Zenith Insurance Company

21255 Califa Street
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Zenith
Utilization Review Plan

Nevada

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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:

1. "ACOEM Practice Guidelines" means the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, most current Edition.

2. "Certify" or "Certification" means to approve services under the injured workers plan of coverage.

3. "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.

4. "Claims Examiner" means staff employed by Zenith to process claims. They 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.

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

6. "Criteria" as defined by Zenith means the use of ACOEM Practice Guidelines and/or other evidenced base medicine guidelines to evaluate Treatment Requests.

7. "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.

8. "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.

9. "Expert Peer 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 Mitchell International to conduct these types of reviews.

10. "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.

11. "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.

12. "Medical Director" is the physician and surgeon licensed by the Medical Board of Nevada or the Osteopathic Board of Nevada who holds an unrestricted license to practice medicine in the State in which the physician resides. The Medical Director is responsible for all decisions made in the Utilization Review Process.

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

14. "Nurse Consultant" (NC) means a registered nurse employed by Zenith's Medical Management department acting as a Nurse Consultant.

15. "Peer Reviewer" means a medical director, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed in the State of Nevada, 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 Mitchell to conduct these types of reviews.

16. "Prior Authorization" means assurance that appropriate reimbursement will be made for an approved or authorized specific course of requested medical treatment to cure or relieve the effects of the industrial injury.

17. "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.

18. "Statute and Regulations" means the Nevada Workers' Compensation Act NV NRS 683A.375 – NV NRS 683A379 and NV NAC 683A.280 – 683A.295

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

20. “The Act” means the Nevada Workers Compensation Act found under Nev. Rev. Stat. Ann. Title 53, Ch. 616A-D and NAC 616A- D.

21. “Treatment Request” is either 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.

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 or nationally recognized peer review guidelines as well as nationally recognized evidence based upon standards as provided in the Nevada Administrative Code. 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 process with the Nevada Division of Insurance, pursuant to Nevada NRS 683A.375 – NRS 683A379 and NAC 683A.280 – 683A.295, 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 as utilization review administrator.

Utilization Review Plan Administrative Overview

The following overview, description and policies and procedures constitute Zenith's Utilization Review Plan. Capitalized terms used herein shall have the meanings ascribed to them in the definitions listed above on pages one through three. As a Nevada Utilization Review Administrator, Zenith has established and maintains this Utilization Review Plan and its Utilization Review Process compliant with Nev. Rev. Stat. Ann. Title 53, Ch. 616A-D and NAC 616A- D and NRS 683A.375 – NRS 683A379 and NAC 683A.280 – 683A.295

Zenith employs a designated Medical Director to oversee its Utilization Review program in the State of Nevada. The designated Medical Director is responsible for oversight of Zenith's Nevada Utilization Review program. Zenith's designated Medical Director holds an unrestricted license to practice medicine in at least one State within the United States. The designated Medical Director's name, address, phone number and license number 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 the Medical Director and Zenith's Assistant Vice President of Medical Management 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 ACOEM Practice Guidelines and other evidence based guidelines.

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

Upon request by the public, Zenith will make available this Utilization Review Plan including policies, procedures as well as a description of the Utilization Review Process. This 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.

Nevada 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's utilization review decisions are made the latest edition of the ACOEM Practice Guidelines as required by Nevada Administrative Regulation 616C.123. If ACOEM does not address the treatment being requested, Zenith will utilize other nationally recognized evidence based guidelines. Zenith employs a Medical Director who is qualified in the area of occupational disease and disorders to oversee its utilization review program. Modification or denials of treatment requests may only be issued by a Peer Reviewer.

II. Utilization Review Process

Zenith maintains telephone access from 8:00 AM to 4:30 PM (Nevada time) on normal working days for Health Care Providers to submit Treatment Requests. Additionally, Zenith maintains facsimile numbers available for Health Care Providers to submit Treatment Requests via fax. For after-hours operations, Zenith maintains the capability for Health Care Providers to submit Treatment Requests through a voice-mail system and/or a facsimile number. Treatment requests not submitted to the correct address or fax number will not be considered valid treatment requests.

Utilization review begins with the receipt of a Written Treatment Request that has been referred into the Utilization Review Process. Any Treatment Request subject to the Utilization Review Process shall be evaluated to determine if the Treatment Request can be approved. In the event that the Treatment Request cannot be approved, the request will be sent to Peer Review.

If the Treatment Request does not meet the ACOEM Practice Guidelines or other evidence-based medicine guidelines, the requesting physician may be contacted to determine if the requestor will agree to modify the treatment request. If they agree, the requestor will be asked to voluntarily amend or withdrawal the original Treatment Request. Upon receipt of the physician's modified request, the request will be approved. If agreement is not reached, or the physician signature confirmation is not received, the Treatment Request will be sent for Peer Review.

Zenith has contracted with a third party vendor who coordinates and conducts a physician level Peer 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.

III. Time Tracking

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

1. Where a Treatment Request is received by mail and a proof of service by mail exists, the request is deemed to have been received 5 calendar days after the date indicated on the proof of service unless

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

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

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

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

5. 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

    - 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

Mail and facsimiles received after 5:30 PM (Nevada time) are considered received the following working day. Mail and facsimiles received on a holiday or weekend are deemed received the next working day.

IV. Types of Treatment Request Reviews

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

1. The treating physician or chiropractor must request Written Prior Authorization before ordering or performing any one of the following services with an estimated billed amount of $200 or more:
    (a) Consultation;

(b) Diagnostic testing;
(c) Elective hospitalization;
(d) Any surgery which is to be performed under circumstances other than an emergency; or
(e) Any elective procedure.

Zenith will respond within 5 working days after receiving a Written request for Prior Authorization for:
(a) Treatment;
(b) Diagnostic testing; or
(c) Consultation,

Pursuant to NAC 616C.129(7), a treatment program that consists of more than six visits, not including the initial evaluation, and is billed under codes 97010 to 97799, inclusive, or 98925 to 98943, inclusive, whether the visits are billed separately or included under different codes, must be authorized in advance by the insurer to verify the medical necessity for continued treatment. The first six visits do not require the Prior Authorization of the insurer. The number of requests for additional visits by the treating physician or chiropractor and any Written authorization granted are not restricted, and are subject only to the treatment prescribed by the treating physician or chiropractor and the determination of the insurer. A report of the status of an injured employee may be requested by an insurer at any time during the course of treatment. The initial evaluation shall be deemed to be separate from the initial six treatments. An initial evaluation may be performed on the same day as the initial treatment.

Pursuant to Nev. Rev. Stat. Ann. §616C.157, if Zenith fails to respond to a request for Prior Authorization within 5 working days, authorization shall be deemed to be given. The insurer, organization for managed care or third-party administrator may subsequently deny authorization. If a subsequent denial is issued, payment must be made, upon request of the provider, for all treatments rendered before the date the provider received notice of the subsequent denial.

Any request for Prior Authorization to order or perform any of the services must contain an explanation of the need for each service to be ordered or performed. If any of the services are performed without Written Prior Authorization, the insurer is not liable for the fee for the service, unless good cause is shown for providing the services without Prior Authorization.

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

   Decisions to Certify, 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 72 hours after receipt of the information reasonably necessary to make the determination

3. Prospective Review is any utilization review conducted prior to the delivery of requested medical services, unless the injured worker is hospitalized.

   Decisions to Certify, delay, modify, non-Certify, or request additional information must be made within 5 working days from receipt of the Treatment Request.

   If Zenith is not in receipt of the information necessary to render a decision, then a Written request for appropriate additional information must be sent within 5 working days from receipt of the Written Treatment Request to the requesting provider.

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

   If the appropriate additional information requested is not received, then the Treatment Request is sent to a Peer Reviewer. A Peer Reviewer may deny the request with the stated condition that the request will be reconsidered upon receipt of the information requested.

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

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

   Decisions to Certify, delay, modify, non-Certify, or request additional information must be made within 5 working days from receipt of the Treatment Request.

   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.

   If Zenith is not in receipt of the information necessary to render a decision, then the Peer Reviewer may contact the requesting provider for additional information, but if the information is not able to be obtained timely, the Peer Reviewer may issue a denial for lack of information.

5. 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, non-Certify or delay must be done within 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.

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 Appeals Process & Dispute Resolution

Informal Hearing Officer 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 appeal from the determination or failure to respond by filing a request for a hearing before a hearing officer pursuant to Nev. Rev. Stat. Ann. § 616C.315, subsection 1 & 3.

Such a request must include the required information as outlined in subsection 2 and must be filed within 70 days after the date on which the notice of the insurer's determination was mailed by the insurer or the unanswered Written request was mailed to the insurer. The failure of an insurer to respond to a Written request for a determination within 30 days after receipt of such a request shall be deemed by the hearing officer to be a denial of the request.

Appeal Officer Process: Any party aggrieved by a decision of the hearing officer relating to a claim for compensation may appeal from the decision by filing a notice of appeal with an appeals officer within 30 days after the date of the decision pursuant to Nev. Rev. Stat. Ann. § 616C.345.

Such a request must include the required information as outlined in subsection 3 and must be filed 70 days after the date on which the notice of the insurer's determination was mailed by the insurer or the unanswered Written request was mailed to the insurer. The failure of an insurer to respond in writing to a Written request for a determination within 30 days after receipt of such a request shall be deemed by the appeals officer to be a denial of the request. The insurer shall provide, without cost, the forms necessary to file a notice of a contested claim to any person who requests them.

Pursuant to Nev. Rev. Stat. Ann. § 616C.360, If there is a medical question or dispute concerning an injured employee's condition or concerning the necessity of treatment for which authorization for payment has been denied, the appeals officer may:

(a) Order an independent medical examination and refer the employee to a physician or chiropractor of his or her choice who has demonstrated special competence to treat the particular medical condition of the employee, whether or not the physician or chiropractor is on the insurer's panel of providers of health care. The insurer shall pay the costs of any examination requested by the appeals officer.

(b) If the medical question or dispute is relevant to an issue involved in the matter before the appeals officer and all parties agree to the submission of the matter to an independent review organization, submit the matter to an independent review organization in accordance with NRS 616C.363 and any regulations adopted by the Commissioner.

The decision of an appeals officer is the final and binding administrative decision on a claim for compensation

VI. Privacy and Security

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

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

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

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