Zenith Insurance Company

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Zenith
Utilization Review Plan

Nevada

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

4. "Criteria" means the use of ACOEM Practice Guidelines and/or other evidenced base medicine guidelines to evaluate Treatment Requests.

5. "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.

6. "Expedited Review" means utilization review conducted when the injured worker's condition is such that: (i) 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); (ii) the normal timeframe for the decision-making process would be detrimental to the injured worker's life or health; or (iii) it could jeopardize the injured worker's permanent ability to regain maximum function.

7. "Expert Peer Reviewer" means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic that: (i) is a practitioner licensed by any state or the District of Columbia; (ii) is competent to evaluate the specific clinical issues involved in the medical treatment services; and (iii) has been consulted by the reviewer or the Medical Director to provide specialized review of medical information. Zenith currently utilizes Genex Services, LLC to conduct these types of reviews.

8. "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).

9. "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.

10. "Medical Director" means a physician that holds an unrestricted license to practice medicine in at least one state within the United States and is responsible for oversight of Zenith's Utilization Review programs.

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

12. "Nurse Consultant" (NC) means a registered nurse employed by Zenith.

13. "Peer Reviewer" means a medical director, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner that: (i) is licensed in the State of Nevada; and (ii) is competent to evaluate the specific clinical issues involved in medical treatment services. Zenith currently utilizes Genex Services, LLC to conduct these types of reviews.

14. "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.

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

16. "Statute and Regulations" means the Nevada Workers' Compensation Act Nev. Rev. Stat. Ann. §§ 683A.375; 683A.379 and 683A.280 – 683A.295.

17. "Retrospective Review" means any 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 Health Care Provider at the time the health care services were provided.

18. "The Act" means the Nevada Workers Compensation Act found under Nev. Rev. Stat. Ann. Title 53, Ch. 616A-D and Nevada Administrative Code §616A- D.

19. "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.

20. "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.

21. "Utilization Review Plan" means this Written plan that is filed as part of the utilization process with the Nevada Division of Insurance pursuant to Nev. Rev. Stat. Ann. §§ 683A.375; 683A379 and Nevada Administrative Code §§683A.280 – 683A.295, which sets forth Zenith's policies and procedures and a description of the Utilization Review Process.

22. "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 the Health Care Provider, 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.

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

24. "Zenith" means Zenith Insurance Company.

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 in the section above. As a Nevada utilization review administrator, Zenith established and maintains this Utilization Review Plan and its Utilization Review Process compliant with Nev. Rev. Stat. Ann. Title 53, Ch. 616A-D and Nevada Administrative Code §616A- D and Nev. Rev. Stat. Ann. § 683A.375 – 379 and Nevada Administrative Code §§683A.280 – 295.

Zenith employs a designated Medical Director to oversee its Utilization Review Plan in the State of Nevada. The designated Medical Director is responsible for oversight of Zenith's Nevada Utilization Review Plan. 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 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 Criteria consists of regular reviews by the Medical Director and Zenith's Vice President of Medical Management to evaluate internal processes, review outcomes and compliance with policies and procedures, which ensures that Zenith (and any of its vendors) utilize the most current Criteria.

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 via electronic means or 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

Zenith provides administrative services for its customers. Utilization Review is conducted by Zenith under its UR license, and Zenith's licensed UR vendor, Genex Services, LLC ("Genex"). Genex performs Utilization Review on behalf of Zenith when Zenith is unable to Certify a Treatment Request for medical necessity based on information submitted with the Treatment Request.

The purpose of the 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 using the latest edition of the ACOEM Practice Guidelines as required by Nevada Administrative Regulation 616C.123. If ACOEM Practice Guidelines 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 Plan. 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, as well as a facsimile number. For after-hours operations, Health Care Providers can submit Treatment Requests through Zenith's voicemail system and/or facsimile number. Treatment Requests not submitted via Zenith's telephone access number or fax number will not be considered valid.

Utilization Review begins with the receipt of a 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 it can be approved. In the event that the Treatment Request cannot be approved, it will be sent to a Peer Reviewer.

If the Treatment Request does not meet the Criteria the requesting Health Care Provider may be contacted to determine if he/she/they will agree to modify the Treatment Request. If the Health Care Provider is willing to modify the Treatment Request, he/she/they will be asked to voluntarily amend or withdrawal the original Treatment Request. Upon receipt of the Health Care Provider's modified Treatment Request, it will be reviewed. If an agreement is not reached, or the Health Care Provider signature confirmation is not received, the Treatment Request will be sent to a Peer Reviewer.

Zenith has contracted with a third-party vendor who coordinates and serves as the Peer Reviewer of the Treatment Request and provided information. The Peer Reviewer may contact the Health Care 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 Treatment Request shall be deemed received by Zenith based on one of the following:

1. Where a Treatment Request is received by mail and a proof of service by mail exists, it will be deemed received 5 calendar days after the date indicated on the proof of service (unless Zenith's mailroom date stamp is at least 5 calendar days before the date indicated on the proof of service, then the date stamp will control); or

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

3. If no proof of service or dated return receipt exists, the Treatment Request is deemed received on the date stamped by Zenith's mailroom;

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; or

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 Health Care Provider is considered the received date; or

    - 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.

Treatment Requests received by mail and facsimiles after 5:30 PM (Nevada time) are deemed received the following working day. Treatment Requests received by mail and facsimiles 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 Prior Authorization requests, Expedited Reviews, Prospective Reviews, Concurrent Reviews and Retrospective Reviews, as set forth below:

1. The treating Health Care Provider 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 Nevada Administrative Code §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 additional visit requests by the Health Care Provider and any Written authorization granted are not restricted and are subject only to the treatment prescribed by the treating Health Care Provider and the determination of the insurer. A report of the status of an injured worker 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 Treatment 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 Health Care Provider, for all treatments rendered before the date the Health Care Provider received notice of the subsequent denial.

Any Treatment 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: (i) 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 (ii) 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 Health Care 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, Non-Certify, delay, modify 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 Health Care Provider.

   If a request for appropriate additional information is sent to the requesting Health Care 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 Treatment 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, Non-Certify, delay, modify 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 Health Care Provider identified in the Treatment Request, has been notified of the decision and a care plan has been agreed upon by the Health Care Provider. The care plan must be appropriate for the medical needs of the injured worker and consistent with the Criteria.

   If Zenith is not in receipt of the information necessary to render a decision, then the Peer Reviewer may contact the requesting Health Care 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, Non-Certify, modify 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 or ordering Health Care 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 worker disagrees with the Utilization Review decision and would like to dispute it, the injured worker 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 of Nev. Rev. Stat. Ann. § 616C.315 and must be filed within 70 days after the date that the notice of the insurer's determination was mailed 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 to be a denial of the request by the hearing officer.

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 of Nev. Rev. Stat. Ann. § 616C.315 and must be filed 70 days after the date on which the notice of the insurer's determination was mailed 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 to be a denial of the request by the appeals officer. 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 worker'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 injured worker to a Health Care Provider of his/her/their choice who has demonstrated special competence to treat the particular medical condition of the injured worker, whether or not the Health Care Provider is on the insurer's panel of Health Care Providers. 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, then the matter may be submitted to an independent review organization in accordance with Nev. Rev. Stat. Ann. § 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; and
- E-mail Security Policy.

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