Zenith Insurance Management Services, Inc., dba Zenith Claims Solutions

21255 Califa Street
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North Carolina
Utilization Review Plan
11/01/2026

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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" or "ACOEM" means the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, Second Edition – Workloss Data Institute – evidence based medicine.
2. "Authorization" means assurance that appropriate reimbursement will be made for an approved or authorized specific course of proposed medical treatment to cure or relieve the effects of the industrial.
3. "Certify" means to approve services under the injured workers plan of coverage.
4. "Claims Administrator" means the entity responsible for day-to-day administration of claims on behalf of itself, or other entities including sister companies, other carriers, self-insured entities, or other entities for which services have been arranged by contract. The Claims Administrator may utilize an entity contracted to conduct its utilization review responsibilities.
5. "Claims Examiner" means staff employed by Zenith to process claims.
6. "Criteria" as defined by Zenith means the use of the Official Disability Guidelines, 13th Edition, ACOEM Practice Guidelines and/or other evidenced base medicine guidelines to evaluate Treatment Requests.
7. "Deny" "Adverse Determination" or "Non-Certify" means a decision by a Physician Reviewer that the requested treatment or service is not Medically Necessary.
8. "DWC" means the North Carolina Division of Workers' Compensation.
9. "Emergency Medical Condition" means an industrial injury or illness manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:
    a. Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
    b. Serious impairment to bodily functions.
    c. Serious dysfunction of any bodily organ or part.
10. "Emergency Services" or Emergency Health Care Services" means health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including pre-hospital care and ancillary services routinely available to the emergency department.
11. "Expedited Review" means utilization review conducted when the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb or other

major bodily function, or the normal timeframe for the decision-making process would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function.

12. "Health Care Provider" means physician, hospital, pharmacy, chiropractor, nurse, dentist, podiatrist, physical therapist, rehabilitation specialist, psychologist, and any other person providing medical care pursuant to North Carolina Workers Compensation Act.

13. "Immediately" or "Urgent" 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.

14. "Insurer means an insurance carrier, self-insured administrator, managed care organization, employer, or any other entity that conducts preauthorization review.

15. "Medical compensation" means medical, surgical, hospital, nursing, and rehabilitative services, and medicines, sick travel, and other treatment, including medical and surgical supplies, as may reasonably be required to effect a cure or give relief and for such additional time as, in the judgment of the Commission, will tend to lessen the period of disability; and any original artificial members as may reasonably be necessary at the end of the healing period and the replacement of such artificial members when reasonably necessitated by ordinary use or medical circumstances.

16. "Medical Director" is the physician licensed by a state Medical Board or a state Osteopathic Board who holds an unrestricted license to practice medicine in a State within the United States of America. The Medical Director is responsible for all decisions made in the Utilization Review Process. The term Medical Director includes but is not necessarily limited to physicians holding any of the following Zenith job titles or a variation of these job titles – Medical Director, National Medical Director, Medical Officer, Chief Medical Officer and Assistant Chief Medical Officer.

17. "Non physician reviewer means a Medical Management Nurse who meets Zenith's requirements for review of a Treatment Request for medical necessity. Non-physicians may only Certify, negotiate with a physician for a voluntary amendment or withdrawal of a Treatment Request, request additional information or refer a claim to a Medical Director, Physician Reviewer or Expert Reviewer. Non-physicians may not non-Certify, delay, or unilaterally modify a Treatment Request.

18. "Nurse Consultant" or "NC" means a registered nurse employed by Zenith's medical management department or employed by a Claims Administrator.

19. "Physician Reviewer" means a medical director, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the reviewer's practice. Zenith currently utilizes Genex Services, LLC (formerly Mitchell International, Inc., and UniMed Direct) to conduct these types of reviews.

20. "Preauthorization" means the determination that a proposed surgical or inpatient treatment is medically necessary.

21. "Preauthorization review" means a prospective review process conducted by an insurer to determine whether a proposed surgical or inpatient treatment is medically necessary.

22. "Prudent Layperson Standard" means that with respect to obtaining Emergency Medical Services the person acted as a prudent layperson would have under a reasonable belief that an Emergency Medical Condition existed and that a delay in care would worsen the emergency.

23. "Statute and Regulations" means the North Carolina General Statutes §97 et seq. and the N.C. Industrial Commission Utilization Review Rules.

24. "The Act" means the North Carolina Workers Compensation Act found under General Statutes Chapter §97 et seq.

25. "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.

26. "Utilization Review" means a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities. These techniques may include:
    a. Ambulatory review. – Utilization review of services performed or provided in an outpatient setting.
    b. Case management. – A coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.
    c. Concurrent review. – Utilization review conducted during a patient's hospital stay or course of treatment.
    d. Prospective review. – Utilization review conducted before an admission or a course of treatment including any required Preauthorization or precertification.
    e. Retrospective review. – Utilization review of medically necessary services and supplies conducted after services have been provided to a patient, but not the review of a bill that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment. Retrospective review includes the review of claims for emergency services which may include review of whether the North Carolina Prudent Layperson Standard has been met.
    f. Second opinion. – An opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed service to assess the clinical necessity and appropriateness of the proposed service. The second opinion provider may ultimately assume responsibility for care.

27. "Utilization Review Plan" means this Written plan, which is filed as part of the utilization review processes filed with the Department of Financial and Professional Regulation pursuant to the North Carolina Workers Compensation Act, North Carolina General Statutes §97-25.3, §97-25.4, §97-25.5 and the N.C. Industrial Commission Utilization Review Rules and which sets forth Zenith's policies and procedures and a description of the Utilization Review Process.

28. "Utilization Review Process" means utilization management functions that prospectively, retrospectively or concurrently review and approve, modify, delay or deny, based in whole or in part on medical necessity to cure or relieve, treatment recommendations by physicians, prior to, retrospectively, or concurrent with the provisions of medical treatment services.

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

30. "Zenith" means Zenith Insurance Management Services, Inc. ("ZIMS"), dba Zenith Claims Solutions, acting as the bill review and/or utilization review agent on behalf of affiliated and non-affiliated entities. Zenith National Insurance Corp. is the ultimate parent of both ZIMS and its affiliate Zenith Insurance Company.

North Carolina Utilization Review Plan Administrative Overview

The following overview, description and policies and procedures constitute Zenith's Utilization Review Plan. Capitalized terms used in this Utilization Plan have the meanings ascribed to them in the Definitions section of this Plan. As a North Carolina Claims Administrator, Zenith has established and maintains this Utilization Review Plan and its Utilization Review Process compliant with the North Carolina Workers' Compensation Act GS 97 et seq (the Act), and applicable regulations including but not limited to GS§97-25.3, §97-25.4, §97-25.5 and the N.C. Industrial Commission Utilization Review Rules.

Zenith will update its review Criteria and other relevant data on a regular basis to help ensure that it is using the most up-to-date Criteria when it reviews Treatment Requests. Zenith's methodology for updating its review Criteria consists of regular reviews by the Medical Director and Zenith's Vice President or Assistant Vice President of Medical Management to evaluate internal processes, review outcomes and compliance with policies and procedures.

Upon request, Zenith will provide the requestor a copy of this Utilization Review Plan. This may be made available through electronic means or via hard copy for a reasonable copying and postage fee that shall not exceed $0.25 per page plus actual postage costs. A copy of Zenith's utilization review plan including preauthorization requirements is available online via Zenith's public website.

North Carolina Utilization Review Process Description

I. Overview

The purpose of the Zenith Utilization Review Process is to provide an assessment of clinical appropriateness and medical necessity of Treatment Requests and goods provided to injured workers for accepted and delayed claims. The Utilization Review Process does not include determinations of the work relatedness of the injury or disease or bill review for the purpose of determining whether the medical services were accurately billed.

Zenith strives to work collaboratively with Health Care Providers in order to certify care that is consistent with Medical Treatment Guidelines or other evidence-based medicine guidelines utilized by Zenith and to provide consistent education and information to all stakeholders. Each injured worker's medical treatment is evaluated on an individual basis related to their diagnosis and the receipt of a Treatment Request outlining proposed treatment and medical care.

Medical Director

Zenith employs a designated Medical Director to oversee its Utilization Review Process. The designated Medical Director holds an unrestricted license to practice medicine. The Zenith Medical Director oversees and evaluates the process by which Zenith reviews, certifies, modifies or non-certifies requests by physicians prospectively, concurrently or retrospectively with the provision of medical services in compliance with the North Carolina Workers' Compensation Act GS 97 et seq (the Act), and applicable regulations. The designated Medical Director's name, address, phone number and license number are set forth in Attachment "A".

Treatment Guidelines

Zenith's utilization review decisions are made using evidence based guidelines. A listing of the guidelines utilized by Zenith and its utilization review vendor are attached as Attachment "B".

Reviewers

Zenith requires that qualified staff be utilized to perform the utilization review functions. At the time of hire, credentials, including designations, licensure, degrees or certifications, are verified. Staff is required to maintain appropriate licensure and certifications throughout the course of employment with Zenith. The Utilization Review Process is managed internally by a team that includes medical directs, Nurse Consultant (NC), Claims Examiner and administrative support staff. The Utilization Review Process has multiple levels and non-certifications can only be rendered by an appropriate external Physician Reviewer pursuant to Zenith's National Utilization Review Policy. See attached Zenith National Utilization Review Policy - Policy Number: IP01.1

II. Utilization Review

Zenith maintains telephone access from 8:00 AM to 4:30 PM (Eastern Time) on normal business days for Health Care Providers to submit Treatment Requests telephonically and orally. Additionally, Zenith maintains facsimile numbers available for Health Care Providers to submit Treatment Requests via fax. Zenith accepts Treatment Requests after normal business hours via either voice-mail and/or facsimile transmission. Mail, voice-mail and facsimiles received after 4:30 PM (Eastern Time) are considered received the following business day. Mail and facsimiles received on a holiday or weekend are deemed received the next business day.

The utilization review process is initiated upon receipt of a valid treatment request. Zenith generally requires that Treatment Requests be submitted in writing along with appropriate information to support the medical necessity of the treatment being requested. Zenith allows internal staff to approve Treatment Requests but requires that Treatment Requests that cannot be approved be sent to a qualified Physician Reviewer for review. Upon receipt of a request, Zenith uses the following review process:

1. A Zenith Claims Examiner reviews the Treatment Request for the purpose of rendering coverage determinations or application of prior determinations. Claims Examiners may not make medical necessity determinations including decisions to non-certify, delay or modify a Treatment Request. Claims Examiners may apply a medical necessity determination that was previously made by an appropriate Physician Reviewer or apply administrative decisions or guidelines that do not require a medical necessity determination. Zenith Claims Examiners are provided both tutorial training as well as reference materials to facilitate their understanding and help ensure compliance with Zenith's processes. If medical necessity is an issue, the Claims examiner will refer the review to a NC for further review.

2. NCs are registered nurses who, at a minimum: (1) have undergone formal training in nursing and/or a health care field, or hold an associate or higher degree in nursing; (2) hold a valid nursing license, and (3) have professional experience providing direct patient care. The NC can review a Treatment Request for certification or referral to a Physician Reviewer or a Zenith Medical Officer. The NC is not permitted to deny a Treatment Request. The NC refers Treatment Requests that cannot be certified for further review by a physician. The NC may seek review by either an internal Medical Officer or an external Physician Reviewer. The NC may discuss Criteria or guidelines with the requesting physician if the Treatment Request appears to be inconsistent with or exceeds applicable guidelines. If the requesting physician voluntarily amends a Treatment Request and confirms the amendment in writing, the NC reviewer may certify the amended Treatment Request. If the NC determines that a Treatment Request was not accompanied with sufficient medical information to allow Zenith to render a decision, then the NC within 2 business days of receipt of the request, will send a letter to the parties stating that the Treatment Request has been forwarded to Zenith's third party review vendor for review by a Physician Reviewer.

3. Zenith Medical Officers may review Treatment Requests for certification or peer to peer

discussion for voluntary modifications. Zenith Medical Officers are not permitted to issue denials based on Medical Necessity. If Zenith Medical Officers are unable to certify a Treatment Request, the Treatment Request is sent to an external Physician Reviewer. A Zenith Medical Officer is permitted to override a denial by an external Physician Reviewer if appropriate, for example when Zenith receives additional information after a decision has already been rendered.

4. If the request a Treatment Request cannot be certified through internal review processes, the Treatment Request is sent to Zenith's external utilization review organization for review by a Physician Reviewer.

Oral Treatment Requests

Zenith requires Treatment Requests to be submitted in writing. However, at the discretion of the NC, oral requests that are deemed time-sensitive (e.g. the patient is in the emergency room or there is a life-threatening condition) or for requests for which appropriate information has already been provided will be handled by the NC in accordance with Zenith's Utilization Review Process. Zenith will advise the provider that Preauthorization is not required for emergency services and that failure to obtain Preauthorization for emergency health care services will not be used to as a basis to refuse reimbursement for services provided to treat and stabilize an injured worker presenting for emergency health care services. However, emergency health care services are subject to retrospective review for medical necessity. If the NC has received the appropriate information, review will be completed and a certification rendered or the request will be forwarded for immediate review to Zenith's third party vendor. The third party vendor will have the treatment request reviewed by a Physician Reviewer.

Review of Treatment Requests by Contracted Utilization Review Organization

Zenith has contracted with a third party vendor utilization review organization ("URO") to coordinate and conduct a Physician Review of Treatment Requests and provided information when Zenith staff is unable to approve the Treatment Request (see Attachment "C"), Third Party Utilization Review Organization). The URO is required to comply with all North Carolina statutory and regulatory requirements, including maintaining a properly filed utilization review plan. All services performed by the URO on behalf of Zenith are performed in compliance with the URO's filed utilization review plan.

As part of the review process, the third party Physician Reviewer may contact the requesting provider for additional appropriate information or clarification. The Physician Reviewer will render a decision to Certify, Deny, modify or delay the Treatment Request. The URO is responsible for notifying Zenith, the requesting physician, the injured worker, and, if the injured worker is represented by counsel, the injured worker's attorney of the utilization review decision. The URO notifications are generated by the URO and comply with regulatory requirements. The provider letter includes the URO's contact information and availability in the event the provider wants to talk to the Physician Reviewer.

Tracking of Treatment Request

Zenith shall use the following rules to determine the date a Written Treatment Request was received:

1. If a Treatment Request is received by mail and a proof of service by mail exists, the request is deemed to have been received 5 business days after the date indicated on the proof of service or after deposit in the mail at a facility regularly maintained by the United States Postal Service unless:

    a. the Zenith mailroom date stamp is before the 5 calendar days, then the date stamp will control; or
    b. the Zenith mailroom date stamp is after the 5 calendar days, then the proof of service will control.

2. If the Written Treatment Request is received by certified mail with return receipt, the request is deemed received on the receipt date entered on the return receipt.

3. If the Written Treatment Request was submitted without a proof of service or there is not dated return receipt, the Treatment Request is deemed received on the date stamped by Zenith's mail room.

4. If the Written 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 the date actually received if known.

5. If the Treatment Request is received by facsimile or secure electronic mail the received date is considered as follows:

    a. If Zenith's electronic receive date stamp is present, this is considered the received date; or
    b. If no Zenith electronic or email receive date stamp is present, the date of the fax transmission from the requesting sender is considered the received date; or
    c. If there is no fax transmission date or an erroneous date as the fax transmission date, the received date is the date the fax was transmitted to Zenith pursuant to the North Carolina Workers Compensation Act, North Carolina General Statutes §97-25.3., §97-25.4., §97-25.5 and the N.C. Industrial Commission Utilization Review Rules. An erroneous fax date occurs when the sender of the fax has failed to set up the time stamp on the sender's fax machine and the date on the fax reflects a date far in the past.

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

III. Preauthorization Requirements and Treatment Request Reviews

Zenith's Utilization Review Process provides for Expedited Reviews, Prospective Reviews, Concurrent Reviews, and Retrospective Reviews. Zenith complies with the Preauthorization requirements set forth in NC GS 97-25.3. The review and decision to deny, delay, or modify a request for medical treatment must be conducted by a Physician Reviewer, who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the individual's practice. The first day in counting any timeframe requirement is the day after receipt of the Treatment Request. Pursuant to these requirements:

(i) The following services require preauthorization under Zenith's utilization review program. As such, treatment requests for the listed services should be submitted to Zenith Claims Solutions for utilization review. Pursuant to 04 NCAC 10A.1001 Zenith requires the following:

1. Diagnostics Requiring Preauthorization:

- Any diagnostic study or services including an initial MRI, CT, general radiology studies/services, neurological studies or other diagnostic studies or services. Diagnostic studies are defined as "any test used to help establish or exclude the presence of diseases/injury in symptomatic persons."

- Cardiac and pulmonary or other diagnostics that are possibly not related to an industrial accident, discograms, myelograms, venograms, EMG/Nerve Conduction Studies, Spine Cord Stimulators or trials, Interferential Units/H-Waves/multichannel TENS/RS41 units and Somatosensory evoked potential testing require preauthorization.

2. Treatment Requiring Pre-Authorization:

- Physical Therapy and Occupational Therapy exceeding 24 visits
- Chiropractic therapy (includes chiropractic therapy manipulation without anesthesia) exceeding 24 visits More than 3 injections (including steroid, facet, trigger point, sacroiliac joint) to any single body part except cervical spine
- More than 3 injections combined (including steroid, facet, trigger point, sacroiliac joint) to multiple body parts
- Dental services
- Durable Medical Expenses (DME) estimated to cost more than $750.00

3. All surgeries require Pre-Authorization:

The following requirements apply to inpatient admission or outpatient surgery:

a. 10 days advance notice of the inpatient admission or surgery except in the case of an emergency;

b. All requests for preauthorization and all preauthorization determinations shall be submitted on Industrial Commission Form 25PR.
c. The Preauthorization Agent is responsible for providing the preauthorization review (PR) claim number and forwarding medical records, communications, and review determinations to the proper entities upon receipt;
d. Delivery of a request for preauthorization, via email, fax or telephone, to the claims adjustor or other designated Preauthorization Agent shall constitute receipt of the preauthorization request by the claims adjustor;
e. Zenith will respond to a request for Preauthorization within 2 business days of the request;
f. Upon receipt of the request for preauthorization, Zenith will provide to the health care provider or person making the request the name, telephone number, fax number and secured email address of the Preauthorization Agent. The Preauthorization Agent must be available on a continuous basis, every business day (excluding weekends and holidays) from 8:00am to 8:00pm Eastern Standard Time to facilitate responses to insurer communications or determinations.
g. Any Peer Review Physician used for preauthorization determinations shall be licensed in North Carolina, South Carolina, Georgia, Virginia, or Tennessee and shall hold professional qualifications at least equal to that of the treating provider requesting preauthorization of surgery of inpatient treatment.
h. If Zenith utilizes a Peer Review Physician in making preauthorization decisions, then the policy must include the name, licensure, and specialty area of that Peer Review Physician and Zenith shall provide a profile of that Physician
i. Zenith will review the need for the inpatient admission or surgery and may require the employee to submit to an independent medical examination pursuant to G.S. 97-27(a). The examination must be completed and Zenith must make its determination on the request for Preauthorization within seven (7) days of the date of the request unless this time is either agreed upon by Zenith and the medical provider requesting preauthorization; or extended by the Commission for good cause.
j. Zenith will document its review findings and determination in writing and shall provide a copy of the findings and determination to the employee and the employee's attending physician, and, if applicable, to the hospital or treatment center.
k. If denied, Zenith will provide supporting documentation of the substantive clinical justification for a denial of preauthorization, including the relevant clinical data upon which the denial is based and will advise of the right to request a hearing. Denials based on lack of information shall specify what information is needed to make a determination.;
l. Zenith will authorize the general and inpatient admissions or surgery when it requires the employee to submit to a medical examination as provided in G.S. 97-27(a) and the examining physician concurs with the original recommendation for the general and inpatient admission or surgery. Zenith will also authorize the general and inpatient admission or surgery when the employee obtains a second opinion from a physician approved by the insurer or the Commission, and the second physician concurs with the original recommendation for the inpatient

admission or surgery. However, Zenith is not required to authorize the general and inpatient admission or surgery if it denies liability for the particular medical condition for which the services are sought.

m. Zenith will authorize any surgery or inpatient treatment provided as provided in G.S. 97-25.3 for which preauthorization was requested for an admitted condition after the right to contest the preauthorization request is waived in accordance with G.S. 97-18(i).
n. Except as provided below in subsection (iii), Zenith may reduce its reimbursement of the provider's eligible charges by up to fifty percent (50%) if Zenith notified the provider in writing of its Preauthorization requirement and the provider failed to timely obtain Preauthorization. The employee shall not be liable for the balance of the charges.
o. Zenith will also follow all other procedures for Preauthorization prescribed by the Commission.

4. All Medications require authorization through the Pharmacy Benefit Manager and pre-authorization is initiated at the Point of Sale.

(ii) Zenith will not require Preauthorization for the following:

a. Emergency services;

b. Services rendered in the diagnosis or treatment of an injury or illness for which the Zenith has not admitted liability or authorized payment for treatment; and

c. Services rendered in the diagnosis and treatment of a specific medical condition for which Zenith has not admitted liability or authorized payment for treatment although Zenith admits the employee has suffered a compensable injury or illness.

(iii) The Commission may, upon reasonable grounds, upon the request of the employee or provider, authorize treatment for which Preauthorization is otherwise required but was not obtained if the Commission determines that the treatment is or was reasonably required to affect a cure or give relief.

Based on the type of review being conducted, the following will apply:

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

Decisions to Certify, non-Certify, modify, or delay Treatment Requests must be made in a timely fashion that is appropriate for the nature of the injured worker's condition, but

not to exceed 2 business days after receipt of the information reasonably necessary to make the determination

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

   Decisions to Certify, delay, modify, non-Certify, or request additional information must be made within 2 business days from receipt of the Treatment Request.

3. Concurrent Review is a utilization review conducted during an inpatient stay and ongoing treatment.

   Decisions to Certify, delay, modify, non-Certify, or request additional information must be made within 2 business days from receipt of the Treatment Request.

   Medical care shall not be discontinued nor denied until the requesting physician and the provider of goods or services, identified in the Treatment Request, have been notified of the decision and a care plan has been agreed upon by the requesting physician. The care plan must be appropriate for the medical needs of the injured worker and consistent with the Official Disability Guidelines, 13th Edition, ACOEM Practice Guidelines and/or other evidence based medicine guidelines.

4. Retrospective Review is a utilization review conducted after medical services have been provided and for which certification has not already been given. Decisions to Certify, modify, non-Certify or delay must be done within 30 calendar days of receipt of the information that is reasonably necessary to make a determination.

   Emergency Health Care Services may be subject to Retrospective Review; however, coverage for emergency services will not be denied for failure to obtain Preauthorization. Retrospective review of emergency services may include a review to determine whether the North Carolina Prudent Layperson Standard has been met.

IV. Utilization Review Dispute Resolutions

North Carolina Workers' Compensation Act §97-25 - Medical treatment and supplies:

In case of a controversy arising between Zenith and the employee relative to the continuance of medical, surgical, hospital, or other treatment, the employee may request review by the North Carolina Industrial Commission pursuant to the North Carolina Workers' Compensation Act and North Carolina Administrative Code - Title 4, Chapter 10. Pursuant to GS 97-25, in the even that a controversy arises between Zenith and the employee regarding the continuance of medical, surgical, hospital, or other treatment, the Industrial Commission may order further treatments which the Commission in their discretion find to be necessary.

The Commission may at any time upon the request of an employee order a change of treatment and designate other treatment suggested by the injured employee subject to the approval of the Commission. If the Commission orders treatment, Zenith is responsible for payment of the services provided subject to the same terms and conditions provided under GS 97-25 for medical and surgical treatment and attendance. Upon notification that the Commission has ordered treatment, Zenith will approve the requested treatment without delay, unless Zenith intends to controvert the decision.

The refusal of the employee to accept any medical, hospital, surgical or other treatment or rehabilitative procedure when ordered by the Industrial Commission bars the employee from further compensation until the refusal ceases. No compensation is payable during the period of suspension unless in the opinion of the Industrial Commission the circumstances justified the employee's refusal to accept medical treatment. In that situation, the Industrial Commission may order a change in the medical or hospital service that was previously ordered by the Industrial Commission.

Policy and Procedure Attachments List

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

Policy Directory:

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

Attachments:

Attachment "A" Designated Medical Director Information
Attachment "B" Treatment Guidelines
Attachment "C" Utilization Review Organization
Attachment "D" Applicable Confidentiality and Privacy Policies and Guidelines

COMPANY POLICY	
Title: Zenith National Insurance Corp. National Utilization Review Policy	
Application: Zenith Insurance Company, ZNAT Insurance Company, ZIMS and Affiliated and Non-Affiliated Entities	
Policy Number: IP01.1	**Issued: January 22, 2008**
Updated:	As most recently revised 7-27-2020 As most recently reviewed 9-1-2026
Approved By: Dr. Rupali Das, SVP & Medical Director; Jackie Hilston, SVP - Claims	

POLICY STATEMENT

It is the policy of Zenith that all Utilization Review denials be rendered by external Clinical Peer Review. Decisions to overturn or modify a Clinical Peer Review decision may only be made by a Zenith Medical Officer or external Clinical Peer Reviewer. Zenith Medical Officers may not overturn a Clinical Peer Reviewer's decision to authorize treatment but may overturn a decision to Modify or Deny treatment in order to authorize the requested treatment based on information available to the Medical Officer. It is further the policy of Zenith that Utilization Review determinations (coverage, modification or denials) made by either a Zenith Medical Officer or the Clinical Peer Review process be followed and implemented without delay. No individual employee may override, modify or delay implementation of a treatment determination made by a Zenith Medical Officer or Clinical Peer Review except as set forth in this policy.

PURPOSE

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

DEFINITIONS

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

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

3. "Treatment Request is a request for Medical Services or treatment for an Injured Employee that is subject to Utilization Review.

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

PROCEDURES FOR POLICY COMPLIANCE

Policies

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

   If compensability has not yet been determined and the basis for denial is Medical Necessity, the denial must be rendered by external Clinical Peer Review. If the denial is based on compensability still being undetermined, then the denial must be approved by a Zenith Medical Officer. If the denial is procedural (e.g. treatment outside of the network, Treatment Request not made by a party authorized to treat under the law, or other reasons not based in causation or Medical Necessity) the underlying request for Authorization does not meet the definition of a Treatment Request and is not subject to this policy, therefore the claim handler is authorized to respond to these requests in compliance with the law.

2. Determinations and recommendations made by a Zenith Medical Officer or external Clinical Peer Review must be followed and implemented in a timely manner subject to the Internal Review Process set out in (3) below.

3. **Internal Review Process:** In the event a Zenith employee disagrees with or has legal process or other concerns regarding a Utilization Review determination made by a Zenith Medical Officer, or external Clinical Peer Review, the determination must be escalated for an interdepartmental branch staffing (with representation from claims, legal and medical management).

4. The Zenith employee should schedule the interdepartmental file review staffing meeting to address the concerns or issues arising from the Utilization Review determination within 48 hours of determining a concern exists and the meeting must take place as soon as reasonably possible but no later than 30 calendar days from the date the concern became known. The review staffing meeting must include the appropriate departmental AVP, any Zenith Medical Officer involved in the determination and if none, a Zenith Medical Officer and other appropriate Medical Management, Claims Manager, Claims Examiner, Medical Management Nurse Supervisor and Legal staff given the issues or concerns. The Zenith Medical Officer(s) may choose to include the external Clinical Peer Review physician and/or the Medical Director of the external Clinical Peer Review Company.

   No referral for a second or third opinion may be made in lieu of this interdepartmental staffing. The Medical Officer shall have final authority in consultation with the staffing team set out above for

Authorization, modification or denial of Treatment Requests subject to the Utilization Review Process.

No individual employee may Certify denied care or deny Certified care without Written approval by a Zenith Medical Officer.

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

   a. officially rejected compensability of the underlying claim for workers compensation. In these situations, all denials must be for lack of compensability and not on the basis of Utilization Review Criteria; or
   b. determined that certain body parts or medical conditions are not part of or related to the accepted compensable claim and therefore, requests for care related to those conditions or body parts should be denied.

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

ATTACHMENT "A"

DESIGNATED MEDICAL DIRECTOR INFORMATION

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

Name: Dr**.** Rupali Das
Job Title: SVP and Medical Director
Address: Zenith Claims Solutions
21255 Califa Street
Woodland Hills, CA 91367

ATTACHMENT "B"
ZENITH UTILIZATION REVIEW GUIDELINES

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

- ACOEM
- ODG

ATTACHMENT "C"
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

ATTACHMENT "D"
ZENITH
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 (herein referred to as "Company") 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).*

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; 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.