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Mississippi
Utilization Review Plan

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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. "Appeal" means a formal request to reconsider a determination not to Certify an admission, extension of stay, or other medical service.

2. "Attending Physician" means the physician with primary responsibility for the care provided to a patient in a Hospital or other health care facility.

3. "Authorization" means an approval of medical services by a carrier/payer/employer, usually prior to service being rendered.

4. "Case Management" means the clinical and administrative process in which timely, individualized, and cost-effective medical rehabilitation services are implemented, coordinated, and evaluated, by a nurse, other case manager, or other Utilization Reviewer employed by the payer, on an ongoing basis for patients who have sustained an injury or illness.

5. "Certification" or "Certify" means a determination by a Utilization Review organization that an admission, extension of stay, or other medical treatment or health care services has been reviewed and, based on the information provided, qualifies as Medically Necessary and appropriate as set forth in the Fee Schedule.

6. "Clinical Peer" means a health professional that holds an unrestricted medical or equivalent license and is qualified to practice in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession (i.e., the same licensure category as the ordering provider).

7. "Clinical Rationale" means a statement or other documentation that taken together provides additional clarification of the clinical basis for a non-Certification determination. The Clinical Rationale should relate the non-Certification determination to the worker's condition or treatment plan and must include a detailed basis for denial or non-Certification of the proposed treatment to give the provider or patient a sufficient basis for a decision to pursue an Appeal. Clinical Rationale must include specific reference to any applicable provisions of the Mississippi Workers' Compensation Medical Fee Schedule, which

allegedly support the determination of the reviewer, or a statement attesting to the fact that no such provision(s) exists in the Fee Schedule.

8. “Concurrent Review” means Utilization Review conducted during a patient's Hospital stay or course of treatment.

9. “Consulting Physician” means a Medical Doctor, Doctor of Osteopathy, Dentist, Psychologist, Podiatrist or Chiropractor who possess the degree of skill ordinarily possessed and used by members of his or her profession in good standing, and actively engaged in the same type of practice and relevant specialty. The Boards within the American Board of Medical Specialists or the American Board of Osteopathy shall Certify the medical and osteopathy specialist.

10. “Discharge Planning” means the process of assessing a patient's need for medically appropriate treatment after Hospitalization including plans for an appropriate and timely discharge.

11. “Enrollee” means the individual who has elected to contract for, or participate in, a health benefit plan for their self and/or their dependents.

12. “Expedited Appeal” means a request for additional review of a Utilization Review organization's determination not to Certify an admission, extension of stay, or other medical services of an emergency, imminent, or ongoing nature. An expedited Appeal request may be called a reconsideration request by some Utilization Review organizations.

13. “First Level Clinical Review” means a review conducted by a registered nurse, nurse case manager, or other appropriate licensed or certified health professional. First level clinical review staff may Certify requests for admissions, procedures, and services that meet the standard of medical necessity as defined elsewhere in the Fee Schedule, but must refer requests that do not meet this medical necessity standard, in their opinion, to second level Clinical Peer reviewers for approval or denial.

14. “Hospital” means an institution which is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons, or rehabilitation services for the rehabilitation of injured, disabled or sick persons, and also, means a place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment and illness, disease, injury or deformity, or a place devoted primarily to providing obstetrical or other medical, surgical or nursing care of individuals, whether or not any such place be organized or operated for profit and whether any such place be publicly or privately owned.

The term "Hospital" does not include convalescent or boarding homes, children's homes, homes for the aged or other like establishments where room and board only are provided, nor does it include offices or clinics where patients are not regularly kept as bed patients.

15. “Medically Necessary” means any reasonable medical service or supply used to identify or treat a work-related injury/illness which is appropriate to the patient’s diagnosis, is based upon acceptable standards of the health care specialty involved, represents an appropriate level of care given the location of service, the nature and seriousness of the condition, and the frequency and duration of services, is not experimental or investigational, and is consistent with or comparable to the treatment of like or similar non-work related injuries. Utilization management or review decisions should not be based on application of clinical guidelines but must include review of clinical information submitted by the provider and represent an individualized determination based on the worker’s current condition and the concept of medical necessity predicated on objective or appropriate subjective improvements in the patient’s clinical status.

16. “Notification” means correspondence transmitted by mail, telephone, facsimile, email, and/or other reliable electronic means.

17. “Patient” means the intended recipient of the proposed health care, his/her representative, and/or the enrollee.

18. “Pre-certification” or “Preadmission” means the review and assessment of proposed admission, extension of stay, or other medical treatment or health care services before they occur to determine if such treatment or services are Medically Necessary.

19. “Private Review Agent” means a non-Hospital affiliated person or entity performing Utilization Review on behalf of:
    - An employer or employees in the State of Mississippi; or
    - A third party that provides or administers Hospital and medical benefits to citizens of this state, including: a health maintenance organization issued a certificate of authority under and by virtue of the laws of the State of Mississippi, or a health insurer, nonprofit health service plan, health insurance service organization, or preferred provider organization or other entity offering health insurance policies contracts or benefits in this state.

20. “Retrospective Review” means a review for Authorization conducted after services have been provided to the worker.

21. “Review Criteria” means the written policies, decision rules, medical protocols, or guides used by the Utilization Review organization to determine Certification [e.g., Appropriateness Evaluation Protocol (AEP) and Intensity of Service, Severity of Illness, Discharge, and Appropriateness Screens (ISD-A)].

22. “Second Level Clinical Review” means peer review conducted by appropriate Clinical Peers when the First Level Clinical reviewer is unable to determine whether a request for an admission, procedure, or service satisfies the standard of medical necessity as defined elsewhere in this Fee Schedule. A decision to deny, or not Certify, proposed treatment or services, must be supported by the express written evaluation, findings and concurrence of a physician licensed to practice medicine in the State of Mississippi and properly trained in the same specialty as the requesting provider.

23. “Standard Appeal” means a request by or on behalf of the patient or provider to reconsider a prior decision by the payer or its Utilization Review agent to deny proposed medical treatment or service, including but not limited to, a determination not to Certify an admission, extension of stay, or other health care service.

24. “Third Level Clinical Review” means medical necessity review conducted by appropriate Clinical Peers who were not involved in the first or second level review when a decision not to Certify a requested

    admission, procedure, or service has been Appealed. The third level peer reviewer must be in the same or like specialty as the requesting provider. A decision to deny, or not Certify, proposed treatment or services, must be supported by the express written evaluation, findings and concurrence of a physician licensed to practice medicine in the State of Mississippi and properly trained in the same specialty as the requesting provider.

25. “Treatment Request” means a request for medical services or treatment for an injured employee that is subject to Utilization Review.

26. “Utilization Review” means a system for reviewing the appropriate and efficient allocation of Hospital resources and medical services given or proposed to be given to a patient or group of patients. More specifically, Utilization Review refers to pre-service determination of the medical necessity or appropriateness of medical services to be rendered in a Hospital setting or non-Hospital setting either on an inpatient or outpatient basis, when such determination results in approval or denial of payment for the services. It includes both prospective and concurrent review as well as discharge planning. It may include retrospective review under certain circumstances. In addition, mandatory Utilization

Review is required of certain medical services covered under the Act and subject to the Mississippi Fee Schedule.

27. "Utilization Reviewer" means an entity, organization, or representative/person performing Authorization/pre-certification activities or services on behalf of an employer, payer or third-party claims administrator.

28. "Utilization Review Plan" means a description of the Utilization Review procedures of a private review agent.

29. "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.

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.

Zenith

Mississippi Utilization Review Plan Administrative Overview

The following overview, description of processes, policies, and procedures constitute Zenith's Utilization Review Plan (Plan). Capitalized terms used in this Utilization Review Plan have the meanings ascribed to them in the Definitions section of this Plan. As a Mississippi Claims Administrator, Zenith has established and maintains this Utilization Review Plan and its Utilization Review Process in compliance with Title 15: Health Facilities, Part 16, Subpart 1, Title 20: Labor, Part 2, Mississippi Fee Schedule as well as other applicable regulations.

Zenith employs a designated Medical Director to oversee its Utilization Review Process. The designated Medical Director holds an unrestricted license to practice medicine. Zenith's Medical Director oversees and evaluates that process by which Zenith reviews, Certifies or denies requests by Physicians for an admission, procedure, extension of stay, or other medical service prior to, retrospectively or concurrent with the provision of medical services. The Medical Director is responsible for all decisions rendered through Zenith's Utilization Review program. Please refer to Exhibit "A" regarding Medical Director licensure and additional information.

Zenith will update its review Criteria and other relevant data on a regular basis to ensure that it is using the most up-to-date Criteria when it reviews Treatment Requests. Zenith's methodology for updating its review Criteria consists of regular reviews by appropriate staff that include the evaluation of internal processes, review outcomes and compliance with policies and procedures, and to help ensure that Zenith and any of its vendors are utilizing the most current and up-to-date evidence based guidelines such as the American College of Occupational and Environmental Medicine ("ACOEM") and/or the Official Disability Guidelines ("ODG") when the Mississippi Fee Schedule guidelines do not apply.

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

I. Overview

The purpose of the Zenith Utilization Review Process is to provide an assessment of clinical appropriateness and medical necessity of medical care and services provided pursuant to Miss. Code Ann. § 71-3-1, et. Seq. and Title 20: Labor, Part 2: Mississippi Workers' Compensation Medical Fee Schedule.

Zenith strives to work collaboratively with health care providers in order to Certify care that is consistent with the Fee Schedule guidelines and, when applicable, evidence-based medicine guidelines utilized by Zenith and to provide consistent education and information to all other stakeholders. To meet this objective Zenith employs a Medical Director who is qualified in the area of occupational disease and disorders.

Staff Qualifications

Zenith hires qualified staff to implement the Utilization Review Plan in an honest and ethical manner pursuant to CMSR 15-016-082, Subchapter 13, Rule 82.13.1 Staff are properly trained, supervised and supported by written clinical criteria and review procedures. At the time of hire, credentials, including designations, licensure, degrees or Certifications are verified. Zenith uses written clinical criteria, as needed, for determining the appropriateness of the Certification. This criterion is periodically evaluated and updated. Staff including nurses, physicians and other licensed health professionals conducting reviews of medical services, and other clinical reviewers conducting specialized reviews in their area of specialty is required to maintain appropriate licensure and Certifications throughout their course of employment with Zenith pursuant to *CMSR 15-016-082, Subchapter 13, Rule 82.13.2*. For further information regarding Zenith's internal medical director and nursing staff refer to Exhibit "G". For detailed information regarding the peer and physician advisor panel that Zenith's URO utilizes, refer to Exhibit "F".

Clinical Criteria/Review Procedures

Clinical criteria and review procedures shall be established with appropriate involvement from physicians. Pursuant to CMSR 15-016-082, Subchapter 13, Rule 82.13.5 Zenith utilizes the following criteria:

1. Physician consultants or specialists who are certified by the Boards within the American Board of Medical Specialists or the American Board of Osteopathy from the major areas of clinical services. Listings of reviewers are included in Exhibit F.
2. A formal program for orientation and training of Utilization Review staff. Zenith provides training to all staff and makes the Utilization Review plan available online for easy access.
3. Written documentation of an active Quality Assessment Program. Zenith's Quality Assessment Program is described below.

Quality Assessment Program: Zenith utilizes a cross functional approach to quality assessment. The program includes the following:

1. Quarterly quality reviews are conducted for each nurse to assess the Utilization Review decisions and outcomes.
2. Quality reviews are completed by the supervisors and reviewed with the individual nurses each quarter. Each injured worker's medical treatment is evaluated on an individual basis and is related to his or her diagnosis and receipt of a Treatment Request outlining proposed treatment and medical care with appropriate supporting documentation.
3. Zenith meets with its external review agent regularly to review determinations and decisions. Discussions include quality, concerns and other issues.
4. Zenith verifies external review agency licensing and reviewer licensing annually.
5. Zenith utilizes an internal Network Review Committee to review issues related to specific providers. The Committee utilizes medical directors, claims, nursing, corporate legal, and claims legal as needed to address issues under review. Appropriate actions are taken to address concerns including monitoring provider compliance with guidelines, mentoring and referral for additional action.

Zenith's Utilization Review decisions are determined using the standards set forth in the Mississippi Workers' Compensation Medical Fee Schedule ("Fee Schedule"). If the Fee Schedule does not address the procedure, Zenith utilizes ODG, ACOEM and/or other evidence-based guidelines as addressed in Exhibit "C". For Utilization Review of pain management, Zenith relies on the guidelines set forth in the Pain Management section of the Fee Schedule. In the event that a surgically invasive pain management procedure is not specifically addressed in the Pain Management Fee Schedule guidelines, the services requiring Utilization Review under the Utilization Review Rules section of the Fee Schedule will control.

A team that includes the Nurse Consultant (NC), Claims Examiner, and administrative support staff supports the Utilization Review Process. The Utilization Review Process has multiple levels. Modifications and denials of Treatment Requests can only be rendered by an appropriate Clinical Peer reviewer. Zenith's multi-level Utilization Review Process includes:

- Claims Examiners may review Treatment Request plans for rendering coverage determinations or application of prior determinations. Claims Examiners may not make medical necessity determinations including decisions to Certify or non-Certify, a Treatment Request plan. Claims Examiners may apply a medical necessity determination that was previously made by an appropriate reviewer or apply administrative decisions or guidelines that do not require a medical necessity determination. Claims Examiners are provided both tutorial training as well as reference materials to facilitate their understanding and ensure compliance with Zenith's policies and procedures. If medical necessity is an issue, the Claims Examiner will refer the review to a NC for further review.
- Nurse Consultants (NC's) 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 plan for approval or referral to a Clinical Peer reviewer or a Medical Director. The NC is not permitted to deny a Treatment Request plan. The NC refers Treatment Request plans that cannot be Certified for further review by a physician. The NC may seek review by either a Medical Director or an external Clinical Peer reviewer. The NC may discuss Criteria or guidelines with the requesting physician if the Treatment Request plan appears to be inconsistent with or exceeds applicable guidelines. If the requesting physician voluntarily amends a Treatment Request plan and confirms the amendment in writing, the NC reviewer may Certify the amended Treatment Request plan.
- A Medical Director may review Treatment Request plans for approval or peer-to-peer discussion for voluntary modifications. Medical Directors are not permitted to issue denials based on medical necessity. If Medical Directors are unable to Certify a Treatment Request plan, the Treatment Request plan is sent for external physician review.
- If a Treatment Request cannot be Certified through internal review processes, the Treatment Request plan will be sent to Zenith's external certified URO for review by a Clinical Peer reviewer. The Clinical Peer reviewer will issue a decision to Certify, Modify or Deny. Per CMSR 15-016-082,
  Subchapter 13, Rule 82.13.3 the Clinical Peer reviewer will be a physician for any services that is modified or denied. If the Clinical Peer reviewer modifies or denies the

Treatment Request, the reviewer will be reasonably available by telephone to discuss the determination with the requesting physician.

- Per CMSR 15-016-082, Subchapter 13, Rule 82.13.4 in cases where the requesting physician Appeals an adverse determination, Zenith requires the Appeal review to be conducted by a physician with the same or similar general specialty as typically manages the medical condition, procedure or treatment. If the adverse determination is upheld, the reviewing physician on Appeal is required to be reasonably available, as appropriate, to review the case with the requesting physician. For the purpose of this review, the phrase "reasonably available" shall mean within one (1) working day, unless extenuating circumstances exist. Extenuating circumstances shall be in writing.

II. Utilization Review Process

Telephone Access

Pursuant to *CMSR 15-016-082, Subchapter 14, Rule 82.14.1 – 82.14.2* Zenith maintains telephone access five (5) days a week during normal business hours in this state from 9 A.M. to 5 P.M. Central Standard Time (CST) for Health Care Providers to submit Treatment Requests telephonically and orally and receive timely call-backs from providers. Zenith's toll-free number is (800) 440-5020. Additionally, Zenith maintains facsimile numbers available for Health Care Providers to submit Treatment Requests via fax at (800) 364-0443. Zenith accepts Treatment Requests after normal business hours via voicemail and/or facsimile transmission. Mail, voicemail and facsimiles received after 5:00 PM (CST) are considered received the following business day. Mail and facsimiles received on a holiday or weekend are deemed received the next business day.

Precertification

Precertification is required for services listed in Exhibit "E" of the Utilization Review Plan. Prior to providing treatment to the injured worker, the provider is required to submit a Treatment Request plan for Precertification in compliance with Title 20, IX. Failure to obtain Precertification of services will not, in and of itself, result in denial of payment for the services provided. Instead, a retrospective review of the services will be performed if requested to do so by the provider within one (1) year of the date the service or discharge. If it is determined that the services provided were Medically Necessary, then the provider will be reimbursed for the services found to be Medically Necessary. Reimbursement will be at either the provider's contracted rate or fee schedule less a 10% penalty for failure to obtain Precertification as required. If it is determined the services are not Medically Necessary and would have been denied, then the bill will be disputed pursuant to the Billing and Reimbursement Rules contained in the Fee Schedule.

Treatment Request Overview Process

The Utilization Review Process is initiated upon receipt of a valid Treatment Request. Verbal requests will be followed up on with the provider prior to rendering a Utilization Review determination and a Written request will be requested. Any Treatment Request subject to the Utilization Review Process shall be evaluated by a Claims Examiner to determine coverage given the scope of decision-making authority of the Claims Examiner. If the Claims Examiner determines coverage is available and a medical necessity determination is needed, the Treatment Request is forwarded to a Nurse Consultant (NC) for review.

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

In the event the Treatment Request does not have appropriate information to allow Zenith to render a decision, the requesting physician may be contacted for the appropriate additional information necessary to render a decision. The provider must make reasonable efforts to provide timely and complete reports of clinical information needed to support a request for treatment. If the provider fails to make reasonable efforts, Zenith will non-Certify the Treatment Request for lack of information. A letter notifying the provider of the non-Certification is sent to the provider, injured worker and applicant's attorney, if any. Billings for such services are not compensable and the provider may not collect for the services from the claims administrator, the injured worker or the employer. Reporting requirements and requests for information imposed on providers must be reasonable and cannot be unduly burdensome.

If the provider does supply the appropriate additional information requested, upon receipt, the Treatment Request is evaluated by the NC to determine if the Treatment Request can be Certified. If the Treatment Request does not meet applicable Mississippi Fee Schedule guidelines and/or ODG, ACOEM or other evidence-based medicine guidelines, the request may be referred to the Medical Director. The Medical Director may either directly contact or instruct appropriate staff to contact the requesting physician for an agreement to voluntarily amend or withdraw the original Treatment Request. If agreement is reached on an amendment of the original Treatment Request, the Medical Director or appropriate staff may Certify the Treatment Request. If such agreement is not reached, the Treatment Request will be referred to a Clinical Peer reviewer. Proper Notifications will be provided for any actions taken by internal staff.

Treatment Requests can be modified or denied only by a physician. Zenith utilizes external Clinical Peer reviewers for denials and either external Clinical Peer reviewer or an internal Medical Director for modifications. No non-physician Zenith employee may override (or attempt to override by additional opinions) a decision for coverage, modification or denial made by a Medical

Director or external Clinical Peer Review. Proper Notifications will be provided for any actions taken by internal staff.

If compensability has not yet been determined and the basis for denial is medical necessity, the denial must be rendered by an external Clinical Peer reviewer. If the denial is procedural (e.g. treatment outside of the network, Treatment Request not made by a party authorized to treat under the law, or other reasons not based in causation or medical necessity) the underlying request for Authorization does not meet the definition of a Treatment Request therefore the Claims Examiner is authorized to respond to these requests in compliance with the law.

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

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

The relevant portion of the Criteria or guidelines relied upon to modify, delay or deny services shall be disclosed in writing to the requesting physician, the injured worker and the injured worker's attorney, if applicable. Neither Zenith nor the claims administrator will charge an injured worker, the injured worker's attorney or the requesting physician for a copy of the relevant portion of the Criteria or guidelines relied upon to modify, delay or deny the Treatment Request.

III. Time Tracking

Tracking Process

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

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

- the mailroom date stamp is before the five (5) calendar days, then the date stamp will control

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

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

If no proof of service or dated return receipt exists, the request is deemed received on the date stamped by the mailroom.

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

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

- If the electronic receive date stamp is present, this is considered the received date. Verbal Treatment Requests will be entered into the system the date received. Pursuant to requirements, Verbal Treatment Requests must also be followed up with a Written request. Verbal Treatment Requests will be tracked from the date the verbal request was originally received and entered into the system.
- If no Electronic receive date stamp is present, the date of the fax transmission from the requesting sender is considered the received date.
- If there is no fax transmission date or an erroneous date as the fax transmission date, the received date
  is considered the latest date indicated on the Treatment Request.

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

- If the telephonic request is received after 5:00 p.m. (CST), the received date for the Treatment Request will be considered the following business day; and the Certification determination will be rendered within two business days of receipt of the necessary information.
- If the telephonic request is received prior to 5:00 p.m. (CST), the received date for the Treatment Request will be considered that business day.

Mail and facsimiles received after 5:00 PM (CST) are considered received the following business day. Mail and facsimiles received on a holiday or weekend are deemed received the next business day.

Telephone and on-site information gathering reviews and Hospital communications are conducted during the Hospitals' and physicians' reasonable and normal business hours, unless otherwise mutually agreed.

On-Site Review Procedures

Staff shall identify themselves by name and by the name of their organization and, for on-site reviews, should carry picture identification and the private review agent company identification card. On-site reviews should, whenever possible, be scheduled at least one business day in advance with the appropriate Hospital contact. Private review agents shall agree, if so requested, that the medical records remain available in designated areas during the on-site review and that reasonable Hospital administrative procedures shall be followed by on-site review staff to not disrupt Hospital operations or patient care.

IV. Treatment Request Reviews

When conducting reviews, only the information necessary to make a Utilization Review determination will be requested. Pursuant to CMSR 15-016-082, Subchapter 1, Rule 82.7.2, those standards mandated by the state of Mississippi are abided by. Those include, but are not limited to, the following:

1. When conducting routine prospective and concurrent Utilization Review, only the information necessary to Certify the admission, procedure or treatment and length of stay is collected.
2. During prospective and Concurrent Review, copies of medical records are only required when a difficulty develops in Certifying the medical necessity or appropriateness of the admission or extension of stay. In those cases, only the necessary or pertinent sections of the record are required.
3. As a Private Review Agent, Zenith may request copies of medical records retrospectively for a number of purposes, including auditing the services provided, quality assurance, and evaluation of compliance with the terms of the health benefit plan or UR provisions.

In addition, initial data requirements are limited to those elements listed in CMSR 15-016-082, Subchapter 1, Rule 82.7.3. These requirements may include patient, enrollee and Attending Physician/practitioner information, clinical diagnostic and treatment information, facility continued stay information and information regarding admissions to facilities other than acute medical surgical Hospitals.

Additional information may be required when special situations arise, such as Discharge Planning, second surgical opinion, and/or there is a significant lack of agreement between Zenith and the

health care provider per Rule 82.7.4. Additionally, information may be requested by the private review agent or voluntarily submitted by the provider, when there is significant lack of agreement between the private review agent and health care provider regarding the appropriateness of Certification during the review or Appeal process. A significant lack of agreement may occur when the private review agent has:

- Tentatively determined, through its professional staff, that a service cannot be certified;
- Referred the case to a physician for review; and
- Talked to or attempted to talk to the Attending Physician for further information.

Clinical and demographic information is shared on individual patients among its various divisions (e.g., Certification, Discharge Planning, Case Management) to avoid duplicate requests for information from Enrollee or providers.

The Utilization Review process provides for Initial Reviews, Concurrent Reviews, and Retrospective Reviews.

Initial Utilization Review pursuant to Title 20, IV A, B, C

Initial review determinations regarding Certification, recertification or extensions of prior authorized length of stay must be made within two (2) business days of receipt of the necessary information on a proposed non-emergency admission or service requiring a review determination. Pursuant to II Reimbursement A. Guidelines, prior Authorization may be made by telephone as long as it is documented in patient's medical record indicating the date and name of payer representative giving the Authorization for continued therapy

When an initial determination is made to Certify Hospital or surgery facility admission or extension of a Hospital stay or other service requiring determination, Notification shall be provided promptly, at least within one (1) business day or before the service is scheduled, whichever first occurs, either by telephone or by written or electronic Notification to the provider or facility rendering the service. If an initial determination to Certify is provided by telephone, a written Notification of the determination shall be provided within two (2) business days thereafter. The written Notification shall include the number of days Certified, the new total number of days or services Certified, and the date of admission or onset of services.

When a determination is made not to Certify an admission, procedure, stay or other service, Notification to the attending or ordering provider or facility must be provided by telephone or electronic means within two (2) business days followed by a written Notification within one (1) business day thereafter to the requesting provider. The written Notification must include the principal reason/Clinical Rationale for the determination not to Certify, including specific

reference to any provision of the Fee Schedule relied upon by the reviewer, and instructions for initiating an Appeal and/or reconsideration request.

No determination adverse to a patient or to any affected health care provider shall be made on any question relating to the necessity or justification for any form of Hospital, medical or other health care services without prior evaluation and concurrence in the adverse determination by a physician currently licensed to practice in Mississippi and properly training in the same specialty or subspecialty as the requesting provider who is seeking approval for treatment or services. The physician who made the adverse determination shall discuss the reasons for any adverse determination with the affected health care provider, if the provider so requests. The physician shall comply with this request within fourteen (14) calendar days of being notified of a request.

Retrospective Utilization Review pursuant to Title 20, IV D.(3)

The review determination shall be based on the medical information available to the attending or ordering provider at the time the medical care was provided, and on any other relevant information regardless of whether the information was available to or considered by the provider at the time the care or service was provided. Retrospective Review is not optional or conducted solely at the discretion of the review agent. A request for review and approval of services already provided must be handled by the payer or its Utilization Reviewer in the same manner any other request for approval of services is handled.

Healthcare providers are reimbursed reasonable direct costs of duplicating requested records for retrospective review unless the records pertain to a review of records that pertain to a review of records associated with an Appeal or with an investigation of data discrepancies and unless otherwise provided by contract or law.

When there is retrospective determination not to Certify an admission, procedure, stay, or other service, the Attending Physician or other ordering provider and Hospital or facility shall receive written Notification, by facsimile or electronic mail, within twenty (20) calendar days after receiving the request for Retrospective Review and all necessary and supporting documentation.

Failure of Precertification under the Fee Schedule shall not result in denial of payment of services provided. Instead, if requested to do so by the provider within one (1) year of the date of service or discharge, a retrospective review of the services shall be conducted. If it is determined the services provided would have been pre-certified (in whole or in part) and if the Precertification had been timely sought by provider, then the provider shall be reimbursed for Certified services per the Fee Schedule less 10% penalty or accordingly to an applicable separate fee agreement between the payer and provider less 10% penalty, or if it is determined that Precertification for services would not have been given, then the claims administrator shall dispute the bill per the Billing and Reimbursement Rules.

Concurrent Review pursuant to CMSR 15-016-082, Subchapter 7, Rule 82.7.5(4)(b)

A determination to Certify an admission, procedure, stay or other service resulting from concurrent review shall be transmitted to the Attending Physician by telephone or in writing within one (1) business day of receipt of all information necessary to complete the review process or prior to the end of the current certified period.

Emergency Admissions or Surgical Procedures Utilization Review pursuant to Title 20, IV D.(4)

Emergency admissions or surgical procedures must be reported to the payer by the end of the next business day. Post review activities will be performed following emergency admissions, and a continued stay review may be initiated.

If a licensed physician certifies in writing to the payer or its agent or representative within seventy-two (72) hours of an admission that the injured worker admitted was in need of emergency admission to Hospital care, such shall constitute a prima facie case for the medical necessity of the admission. An admission qualifies as an emergency admission if it results from a sudden onset of illness or injury which is manifested by acute symptoms of sufficient severity that the failure to admit to Hospital care could reasonably result in (1) serious impairment of bodily function(s), (2) serious or permanent dysfunction of any bodily organ or part or system, (3) permanently placing the person's health in jeopardy, or (4) other serious medical consequence.

To overcome a prima facie case for emergency admission as established above, the Utilization Reviewer must demonstrate by clear and convincing evidence that the patient was not in need of an emergency admission.

Precertification for Non-Emergency Surgery

Providers must pre-Certify all non-emergency surgery. However, certain catastrophic cases that require frequent returns to the operating room may allow provider to obtain Certification of the Treatment Request plan to include multiple surgical procedures. In those cases, the Treatment Request plan must be specific and agreement mutual between the provider and payer regarding number and frequency of procedures certified.

Timely Notification

Per CMSR 15-016-082, Subchapter 11, Rule 82.11.1 Zenith shall forward, either electronically or in writing, a Notification of Certification or determination not to Certify to the appropriate claims administrator for the health benefit plan. Failure of a payer or its Utilization Review agent to timely notify the provider of a decision whether to Certify an admission, procedure, service or other treatment shall be deemed to constitute approval by the payer of the requested treatment and shall obligate the payer to reimburse the provider in accordance with other applicable provisions of the

Fee Schedule should the provider elect to proceed with the proposed treatment or service. Timely Notification means Notification by mail, facsimile, electronic mail, or telephone, followed by written Notification, to the provider, within the applicable time periods set forth in the Utilization Review Rules in the Fee Schedule.

Third Party Utilization Review Organization

Zenith has contracted with a third-party vendor Utilization Review organization ("URO") to coordinate and conduct a physician review of Treatment Request plans and provide information when internal staff is unable to Certify the Treatment Request plan. The URO is required to comply with all Mississippi statutory and regulatory requirements, including maintaining a properly filed Utilization Review Plan (refer to Attachment "B"). All services performed by the URO are performed in compliance with the URO's filed Utilization Review Plan (MS Private Review Agent certificate# R0204).

During the First Level Clinical Review process, if the request cannot be Certified due to lack of medical necessity, requests are referred to the URO for the Second Level Clinical Review where Clinical Peer reviewers then determine whether a request for an admission, procedure, or service satisfies the standard of medical necessity as defined elsewhere in this Fee Schedule. A decision to deny, or not Certify, proposed treatment or services, must be supported by the express written evaluation, findings and concurrence of a physician licensed to practice medicine in the State of Mississippi and properly trained in the same specialty as the requesting provider. The third-party vendor may contact the requesting provider for additional appropriate information or clarification. A decision will be rendered to Certify or non-Certify based on the information provided. When a decision not to Certify a requested admission, procedure, stay or service has been Appealed, a Third Level Clinical Review is conducted by appropriate Clinical Peers who were not involved in the First or Second Level Clinical Review The third level peer reviewer must be in the same or like specialty as the requesting provider. A decision to deny, or not Certify, proposed treatment or services, must be supported by the express written evaluation, findings and concurrence of a physician licensed to practice medicine in the State of Mississippi and properly trained in the same specialty as the requesting provider.

Contracted UR/MBA Vendors

Treatment Requests are reviewed internally. Staff may Certify treatment or may work with the requesting physician to mutually Modify the treatment. Staff may not Non-Certify any Treatment Request based on Medical Necessity. If staff cannot Certify a Treatment Request, the request is sent to Zenith's external certified URO Genex for further review by a physician with appropriate licensing. Zenith provides Utilization Review services for itself and several sister companies through intercompany agreements. Zenith also provides services for other clients pursuant to

agreements with those clients. The list of entities for which Zenith provides services is located in Exhibit "H".

V. Utilization Review Dispute Resolution

Appeals of Determinations not to Certify PURSUANT TO CMSR 15-016-082, Subchapter 8, Rule 82.8.1

Any person aggrieved by a final decision of the department or a private review agent in a contested case under this act shall have the right of judicial Appeal to the chancery court of the county of the residence of the aggrieved person. Notwithstanding any provisions of this act, the insured shall have the express right to pursue any legal remedies s/he may have in a court of competent jurisdiction.

The following are the procedures utilized for Appeals made in writing and/or by telephone (refer to Exhibit B):

Standard Appeal pursuant to CMSR 15-016-082, Subchapter 10, Rule 82.10.1-82.10.5

A Standard Appeal will be considered as a request for reconsideration. A written request for a Standard Appeal may be submitted by mail or fax. A Standard Appeal will be processed twenty (20) calendar days after receipt of all necessary documentation and medical information.

Notification of the Appeal decision, and applicable Appeal rights and procedures to do so, is sent to the patient, provider and claims administrator as soon as practicable but not later than sixty (60) calendar days after receiving the required documentation on the Appeal. Examples of sufficient documentation include copies of all or part of the medical record and/or written statements from the Attending Physician.

Prior to making a decision not to Certify for clinical reasons, a review of documentation is completed by a physician who did not make the original determination.

The Attending Physician, who has been unsuccessful in an attempt to reverse a determination not to Certify treatment or services, is provided by Notification the following: Clinical Rationale for the denial, including a statement or documentation regarding the clinical basis for the denial; a sufficient basis for a decision to pursue an Appeal; and specific reference to the Mississippi Fee Schedule, either in support of the denial decision, or a statement attesting to the fact that no such provision exists in the Fee Schedule.

Expedited Appeal pursuant to CMSR 15-016-082, Subchapter 9, Rule 82.9.1 & Rule 82.9.2

When an initial determination not to Certify a health care service is made prior to or during an ongoing service requiring imminent or expedited review, and the Attending Physician believes that the determination warrants immediate Appeal, the Attending Physician shall have an opportunity to Appeal that determination over the telephone on an expedited basis within one (1) working day. Zenith and its URO provide for prompt and expeditious access to its Consulting Physician(s) for such Appeals. In these cases, the maximum information possible is shared by phone, fax, or otherwise to resolve the Expedited Appeal (sometimes called a reconsideration request) satisfactorily.

Expedited Appeals, which do not resolve a difference of opinion, may be resubmitted through the Standard Appeal process, or submitted directly to the Commission's Medical Cost Containment Division as a Request for Resolution of Dispute. A disagreement warranting expedited review or reconsideration does not have to be resubmitted to the payer or Utilization Review agent through the Standard Appeal process unless the requesting provider so wishes.

Request for Dispute Resolution

When a payer and provider have completed the Utilization Review Appeals process and cannot agree on a resolution to a dispute, either party, or the patient, can Appeal to the Cost Containment Division of the Mississippi Workers Compensation Commission, and should submit this request on the Request for Dispute Resolution Form adopted by the Commission. A request for resolution of a Utilization Review dispute should be filed with the Commission within twenty (20) calendar days following the conclusion of the underlying Appeal process provided by the payer or it’s Utilization Reviewer.

The Commission shall consider and decide a request for resolution of a Utilization Review dispute in accordance with the Dispute Resolution Rules provided elsewhere in the Mississippi Fee Schedule.

VI. Privacy and Security

Zenith requires staff to protect the privacy of the information used, maintained or accessed by Zenith in the normal course of the business (refer to Attachment "D"). To help ensure compliance with privacy and confidentially, and in accordance to applicable federal and state laws, Zenith has implemented the following policies:

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

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

Additionally, pursuant to ***CMSR 15-016-082, Subchapter 12,*** Rule 82.12.1, Zenith has written procedures for assuring that patient-specific information obtained during the process of Utilization Review will be:

1. Kept confidential in accordance with applicable federal and state laws;
2. Used solely for the purposes of Utilization Review, quality assurance, Discharge Planning and catastrophic Case Management; and
3. Shared with only those agencies (such as the claims administrator) who have authority to receive such information.

*Additionally, pursuant to ***CMSR 15-016-082, Subchapter 12,*** Rule 82.12.2, summary data shall not be considered confidential if it does not provide sufficient information to allow identification of individual patients.

EXHIBIT "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

EXHIBIT "B"

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 Certify a Treatment Request for Medical Necessity based on information submitted with the Treatment Request:

Genex Services, LLC
440 East Swedesford Road, Suite 1000
Wayne, PA 19087
Contact: Bobbie Doyle
Phone: (800) 477-1828
Email: bobbie.doyle@genexservices.com
Fax: (877) 838-4127

Mississippi Plan # R0204

Genex Services, LLC complies with the requirements of its filed Utilization Review Plan when performing services on behalf of Zenith.

EXHIBIT "C"

ZENITH MISSISSIPPI UTILIZATION REVIEW GUIDELINES

Zenith's utilization review organization (URO) will include specific reference to any provision of the MFS relied upon by a Mississippi-licensed reviewer in any determination to not certify. The sole use of extraneous guidelines, including, but not limited to, ODG guidelines, to determine appropriateness or extent of treatment is prohibited.

The specific section under Pain Management of the MFS (most current version) must be cited and rationale provided for any non-certified procedure/treatment. In addition, the use of any outside guidelines to deny interventional pain management care is prohibited per the MFS, Sect. VII, Pain Management Criteria, (A).

To support the Authorization/pre-certification and utilization review processes, Zenith, claims administrators and its contracted URO follow the Mississippi Fee Schedule where applicable as noted above, based on the concept of medical necessity and predicated on objective or appropriate subjective improvements in the patient's clinical status. In addition, when appropriate, the following other evidence-based guidelines (most current editions) may also be used:

- Guidelines for the Prescription of Opiates promulgated by the Mississippi State Board of Medical Licensure for chronic, non-terminal pain
- *ODG by MCG - Treatment Guidelines,* excluding the return-to-work pathways, (ODG), published by MCG Health
- *American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines*, (ACOEM), electronic version published by ReedGroup, a wholly owned subsidiary of Guardian
- Other applicable evidence-based medicine guidelines where appropriate

EXHIBIT "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 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 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 "E"

MISSISSIPPI PRECERTIFICATION LIST

Prior to providing treatment to the injured worker, the provider is required to submit a Treatment plan for Precertification in compliance with the Mississippi Workers' Compensation Fee Schedule (MFS), Title 20, Authorization/Pre-certification Rules and Title 20, Pain Management. Experimental or investigational treatment as defined and set forth in the Mississippi Fee Schedule is not reimbursable. The following procedures require Pre-certification or mandatory Utilization Review:

Pre-certification is required for the services listed below:

1. All elective admissions to inpatient facilities of any type
2. All elective surgical procedures, inpatient or outpatient (applies to facilities of any type). (All surgical or other invasive procedures administered in the context of pain management treatment are regulated by the specific guidelines in the Pain Management section of the MFS.) Provider may request approval of a treatment plan for catastrophic cases that require frequent returns to the operating room, such as with burns requiring daily debridement.
3. Pain Management Procedures. Repeat MRI scans, repeat CT scans, repeat EMG/NCS studies, and repeat Myelograms for the same injury except post-surgery following an approved procedure. In such post-surgery situation, the treating physician is entitled to obtain one repeat of the above-mentioned diagnostic procedures without pre-certification. In other words, surgical cases merit two diagnostic procedures of the kind listed above without the necessity of pre-certification. The two diagnostic procedures selected by the treating provider may be the same two diagnostic procedures, or any two procedures listed above.
4. Physical medicine treatments (including but not limited to physical, occupational and chiropractic treatments) after 15 visits or 30 days, whichever comes first, and/or 15 visits post-operatively.
5. Rental or purchase of supplies or equipment over $300.00 per item
6. Rental or purchase of TENS
7. Home health services
8. Pain clinic/therapy programs, including interdisciplinary pain rehabilitation programs
9. External spinal stimulators
10. Pain control programs
11. Work hardening programs, functional capacity testing, ISO kinetic testing
12. Orthotics or prosthetics
13. Psychological testing/counseling/treatment
14. Substance abuse program
15. Weight reduction program
16. Any non-emergency medical service outside the state of Mississippi
17. Repeat MRI (more than once per injury and/or more than one post-operatively)
18. Repeat CT scan (more than once per injury and/or more than one post-operatively)
19. Repeat EMG/NCS (more than once per injury and/or more than one post-operatively)

20. Repeat Myelograms (more than once per injury and/or more than one post-operatively)
21. Massage therapy, acupuncture and biofeedback
22. Intraoperative neurophysiological monitoring (e.g. SSEP, VEP, DEP, BAEP, MEP) in the following cases:
23. Neuromuscular junction testing of each nerve during intraoperative monitoring;
24. Intraoperative monitoring during peripheral nerve entrapment releases, such as carpal release, ulnar never transposition at the elbow, and tarsal tunnel release;
25. During decompression of cervical nerve roots without myelopathy;
26. During placement of cervical instrumentation absent evidence of myelopathy;
27. During lumbar discectomy for radiculopathy; or
28. During lumbar decompression for treatment of stenosis without the need for instrumentation.
29. Neurostimulation
30. Repeat comparison X-rays
31. Pain management diagnostic injections – more than one type in the same anatomic area on the same date of service
32. Intrathecal drug delivery/pumps. Requests must have the recommendation of at least one physician experienced in chronic pain management in consultation with the primary treating physician. Due to the complication rate for long-term use, it may be considered only in very rare occasions when dystonia and spasticity are dominant features or when pain is not able to be managed using any other non-operative treatment.
33. Botulinum Toxin
34. For all agents **not** recommended in the MFS Pain Management Criteria chapter, Section M. Topical Drug Delivery. Agents recommended include:
35. Capsaicin
36. Ketamine and tricyclics
37. Lidocaine
38. Topical salicylates and non-salicylates
39. Pre-certification is required beyond the initial prescription of ketamine and tricyclics as well as all other agents not listed above
40. Controlled substances not documented and/or not in compliance with the Prescription of Opiates promulgated by the Mississippi State Board of Medical Licensure for chronic, non-terminal pain
41. Treatment provided in federal facilities requires authorization from the payer. However, federal facilities are exempt from the billing requirements and reimbursement policies in the Mississippi Fee Schedule.

(Back schools are not covered under the Fee Schedule)

EXHIBIT "F"

Genex Peer and Physician Advisor Panel

Genex Peer and Physician Advisor Panel on file with MS State Dept of Health, Bureau of Health Facilities, Licensure & Certification.

EXHIBIT "G"

Zenith's Internal Staff Qualifications List

See *Staff Qualifications* above.

EXHIBIT "H"

Entities for Which Zenith Performs Utilization Review

Zenith currently provides Utilization Review services for the following entities:

Entity Name	Address
Zenith Insurance Company	21255 Califa Street Woodland Hills, CA 91267
ZNAT Insurance Company	21255 Califa Street Woodland Hills, CA 91267
RiverStone Claims Management, LLC oversight of legacy claims under a Loss Portfolio Transfers:	RiverStone Claims Management LLC, 250 Commercial St., Suite 5000, Manchester, NH 03101
a. First Mercury Insurance Company	Crum & Forster, 305 Madison Avenue, Morristown, NJ 07960
b. Crum & Forster Indemnity Company	Crum & Forster, 305 Madison Avenue, Morristown, NJ 07960
c. Crum and Forster Insurance Company	Crum & Forster, 305 Madison Avenue, Morristown, NJ 07960
d. The North River Insurance Company	Crum & Forster, 305 Madison Avenue, Morristown, NJ 07960
e. United States Fire Insurance Company	Crum & Forster, 305 Madison Avenue, Morristown, NJ 07960
TIG Insurance Company (entities below merged into TIG)	TIG Insurance Company, 8880 Rio San Diego Drive, Suite 800, San Diego, CA 92108
a. International Insurance Company	See above address for TIG Insurance Company
b. Old Lyme Insurance Company of Rhode Island, Inc.	See above address for TIG Insurance Company
c. Fairmont Specialty Insurance Company, f/k/a Ranger Insurance Company	See above address for TIG Insurance Company
	See above address for TIG Insurance Company
d. Fairmont Premier Insurance Company	See above address for TIG Insurance Company
e. Fairmont Insurance Company	See above address for TIG Insurance Company
f. General Fidelity Insurance Company	See above address for TIG Insurance Company
g. American Safety Indemnity Company	See above address for TIG Insurance Company
h. American Safety Casualty Insurance Company	See above address for TIG Insurance Company
TIG Insurance Company responsibility of legacy claims under assumption reinsurance:	TIG Insurance Company, 8880 Rio San Diego Drive, Suite 800, San Diego, CA 92108
a. First Mercury Insurance Company	Crum & Forster, 305 Madison Avenue, Morristown, NJ 07960
b. Crum & Forster Indemnity Company	Crum & Forster, 305 Madison Avenue, Morristown, NJ 07960
c. Crum and Forster Insurance Company	Crum & Forster, 305 Madison Avenue, Morristown, NJ 07960
d. The North River Insurance Company	Crum & Forster, 305 Madison Avenue, Morristown, NJ 07960
e. United States Fire Insurance Company	Crum & Forster, 305 Madison Avenue, Morristown, NJ 07960
Seneca Insurance Company	Seneca Insurance Company 160 Water Street, 16th floor New York, New York, 10038
Tokio Marine Management, Inc. for the following sister insurance companies:	Tokio Marine P.O. Box 483

Entity Name	Address
	Jersey City, NJ 07303
a. Trans Pacific Insurance Company	See address for Tokio Marine
b. TNUS Insurance Company	See address for Tokio Marine
c. Tokio Marine America Insurance Company	See address for Tokio Marine