Zenith Insurance Management Services

21255 Califa Street
Woodland Hills, CA 91367

Utilization Review Plan
For
Zenith Insurance Company and
ZNAT Insurance Company

Texas – Network and Non-Network Arrangements

May 2022

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Policies and Procedures
Tab 2

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" mean the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, Second Edition – Workloss Data Institute – evidence based medicine.
2. "Adverse Determination" means a determination by a URA that the health care services provided or proposed to be provided to an injured worker are not medically necessary or appropriate. The term does not include a denial of health care services due to the failure to request prospective or concurrent Utilization Review. An Adverse Determination does not include a determination that health care services are Experimental or Investigational. Adverse determinations must be referred to and may only be determined by a physician, doctor, or other health care provider with appropriate credentials under Chapter 180 of this title (relating to Monitoring and Enforcement) and § 19.2006 of this title (relating to Requirements and Prohibitions Relating to Personnel). Physicians and doctors performing utilization review must also comply with Labor Code §§ 408.0043, 408.0044, and 408.0045.
3. "Ambulatory Surgical Services" means surgical services provided in a facility that operates primarily to provide surgical services to patients who do not require overnight hospital care.
4. "Certify" means to approve services under the injured workers plan of coverage.
5. "Claims Examiner" means non-clinical personnel employed by Zenith to process claims. They do not perform any aspect of Utilization Review, in compliance with §4201.252(b) and 28 TAC 19.2006(a)."Concurrent Review" means a review of on-going health care listed in 28 TAC § 134.600 subsection (q) for an extension of treatment beyond previously approved health care listed in 28 TAC § 134.600 subsection (p).
6. "Criteria" as defined by Zenith means the use of the Official Disability Guidelines, most current edition, ACOEM Practice Guidelines and/or other evidence based medicine guidelines to evaluate Treatment Requests.
7. "Diagnostic Study" means any test used to help establish or exclude the presence of disease/injury in symptomatic persons. The test may help determine the diagnosis, screen for specific disease/injury, guide the management of an established disease/injury, and formulate a prognosis.
8. "Division" or "TDI" or "TDI-DWC" mean the Texas Division of Workers' Compensation.
9. "Emergency Health Care Services" means services provided to treat either a Medical Emergency or Mental Health Emergency.
10. "Experimental" or "Investigational" mean a health care treatment, service, or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service or device but that is not yet broadly accepted as the prevailing standard of care.
11. "Health Care Practitioner" means:

    (A) An individual who is licensed to provide or render and provides or renders health care; or

(B) a nonlicensed individual who provides or renders heatlh care under the direction or supervision of a doctor.

12. “Health Care Provider” means a health care facility or health care practitioner.pursuant to The Texas Workers’ Compensation Act.
13. “Independent Review Organization” or “IRO” means an entity that is granted a certificate of registration by the commissioner to conduct independent reviews under the authority of Insurance Code Chapter 4202. An IRO must have the capacity for independent review of all specialty classifications and subspecialties contained in the two-tiered structure of specialty classifications set out in §12.402 of this chapter.
14. “Medical Director” means the physician licensed by the Medical Board of Texas who holds an unrestricted license to practice medicine in the State of Texas and is responsible for oversight of all Zenith Utilization Review programs.
15. “Medical Emergency” means the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:
    - placing the patient's health or bodily functions in serious jeopardy, or
    - serious dysfunction of any body organ or part.
16. “Mental Health Emergency” means a condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person.
17. “ODG Guidelines” means the Work Loss Data Institute’s *Official Disability Guidelines – Treatment in Workers Comp* adopted by the Texas Department of Insurance (TDI) Division of Workers’ Compensation (DWC) as the official guidelines to be utilized for health care provided to Texas injured workers on or after May 1, 2007.
18. “Peer Review” means an administrative review by a Health Care Provider performed at the insurance carrier's request without a physical examination of the injured employee.
19. “Peer Reviewer” means a doctor of medicine, osteopathic medicine, optometry, dentistry, podiatry, or chiropractic who is licensed in Texas and holds a professional certification in a health care specialty appropriate to the type of health care that the injured employee is receiving as mandated by Texas Workers’ Compensation Act Sections 408.0043-45 and Division rules. Zenith currently utilizes contracted Utilization Review Agents Genex Services and Oristech to conduct these types of reviews.
20. “Preauthorization” means a form of prospective utilization review conducted by Zenith or Zenith’s contracted URA of health care services proposed to be provided to an injured employee.
21. “Provider of Record” means the physician, doctor, or other Health Care Provider with primary responsibility for the health care services provided to or requested on behalf of an enrollee or the physician or other health care provider that has provided or has been requested to provide the health care services to the enrollee. The term includes a health care facility where health care services are provided on an inpatient or outpatient basis.
22. “Reasonable Opportunity” means at least one documented good faith attempt to contact the Provider of Record that provides an opportunity for the provider of record to discuss the services under review with the URA during normal business hours prior to issuing a prospective, concurrent, or retrospective utilization review adverse determination:
    - no less than one working day prior to issuing a prospective Utilization Review Adverse Determination;

- no less than five working days prior to issuing a Retrospective Utilization Review Adverse Determination; or
- prior to issuing a concurrent or post-stabilization review Adverse Determination.

23. “Requestor” means the Health Care Provider or designated representative, including office staff or a referral Health Care Provider/health care facility that requests Preauthorization, Concurrent Review, or voluntary certification.

24. “Retrospective Utilization Review” means a form of Utilization Review for health care services that have been provided to an injured employee. Retrospective Utilization Review does not include review of services for which prospective or concurrent Utilization Reviews were previously conducted or should have been previously conducted.

25. “Screening Criteria” means the Written policies, decision rules, medical protocols, or treatment guidelines used by a URA as part of the Utilization Review Process.

26. “The Act”, “The Texas Workers’ Compensation Act” and “The Workers’ Compensation Act” mean the Texas Workers’ Compensation Act found under Texas Code Title 5, Subtitle A. Chapter 401.

27. “Treatment Request” is a Written or oral request for a specific course of proposed medical treatment along with all supporting documentation. The term “Treatment Request”, as used in this Utilization Review Plan, is synonymous with a “Request for Authorization”. Time frames for responding to a Treatment Request do not begin to run until both the request and all supporting documentation is received by Zenith and Zenith has accepted compensability of the underlying claim.

28. "Utilization Review" means a system for prospective, Concurrent Review or retrospective review of the medical necessity and appropriateness of health care services and a system for prospective, concurrent, or retrospective review to determine the Experimental or Investigational nature of health care services. The term does not include a review in response to an elective request for clarification of coverage.

29. "Utilization Review Agent" or “URA” mean an entity that conducts Utilization Review for:

    - an employer with employees in this state who are covered under a health benefit plan or health insurance policy;
    - a payor; or
    - an administrator holding a certificate of authority under Texas Insurance Code, Chapter 4151.

30. “Utilization Review Plan” means the Screening Criteria and Utilization Review procedures of a Utilization Review Agent.

31. “Voluntary Certification” means a voluntary prospective or concurrent discussion between Zenith and a Health Care Provider to address health care treatment, treatment plans or pharmaceutical services to clarify the coverage of services. Zenith is liable for any services that are voluntarily certified and may not dispute the certified or agreed upon services at a later date.

32. “Written” means written communication, of a determination made in utilization review to the individuals specified and within the timeframes required for utilization review, delivered by mail.

33. “Zenith” means Zenith Insurance Management Services (ZIMS), Zenith Insurance Company and/or ZNAT Insurance Company. ZIMS will hold the Utilization Review Agent registration as a wholly owned subsidiary of Zenith Insurance Company.

Zenith Insurance Management Services
Utilization Review for Texas Managed Care and Non-Managed Care Business

Exhibit 1

Attachment A

I. Texas Utilization Review Plan Administrative Overview

Zenith Insurance Management Services (ZIMS) is a wholly owned subsidiary of Zenith Insurance Company (ZIC). ZIC utilizes ZIMS to provide various administrative services and utilization review to its customers.

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 Texas Utilization Review Agent, ZIMS has established and maintains this Utilization Review Plan and its Utilization Review Process compliant with Texas Insurance Code, Title 14 Utilization Review and Independent Review, et seq..

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

Material Plan Changes: Zenith will report any material change to the Plan information not later than the 30th day after the date the change takes effect pursuant to Tex. Ins. Code §4201.107.

Availability to Public: 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 $0.10 per page plus actual postage costs.

General Standards of Utilization Review: The Zenith Chief Medical Officer is responsible for the Utilization Review program and holds an unrestricted administrative license practice medicine in the State of Texas (See Exhibit "A" Designated Medical Director Information). The Chief Medical Officer has oversight responsibilities for all Zenith Utilization Review programs including review and approval of the Utilization Review Plan. The Chief Medical Officer does not provide health care services, perform medical Peer Review, or perform Utilization Review of medical benefits or issue or review requests for Adverse Determinations in the role as Chief Medical Officer on Texas claims. These services are performed by our Texas external URA vendors Genex Services (Genex Services) and Oristech.

Program Approval (28 TAC §19.2005(a)): Zenith's Utilization Review program and plan is approved by Zenith's Chief Medical Officer, who holds an unrestricted administrative license in the State of Texas (See Exhibit "A"). The program is conducted using standards developed and periodically updated with input from both primary and specialty care physicians, including practicing Health Care Providers as appropriate.

Special Circumstances (28 TAC §19.2005(b)): Zenith requires that Utilization Review determinations be made in a manner that takes special circumstances of the case into account that may require deviation from the norm stated in the Screening Criteria or relevant guidelines. Special circumstances include, but are not limited to, an individual who has a disability, acute

condition, or life-threatening illness. For the purposes of this section, disability must not be construed to mean an injured employee who is off work or receiving income benefits.

Screening Criteria for Utilization Review Process (Tex. Ins. Code § 4201.153 and 28 TAC 19.2005(c)): Zenith utilizes Screening Criteria that is evidence based, scientifically valid, outcome-focused, and that complies with the requirements in Insurance Code §4201.153. Zenith periodically reviews the Criteria used and other relevant data to help ensure 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 Chief Medical Officer and Zenith's Vice President or Assistant Vice President of Medical Management to evaluate internal processes, review outcomes and compliance with policies and procedures.

Zenith utilizes the Work Loss Data Institute's *Official Disability Guidelines – Treatment in Workers Comp* (ODG) as the treatment guidelines to be utilized for health care provided to both in-network and non-network claimants on or after May 1, 2007 pursuant to 28 TAC § 137.100. Utilizing strict principles of evidence based medicine, the ODG tool supports evidence based decisions for disability duration and medical treatment for workers' compensation injuries and illnesses. ODG provides expected length of disability for every reportable condition and provides for different levels of intervention. The intervention can range from a limited claims management role by an adjuster to active and hands on case management by a nurse case manager.

In addition, Zenith has adopted the most current edition of the American College of Occupational and Environmental Medicine (ACOEM) *Occupational Medicine Practice Guidelines* for use as a secondary guideline for network claimants. The ACOEM *Guidelines* represent established standards and practices in the management of occupational medicine. The goal for the use of the guidelines is to utilize the tool to aid prevention, evaluation and treatment of work-related injuries and conditions.

In the event that neither the ODG nor ACOEM provide a guideline for the treatment at issue, Zenith will apply other nationally recognized evidence based guidelines.

See Exhibit D for guideline listing.

Referral and Determination of Adverse Determinations (28 TAC 19.2005(d): Pursuant to 28 TAC §180 (relating to Monitoring and Enforcement) and 28 TAC §19.2006, Zenith requires that all Treatment Requests that cannot be approved be referred to and reviewed by a physician, doctor or other Health Care Provider with appropriate credentials. Only these provider types are permitted to issue an Adverse Determination. Pursuant to Labor Code §§408.0043, 408.0044, and 408.0045, Zenith requires that physicians performing Utilization Review hold a professional license or certification relating to the type of health care being requested for the injured employee. Therefore, Zenith requires that dental services be reviewed by a provider licensed to practice dentistry and chiropractic services be reviewed by a provider licensed to engage in the practice of chiropractic. However, if the service provided is one that can be rendered by a physician, then the review may be conducted by a licensed physician with appropriate credentials. Genex Services and Oristech have represented that all physicians are Texas licensed physicians and comply with 28 TAC Section 19.2005(d).

Complaint System (28 TAC 19.2005(f)): Zenith has developed and maintains a complaint system for resolution of oral and Written complaints initiated by injured employees, the injured employees representatives, or Health Care Providers concerning Utilization Review. Zenith maintains records of complaints for a minimum of three years from the date the complaints are filed. Zenith's complaint procedure includes a requirement that a Written response to the

complainant or their representative be sent within 30 calendar days of the date the complaint is received. The Written response must include the TDI's address, toll-free telephone number, and a statement explaining that the complainant is entitled to file a complaint with the TDI. Please see Exhibit C for additional information.

Expedited Provision of Medical Benefits for First Responders (28 TAC 19.2005(g)): Zenith Tex. Lab. Code § 504.055: Zenith will use expedited review processes for treatment of first responders as defined under Labor Code §504.055. In order to expedite treatment, emergency services, as with all emergency health services are provided without requiring preauthorization or Voluntary Certification. Zenith also accelerates and gives priority to an injured first responder's claim for medical benefits, including all health care required to cure or relieve the effects naturally resulting from a compensable injury described by Labor Code §504.055(b). As part of Utilization Review Process, if Zenith is unable to approve a Treatment Request and sends the request for review to its external reviewer, Zenith will notify the reviewing entity that the injured employee is a first responder and request that the review be expedited accordingly. If the injured employee disagrees with an Adverse Determination, Zenith will request expedited review of any appeal filed by the injured employee and again notify the reviewer that the injured employee is a first responder. This includes the appeal processes provided under Labor Code §504.053(d)(3) and §504.054. This process will help ensure that during each review and appeal stage, the applicable review entity will be aware that the injured employee is a first responder and expedite review and legal processes to the extent permitted by law.

II. Overview of Zenith's Texas Business Structure and Utilization Review Process

As previously noted, ZIMS provides administrative services for its customers. Services are provided for two blocks of business in Texas. The first block of business is comprised of employer groups that have elected to obtain workers compensation through the ZHCN managed care network arrangement. The second block of workers compensation business is for employer groups that opt not to provide services through a health care network. Utilization Review for both blocks of business will be conducted by ZIMS under URA Certification #2528257 and Zenith's URA vendor Genex Services, Texas under URA Certification #4904. ZIMS will perform first level review and if ZIMS cannot approve the treatment request, ZIMS will send the request to Genex Services. This means that all Adverse Determinations and physician level reviews will be made by Zenith's URA vendors, Genex Services and Oristech.

All Utilization Review personnel used by ZIMS and Genex Services must meet the requirements of 28 TAC §19.2006. This means that physicians, doctors, and other health care providers employed by or under contract with ZIMS or Genex Services to perform utilization review must be appropriately trained, qualified and licensed. Personnel conducting utilization review must hold an unrestricted license or an administrative license in Texas or be otherwise authorized to provide health care services in Texas. Physicians and doctors conducting utilization review must hold a professional certification in a health care specialty appropriate to the type of health care the injured employee is receiving as required by Labor Code §§408.0043, 408.0044, and 408.0045. Physicians, doctors, and other health care providers conducting utilization review must have the appropriate credentials as required by Chapter 180 of Title 28 of the TAC (relating to Monitoring and Enforcement).

ZIMS' Utilization Review personnel may conduct preliminary Utilization Review activities prior to sending the file to Genex Services; however, all denial decisions will be made by Genex Services.

There are occasions in which a file will be sent to a secondary Utilization Review vendor. Zenith uses Oristech, Texas Workers' Compensation URA Certification #5283, primarily for retrospective or bill review functions. Oristech is also frequently used when a physician is required to review images or films.

Zenith may delegate the Utilization Review to qualified personnel in a hospital or other health care facility in which the health care services to be reviewed were, or are, to be provided. The delegation does not relieve Zenith as the URA of full responsibility for compliance with Insurance Code Chapter 4201, the Texas Workers' Compensation Act, and applicable TDI-DWC rules, including responsibility for the conduct of those to whom Utilization Review has been delegated.

Zenith will not observe, participate in or otherwise be present during an injured worker's examination, treatment, procedure or therapy unless the treating provider has approved of the observation or participation. Nothing in this policy limits or prohibits Utilization Review personnel from contacting the injured worker for purposes of conducting Utilization Review and case management functions unless otherwise specifically prohibited by law.

Zenith shall process Treatment Requests related to Emergency Health Care Services in an expeditious manner, and ensure reviews are all processed in a uniform manner, in accordance with the following standards:

1. Neither Voluntary Certification nor Preauthorization is required for Emergency Health Care Services..
2. Documentation for Emergency Health Care Services shall be made available to Zenith upon request.

Zenith has appropriate personnel reasonably available by toll-free telephone at least 40 hours per week during normal business hours in both Central and Mountain Time, to discuss an injured employee's care and to respond to telephone review requests. Zenith has procedures in place that the URA will implement when responding to requests for:

1. Drugs that require Preauthorization, in situations in which the injured employee has received or is currently receiving the requested drugs and an Adverse Determination could lead to a Medical Emergency; and

2. Post-stabilization care and pain management medication immediately subsequent to surgery or emergency treatment, as requested by the treating physician or Provider of Record.

Pursuant to Tex. Lab. Code § 413.014(f) requests for Voluntary Certification are initially reviewed by ZIMS' internal medical management Utilization Review personnel. However, if ZIMS determines that Voluntary Certification cannot be approved, the Voluntary Certification request is sent to Genex Services or Oristech, whichever is appropriate, for review. ZIMS Utilization Review personnel is permitted only to authorize the Voluntary Certification of care, any denial or modification of care must be made by a Genex Services or Oristech physician. A template Voluntary Certification Letter is enclosed under Tab 16. All Utilization Review personnel is appropriately licensed pursuant to the requirements ofTexas Labor Code §§408.0043, 408.0044, and 408.0045. The Zenith Chief Medical Officer oversees the program but does not engage in actual Utilization Review. If a Medical Director level physician is required for the review process, Zenith utilizes, and will continue to utilize, providers through its contracted URA vendors who have doctors with the appropriate specialty and Texas licensing to perform the review. If Zenith ever decides to have its internal Chief Medical Officer engage in the Utilization Review decisions within Texas, the Chief Medical Officer will seek registration pursuant to Tex. Lab. Code § 408.023(e).

The ZHCN and non-network block of business both utilize a medical case management program. Details of the ZHCN medical case management program were previously filed as part of the ZHCN filing with the TDI and approved December 29, 2006. Components of the case management program, such as the utilization of evidence based medicine guidelines to determine appropriate delivery of health care will at times overlap with and be handled through the Utilization Review program. Both programs are operated in compliance with applicable Texas statutes, rules and regulations, including but not limited to Tex. Lab. Code § 504.055 that relate to the expedited provision of medical benefits to first responders employed by political subdivisions who sustain a serious bodily injury in course and scope of employment.

To enable efficient time tracking Zenith will (1) have appropriate personnel reasonably available, by toll-free telephone at least 40 hours per week during normal business hours set out above in Texas, to discuss patients' care and allow response to telephone review requests, (2) have a telephone system capable, during hours other than normal business hours, of accepting or recording incoming telephone calls or of providing instructions to a caller; and (3) respond to a call made during hours other than normal business hours not later than the second working day after the later of:

1. the date the call was received; or

2. the date the details necessary to respond have been received from the caller.

III. Utilization Review and Retrospective Review Description

Zenith has elected to implement a Preauthorization process as part of its medical Utilization Review Process and is compliant with the TDI Preauthorization requirements. This process is described in the provider network contracts and was communicated to all network providers prior to the commencement of network operations.

The Zenith Utilization Review Process is subject to legislative restrictions and time deadlines found in Texas Insurance Code §§1305.351-1305.355, Chapter 4201 and Texas Department of Insurance Rules §§10.100-10.104. Should any legislative or regulatory amendments change these statutes or rules; the Zenith Utilization Review Process will be amended and interpreted to conform with those changes. In the event of a conflict between Chapter 1305 and Chapter 4201, Chapter 1305 prevails.

The following detailed description sets forth the processes utilized by Zenith as part of its network operations.

Non-network claims and processes, while similar, are not identical to the processes set out below. Non-network processes comply with Tex. Lab. Code § 413.014 and Division Rule 28 TAC § 134.600.

Voluntary Certification of Services Tex. Lab. Code § 413.014(f)
Zenith allows providers to submit voluntary requests for Voluntary Certification of treatments. Under this process, Zenith employees that are Texas licensed registered nurses review the requests. Additionally, Zenith has a dedicated team of trained Claims Examiners who may assist the nurses in clerical and administrative requests. Claims Examiners do not perform any aspect of Utilization Review, in compliance with Texas Insurance Code, Title 14, Chapter 4201, Subchapter F. Nursing staff complete the evaluation of proposed or provided health care services to determine the medical necessity of such services as well as to evaluate the quality of the health care services provided to an injured worker, including evaluation of their efficiency, efficacy and appropriateness of treatment, hospitalization, or office visits or services based on medically accepted standards including ODG. In the event that Zenith determines that proposed or provided health care services are consistent with evidence based medical guidelines such as ODG, Zenith may Certify the services proposed or provided. In the event Zenith is unable to Certify the services proposed or provided Zenith will forward the request to the appropriate Zenith Utilization Review Agent, Genex Services or Oristech, for further review. Pursuant to Zenith policy, Zenith Utilization Review personnel are not permitted to deny or modify care as part of this review process. Denials and modifications of care must be made by a physician of either Genex Services or Oristech.

Preauthorization of Services Tex. Lab. Code § 413.014
Zenith utilizes Genex Services, Inc. – Texas URA 4904 and Oris Technologies, Inc. (Oristech) – Texas URA 5283, both Texas certified URAs, to support the Preauthorization process as part of its medical Utilization Review Process. This process is used when the proposed or provided health care services need to be evaluated for medical necessity of such services as well as to evaluate the quality of the health care services provided to an injured worker, including evaluation of their efficiency, efficacy and appropriateness of treatment, hospitalization, or office visits or services based on medically accepted standards. The evaluation of such services is conducted by a URA approved entity, Genex Services or Oristech. The majority of Utilization

Review activities are handled through Genex Services. Oristech is used primarily for retrospective or bill review functions and when physician review of images or films is required.

Utilization evaluations may include prospective review, second opinions, Concurrent Review, Peer Review, independent medical examinations, and Retrospective Review.

Attachment B

Mental Health Therapy TIC §4201.203 and 28 TAC §19.2007(d)

Zenith will not require, as a condition of treatment approval or for any other reason, the observation of a psychotherapy session or the submission or review of a mental health therapist's process or progress notes. However, Zenith may require submission of a patient's medical record summary as part of the Utilization Review and case management functions.

Attachment C

Notice of Utilization Review Determinations Tex. Ins. Code § 1305.353 and 28 TAC §19.2009(a)-(c)

The Zenith Utilization Review Agent shall notify the employee, employee representative and the requesting network provider in writing of a determination made in Utilization Review to the individuals specified and within the timeframes required for Utilization Review and in response to a request for Voluntary Certification or Preauthorization in accordance with Texas Insurance Code §1305.353. Zenith, or its designated review agent (Genex), will approve or deny requests for Preauthorization or Concurrent Review based solely upon the reasonable and necessary medical health care required to treat the injury, regardless of unresolved issues of compensability, extent of or relatedness to the compensable injury, the carrier's liability for the injury, or the fact that the employee has reached maximum medical improvement.

A Preauthorization determination is not required for any medical treatment or medical service that has been pre-certified in writing by Zenith under Tex. Lab. Code § 413.014 including treatment covered by a pre-certified Written treatment plan. Preauthorization determination from the ZHCN's Utilization Review Agent does not constitute a guarantee of payment by Zenith. Preauthorized treatment is subject to retrospective review by Zenith to determine if the medical treatment is causally related to the compensable injury. Preauthorized treatment is not subject to retrospective review by Zenith to determine if the treatment is medically necessary.

Zenith will ensure that Preauthorization numbers assigned comply with the data and format requirements contained in the standards adopted by the federal Department of Health and Human Services in 45 CFR s 162.1102 (relating to Standards for Health Care Claims or Equivalent Encounter Information Transaction), based on the type of service in the Preauthorization request.

Timelines for Determinations: Zenith requires that notices of favorable or Adverse Determinations be sent within the following timelines:

- **Concurrent Review** – Requests for Concurrent Review will be handled within the following timeframes:
    1. ZHCN Only If the proposed services are for concurrent hospitalization care, the person performing Utilization Review must, within 24 hours of receipt of the request, transmit a determination indicating whether the proposed services are preauthorized per 28 TAC §10.102.(e).
    2. Non-ZHCN – Zenith shall contact the requestor or Injured Employee by telephone, facsimile, or electronic transmission with the decision to approve the request; issue an adverse determination on a request; or deny a request under 28 TAC 134.600(g) because of an unrelated injury or diagnosis within three working days of receipt of a request of a request for Concurrent Review, except for a request for extension of a previously approved inpatient length of stay under 28 TAC 134.600(q)(1), which is due within one working day of the receipt of the request.

- **Post-Stabilization or Life Threatening Conditions** ZHCN Only - If the proposed health care services involve post-stabilization treatment or a life-threatening condition, the person performing Utilization Review must transmit to the requesting provider a determination indicating whether the proposed services are preauthorized within the time appropriate to the circumstances relating to the delivery of the services and the condition

of the patient, not to exceed one hour from receipt of the request pursuant to 28 TAC §10.102.(f).

If the Utilization Review Agent issues an Adverse Determination in response to a request for post-stabilization treatment or a request for treatment involving a life-threatening condition, the Utilization Review Agent shall provide to the employee or the employee's representative, if any, and the employee's treating provider pursuant to 28 TAC §10.102(b) and (c).

For life-threatening conditions, the notification of Adverse Determination will include notification of the availability of independent review in the form prescribed by the commissioner of TDI. The notice must describe how to obtain independent review of the Adverse Determination and how TDI assigns a request for independent review to an IRO.

- **Emergency Health Care Services** - Treatments and services for an Emergency Health Care Services do not require Preauthorization. **Preauthorization** - For all other services requiring Preauthorization, Zenith will issue and transmit the Preauthorization determination not later than the third working day following the receipt of the request pursuant to Texas Insurance Code §1305.353 and 28 TAC §10.102.(g) for ZHCN claims and 28 TAC §134.600(i) for non-network claims.

- **Retrospective Review – ZHCN (28 TAC §§133.240, 133.250 and 10.102) and Non-Network (28 TAC §§133.240 and 133.250) –** Zenith will provide a Retrospective Review determination within a reasonable period, but not later than 30 days from the earliest of the date the request for Retrospective Review was received or the date a bill was received that was subject to Retrospective Review. Zenith may extend the review period one time for a period not to exceed 15 days for a total review period not to exceed 45 days from the date the bill or request for Retrospective Review was received if Zenith:

    1. determines that an extension is necessary due to matters beyond the utilization review agent's control; **and**
    2. notifies the provider of record and the patient before the expiration of the initial 30-day period of the circumstances requiring the extension and the date by which the utilization review agent expects to make a determination.

  If the extension is required because of the failure of the provider of record or the injured employee to submit information necessary to reach a determination on the request, the notice of extension must:

    1. specifically describe the required information necessary to complete the request; and
    2. give the provider of record and the patient at least 45 days from the date of receipt of the notice of extension to provide the specified information.

  If no Retrospective Review is required, Zenith will take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill no later than the 45th day after the date Zenith received the complete medical bill. The deadline to make or deny payment on a bill will not be extended as a result of any pending request for additional documentation. Requests for additional documentation, in accordance with 28 TAC §133.210 (relating to Medical Documentation), will be made no later than the 45th day after receipt of the medical bill to clarify the Health Care Provider's charges. Zenith

may decrease the documentation requirements of 28 TAC §133.210 for treatment provided through the ZHCN.

An explanation of benefits (EOB) shall be provided either electronically or via paper format for all items included in a reconsideration request in the form and format prescribed by the division when there is a change in the original, final action; or when there is no change in the original, final action. Electronic versions of the EOB will contain all elements required by §133.500 and §133.501. Paper versions of the EOB will include all elements required by 28 TAC § 133.240 (f).

Zenith will not retrospectively review and deny medical treatment based on medical necessity if the treatment is provided to an injured employee whose claim is not part of the ZHCN and the treatment was preauthorized or voluntarily certified under 28 TAC §134. Additionally, pharmaceutical services provided to any injured employee, will not be denied based on medical necessity if the service was preauthorized or agreed to under 28 TAC 134(F).

Adverse Determination Notice Requirements: Zenith requires that Utilization Review decisions be issued in writing to the requesting provider with a copy to the injured employee and the injured employee's representative, if any. Zenith does not conduct internal reviews for Adverse Determination. Zenith reviews the Treatment Request and if Zenith cannot approve the determination, Zenith sends the request to its designated URA, Genex Services, LLC ("Genex"), for review by a physician. Zenith requires that Genex comply with all regulatory and legal requirements, including but not limited to notification letters. All prospective, concurrent, and Retrospective Review and Reconsideration Adverse Determination notice letters for both ZHCN and non-network claims must include the following:

1. the principal reasons for the Adverse Determination;
2. the clinical basis for the Adverse Determination;
3. a description of the procedure for filing a complaint with TDI;
4. the professional specialty and Texas license number of the physician, doctor, or other Health Care Provider that made the Adverse Determination;
5. a description of the Zenith's appeal process, required by 28 TAC §19.2011 (relating to Written Procedures for Appeal of Adverse Determination). Notice that in the event an injured employee has a life-threatening condition, the injured employee is entitled to an immediate review of the Adverse Determination by an IRO and is not required to comply with procedures for an internal review of the Adverse Determination by Zenith for prospective and concurrent Utilization Review;
6. for Zenith Health Care Network claims, a description or the source of the Screening Criteria used in making the determination, including a description of treatment guidelines used, as applicable;
7. for Zenith's non-network claims, a description of treatment guidelines used under 28 TAC Chapter 137 (relating to Disability Management) or Labor Code §504.054(b) in making a determination; and
8. notice of the of the right to seek review of the Adverse Determination by an IRO under 28 TAC §19.2017 by filing a request for IRO no later than 45 calendar days after the date of denial of a request for reconsideration;
9. Notice of the independent review process and the notice will either include a copy of the required IRO form or include notice in at least 12 point font that the injured employee can obtain a copy of the request for review by and IRO form by:
    a. Accessing the TDI's website at www.tdi.texas.gov/forms; or
    b. Calling Zenith at 1-800-841-5020 to request a copy of the IRO form, at which time, Zenith will send a copy of the IRO request form to the injured employee, their representative or the Health Care Provider;

10. notice of the right and procedures to file a complaint with Zenith or with the TDI including the TDI's address, and toll-free telephone number pursuant to 28 TAC §19.2005(f) (relating to General Standards of Utilization Review).

Zenith combines both the Utilization Review determination and the peer review report required by 28 TAC 180.28 into one decision letter that meets all requirements of 28 TAC 180.28, 28 TAC § 134.600 and 28 TAC §19.2009.

Zenith will send a copy of the Utilization Review determination letter to the injured employee and/or their representative and Requestor, if not previously sent by facsimile or electronic transmission within one working day of the date of the decision.

Notices for Concurrent Hospital Care and Life Threatening Conditions: If the proposed services are for concurrent hospitalization care, Zenith shall, within 24 hours of receipt of the request, transmit a determination indicating whether the proposed services are preauthorized. In cases of a life threatening condition, the Zenith shall transmit to the requesting provider a determination indicating whether the proposed services are preauthorized within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, not to exceed one hour from receipt of the request. If the Utilization Review agent issues an Adverse Determination in response to a request for post stabilization treatment or a request for treatment involving a life-threatening condition, the Utilization Review agent shall provide to the employee or the employee's representative, if any, and the employee's treating provider the required notification mentioned above.

For life-threatening conditions, the notification of Adverse Determination must include notification of the availability of independent review in the form prescribed by the commissioner.

Treatments and services for an emergency do not require preauthorization.

Services Requiring Preauthorization are met.
Zenith requires Preauthorization for services listed on the Zenith Health Care Network and Non-Network – Services Requiring Preauthorization list included as Exhibit "G".

Services Requiring Concurrent Review 28 TAC § 134.600
The health care requiring Concurrent Review for an extension for previously preauthorized or pre-certified services includes:

(1) inpatient length of stay;
(2) all work hardening or work conditioning services;
(3) physical and occupational therapy services as referenced in subsection (p)(5) of this section;
(4) Investigational or Experimental services or use of devices;
(5) chronic pain management/interdisciplinary pain rehabilitation; and
(6) required treatment plans.

Attachment D

Requirements Prior to Issuing Adverse Determination 28 TAC § 19.2010

In any instance in which a Zenith is questioning the medical necessity or appropriateness of the health care services prior to issuance of an Adverse Determination, Pursuant to 28 TAC §19.2003(b)(28), Zenith must afford the Provider of Record a Reasonable Opportunity to discuss the plan of treatment for the injured employee with a physician. At least one documented good faith attempt to contact the provider of record must be made that provides an opportunity for the provider of record to discuss the services under review. This contact must be made during normal business hours prior to issuing a prospective, concurrent, or retrospective utilization review adverse determination. The discussion must include, at a minimum, the clinical basis for the decision and a description of documentation or evidence, if any, that can be submitted by the Provider of Record that, upon appeal, might lead to a different Utilization Review decision. The contact must be made no less than:

1. one working day prior to issuing a prospective utilization review adverse determination;
2. no less than five working days prior to issuing a retrospective utilization review adverse determination; or
3. prior to issuing a concurrent or post-stabilization review adverse determination.

When leaving a message or making contact, Zenith must provide the URA's telephone number so that the Provider of Record may contact the URA to discuss the pending Adverse Determination. Zenith must maintain, and submit to TDI or TDI-DWC upon request, documentation that details the discussion opportunity provided to the Provider of Record, including the date and time the URA offered the Reasonable Opportunity to discuss the Adverse Determination, the date and time that the discussion, if any, took place, and the discussion outcome.

Reconsideration of Adverse Determination Tex. Ins. Code § 1305.354

The network provider, the employee, or a person acting on behalf of the employee may request, either orally or in writing, that the network Utilization Review Agent reconsider the denial of Preauthorization or Concurrent Review services not later than the 30th day of the date of the issuance of the Written Adverse Determination.

Not later than the 5th calendar day after receipt of the request for timeframes, the network Utilization Review Agent will send a letter to the requesting party acknowledging the date of the receipt of the request that includes a list of the documents the requesting party is required to submit, if any.

Appeal decisions must be made by a physician, dentist, or chiropractor who has not previously reviewed the case, as required by 28 TAC 180 (relating to Monitoring and Enforcement); Insurance Code §1305.354; and 28 TAC §10.103 (relating to Reconsideration of Adverse Determination). If the health care services in question are dental services, then a dentist may make the appeal decision if the services in question are within the scope of the dentist's license to practice dentistry. If the health care services in question are chiropractic services, then a chiropractor may make the appeal decision if the services in question are within the scope of the chiropractor's license to practice chiropractic. Zenith will issue Written notification to the requesting party of the determination of the request for reconsideration as soon as practicable but, in no event, later than the 30th after Zenith received the request.

If the denial of proposed health care services involves post-stabilization treatment or denials of continued days of hospitalization, the review for the request for reconsideration will be performed by a provider who did not issue the initial Adverse Determination and who is of the same or similar specialty as a provider who typically manages the condition, procedure or condition under review. The review for the request for reconsideration will be completed within the time required by the medical or clinical immediacy of the medical condition, treatment or procedure under review but not to exceed one calendar day from the date of receipt of the information necessary to complete the reconsideration.

If the appeal is denied (i.e. Zenith continues to deny the services or treatment previously described) or the employee has a life-threatening condition or an interlocutory order, the employee, the employee's representative and the provider of record shall be notified that they have the right to request a review by an IRO. Zenith will provide a Notice of Determination describing the independent review process and the right to request an IRO review. The Notice of Determination letter will include notice that a request for independent review must be made no later than the 45th calendar day after receipt of the denial of the appeal. The notice letter will also include all elements required under the **Adverse Determination Notice Requirements** section of this Utilization Review Plan.

Review of Adverse Determination for Life Threatening Condition and Medical Interlocutory Orders: Pursuant to 28 TAC 19.2009 (a)(2), if the employee has a life-threatening condition, or the request involves a medical interlocutory order, the employee, his/her representative and his/her provider of record can request an immediate review by an independent review organization (IRO) and are not required to follow Zenith's customary internal appeal procedures which include the following: If the appeal relates to preauthorization or concurrent denials, the Requestor must send us the appeal no later than the 30th day after the date of issuance of the Written notification of the Adverse Determination and if the appeal relates to a denial of a claim (retrospective denial after services rendered), the Requestor must send us the appeal no later than 10 months from the date of service.

Resubmission of Request for Preauthorization 28 TAC § 134.600

A request for Preauthorization for the same health care shall only be resubmitted when the Requestor provides objective clinical documentation to support a substantial change in the injured employee's medical condition or that demonstrates that the injured employee has met clinical prerequisites for the requested health care that had not been previously met before submission of the previous request. The insurance carrier shall review the documentation and determine if any substantial change in the injured employee's medical condition has occurred or if all necessary clinical prerequisites have been met.

Attachment E

Independent Review of Adverse Determination – Network and Non-Network 28 TAC § 19.2017, 28 TAC § 133.308 & 28 TAC § 10.104

A request for a review of an Adverse Determination may be appealed to an IRO. To begin the independent review process, the requesting network provider, non-network provider, employee or a person acting on behalf of the employee may seek review of the Adverse Determination by completing a TDI Form LHL009 and returning it to the insurance carrier or URA that made the Adverse Determination. The IRO request form may be obtained from the TDI at the department's website at: http://www.tdi.texas.gov; or from the Managed Care Quality Assurance Office, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, TX 78714-9104.

Time for Submission of IRO: IRO requests for both ZHCN and non-network claims must be submitted on the appropriate form no later than 45 calendar days after receipt of the denial of an appeal.

Zenith must notify the TDI of the request for IRO within one working day from the date the request was received by Zenith or its designated URA. In a Preauthorization or Concurrent review dispute request, an injured employee with a life threatening condition, as defined in 28 TAC §133.305 (related to MDR-General), is entitled to an immediate review by an IRO and is not required to comply with the procedures for appeal to Zenith. "Life-threatening" means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. An injured worker, the injured workers' representative or the injured worker's Provider of Record is required to determine the existence of a life-threatening condition on the basis that a prudent layperson possessing an average knowledge of medicine and health would believe that the injured worker's disease or condition is a life-threatening condition.

Request for IRO ZHCN Claims –The request for IRO on a ZHCN claim may be submitted by:

1. Health Care Providers, or qualified pharmacy processing agents acting on behalf of a pharmacy, as described in Labor Code § 413.0111, for Preauthorization, concurrent, and retrospective medical necessity dispute resolution;
2. injured employees or injured employee's representative for Preauthorization and concurrent medical necessity dispute resolution; and, for retrospective medical necessity dispute resolution when reimbursement was denied for health care paid by the injured employee;
3. subclaimants in accordance with 28 TAC §140.6 (relating to Subclaimant Status: Establishment, Rights, and Procedures), 28 TAC §140.7 (relating to Health Care Insurer Reimbursement under Labor Code § 409.0091), or 28 TAC §140.8 (relating to Procedures for Health Care Insurers to Pursue Reimbursement of Medical Benefits under Labor Code § 409.0091), as applicable.

Fees for an IRO related to a medical necessity dispute for health care provided by the ZHCN will be paid by Zenith. Zenith must remit payment to the assigned IRO within 15 days after receipt of an invoice from the IRO.

Request for IRO Non-network Claims – The request for IRO on a non-network claim may be submitted by:

a) Health Care Providers, or qualified pharmacy processing agents acting on behalf of a pharmacy, as described in Labor Code §413.0111, for Preauthorization, concurrent, and retrospective medical necessity dispute resolution;

b) injured employees or a person acting on behalf of an injured employee for Preauthorization, concurrent, and retrospective medical necessity dispute resolution; and
c) subclaimants in accordance with 28 TAC §§ 140.6, 140.7, or 140.8, as applicable.

Fees an IRO on a non-network claim will be paid as follows:

1. in a Preauthorization or Concurrent Review medical necessity dispute or retrospective medical necessity dispute resolution when reimbursement was denied for health care paid by the injured employee, the Zenith shall remit payment to the assigned IRO within 15 days after receipt of an invoice from the IRO.
2. in a retrospective medical necessity dispute, the Requestor must remit payment to the assigned IRO within 15 days after receipt of an invoice from the IRO. If the IRO fee has not been received within 15 days of the Requestor's receipt of the invoice, the IRO shall notify the department and the department shall dismiss the dispute with prejudice.

   After an IRO decision is rendered, the IRO fee must be paid or refunded by the nonprevailing party as determined by the IRO in its decision. The fee must be paid or refunded not later than 15 days regardless of whether an appeal of the IRO decision has been or will be filed.

For independent review involving life threatening and non-life threatening conditions, a URA is required to notify TDI within one working day from the date a request for an independent review is received. The URA must submit the completed Form No. LHL009 to TDI through TDI's internet website.

Within one working day of receipt of a complete request for independent review, TDI will randomly assign an IRO to conduct the independent review and notify the URA, payor, the IRO, injured worker or injured worker's representative, injured worker's Provider of Record and any other providers listed by the URA as having records relevant to the review of the assignment.

The review request shall be assigned to an IRO by the TDI in accordance with Texas Insurance Code Chapter 4202 and TDI commissioner rules. Zenith shall pay for the independent review in compliance with the requirements set forth under 28 TAC §133.308(r).

Time Frame For Response by URA/Carrier to the IRO: Zenith shall provide to the appropriate IRO documentation not later than the third business day after the date that Zenith receives the notification of the assignment of the request to an IRO. When sending medical information to the IRO, Zenith will submit the forms prescribed by the TDI for requesting IRO review, such as the IRO request form (LHL009) and the online form filed by Zenith. The documentation sent to the IRO will also include:

(1) the forms prescribed by the department for requesting IRO review;
(2) all medical records of the injured employee in the possession of Zenith or its URA that are relevant to the review, including any medical records used by Zenith or the URA in making the determinations to be reviewed by the IRO;
(3) all documents, including guidelines, policies, protocols and Criteria used by Zenith or its URA in making the decision;
(4) all documentation and Written information submitted to Zenith in support of the appeal;
(5) the Written notification of the initial Adverse Determination and the Written Adverse Determination of the appeal to Zenith or its URA; and
(6) any other information required by the department related to the request from

Zenith for the assignment of an IRO.

Network Appeal Procedures 28 TAC § 10.104: A party to a medical necessity dispute may seek judicial review of a dismissal or the IRO decision as provided in Insurance Code § 1305.355 and 28 TAC § 10.104 (relating to Workers' Compensation Healthcare Networks).

a) When Zenith denies a referral request because the referral is not medically necessary, or denies a request for deviation from treatment guidelines, individual treatment protocols or Screening Criteria, Zenith must:

(1) permit the employee, a person acting on behalf of the employee, or the employee's requesting provider to seek review of the referral denial or reconsideration denial within the period prescribed by subsection (b) of this section by an IRO assigned in accordance with *Insurance Code Article 21.58C* and commissioner rules; and

(2) provide to the appropriate IRO, not later than the third business day after the date the person receives notification of the assignment of the request to an IRO:

(A) any medical records of the employee that are relevant to the review;
(B) any documents, including treatment guidelines, used by the person in making the determination;
(C) the response letter described by Insurance Code §1305.354(a)(4) and §10.103(a)(4) of this subchapter (relating to Reconsideration of Adverse Determination);
(D) any documentation and Written information submitted in support of the request for reconsideration; and
(E) a list of the providers who provided care to the employee and who may have medical records relevant to the review.

b) A Requestor must timely file a request for independent review as follows:

(1) for a request regarding Preauthorization or Concurrent Review, not later than the 45th day after the date of denial of a reconsideration; or

(2) for a request regarding retrospective medical necessity review, not later than the 45th day after the denial of reconsideration.

c) Zenith must pay for the independent review within 15 days after receipt of an invoice from the IRO. [28 TAC §133.308(r)(1)].
d) The department shall assign the review request to an IRO.
e) At a minimum, the decision of the IRO must include the elements listed and the certification required under *Labor Code § 413.032*.
f) After an IRO's review and decision under this section, a party to a medical dispute that disputes the decision may seek judicial review of the decision. The division of workers' compensation and the department are not considered to be parties to the medical dispute.
g) A decision of an IRO related to a request for Preauthorization or Concurrent Review is binding. The carrier is liable for health care during the pendency of any appeal, and the carrier and network shall comply with the decision.
h) If judicial review is not sought under this section, the carrier and network shall comply with the IRO's decision.

Time Frame for IRO Decision: The IRO will render a decision as follows:

a) for life-threatening conditions, no later than eight days after the IRO receipt of the dispute;

b) for Preauthorization and concurrent medical necessity disputes, no later than the 20th day after the IRO receipt of the dispute;
c) for retrospective medical necessity disputes, no later than the 30th day after the IRO receipt of the IRO fee; and
d) if a designated doctor examination has been requested by the IRO, the above time frames begin on the date of the IRO receipt of the designated doctor report.

After an IRO's review and decision under this section, a party to a medical dispute that disputes the decision may seek judicial review of the decision. The division of workers' compensation and the department are not considered to be parties to the medical dispute. 28 TAC §10.104 (f)

A decision of an IRO related to a request for Preauthorization or Concurrent Review is binding. Zenith is liable for health care during the pendency of any appeal, and Zenith and the network shall comply with the decision. 28 TAC §10.104 (g)

If judicial review is not sought under 28 TAC §10.104 (h), Zenith and the network shall comply with the IRO's decision.

Non-Network Appeal Procedures 28 TAC § 133.308: A decision issued by an IRO is not considered an agency decision and neither the department nor the division is considered a party to an appeal. In a division Contested Case Hearing (CCH), the party appealing the IRO decision has the burden of overcoming the decision issued by an IRO by a preponderance of evidence based medical evidence. A party to a medical necessity dispute may seek review of a dismissal or decision as follows:

A party to a medical necessity dispute may appeal the IRO decision by requesting a division CCH conducted by a division hearing officer. A benefit review conference is not a prerequisite to a division CCH under this subsection.

(A) The Written appeal must be filed with the division's Chief Clerk of Proceedings no later than the later of the 20th day after the effective date of this section or 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the division. Requests that are timely submitted to a division location other than the division's Chief Clerk of Proceedings, such as a local field office of the division, will be considered timely filed and forwarded to the Chief Clerk of Proceedings for processing; however, this may result in a delay in the processing of the request.

(B) The party appealing the IRO decision shall send a copy of its Written request for a hearing to all other parties involved in the dispute. The IRO is not required to participate in the division CCH or any appeal.

(C) Except as otherwise provided in this section, a division CCH shall be conducted in accordance with Chapters 140 and 142 of this title (relating to Dispute Resolution--General Provisions and Dispute Resolution—Benefit Contested Case Hearing).

(D) At a division CCH, the hearing officer shall consider the treatment guidelines: (i) adopted by the network under Insurance Code § 1305.304, for a network dispute; (ii) adopted by the division under Labor Code § 413.011(e) for a non-network dispute; or (iii) adopted, if any, by the political subdivision or pool that provides medical benefits under Labor Code § 504.053(b)(2) if those treatment guidelines meet the standards provided by Labor Code § 413.011(e).

(E) Prior to a division CCH, a party may submit a request for a letter of clarification by the IRO to the division's Chief Clerk of Proceedings. A copy of the request for a letter of clarification must be provided to all parties involved in the dispute at the time it is submitted to the division.

(i) A party's request for a letter of clarification must be submitted to the division no later than 10 days before the date set for hearing. The (F) A party to a medical necessity dispute who has exhausted all administrative remedies may seek judicial review of the Division's decision. Judicial review under this paragraph shall be conducted in the manner provided for judicial review of contested cases under Chapter 2001, Subchapter G Government Code. A decision becomes final and appealable when issued by a Division hearing officer. If a party to a medical necessity dispute files a petition for judicial review of the Division's decision, the party shall, at the time the petition is filed with the district court, send a copy of the petition for judicial review to the Division's Chief Clerk. The Division and the Department are not considered to be parties to the medical necessity dispute pursuant to Labor Code §§ 413.031(k-2) and 413.0311(e).

(F) A party to a medical necessity dispute who has exhausted all administrative remedies may seek judicial review of the division's decision. Judicial review under this paragraph shall be conducted in the manner provided for judicial review of contested cases under Chapter 2001, Subchapter G Government Code, and is governed by the substantial evidence rule. The party seeking judicial review under this section must file suit not later than the 45th day after the date on which the division mailed the party the decision of the hearing officer. The mailing date is considered to be the fifth day after the date the decision of the hearing officer was filed with the division. A decision becomes final and appealable when issued by a division-hearing officer. If a party to a medical necessity dispute files a petition for judicial review of the division's decision, the party shall, at the time the petition is filed with the district court, send a copy of the petition for judicial review to the division's Chief Clerk of Proceedings. The division and the department are not considered to be parties to the medical necessity dispute pursuant to Labor Code § 413.031(k-2) and § 413.0311(e). If a party to a medical necessity dispute properly requests review of an IRO decision, the IRO, upon request, shall provide a record of the review and submit it to the Requestor within 15 days of the request.

Retrospective Review of Medical Treatment- Texas Insurance Code Chapter 1305 and Chapter 4201, §4201.305

All medical care performed that is not life-threatening, subject to Preauthorization, Concurrent Review, or has not been pre-certified by Zenith is subject to retrospective review for medical necessity and relatedness to the compensable injury. Retrospective Utilization Review shall be conducted in compliance with Texas Insurance Code Chapter 1305 and Chapter 4201, §4201.305. Written notice of determinations must be sent within the time frames specified by Section 133.240 and §10.102. Screening Criteria for Retrospective Utilization Review will be consistent with the network adoption of the most current edition of the *Official Disability Guideline* (ODG) as the primary treatment guideline and the adoption of the most current edition of the American College of Occupational and Environmental Medicine (ACOEM) *Occupational Medicine Practice Guidelines* as the secondary treatment guideline. Pursuant to Section III(16) above, treatment outside the range of treatments recommended by the adopted treatment guidelines must be preauthorized by the network Utilization Review Agent or pre-certified in writing by Zenith prior to being performed. Adverse retrospective review determinations based on medical necessity are subject to medical dispute resolution under TDI Division Rule §133.308. Adverse retrospective review determinations based on relatedness to the compensable injury are subject to benefit dispute resolution under TDI Division Chapters 141-143.

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 to Zenith's Privacy and Security Officer immediately, but no later than 24 hours of knowledge of the potential breach.

Disclosure of Information
Zenith will not disclose individual medical records, personal information, or other confidential information about a patient obtained in the performance of Utilization Review without the patient's prior Written consent or except as otherwise required by law.
(b) If the prior Written consent is submitted by anyone other than the patient who is the subject of the personal or confidential information requested, the consent must:
(1) be dated; and
(2) contain the patient's signature.
The patient's signature must have been obtained one year or less before the date, the disclosure is sought or the consent will be deemed invalid.

Providing Information To Affiliated Entities
Zenith may provide confidential information to a third party who has contracted with Zenith to perform or assist with Utilization Review on behalf of Zenith. Information provided to a third party under this section remains confidential.

Providing Information To Commissioner.
Zenith will provide to the commissioner on request individual medical records or other confidential information to enable the commissioner to determine compliance with Texas utilization law, rules and regulations. The information provided to the commissioner is confidential and privileged and is not subject to Chapter 552, Government Code, or to subpoena, except to the extent necessary to enable the commissioner to enforce the law.

EXHIBIT A

DESIGNATED MEDICAL DIRECTOR INFORMATION

On file with the state. Please contact the assigned claims examiner or Zenith toll free at 800-440-5020 if you would like to speak with our Designated Medical Director.

EXHIBIT 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.

EXHIBIT C

COMPLAINT POLICY AND PROCEDURE

It is the policy of the Zenith Health Care Network (ZHCN) to ensure all complaints are documented in the Texas Complaint Log **(A1),** forwarded to the appropriate department, and resolved in a consistent and timely manner in compliance with applicable law.

Complainants are entitled to file a complaint with Texas Department of Insurance (TDI). The ZHCN will not engage in any retaliation against a Complainant who has filed a complaint.

All ZHCN providers are required to post a notice in their office regarding the Network's process for resolving complaints. The Notice shall include TDI's telephone number for filing complaints, (800) 252-3439.

Complaints will be received and responded to as follows:

1. Complaints relating to the ZHCN providers shall be forwarded for investigation and resolution to Coventry. Complaints will be subject to the complaint system of Coventry, which shall be implemented and maintained in accordance with TIC §§1305.401 – 1304.405 and 28 Tex. Admin. Code §10.120. The ZHCN hereby adopts the policy and procedures utilized by Coventry for complaint review and resolution.
2. All complaints regarding delivery of care, eligibility issues, compensability questions, payment issues, return to work, Utilization Review services, and case management services will be reviewed and responded to by the ZHCN, as applicable. All issues will be resolved in accordance with the Workers' Compensation Act and other applicable statutory and regulatory requirements.

SCOPE:
This ZHCN policy applies to ZIMS, Zenith Insurance Company, ZNAT Insurance Company (collectively Zenith) and their customers, as applicable. The ZHCN has adopted Coventry's complaint policy as it relates to complaints for Complaints received by Zenith. Complaints relating to the ZHCN shall be forwarded for investigation and resolution to the complaint system of Coventry, which shall be implemented and maintained in accordance with TIC §§1305.401 – 1304.405 and 28 Tex. Admin. Code §10.120.

All complaints regarding delivery of care, eligibility issues, compensability questions, payment issues, return to work, Utilization Review services, and case management services will be handled by Zenith or its customer, as applicable. Issues will be resolved in accordance with the Workers' Compensation Act and other applicable statutory and regulatory requirements.

PROCESS:
Complaints may be initiated by an injured employee, their representative or Health Care Provider. All Written and verbal complaints will be processed, documented and acknowledged in writing within 7 calendar days. **(A2).** All complaints will be resolved in 30 calendar days **(A3).** All service area issues will be resolved within 7 calendar days.

DEFINITION:
A complaint is any dissatisfaction expressed orally or in writing by a complainant to a Network regarding any aspect of the Network's operation, including dissatisfaction relating to medical fee disputes and the Network's administration and the manner in which a service is provided. The term does not include:

(A) a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the complainant; or
(B) an oral or Written expression of dissatisfaction or disagreement with an Adverse Determination.

PROCEDURE:
All complaints must be submitted to the address specified in the Notice of Network Requirements.

1. If an oral or Written complaint is received, all substantive information relevant to the complaint will be entered into a Texas Complaint Log (TXCL) and assigned a reference number as outlined by the rows of the TXCL. The row number will be preceded by the letters TXCL when referenced.
2. No later than the 7th calendar day after the date on which the complaint was received, the ZHCNwill respond to the complainant, to acknowledge the date of receipt of the complaint and provide a description of the ZHCN complaint procedures and deadlines.
3. Once the complaint is recorded, appropriate steps and action will be taken to ensure the complaint is researched and if needed forwarded to the appropriate department for proper and timely follow-up.
4. Full investigation of the complaint, including any aspect of clinical care, will be completed
5. Within 30 calendar days, the ZHCN will follow up in writing to the complainant. This Written response shall include TDI's address, toll-free telephone number, and a statement explaining that a complainant is entitled to file a complaint with TDI.
6. Upon resolution, Written notification will be made to the appropriate party including the resolution of the complaint, the specific reasons for the resolution, the specialization of any Health Care Provider consulted; and if the complainant is dissatisfied with the resolution of the complaint or the complaint process, the complainant will be advised that they may file a complaint with the department as described in Texas administrative code chapter 10.122.
7. All Written responses and all original documentation will be maintained for a minimum of three years.
8. All findings and resolution on complaint will be documented and tracked in the Texas Complaint Log.
9. Complaints are defined in the following categories:
    - Quality of care or services
    - Accessibility and availability of services or providers
    - Utilization Review and retrospective review, as applicable
    - Complaint procedures
    - Health Care Provider contracts
    - Bill payment
    - Fee disputes
    - Miscellaneous
10. If requested, the ZHCN will provide a copy of the Complaint File and any proceeding related to the complaint to the Complainant and commissioner in the form specified by the commissioner.

EXHIBIT D

ZENITH TEXAS UTILIZATION REVIEW GUIDELINES

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

Non-Network – Zenith uses the *Official Disability Guidelines - Treatment in Workers' Comp*, excluding the return to work pathways, (ODG), published by Work Loss Data Institute (Division treatment guidelines) – pursuant to 28 TAC §137.100

Network – Zenith uses:

1. the *Official Disability Guidelines - Treatment in Workers' Comp*, excluding the return to work pathways, (ODG), published by Work Loss Data Institute (Division treatment guidelines)
2. American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, Second Edition – Workloss Data Institute – evidence based medicine (ACOEM) or
3. other applicable evidence based medicine guidelines where appropriate.

EXHIBIT E

THIRD PARTY UTILIZATION REVIEW ORGANIZATION

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

Genex Services, LLC
Full information on file with state but omitted from public version to avoid misdirection of treatment requests.

EXHIBIT F

UTILIZATION REVIEW LETTERS

(Letters are submitted with the Plan as Exhibit “F” but not attached to the Plan due to volume.)

EXHIBIT G

PREAUTHORIZATION LIST

See Exhibit “G”