer review for certification and/or Zenith Medical Director Review for certification.

II. Utilization Review Process

Zenith maintains telephone access from 8:00 AM to 4:30 PM (Central Standard Time "CST") on normal business days for Health Care Providers to submit Treatment Requests. Additionally, Zenith maintains facsimile numbers available for Health Care Providers to submit Treatment Requests via fax. For after-hour operations, Zenith maintains the capability for Health Care Providers to submit Treatment Requests through a voice-mail system and/or a facsimile number.

Utilization Review begins with the receipt of a Written Treatment Request that has been referred into the Utilization Review Process. Verbal requests will be followed up on with the provider prior to rendering a Utilization Review determination and a Written request will be requested. 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. If the Claims Examiner determines coverage is available and a medical necessity determination is needed, the Treatment Request is forwarded to a medical management nurse (MMN) for review. At that time, Zenith will notify the provider that it is initiating the Utilization Review Process for a medical necessity determination.

Upon receipt of Zenith's Written notice that Utilization Review is being initiated, the provider of medical, surgical or hospital services must comply with the Utilization Review Process.

In the event the Treatment Request does not have appropriate information to allow Zenith to render a decision, the MMN may contact the requesting physician for the appropriate additional information necessary to render a decision. The provider must make reasonable efforts to provide timely and complete reports of clinical information needed to support a request for treatment. If the provider fails to make reasonable efforts, Zenith will Non-Certify the Treatment Request for lack of information. A letter notifying the provider of the non-certification will be sent to the provider, injured worker and

applicant's attorney, if any. Billings for such services are not compensable and the provider may not collect for the services from Zenith, the injured worker or the employer. Reporting requirements and requests for information imposed on providers must be reasonable and cannot be unduly burdensome.

Upon receipt of the appropriate additional information, the Treatment Request is evaluated by the MMN to determine if the Treatment Request can be approved. If the requested information is not received, the MMN will refer the Treatment Request to a Peer Reviewer or Medical Director.

If the Treatment Request does not meet applicable ODG, ACOEM or other evidence-based medicine guidelines, the MMN may refer the request to the Zenith Medical Director. The Zenith Medical Director may either directly contact or instruct the MMN to contact the requesting physician for an agreement to voluntarily amend or withdraw the original Treatment Request. If agreement is reached on an amendment of the original Treatment Request, the Medical Director or MMN may Certify the Treatment Request. If such agreement is not reached, the MMN will refer the Treatment Request to a Peer Reviewer or the Zenith Medical Director. Proper notifications will be provided for any actions taken by internal staff.

Pursuant to Zenith's National Utilization Review Policy (see attached), Treatment Requests can be modified or denied only by a physician. Zenith utilizes external Peer Reviewers for denials and either external Peer Reviewer or an internal Medical Director for modifications. No Zenith employee may override (or attempt to override by additional opinions) a decision for coverage, modification or denial made by a Zenith Medical Director or external Clinical Peer Review. Proper notifications will be provided for any actions taken by internal staff.

If compensability has not yet been determined and the basis for denial is medical necessity, the denial must be rendered by external Peer Reviewer. 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 the National Utilization Review Policy, therefore the Claims Examiner is authorized to respond to these requests in compliance with the law.

Utilization Review decisions must be sent in writing to the provider, injured worker and applicant's attorney, if applicable. Written decisions must include the clinical rationale for the certification or non-certification. Zenith may only deny payment or Non-Certify payment of medical services rendered or proposed to be rendered on the ground that the extent and scope of the medical treatment is excessive and unnecessary in compliance with Zenith's accredited Utilization Review Program.

Zenith has contracted with a third party vendor who coordinates and conducts a physician review of the Treatment Request and provided information. The Peer Reviewer may contact the requesting provider for additional appropriate information or clarification. The Peer Reviewer then renders a decision to Certify, Non-Certify, modify or delay the Treatment Request.

The relevant portion of the Criteria or guidelines relied upon to modify, delay or deny services shall be disclosed in writing to the requesting physician, the injured worker and the injured worker's attorney, if applicable. Zenith will not charge an injured worker, the injured worker's attorney or the requesting

physician for a copy of the relevant portion of the Criteria or guidelines relied upon to modify, delay or deny the Treatment Request.

III. Time Tracking

A Written Treatment Request shall be deemed to have been received by Zenith as follows:
Where a Treatment Request is received by mail and a proof of service by mail exists, the request is deemed to have been received five (5) calendar days after the date indicated on the proof of service unless

- Zenith mailroom date stamp is before the five (5) calendar days, then the date stamp will control
- Zenith mailroom date stamp is after the five (5) calendar days, the proof of service will control

Where the Treatment Request is received via certified mail with return receipt, the request is deemed received on the receipt date entered on the return receipt.

If no proof of service or dated return receipt exists, the request is deemed received on the date stamped by Zenith's mail room.

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

Where the Treatment Request is received by facsimile the received date is considered as follows:

- If Zenith's electronic receive date stamp is present, this is considered the received date. Verbal Treatment Requests will be entered into the system the date received. Pursuant to Zenith requirements, Verbal Treatment Requests must also be followed up with a Written request. Verbal Treatment Requests will be tracked from the date the verbal request was originally received and entered into the system.

- If no Zenith Electronic receive date stamp is present, the date of the fax transmission from the requesting sender is considered the received date.

- If there is no fax transmission date or an erroneous date as the fax transmission date, the received date is considered the latest date indicated on the Treatment Request.

When the Treatment Request is received by telephone, the received date is considered as follows:

- If the telephonic request is received after 3:00 p.m. the received date for the Treatment Request will be considered the following business day; and the certification determination will be rendered within two business days of receipt of the necessary information.

- If the telephonic request is received prior to 3:00 p.m., the received date for the Treatment Request will be considered that business day.

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

IV. Treatment Request Reviews

When conducting reviews, Zenith will request only the information necessary to make a Utilization Review.

Zenith may review ongoing inpatient stays, but will not routinely conduct daily reviews. The frequency of length of stay reviews, when performed, will vary based on the severity or complexity of the injured worker's condition or on the necessary treatment and discharge planning activity. Zenith will establish a reasonable target review period for each admission based on medical necessity. Except for any contractually required case management activities related to discharge planning programs, neither Zenith nor Zenith's vendors may contact a hospitalized injured worker until the final day of the established target period.

Zenith's Utilization Review Process provides for Expedited Reviews, Prospective Reviews, Concurrent Reviews, and Retrospective Reviews, as set forth below:

1. Expedited Review Decisions to Certify, Non-Certify, modify, or delay Treatment Requests must be made in a timely fashion that is appropriate for the nature of the injured worker's condition, but not to exceed (seventy-two (72) hours after receipt of the information reasonably necessary to make the determination

2. Prospective Review and Concurrent Review decisions to Certify, delay, modify, Non-Certify, or request additional information must be made within five (5) business days from receipt of the Treatment Request.

   If Zenith is not in receipt of the information necessary to render a decision, then the MMN shall contact the provider within five (5) business days of the date the Treatment Request was received and attempt to obtain the necessary information. The provider will be given a maximum of thirty (30) calendar days in which to submit the additional information. If the appropriate additional information requested is received, then upon receipt of such information a decision must be made within five (5) business days of receipt of the additional information.

   If the information is not provided within 30 days, the MMN shall send a non-certification letter for lack of information to the provider in compliance with Illinois code ILCS305/8.7(i). If additional information is subsequently received from the provider, a new Treatment Request will be created and reviewed using established processes.

If the appropriate additional information requested is received, then upon receipt of such information a decision must be made within five (5) business days of receipt of the additional information.

For Concurrent Reviews, medical care shall not be discontinued nor denied until the requesting physician and the provider of goods or services, identified in the Treatment Request, have been notified of the decision and a care plan has been agreed upon by the requesting physician. The care plan must be appropriate for the medical needs of the injured worker and consistent with ACOEM Practice Guidelines and/or other evidence based medicine guidelines.

3. Retrospective Review decisions to Certify, modify, Non-Certify or delay must be completed within thirty (30) calendar days of receipt of the information that is reasonably necessary to make a determination. Retrospective Reviews shall be based solely on the medical information available to the attending physician or ordering provider at the time the health care services were provided. Retrospective Utilization Review may be invoked by either the Claims Examiner or a bill review nurse by notifying the MMN. The MMN will send the provider the notice that Zenith is invoking Utilization Review. If Zenith is not in receipt of the information necessary to render a decision, then the MMN shall also contact the provider within five (5) business days of the date the MMN is requested to invoke Utilization Review and attempt to obtain the necessary information. The provider will be given a maximum of thirty (30) calendar days in which to submit the additional information. If the appropriate additional information requested is received, then upon receipt of such information a decision must be made within thirty (30) calendar days of receipt of the additional information. If the information is not provided within thirty (30) calendar days, the MMN shall send a non-certification letter for lack of information to the provider in compliance with Illinois code ILCS305/8.7(i). If additional information is received from the provider after the provider's thirty (30) calendar days to respond has expired, Zenith will deny review due to the provider's untimely response.

4. Emergency Health Care Services may be subject to Retrospective Review; however, failure to obtain prior Authorization for Emergency Health Care Services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for Emergency Health Care Services.

V. Utilization Review Dispute Resolution

There are two options available in the event of a delay, non-certification or modification of a Treatment Request.

Pursuant to the first option, open to the requesting medical provider, Zenith's contracted Expert Review vendor offers a voluntary internal appeals process that is compliant with both state Regulations as well as the Utilization Review Accreditation Commission (URAC) standards. Zenith may also utilize the Expert Reviewer when an injured worker disputes a Utilization Review determination. Pursuant to the second option, the dispute may be resolved in accordance with processes established under the Illinois Workers' Compensation Act, 820 ILCS 305 (The Act).

Use of the voluntary internal appeals process does not preclude the ability for dispute resolution in accord with The Act. Use of an objection based upon The Act does not preclude the requesting physician's ability to utilize the voluntary internal appeals process. Notification of these appeals processes are described in the Expert Review decision notification letters. The following sets forth in more detail these two alternatives:

Voluntary Appeals Process: The voluntary appeals process may be initiated by the requesting physician or injured worker. When an injured worker disputes a medical necessity determination, the physician must submit the request in writing to initiate an appeal. New or updated medical information is accepted for this process. The requesting physician has thirty (30) calendar days from the receipt of the notice of a non-certification to appeal the decision made by the Peer Reviewer. The appeal is made directly to the third party vendor. If an appeal is sent to Zenith, the appeal request will be forwarded to the third party vendor for review. A Peer Reviewer not involved in the original review will evaluate the medical information and render a decision. The third party vendor will issue notifications of the outcome of the appeal to the provider, facility or provider of goods and services (if known), the injured worker and if represented by counsel, the injured worker's attorney, and Zenith.

Burden of Proof

When a payment of medical services is denied or non-certified by Zenith or its vendor pursuant to Utilization Review, the injured employee has the burden of proof to show by a preponderance of the evidence that a variance from the applicable evidence based medical guidelines is reasonably required to cure or relieve the effects of the work related injury or illness.

Testimony of Reviewer

The Peer Reviewer, Expert Reviewer or Medical Director that rendered the final Utilization Review or appeal determination, whichever applies, must:

1. be available for interview or deposition in the State of Illinois; or
2. be available for deposition by telephone, video conference, or other remote electronic means.

Any Peer Reviewer, Expert Reviewer or Medical Director who works or resides outside the State of Illinois may comply with this requirement by submitting to an interview or deposition in person or through telephone, video conference, or other remote electronic means. Zenith is responsible for the expense of the deposition. Requests for deposition or testimony should be relayed by the receiving party to Zenith's claims legal department for handling Immediately upon receipt.

Illinois Workers' Compensation Act 19(b) Petition:

An injured worker may file their claim with the Illinois Workers' Compensation Commission (Commission). In order to open the claim with the Commission, the worker must file three copies of the *Application for Adjustment of Claim*, along with a *Proof of Service* stating that a copy of the application was given to the employer. Claims may be filed by mail or in person at any Commission office. There are no fees for the forms or to file a claim.

Failure of the injured worker to file a claim within the applicable statutory time frame results in loss of the right to claim future benefits.

Disputes are resolved through trial in front of an arbitrator following the Illinois law, rules of evidence, precedents set by previous workers' compensation cases, and the *Rules Governing Practice Before the Commission*.

For medical bills that are unpaid, a party may petition for an emergency hearing under Section 19(b) of The Act. A final decision will be issued within one hundred eighty (180) days of the date the *Petition for Review* was filed. An employee who claims to be owed medical or compensation benefits may file a 19(b) petition, regardless of whether the employee is working.

Once the issues contained in the Section 19(b) emergency process are decided, the case will go back on the arbitration call to resolve other issues in dispute.

Commission decisions are final for cases involving employees of the State of Illinois. In all other cases, either party may appeal to the Circuit Court, the Appellate Court, and in some cases, to the Illinois Supreme Court.

Policy and Procedure Attachments List

The following pages contain Zenith policies and procedures which set out in more detail how Zenith maintains the Utilization Review Process. These policies and procedures are incorporated in whole as part of this Utilization Review Plan.

Policy Directory:

- **Zenith Insurance Company National Utilization Review Policy - Policy Number: IP01.1**

C O M P A N Y P O L I C Y	
Title: Zenith Insurance Company National Utilization Review Policy	
Application: Zenith Insurance Company, ZNAT Insurance Company, ZIMS and	
Policy Number: IP01.1	**Issued: January 22, 2008**
Updated:	As most recently revised 12-18-2017
Approved By: Dr. Jill Rosenthal, SVP & Medical Officer; Mike Gillikin, VP-Claims; Jackie Hilston, VP - Claims	

POLICY STATEMENT

It is the policy of Zenith that all utilization review denials be rendered by external Clinical Peer Review. Decisions to overturn or modify a Clinical Peer Review decision may only be made by a Zenith Medical Officer or external Clinical Peer Reviewer. 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 either a Zenith Medical Officer or Clinical Peer Review except as set forth in this policy.

PURPOSE

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

DEFINITIONS

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

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

3. "*Treatment Request*" is a request for Medical Services or treatment for an Injured Employee that is subject to utilization review.

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

PROCEDURES FOR POLICY COMPLIANCE

Policies:

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

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 30 calendar days from the date the concern became known. The review staffing meeting must include the appropriate departmental AVP, any Zenith Medical Officer involved in the determination and if none, a Zenith Medical Officer and other appropriate Medical Management, Claims Manager, Claims Examiner, Medical Management Nurse Supervisor and Legal staff given the issues or concerns. The Zenith Medical Officer(s) may choose to include the external Clinical Peer Review physician and/or the medical director of the external Clinical Peer Review company.

No referral for a second or third opinion may be made in lieu of this interdepartmental

staffing. The Medical Officer shall have final authority in consultation with the staffing team set out above for authorization, modification or denial of Treatment Requests subject to the Utilization Review Process.

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

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

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

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

5. There may be occasions when other medical reviews must be considered such as an Independent Medical Examination performed by either a Qualified Medical Evaluator or, Agreed Medical Evaluator. Under those circumstances, you should consult your local Medical Officer and legal staff to determine which medical decision should be followed.

ATTACHMENT "A"

DESIGNATED MEDICAL DIRECTOR INFORMATION

Zenith's designated Medical Director holds an unrestricted license to practice medicine in the States of California, Florida and Texas and is Board Certified in Occupational Medicine. The designated Medical Director is:

Name: Jill Rosenthal, MD
Job Title: SVP and Medical Officer
Address: Zenith Insurance Company
21255 Califa Street
Woodland Hills, CA 91367

ATTACHMENT "B"

ZENITH INSURANCE COMPANY
APPLICABLE CONFIDENTIALITY AND PRIVACY POLICIES AND GUIDELINES

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

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

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

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

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

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

ATTACHMENT "C"

ZENITH - ILLINOIS UTILIZATION REVIEW GRIEVANCE PROCESS

A "Grievance" means a complaint concerning the Utilization Review process or other complaint related to Utilization Review that is not an appeal of a Utilization Review decision.
Grievances shall be handled using the following procedures:

1. Upon receipt of a grievance, the grievance will be forwarded to the Illinois Assistant Vice President of Medical Management for logging and review.
2. The Assistant Vice President of Medical Management will review the Grievance and oversee the investigation of the Grievance in conjunction with appropriate business staff and the Assistant General Counsel of Med Legal.
3. Following completion of the investigation, a response to the Grievance will be drafted and sent to the individual that submitted the Grievance within 30 days of receipt of the Grievance unless additional time is needed to complete the investigation or additional information is required. The Grievance response letter will set forth the final result of the investigation with an explanation along with how to appeal the decision.
4. If additional time or information is needed to complete the investigation, a notice will be sent to the individual who filed the Grievance within 30 days of the date the Grievance was received by Zenith explaining that additional time or information is needed to complete the review of the Grievance and that response to the Grievance will be issued within 60 days of the date the Grievance was received.
5. All investigations must be completed and a response sent no later than 60 days from the date the Grievance was received. If the additional information is requested and not received, a Written response to the Grievance will be sent within 60 days of the date the Grievance was received setting forth the information that was requested and indicating that the Grievance cannot be resolved and is being closed due to lack of information.
6. The Grievance will be re-opened if additional information is received after the Grievance closure letter is sent.
7. The Grievance process will be considered confidential however; results of the review will be shared with pertinent parties such as Zenith's contracted Utilization Review vendor and the physician reviewer, if applicable.
8. The aggrieved party may submit an appeal to a Grievance within 30 days of the date the final Grievance response letter was sent. The appeal must be clearly labeled as an appeal of a Grievance and will be directed to the Assistant General Counsel of Med-Legal.
   The appeal will be reviewed and responded to by the Assistant General Counsel within 30 days of receipt unless additional time to complete the review is required.

If additional time is required, the Assistant General Counsel will send a letter to the aggrieved party indicating that the investigation is continuing and that a response will be sent within 60 days of the date the appeal was received. The final appeal response letter will set for the final decision and explanation.