Zenith Insurance Management Services, Inc.,
dba Zenith Claims Solutions
21255 Califa Street
Woodland Hills, CA 91367

Kentucky
Utilization Review Plan

11/01/2026

Utilization Review Plan

Title 803 Chapter 25 Regulation 195 • Kentucky Administrative Regulations • Legislative Research Commission

1. The process, policies, and procedures whereby decisions shall be made.

Pages 5-12

2. A statement that medical treatment guidelines adopted by the Commissioner pursuant to KRS 342.035(8)(a) shall be incorporated in the plan as the standard for utilization review medical decision making; Official Disability Guidelines (ODG).

Page 13

3. The criteria by which claims and medical services shall be selected for review.

Page 14

4. The qualifications of internal and consulting personnel who will conduct the utilization review which includes their education, training, and experience, necessary to evaluate clinical issues and services for medical necessity and appropriateness.

Pages 15-16

5. The process to assure that treatment plans are obtained for review by qualified medical personnel in all instances where treatment plans are required by 803 KAR 25:096.

Page 17

6. The process to assure that a physician has been designated by each injured employee as required under 803 KAR 25:096 or 803 KAR 25:110.

Page 18

7. The process for rendering and promptly notifying the medical provider and employee of the initial utilization review decision.

Pages 19-20

   a.) Initial Utilization Review decision within two (2) business days of the initial request for treatment.
   b.) Retrospective Utilization Review decision within seven (7) business days of the initial UR process.
   c.) Expedited Utilization Review decision within twenty-four (24) hours following the UR request.

8. A description of the initial utilization review denial process including the following information contained on the denial letter:

- A statement of the medical reasons for denial;
- The name and U. S. state of licensure, and medical license number of the reviewer;
- An explanation of utilization review reconsideration rights.

Page 20

9. A description of the reconsideration process within the structure of the utilization review program with all applicable timeframes.

Page 21

10. A description of the process when the medical provider whose recommendation for treatment is denied may request reconsideration, and may require the reconsideration to include a peer-to-peer conference with a second utilization review physician.

Pages 22-23

11. A description of the pharmaceutical reconsideration process per 803 KAR 25:270.

Page 24

12. An assurance that a database shall be maintained for a period of no less than two (2) years, subject to audit by the Commissioner, or the Commissioner's agent, and with the details required per KRS 342:035(5)(b).

Page 25

13. A description of the policies and procedures that will protect the confidentiality of patient information.

Pages 26-27

14. An assurance that during the term of an approved plan, the Commissioner shall be notified as soon as practicable of a material change in the approved plan or a change in the selection of a vendor.

Page 28

15. An assurance that a medical payment obligor who contracts with an approved vendor for utilization review or medical bill audit services shall notify the Commissioner of the contract. The contractual arrangement may provide for separate utilization review and medical bill audit vendors.

Page 29

16. Provide a copy of the Medical Director's Curriculum Vitae.

Page 30

17. Include a list of clients that contract you to perform UR/MBA services.

Pages 31-32

18. Submit example letter of approval, denial, reconsideration and final reconsideration, these must be on company letterhead.

Page 33

As described herein, Zenith Insurance Management Services, Inc., dba Zenith Claims Solutions ("Zenith") performs first level review of treatment requests for utilization review. If Zenith cannot approve the treatment request, Zenith sends the treatment request to Genex Services, LLC ("Genex") for review. Zenith performs all levels of bill review internally unless a retrospective review is needed for medical necessity. Those reviews are conducted by Genex. Zenith provides utilization review, bill review and other services for affiliated and non-affiliated entities.

KENTUCKY UTILIZATION REVIEW PLAN

The following overview, description of processes, policies and procedures constitute Zenith's Utilization Review Plan. Capitalized terms used in this Utilization Review Plan have the meanings ascribed to them in the Definitions section of this Plan. As a Kentucky Claims Administrator, Zenith has established and maintains this Utilization Review Plan and its Utilization Review Process in compliance with 803 KAR 25:195. and applicable regulations.

DEFINITIONS

All capitalized terms in this Utilization Review Plan shall have the following definitions, unless otherwise defined in this document:

1. "Appeal" or "reconsideration" means a request to reconsider a determination not to approve an admission, procedure, and extension of stay or other health care service.

2. "Approve" means to approve services under the injured workers plan of coverage.

3. "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 an accepted compensable industrial injury or illness.

4. "Business Day" means any day except Saturday, Sunday, or any day that is a legal holiday.

5. "Calendar Day" means all days in a month, including Saturday, Sunday, and any day which is a legal holiday.

6. "Carrier" means any insurer, or legal representative thereof, authorized to insure the liability of employers under this chapter and includes a self-insurer;

7. "Claims Examiner" means staff trained to process claims.

8. "Commissioner" means the commissioner of the Department of Workers' Claims under the direction and supervision of the secretary of the Education and Labor Cabinet

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

10. "Criteria" as defined by Zenith means the use of Official Disability Guidelines (ODG), and other evidence based medicine guidelines to evaluate Treatment Plans.

11. "Denial" means a determination by the utilization reviewer that the medical treatment or proposed treatment, service or medication under review is not medically necessary or appropriate and, therefore, payment is not recommended.

12. "Department" means the Department of Workers' Claims in the Education and Labor Cabinet;

13. "Discharge Planning" means the process of assessing a patient's need for treatment after hospitalization to facilitate the necessary services and resources for an appropriate and timely discharge.

14. "DWC" means the Kentucky Department of Workers' Claims.

15. "Emergency Health Care Services" means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy.

16. "Health Care Provider" means any attending health care provider, facility or practitioner, authorized under state or federal law to bill for health care services rendered.

17. "Immediately" means within 24 hours after learning the circumstances that would require an extension of the time frame for review decisions in accordance with utilization review standards set forth in this Plan.

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

19. "Medical Director" means a physician licensed by a state Medical Board or Osteopathic Board who holds an unrestricted license to practice medicine in the State in which the physician resides and is responsible for oversight of all Zenith Utilization Review programs. 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 Medical Officer.

20. "Medically Necessary" or "Medical Necessity" means healthcare services, including medications, that a medical provider, exercising prudent clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating, an illness, injury, disease, or its symptoms, and that are: a. In accordance with generally accepted standards of medical practice; b. Clinically appropriate, in terms of type, frequency, extent site and duration; and c. Considered effective for the patient's illness, injury, or disease.

21. "Medical Payment Obligator" means any self-insured employer, carrier, insurance carrier, self-insurer, or any person acting on behalf of or as an agent of the self-insured employer, carrier, insurance carrier, or self-insurer.

22. "Medical Provider" means physicians and surgeons, psychologists, optometrists, dentists, podiatrists osteopathic and chiropractic practitioners, physician assistants, and advanced practice registered nurses, acting within the scope of their license.

23. "NC" means a registered nurse employed by Zenith's medical management department.

24. "Other Party Designated" means any person or entity designated by the injured worker to receive notice of approval or denials thereof. This term shall presumptively include the primary attending health care provider and any other affected health care provider of record.

25. "Physician" means physicians and surgeons, psychologists, optometrists, dentists, podiatrists, and osteopathic and chiropractic practitioners acting within the scope of the license or other credentials required by his or her specialty of practice in the United States jurisdiction in which he or she is authorized to practice. Chiropractors must also meet the requirements under 201 KAR 21:095 as of 08/08/2023 amendment.

26. "Physician Reviewer" means physicians and surgeons, psychologists, optometrists, dentists, podiatrists, and osteopathic and chiropractic practitioners acting within the scope of the license or other credentials required by his or her specialty of practice in the United States jurisdiction in which he or she is authorized to practice, who has been consulted by the reviewer or the Medical Director to provide specialized review of medical information.

27. "Preauthorization" means the process whereby payment for a medical service or course of treatment is assured in advance by a carrier.

28. "Retrospective Review" means utilization review conducted after medical services have been provided and for which approval has not already been given. Retrospective reviews shall be based solely on the medical information available to the attending physician or ordering provider at the time the health care services were provided. Retrospective Reviews of approvals may be conducted only for purposes of internal quality assurance, procedural compliance with Workers Compensation rules and regulations and auditing of the appropriateness of health care services approved and provided. Once approval is issued, then except for fraud committed by the injured worker or medical provider, Retrospective Review of that approval must not result in any additional cost to the injured worker or medical provider.

29. "Same medical specialty" means a branch of medical practice focused regulatory and routinely on a defined group of patients, diseases, skills, body part, or types of injury and performed by a physician with the same or similar qualifications.

30. "The Act" or the "Statute" means the Kentucky Workers Compensation Act found under applicable sections of KRS Chapter 342.

As described herein, Zenith Insurance Management Services, Inc., dba Zenith Claims Solutions ("Zenith") performs first level review of treatment requests for utilization review. If Zenith cannot approve the treatment request, Zenith sends the treatment request to Genex Services, LLC ("Genex") for review. Zenith performs all levels of bill review internally unless a retrospective review is needed for medical necessity. Those reviews are conducted by Genex. Zenith provides utilization review, bill review and other services for affiliated and non-affiliated entities.

31. "Treatment Plan" and "Request for Authorization" means a written plan that:

- **a)** May consist of copies of charts, consultation reports or other written documents maintained by the injured employee's Designated Physician discussing symptoms, clinical findings, results of diagnostic studies, diagnosis, prognosis, and the objectives, modalities, frequency, and duration of treatment;
- **b)** Shall include, as appropriate, details of the course of ongoing and recommended treatment and the projected results; and
- **c)** May be amended, supplemented or changed as conditions warrant.

32. "Utilization review" means a review of the medical necessity and appropriateness of medical care and services for purposes of recommending payments for a compensable injury or disease.

33. "Utilization Review and medical bill audit plan" means the written plan submitted to the Commissioner by each medical payment obligor describing the procedures governing utilization review and medical bill audit activities and which sets forth Zenith's policies and procedures and a description of the Utilization Review Process.

34. "Utilization Review Process" means utilization management functions that initially, retrospectively or concurrently review and approve, modify, delay or deny, based in whole or in part on medical necessity and appropriateness of medical care and services to cure or relieve, treatment recommendations by physicians, prior to, retrospectively, or concurrent with the provisions of medical treatment services. The UR process will result in the treatment being either "approved" or "denied" rather than "certified" or "non-certified". Utilization review does not include determinations of the work-relatedness of injury or disease, or bill review for the purposes of determining whether the medical services were accurately billed.

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

36. "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.

As described herein, Zenith Insurance Management Services, Inc., dba Zenith Claims Solutions ("Zenith") performs first level review of treatment requests for utilization review. If Zenith cannot approve the treatment request, Zenith sends the treatment request to Genex Services, LLC ("Genex") for review. Zenith performs all levels of bill review internally unless a retrospective review is needed for medical necessity. Those reviews are conducted by Genex. Zenith provides utilization review, bill review and other services for affiliated and non-affiliated entities.

1. **The process, policies, and procedures whereby decisions shall be made.**

Utilization Review Process – Policy and Procedures:

Utilization Review Kentucky Administrative Regulations, Title 803, Chapter 25, Regulation 195 (803 KAR 25:195).

The Kentucky DWC has resources available on its Home Page.

Special Processes for This Jurisdiction:

Drug Formulary: Current Edition, ODG by MCG Health.

Kentucky has a drug formulary that applies to all reviews that contain a request for medication.

The rules are defined in 803 KAR 25:270, Section 2. (2) The Commissioner adopts the current edition and any future published updates of the ODG Formulary currently published by MCG Health.

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 Plans and provide information when Zenith staff is unable to approve the Treatment Plan (see "Attachment "B" - Third Party Utilization Review Organization."). The URO is required to comply with all Kentucky 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 Approve or Deny the Treatment Plan. 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 reviewer.

OVERVIEW OF UTILIZATION REVIEW PROCESSES, POLICIES & PROCEDURES

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 803 KAR 25:195. Zenith strives to work collaboratively with Health Care Providers in order to approve care that is consistent with Official Disability Guidelines or other evidence-based medicine guidelines utilized by Zenith and to provide consistent education and information to all other 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 with appropriate supporting documentation.

As described herein, Zenith Insurance Management Services, Inc., dba Zenith Claims Solutions ("Zenith") performs first level review of treatment requests for utilization review. If Zenith cannot approve the treatment request, Zenith sends the treatment request to Genex Services, LLC ("Genex") for review. Zenith performs all levels of bill review internally unless a retrospective review is needed for medical necessity. Those reviews are conducted by Genex. Zenith provides utilization review, bill review and other services for affiliated and non-affiliated entities.

Preauthorization: Pursuant to 803 KAR 25:260, For treatment designated as "Recommended" in the ODG guidelines, preauthorization is not required. For Treatment designated as "Not Recommended," preauthorization is required. When a request is made for preauthorization for treatment designated as "Conditionally Recommended," Zenith must consider any sound medical reasoning submitted by the medical provider and may not deny preauthorization based solely on the basis that conditions precedent have not been met.

Prior to providing treatment to the injured worker, the provider is required to submit a Treatment Plan to Zenith for Preauthorization in compliance with 803 KAR 25:096 §5(c)(2):

A Treatment Plan is required when:

a) Long-term medical care is required as a result of a work-related injury or occupational disease;

b) The injured employee has received treatment with passive modalities, including electronic stimulation, heat or cold packs, massage, ultrasound, diathermy, whirlpool, or similar procedures for a period exceeding sixty (60) days.

c) The Treatment Plan shall detail the need for the passive treatment, the benefits, if any, derived from the treatment, the risks attendant with termination of the treatment, and the projected period of future treatment; or

d) Seven (7) days in advance of an elective surgical procedure or placement into a resident work hardening, pain management, or medical rehabilitation program is recommended. The Treatment Plan shall set forth specific and measurable performance goals for the injured employee through the surgery, work hardening, or medical rehabilitation program.

- The Designated Physician shall provide a copy of the treatment plan to Zenith seven (7) days in advance of an elective surgical procedure or placement into a resident work hardening, pain management, or medical rehabilitation program. In all other instances when a treatment plan is required, a copy of the treatment plan shall be provided within fifteen (15) days following a request by Zenith. An amendment, supplement, or change to a Treatment Plan shall be furnished within fifteen (15) days following a request.
- Preparation of a Treatment Plan shall be a necessary part of the care to be rendered,
  and is included in the fee authorized in the medical fee schedule for the underlying services. An additional fee may not be charged for the preparation of a Treatment Plan or progress report, except for the reasonable cost of photocopying and mailing the records.

Additionally, per KRS §342.035 medical providers shall charge only their customary fee for photocopying requested documents. The photocopying fee of a medical provider or photocopying service shall not exceed fifty cents ($0.50) per page. In addition, a medical provider shall not charge a fee when the initial copy of medical records is provided to the injured worker or his or her attorney in response to a written request pursuant to KRS 422.317. Also, there shall be no charge for reviewing any records of a medical provider, during regular business hours, by any

party who is authorized to review the records and who requests a review pursuant to Chapter 342 of the code.

Case Review Selection Criteria: Pursuant to 803 KAR 25:195 §5(a-e), unless the payment obligor, in good faith, denies the claim as non-compensable or waives utilization review pursuant to KRS 342.035(5)(c), medical services reasonably related or asserted to be related to the claim shall be subject to utilization review if:

a) Upon a medical provider's request for Preauthorization;
b) Upon notification of a surgical procedure, or residential placement/treatment plan is received;
c) When total medical costs cumulatively exceed $3,000;
d) When total lost work days cumulatively exceed thirty (30) days; or
e) An administrative law judge orders a review.

Physician Designation Process: In accordance with 803 KAR 25:096, Treatment Plans should be obtained when required and rendered only by physician designated on physician card or a specialist referred by the designated physician.

Zenith follows the process set forth by 803 KAR 25:096 §§2 & 3(1-3) which allows injured workers to choose a designated physician. Except for emergency care, treatment for a work-related injury or occupational disease shall be rendered under the coordination of a single physician selected by the employee. Within ten (10) days following receipt of notice of a work injury or occupational disease causing lost work time or necessitating continuing medical treatment, the Zenith claims examiner shall mail a Form 113 to the injured employee, including a self-addressed, postage prepaid envelope for returning the Form 113. The injured worker must complete, sign and return the Form 113, identifying the Designated Physician to Zenith within ten (10) days. The physician must also sign the Form 113 agreeing to act as the Designated Physician. Within ten (10) days following receipt of a Form 113 designating a treating physician, the Zenith Claims Examiner must send a Designated Physician card to the injured employee. The claims examiner is responsible for assuring that the form is received timely and a copy of the fully completed form is uploaded into Documentum and notes placed in Athena.

Change of Designated Physician: Pursuant to 803 KAR 25:096 §4, following initial selection of a designated physician, the employee may change designated physicians once without authorization of the employer or Zenith. Referral by a designated physician to a specialist shall not constitute a change of designated physician unless the latter physician is specifically selected by the employee as the second designated physician.

Within ten (10) days of a decision to change the designated physician, the employee shall complete the back of the first designated physician card and return the card with the name of the second designated physician, including a written acceptance by the second designated physician, to Zenith. Zenith must issue a second card to the employee within ten (10) days.

The card shall bear the legend "Second Designated Physician-Workers' Compensation" and shall contain the information required on the first designated physician card. The reverse side of the card shall contain a notice that:

- Treatment shall be performed by or on referral from the second designated physician; and
- A further change of designated physician shall require the written consent of the employer, its Medical Payment Obligor, arbitrator, or the administrative law judge.

Failure of Zenith to timely mail the "Second Designated Physician" card shall waive an objection to treatment by other than a designated physician prior to receipt by the employee of the card.

If an employee's two (2) choices of designated physician have been exhausted, the employee may not, except as required by medical emergency, make an additional selection of a physician without the written consent of the employer, Zenith, arbitrator, or the administrative law judge.

Medical Treatment Guidelines: Pursuant to KRS 342.035(8)(a), Zenith and its contracted URO have incorporated the Official Disability Guidelines (ODG) as published by MCG Health for use by medical providers in the treatment of work related injuries and occupational diseases. When the ODG does not provide applicable guidelines, Zenith relies on other peer reviewed evidence-based medicine guidelines.

If the Treatment Plan does not meet the ODG Guidelines, the NC may contact the requesting physician for an agreement to voluntarily amend or withdrawal the original Treatment Plan. If agreement is reached on an amendment of the original Treatment Plan, the NC will request that the provider sign a written agreement confirming the modification. Upon receipt of the signed modification agreement, the NC may approve the Treatment Plan. If agreement is not reached or if agreement was reached but the physician fails to sign and return the agreement; the NC will refer the Treatment Plan to a Physician Reviewer or Zenith Medical Director.

In the event the NC believes the Treatment Plan was not accompanied with appropriate information to allow Zenith to render a decision, the NC will forward the Treatment Plan to Zenith's third party review vendor. The third party review vendor will have the Treatment Plan reviewed by a Physician Reviewer. If necessary, the Physician Reviewer may contact the requesting physician to obtain appropriate additional information necessary to render a decision. Requests for additional information must be made within five (5) business days of the date the Treatment Plan was originally received. Upon receipt of the appropriate additional information, the Treatment Plan will be reviewed by the Physician Reviewer.

A Physician Reviewer may Approve or Deny Treatment Plans based on their evaluation of the Treatment Plan or may request additional information. Therefore, if the NC is unable to approve a Treatment Plan based on submitted information, the Treatment Plan is sent for external review by Zenith's contracted utilization review organization. Only a Physician Reviewer who is competent to evaluate the specific clinical issues involved in the Treatment Plan, and where the Requested Plan is within the reviewer's scope of practice may Deny Treatment Plans.

Zenith requires that denials be rendered by physicians with an appropriate specialty. Zenith's methodology for updating its review Criteria consists of regular reviews by appropriate staff evaluation of internal processes, review outcomes and compliance with policies and procedures.

Zenith's review criteria also consists of monitoring whether services are being performed in compliance with 803 KAR 25:195 Section 2 including that reviewers are appropriately qualified, medically necessary and appropriate treatment is rendered to injured workers and medically necessary services are not withheld or unreasonably delayed.

Additionally, only a Zenith Medical Director may override (or attempt to override by additional opinions) a decision for approval or denial made by another Zenith Medical Director or external Physician.

Oral Treatment Plans: Zenith requires Treatment Plans 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 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 an approval 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. 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 Approve or Deny the Treatment Plan. 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 reviewer.

Note: A determination based on medical necessity with the information available is preferable; however, Kentucky does allow for denial based on insufficient information if Zenith's URO has documented the good faith effort to obtain the necessary information.

Reconsideration Process: See response 9 and 11 below for Reconsideration Process pursuant to 803 KAR 25:195 and 803 KAR 25:270.

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

a) 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:

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

b) 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 Zenith's mail room.

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

d) Where the Treatment Request is received by facsimile the received date is considered as follows:
   - If Zenith's electronic receive date stamp is present, this is considered the received date. Verbal Treatment Requests will be entered into the system the date received. Pursuant to Zenith 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 Zenith Electronic receive date stamp is present, the date of the fax transmission from the requesting sender is considered the received date.
   - If there is no fax transmission date or an erroneous date as the fax transmission date, the received date is considered the latest date indicated on the Treatment Request.

e) When the Treatment Request is received by telephone, the received date is considered as follows:
   - If the telephonic request is received after 3:00 p.m., the received date for the Treatment Plan will be considered the following business day; and the determination will be rendered with two (2) business days of receipt of the necessary information.
   - If the telephonic request is received prior to 3:00 p.m., the received date for the Treatment Plan will be considered that business day.

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.

Decision Review Tracking: Activities are tracked on appropriate systems to record in compliance with KRS342:035(5)(b):and 803 KAR 25:195 §4(9)(a):

1. Each instance of utilization review;
2. Each instance of medical bill audit;
3. The name of the reviewer;
4. The extent of the review;
5. The conclusions of the reviewer; and
6. The action taken, if any, as a result of the review.

Records related to utilization and bill review audit activities are maintained for a period of two (2) years or more from the date the underlying workers' compensation claim was closed pursuant to Zenith's records retention requirements. Database will be subject to audit by the Commissioner, or the Commissioner's agent pursuant to KRS 342.035(5)(b).

Reviewer Contact Information: Zenith maintains toll-free telephone access for employees and medical providers forty hours per week during normal business hours, which are Mon-Friday, 8 AM - 5 PM CST. That toll free number is 800-440-5020.

Additionally, Zenith maintains facsimile numbers available for Health Care Providers to submit Treatment Plans via fax. Zenith accepts Treatment Plans after normal business hours via either voice-mail and/or facsimile transmission.

Miscellaneous: Pursuant to KRS 342.285(1), a decision of an administrative law judge on a medical dispute is subject to review by the workers' compensation board under the procedures set out in 803 KAR 25:010, Section 22.

As provided under responses 14 and 15 below, in the event Zenith materially changes either its Utilization Review Process or resources, including material changes in the approved plan or vendors that support the Utilization Review Process, Zenith will notify the Commissioner by filing a material modification and updating this Utilization Review Plan pursuant to 803 KAR 25:195. §3 (4) and (5)(b). Furthermore, Zenith will notify the Commissioner of any contracts with an approved vendor for utilization review or medical bill audit services. The contractual arrangement may provide for separate utilization review and medical bill audit vendors.

Zenith uses Genex Services, LLC for utilization review services.

Zenith will update its review Criteria and other relevant data on a regular basis, as required, to ensure that it is using the most up-to-date Criteria when it reviews Treatment Plans. Zenith's methodology for updating its review Criteria consists of regular reviews by the Medical Director and other appropriate medical management staff to evaluate internal processes, review outcomes and compliance with policies and procedures, and to ensure that Zenith and any of its vendors are utilizing the most current and up-to-date Official Disability Guidelines and other peer reviewed evidence-based guidelines. Reviews occur no less frequently than annually.

As described herein, Zenith Insurance Management Services, Inc., dba Zenith Claims Solutions ("Zenith") performs first level review of treatment requests for utilization review. If Zenith cannot approve the treatment request, Zenith sends the treatment request to Genex Services, LLC ("Genex") for review. Zenith performs all levels of bill review internally unless a retrospective review is needed for medical necessity. Those reviews are conducted by Genex. Zenith provides utilization review, bill review and other services for affiliated and non-affiliated entities.

Confidentiality and Privacy Policy:

ATTACHMENT "D"
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.

As described herein, Zenith Insurance Management Services, Inc., dba Zenith Claims Solutions ("Zenith") performs first level review of treatment requests for utilization review. If Zenith cannot approve the treatment request, Zenith sends the treatment request to Genex Services, LLC ("Genex") for review. Zenith performs all levels of bill review internally unless a retrospective review is needed for medical necessity. Those reviews are conducted by Genex. Zenith provides utilization review, bill review and other services for affiliated and non-affiliated entities.

2. **A statement that medical treatment guidelines adopted by the Commissioner pursuant to KRS 342.035(8)(a) shall be incorporated in the plan as the standard for utilization review medical decision making; Official Disability Guidelines (ODG).**

   Pursuant to KRS 342.035(8) (a), Zenith and its contracted URO have incorporated the Official Disability Guidelines (ODG) as published by MCG Health for use by medical providers in the treatment of work related injuries and occupational diseases except for treatment provided in a medical emergency or urine drug screens [803 KAR 25:260]. When the ODG does not provide applicable guidelines, Zenith relies on other peer reviewed evidence-based medicine guidelines that are adopted by the Medical Director.

   If the Treatment Plan does not meet the ODG Guidelines, the NC may contact the requesting physician for an agreement to voluntarily amend or withdrawal the original Treatment Plan. If agreement is reached on an amendment of the original Treatment Plan, the NC will request that the provider sign a written agreement confirming the modification. Upon receipt of the signed modification agreement, the NC may approve the Treatment Plan. If agreement is not reached or if agreement was reached but the physician fails to sign and return the agreement; the NC will refer the Treatment Plan to a Physician Reviewer or Zenith Medical Director.

As described herein, Zenith Insurance Management Services, Inc., dba Zenith Claims Solutions ("Zenith") performs first level review of treatment requests for utilization review. If Zenith cannot approve the treatment request, Zenith sends the treatment request to Genex Services, LLC ("Genex") for review. Zenith performs all levels of bill review internally unless a retrospective review is needed for medical necessity. Those reviews are conducted by Genex. Zenith provides utilization review, bill review and other services for affiliated and non-affiliated entities.

3. The criteria by which claims and medical services shall be selected for review.

Pursuant to 803 KAR 25:195 §5. Claim Selection Criteria.

(1) Unless the medical payment obligor, in good faith, denies the claim as noncompensable or waives utilization review pursuant to KRS 342.035 (5)(c), medical services reasonably related or asserted to be related to the claim shall be subject to utilization review if:

- *a) A medical provider requests Preauthorization of a medical treatment or procedure;*
- *b) Notification of a surgical procedure or resident placement pursuant to an 803 KAR 25:096 treatment plan is received;*
- *c) When total medical cost cumulatively exceeds $3,000;*
- *d) When total lost work days cumulatively exceed thirty (30) days; or*
- *e) An administrative law judge (ALJ) orders a review.*

Zenith's Utilization Review Process provides for Prospective Reviews, Concurrent Reviews, and Retrospective Reviews. Compensable claims are subject to utilization review when any of the aforementioned criteria are met.

As described herein, Zenith Insurance Management Services, Inc., dba Zenith Claims Solutions ("Zenith") performs first level review of treatment requests for utilization review. If Zenith cannot approve the treatment request, Zenith sends the treatment request to Genex Services, LLC ("Genex") for review. Zenith performs all levels of bill review internally unless a retrospective review is needed for medical necessity. Those reviews are conducted by Genex. Zenith provides utilization review, bill review and other services for affiliated and non-affiliated entities.

4. **The qualifications of internal and consulting personnel who will conduct the utilization review which includes their education, training, and experience, necessary to evaluate clinical issues and services for medical necessity and appropriateness.**

> *Pursuant to 803 KAR 25:195 §6. Utilization Review and Medical Bill Audit Personnel Qualifications.*
> *(1) Utilization review personnel shall have education, training, and experience necessary for evaluating the clinical issues and services under review. The following professionals shall issue an initial utilization review approval:*
> *(a) A physician;*
> *(b) A registered nurse;*
> *(c) A licensed practical nurse;*
> *(d) A medical records technician; or*
> *(e) Other personnel whose training and experience qualify them to issue decisions on medical necessity or appropriateness, including a medical doctor, surgeon, psychologist, optometrist, dentist, podiatrist, and osteopathic practitioner, acting within the scope of the license or licenses required by the jurisdiction in which they are employed.*
> *(2) Utilization review personnel shall hold the license required by the United States' jurisdiction in which they are employed.*
> *(3) A physician shall supervise utilization review personnel.*
> *(4) A physician shall authorize and ratify any utilization review denial.*
> *(5) Only a physician may issue an initial utilization review denial. A physician shall supervise utilization review personnel in making utilization review recommendations. Personnel shall hold the license required by the jurisdiction in which they are employed.*
> *(6) Personnel conducting a medical bill audit shall have the education, training, or experience necessary for evaluating medical bills and statements.*

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 that process by which Zenith reviews, approves or denies requests by physicians 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.

Zenith's designated Medical Director holds an unrestricted license to practice medicine in California and is Board Certified in Occupational Medicine. See Attachment "A" for more information. Additionally, per the Commissioner's request, the Curriculum Vitae for Zenith's Medical Director are included in the Plan as "Attachment A-Designated Medical Director Curriculum Vitae."

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 directors, Nurse Consultant (NC), Claims Examiner and administrative support staff. The Utilization Review Process has multiple levels and modifications and denials can only be rendered by an appropriate external Physician Reviewer pursuant to the attached Zenith National Insurance Corp., National Utilization Review Policy - Policy Number: IP01.1 under response #1 above.

As described herein, Zenith Insurance Management Services, Inc., dba Zenith Claims Solutions ("Zenith") performs first level review of treatment requests for utilization review. If Zenith cannot approve the treatment request, Zenith sends the treatment request to Genex Services, LLC ("Genex") for review. Zenith performs all levels of bill review internally unless a retrospective review is needed for medical necessity. Those reviews are conducted by Genex. Zenith provides utilization review, bill review and other services for affiliated and non-affiliated entities.

Staff Qualifications: Zenith hires qualified staff to implement the Utilization Review Plan in an honest and ethical manner pursuant to 803 KAR 25:195, §6 (1) – (6). At the time of hire, credentials, including designations, licensure, degrees or certifications, must be verified. Staff is required to maintain appropriate licensure and certifications throughout their course of employment with Zenith. The Utilization Review Process is managed by a team that includes the Nurse Consultant ("NC"), Claims Examiner, and administrative support staff. Utilization Review Process has multiple levels and denials can only be rendered by an appropriate Physician Reviewer. Zenith's multi-level Utilization Review Process includes:

a) Zenith Claims Examiners may review Treatment Plans for the purpose of rendering coverage determinations or application of prior determinations. Claims Examiners may not make Medical Necessity determinations including decisions to Approve or Deny, a Treatment 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. Zenith 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.
b) 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 Plan for approval or referral to a Physician Reviewer or a Zenith Medical Officer. The NC is not permitted to deny a Treatment Plan. The NC refers Treatment Plans that cannot be approved 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 Plan appears to be inconsistent with or exceeds applicable guidelines. If the requesting physician voluntarily amends a Treatment Plan and confirms the amendment in writing, the NC reviewer may approve the amended Treatment Plan.
c) Zenith Medical Officers may review Treatment Plans for approval 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 approve a Treatment Plan, the Treatment Plan is sent for external physician review.
d) If a Treatment Plan cannot be approved through internal review processes, the Treatment Plan will be sent to Zenith's external certified URO for review by a Physician Reviewer. The Physician Reviewer will issue a decision to Approve or Deny.

As described herein, Zenith Insurance Management Services, Inc., dba Zenith Claims Solutions ("Zenith") performs first level review of treatment requests for utilization review. If Zenith cannot approve the treatment request, Zenith sends the treatment request to Genex Services, LLC ("Genex") for review. Zenith performs all levels of bill review internally unless a retrospective review is needed for medical necessity. Those reviews are conducted by Genex. Zenith provides utilization review, bill review and other services for affiliated and non-affiliated entities.

5. The process to assure that treatment plans are obtained for review by qualified medical personnel in all instances where treatment plans are required by 803 KAR 25:096.

As provided under Definition 31 above, "Treatment Plan" and "Request for Authorization" means a written plan that:

- ***a)*** *May consist of copies of charts, consultation reports or other written documents maintained by the injured employee's Designated Physician discussing symptoms, clinical findings, results of diagnostic studies, diagnosis, prognosis, and the objectives, modalities, frequency, and duration of treatment;*
- ***b)*** *Shall include, as appropriate, details of the course of ongoing and recommended treatment and the projected results; and*
- ***c)*** *May be amended, supplemented or changed as conditions warrant.*

In the event that the Medical Treatment Plan is not received:

a) If the reviewer determines that there is sufficient information, even without the Medical Treatment Plan, to reach an approval determination of medical necessity then the utilization review process shall be completed and approved.

b) If the reviewer determines that the Medical Treatment Plan is required to make a determination of medical necessity, then denial based on insufficient information may be issued, with the condition that a new review may be obtained when the Medical Treatment Plan is provided.

As described herein, Zenith Insurance Management Services, Inc., dba Zenith Claims Solutions ("Zenith") performs first level review of treatment requests for utilization review. If Zenith cannot approve the treatment request, Zenith sends the treatment request to Genex Services, LLC ("Genex") for review. Zenith performs all levels of bill review internally unless a retrospective review is needed for medical necessity. Those reviews are conducted by Genex. Zenith provides utilization review, bill review and other services for affiliated and non-affiliated entities.

6. **The process to assure that a physician has been designated by each injured employee as required under 803 KAR 25:096 or 803 KAR 25:110.**

Zenith follows the process set forth by 803 KAR 25:096 §§2 & 3(1-3) which allows injured workers to choose a designated physician. Except for emergency care, treatment for a work-related injury or occupational disease shall be rendered under the coordination of a single physician selected by the employee. Within ten (10) days following receipt of notice of a work injury or occupational disease causing lost work time or necessitating continuing medical treatment, the Zenith claims examiner shall mail a Form 113 to the injured employee, including a self-addressed, postage prepaid envelope for returning the Form 113. The injured worker must complete, sign and return the Form 113, identifying the Designated Physician to Zenith within ten (10) days. The physician must also sign the Form 113 agreeing to act as the Designated Physician. Within ten (10) days following receipt of a Form 113 designating a treating physician, the Zenith Claims Examiner must send a Designated Physician card to the injured employee. The claims examiner is responsible for assuring that the form is received timely and a copy of the fully completed form is uploaded into Documentum and notes placed in Athena.

Change of Designated Physician: Pursuant to 803 KAR 25:096 §4, following initial selection of a designated physician, the employee may change designated physicians once without authorization of the employer or Zenith. Referral by a designated physician to a specialist shall not constitute a change of designated physician unless the latter physician is specifically selected by the employee as the second designated physician.

Within ten (10) days of a decision to change the designated physician, the employee shall complete the back of the first designated physician card and return the card with the name of the second designated physician, including a written acceptance by the second designated physician, to Zenith. Zenith must issue a second card to the employee within ten (10) days.

The card shall bear the legend "Second Designated Physician-Workers' Compensation" and shall contain the information required on the first designated physician card. The reverse side of the card shall contain a notice that:

- Treatment shall be performed by or on referral from the second designated physician; and
- A further change of designated physician shall require the written consent of the employer, its Medical Payment Obligor, arbitrator, or the administrative law judge.

Failure of Zenith to timely mail the "Second Designated Physician" card shall waive an objection to treatment by other than a designated physician prior to receipt by the employee of the card.

If an employee's two (2) choices of designated physician have been exhausted, the employee may not, except as required by medical emergency, make an additional selection of a physician without the written consent of the employer, Zenith, arbitrator, or the administrative law judge.

As described herein, Zenith Insurance Management Services, Inc., dba Zenith Claims Solutions ("Zenith") performs first level review of treatment requests for utilization review. If Zenith cannot approve the treatment request, Zenith sends the treatment request to Genex Services, LLC ("Genex") for review. Zenith performs all levels of bill review internally unless a retrospective review is needed for medical necessity. Those reviews are conducted by Genex. Zenith provides utilization review, bill review and other services for affiliated and non-affiliated entities.

7. The process for rendering and promptly notifying the medical provider and employee of the initial utilization review decision.

d.) **Initial Utilization Review pursuant to 803 KAR 25:195 §5(2)(a)(1-3): Initial Utilization Review decision within two (2) business days of the initial request for treatment.** If applicable, utilization review shall commence when the Medical Payment Obligor has notice that a claims selection criteria (above) has been met. The Medical Payment Obligor may waive utilization review pursuant to KRS 342.035(5)(c) within two (2) business days of notice that the claims selection criteria has been met. If Preauthorization has been requested and utilization review has not been waived by the Medical Payment Obligor, the initial utilization review decision shall be communicated to the designated medical provider and employee within two (2) business days of the initiation of the utilization review process, unless additional information is required. If additional information is required, tender of a single request shall be made within two (2) additional business days. The Requested information shall be tendered by the medical provider within ten (10) business days. The initial utilization review decision shall be rendered and communicated within two (2) business days following receipt of the requested information.

e.) **Retrospective Utilization Review pursuant to 803 KAR 25:195 §5(2)(b)(1-3): Retrospective Utilization Review decision within seven (7) business days of the initial UR process.** If retrospective utilization review occurs, the initial utilization review decision shall be communicated in writing to the medical provider and employee within seven (7) business days of the initiation of the utilization review process, unless additional information is required. If additional information is required, tender of a single request shall be made within two (2) additional business days. The requested information shall be tendered by the medical provider within ten (10) business days. The initial utilization review decision shall be rendered within two (2) business days following receipt of the requested information.

f.) **Expedited Utilization Review pursuant to 803 KAR 25:195 §5(3): Expedited Utilization Review decision within twenty-four (24) hours following the UR request.** A medical provider may request an expedited utilization review determination for proposed medical treatment or services, the lack of which could reasonably be expected to lead to serious physical or mental disability or death. The expedited utilization review determination shall be rendered and communicated within twenty-four (24) hours following a request for expedited review. Emergency Health Care Services may be subject to Retrospective Review however, failure to obtain prior Authorization for Emergency Health Care Services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for Emergency Health Care Services. Emergency Health Care Services cannot be denied because of a failure to obtain prior Authorization of a Treatment Request. Zenith will not refuse to cover medical services provided to treat and stabilize an injured worker presenting for Emergency Health Services solely on the basis of a failure to obtain prior authorization.

As described herein, Zenith Insurance Management Services, Inc., dba Zenith Claims Solutions ("Zenith") performs first level review of treatment requests for utilization review. If Zenith cannot approve the treatment request, Zenith sends the treatment request to Genex Services, LLC ("Genex") for review. Zenith performs all levels of bill review internally unless a retrospective review is needed for medical necessity. Those reviews are conducted by Genex. Zenith provides utilization review, bill review and other services for affiliated and non-affiliated entities.

8. A description of the initial utilization review denial process including the following information contained on the denial letter:

- **A statement of the medical reasons for denial;**
- **The name and U. S. state of licensure, and medical license number of the reviewer;**
- **An explanation of utilization review reconsideration rights.**

Only a physician may issue an initial utilization review denial. A physician shall supervise utilization review personnel in making utilization review recommendations. Personnel shall hold the license required by the jurisdiction in which they are employed.

Pursuant to 803 KAR 25:195 §7. Written Notice of Denial.
(1) Following initial review of a request for preauthorization, a written notice of denial shall:
(a) Be issued to both the medical provider and the employee in a timely manner but no more than two (2) business days after initiation of the utilization review process unless additional information was required, in which case, the written notice of denial shall be issued no later than two (2) business days after the initial utilization review decision;
(b) Be clearly entitled "UTILIZATION REVIEW - NOTICE OF DENIAL"; and
(c) Contain:
1. A statement of the medical reasons for denial;
2. The name, state of licensure, and medical license number of the reviewer; and
3. An explanation of utilization review reconsideration rights.
(2) Payment for medical services shall not be denied on the basis of lack of information absent documentation of a good faith effort to obtain the necessary information.

A sample of the Utilization Review Denial Letter can be found under response 18 below.

As described herein, Zenith Insurance Management Services, Inc., dba Zenith Claims Solutions ("Zenith") performs first level review of treatment requests for utilization review. If Zenith cannot approve the treatment request, Zenith sends the treatment request to Genex Services, LLC ("Genex") for review. Zenith performs all levels of bill review internally unless a retrospective review is needed for medical necessity. Those reviews are conducted by Genex. Zenith provides utilization review, bill review and other services for affiliated and non-affiliated entities.

9. A description of the reconsideration process within the structure of the utilization review program with all applicable timeframes.

> *Pursuant to 803 KAR 25:195 §8. Reconsideration.*
> *(1) A reconsideration process to appeal an initial decision shall be provided within the structure of utilization review.*
> *(a) A request for reconsideration of the initial utilization review decision shall be made by an aggrieved party within ten (10) business days of receipt of a written notice of denial.*
> *(b) Reconsideration of the initial utilization review decision shall be conducted by a different reviewer of the same medical specialty as the medical provider whose treatment is being reconsidered.*
> *(c) A written reconsideration decision shall be rendered within seven (7) business days of receipt of a request for reconsideration unless a peer-to-peer conference is requested, in which case, the written reconsideration decision shall be rendered within five (5) business days after the day on which the peer-to-peer conference was held. The written decision shall be clearly entitled "UTILIZATION REVIEW - RECONSIDERATION DECISION." If the reconsideration decision is made by an appropriate specialist or subspecialist, the written decision shall further be entitled "FINAL UTILIZATION REVIEW DECISION."*
> *(d) Those portions of the medical record that are relevant to the reconsideration, if authorized by the patient and in accordance with state or federal law, shall be considered and providers shall be given the opportunity to present additional information.*

Reconsideration: If the aggrieved party disagrees with the utilization review determination, they may request a reconsideration process to appeal within ten (10) business days of receipt of a written notice of denial.

Reconsideration of the initial utilization review decision shall be conducted by a different reviewer of the same medical specialty as the medical provider whose treatment is being reconsidered.

A written reconsideration decision shall be rendered within seven (7) business days of receipt of a request for reconsideration unless a peer-to-peer conference is requested, in which case, the written reconsideration decision shall be rendered within five (5) business days after the day on which the peer-to-peer conference was held. The written decision shall be clearly entitled "UTILIZATION REVIEW - RECONSIDERATION DECISION".

Specialty or Sub-Specialty Review: If the reconsideration decision is made by an appropriate specialist or subspecialist, the written decision shall further be entitled "FINAL UTILIZATION REVIEW DECISION". Those portions of the medical record that are relevant to the reconsideration, if authorized by the patient and in accordance with state or federal law, shall be considered and providers shall be given the opportunity to present additional information.

As described herein, Zenith Insurance Management Services, Inc., dba Zenith Claims Solutions ("Zenith") performs first level review of treatment requests for utilization review. If Zenith cannot approve the treatment request, Zenith sends the treatment request to Genex Services, LLC ("Genex") for review. Zenith performs all levels of bill review internally unless a retrospective review is needed for medical necessity. Those reviews are conducted by Genex. Zenith provides utilization review, bill review and other services for affiliated and non-affiliated entities.

10. A description of the process when the medical provider whose recommendation for treatment is denied may request reconsideration, and may require the reconsideration to include a peer-to-peer conference with a second utilization review physician.

Peer-to-peer Conference.
(1) If the medical payment obligor denies preauthorization following utilization review, it shall issue a written notice of denial as required in Section 7 of this administrative regulation.
(2) The medical provider whose recommendation for treatment is denied may request reconsideration and may require the reconsideration include a peer-to-peer conference with a second utilization review physician.
(3) The request for a peer-to-peer conference shall be made by electronic communication and shall provide:
(a) A telephone number for the reviewing physician to call;
(b) A date or dates for the conference not less than five (5) business days after the date of the request unless the peer-to-peer conference request stems from a denial issued pursuant to 803 KAR 25:270, in which case, a date or dates not less than two (2) business days after the date of the request. In either case, the parties may by agreement hold the conference in a shorter time period; and
(c) A one (1)-hour period during the date or dates specified during which the requesting medical provider, or a designee, will be available to participate in the conference between the hours of 8:00 a.m. and 6:00 p.m. (Eastern Time), Monday through Friday.
(4) The reviewing physician participating in the peer-to-peer conference shall be of the same medical specialty as the medical provider requesting reconsideration.
(5)
(a)
1. Failure of the reviewing physician to participate during the date and time specified shall result in the approval of the request for preauthorization and approval of the recommended treatment unless good cause exists for the failure to participate.
2. In the event of good cause for failure to participate in the peer-to-peer conference, the reviewing physician shall contact the requesting medical provider to reschedule the peer-to-peer conference.
(b) The rescheduled peer-to-peer conference shall be held no later than two (2) business days following the original conference date.
(c) Failure of the requesting medical provider or its designee to participate in the peer-to-peer conference during the time he or she specified availability may result in denial of the request for reconsideration.
(6) A written reconsideration decision shall be rendered within five (5) business days of date of the peer-to-peer conference. The written decision shall be entitled "FINAL UTILIZATION REVIEW DECISION."
(7) If a Final Utilization Review Decision is rendered denying authorization for treatment before an award has been entered by or agreement approved by an administrative law judge, the requesting medical provider or the injured employee may file a medical dispute pursuant to 803 KAR 25:012. If a Final Utilization Review Decision is rendered denying authorization for treatment after an award has been entered by or agreement approved by an administrative law judge, the employer shall file a medical dispute pursuant to 803 KAR 25:012.
(8) Pursuant to KRS 342.285(1), a decision of an administrative law judge on a medical dispute is subject to review by the workers' compensation board under the procedures established in 803 KAR 25:010, Section 22.

Peer-to-Peer Conference (Reconsideration): If Zenith denies preauthorization following utilization review, it shall issue a written notice of denial as required by 803 KAR 25:195, Section 7. The medical provider whose recommendation for treatment is denied may request reconsideration and may require the reconsideration include a peer-to-peer conference with a second utilization review physician.

The request for a peer-to-peer conference shall be made by electronic communication and shall provide:

a) A telephone number for the reviewing physician to call;
b) A date or dates for the conference not less than five (5) business days after the date of the request unless the peer-to-peer conference request stems from a denial issued pursuant to 803 KAR 25:270, in which case, a date or dates not less than two (2) business days after the date of the request. In either case, the parties may by agreement hold the conference in a shorter time period; and
c) A one (1)-hour period during the date or dates specified during which the requesting medical provider, or a designee, will be available to participate in the conference between the hours of 8:00 a.m. and 6:00 p.m. (Eastern Time), Monday through Friday.

The reviewing physician participating in the peer-to-peer conference shall be of the same medical specialty as the medical provider requesting reconsideration.

Failure of the reviewing physician or its designee to participate during the date and time specified shall result in the approval of the request for preauthorization and approval of the recommended treatment unless good cause exists for the failure to participate. In the event of good cause for failure to participate in the peer-to-peer conference, the reviewing physician shall contact the requesting medical provider to reschedule the peer-to-peer conference. The rescheduled peer-to-peer conference shall be held no later than two (2) business days following the original conference date. Failure of the requesting medical provider or its designee to participate in the peer-to-peer conference during the time he or she specified availability may result in denial of the request for reconsideration.

A written reconsideration decision shall be rendered within five (5) business days of date of the peer-to-peer conference. The written decision shall be entitled "FINAL UTILIZATION REVIEW DECISION."

If a Final Utilization Review Decision is rendered denying authorization for treatment before an award has been entered by or agreement approved by an administrative law judge, the requesting medical provider or the injured employee may file a medical dispute pursuant to 803 KAR 25:012. If a Final Utilization Review Decision is rendered denying authorization for treatment after an award has been entered by or agreement approved by an administrative law judge, the employer shall file a medical dispute pursuant to 803 KAR 25:012.

Pursuant to KRS 342.285(1), a decision of an administrative law judge on a medical dispute is subject to review by the workers' compensation board under the procedures established in 803 KAR 25:010, Section 22.

As described herein, Zenith Insurance Management Services, Inc., dba Zenith Claims Solutions ("Zenith") performs first level review of treatment requests for utilization review. If Zenith cannot approve the treatment request, Zenith sends the treatment request to Genex Services, LLC ("Genex") for review. Zenith performs all levels of bill review internally unless a retrospective review is needed for medical necessity. Those reviews are conducted by Genex. Zenith provides utilization review, bill review and other services for affiliated and non-affiliated entities.

11. A description of the pharmaceutical reconsideration process per 803 KAR 25:270.

PHARMACEUTICAL FORMULARY

Pursuant to 803 KAR 25:270, Pharmaceutical Formulary, Zenith Insurance Company issues checks at the direction of Zenith and is liable for payment of up to a seven (7) day supply of a "Y" drug dispensed to or prescribed for an injured employee within seven (7) days of a work-related injury in treatment of that work-related injury even if the Zenith ultimately denies liability for the claim. Payment by Zenith Insurance Company at the direction of Zenith and pursuant to this subsection, does not waive the right to contest its liability for the claim or benefits to be provided.

Requests for Preauthorization/Reconsideration: As per §4(1-7), requests for Preauthorization shall be subject to utilization review unless the employer waives utilization review. If as a result of utilization review the carrier denies a request for Preauthorization, the medical provider may request reconsideration of the denial to include a peer-to-peer conference with a utilization review physician. The request for a peer-to-peer conference shall be made by electronic communication and shall provide:

a) A telephone number for the reviewing physician to call;
b) A date for the conference not less than two (2) business days after the date of the request; and
c) A one (1) - hour period during which the requesting medical provider (or its designee) will be available to participate in the conference between the hours of 8:00 a.m. and 6:00 p.m. (Eastern Time), Monday through Friday.

The peer-to-peer conference must be conducted by a physician of the same specialty as the medical provider requesting reconsideration.

Failure of the reviewing physician to participate in the peer-to-peer conference during the date and time specified shall result in the approval of the request for Preauthorization and approval of the requested prescription.

Failure of the requesting medical provider or its designee to participate in the peer-to-peer conference during the time he or she specified availability may result in denial of the request for reconsideration.

Pursuant to 803 KAR 25:195 Section 9(6), a written reconsideration decision shall be rendered within five (5) business days after the day on which the peer-to-peer conference was held. The written decision shall be entitled "FINAL UTILIZATION REVIEW DECISION".

Utilization review shall not be required for a "Y" drug but may be conducted retrospectively to determine medical reasonableness and necessity. A denial of a "Y" drug based on retrospective utilization review shall apply only to refill prescriptions of that drug after the date of the utilization review.

As described herein, Zenith Insurance Management Services, Inc., dba Zenith Claims Solutions ("Zenith") performs first level review of treatment requests for utilization review. If Zenith cannot approve the treatment request, Zenith sends the treatment request to Genex Services, LLC ("Genex") for review. Zenith performs all levels of bill review internally unless a retrospective review is needed for medical necessity. Those reviews are conducted by Genex. Zenith provides utilization review, bill review and other services for affiliated and non-affiliated entities.

12. **An assurance that a database shall be maintained for a period of no less than two (2) years, subject to audit by the Commissioner, or the Commissioner's agent, and with the details required per KRS 342:035(5)(b).**

    Zenith affirms that all activities are tracked on appropriate systems to record in compliance with KRS342:035(5)(b):and 803 KAR 25:195 §4 (9)(a) & (b):

    1. Each instance of All utilization review;
    2. Each instance of medical bill audit;
    3. The name of the reviewer;
    4. The extent of the review;
    5. The conclusions of the reviewer; and
    6. The action taken, if any, as a result of the review.

    Records related to utilization and bill review audit activities are maintained for a period of two (2) years or more from the date the underlying workers' compensation claim was closed pursuant to Zenith's records retention requirements and may be subject to audit by the Commissioner, or the Commissioner's agent.

As described herein, Zenith Insurance Management Services, Inc., dba Zenith Claims Solutions ("Zenith") performs first level review of treatment requests for utilization review. If Zenith cannot approve the treatment request, Zenith sends the treatment request to Genex Services, LLC ("Genex") for review. Zenith performs all levels of bill review internally unless a retrospective review is needed for medical necessity. Those reviews are conducted by Genex. Zenith provides utilization review, bill review and other services for affiliated and non-affiliated entities.

13. A description of the policies and procedures that will protect the confidentiality of patient information.

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, 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
- E-mail Security Policy

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

As described herein, Zenith Insurance Management Services, Inc., dba Zenith Claims Solutions ("Zenith") performs first level review of treatment requests for utilization review. If Zenith cannot approve the treatment request, Zenith sends the treatment request to Genex Services, LLC ("Genex") for review. Zenith performs all levels of bill review internally unless a retrospective review is needed for medical necessity. Those reviews are conducted by Genex. Zenith provides utilization review, bill review and other services for affiliated and non-affiliated entities.

ATTACHMENT "D"
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:

4. Information and Facilities Security Policy
5. Acceptable Use of Resources Policy with Safeguards Attachment A; and
6. 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.

As described herein, Zenith Insurance Management Services, Inc., dba Zenith Claims Solutions ("Zenith") performs first level review of treatment requests for utilization review. If Zenith cannot approve the treatment request, Zenith sends the treatment request to Genex Services, LLC ("Genex") for review. Zenith performs all levels of bill review internally unless a retrospective review is needed for medical necessity. Those reviews are conducted by Genex. Zenith provides utilization review, bill review and other services for affiliated and non-affiliated entities.

14. An assurance that during the term of an approved plan, the Commissioner shall be notified as soon as practicable of a material change in the approved plan or a change in the selection of a vendor.

Zenith affirms that in the event Zenith materially changes either its Utilization Review Process or resources, including material changes in the approved plan, vendor(s), and vendor contract(s) that support the Utilization Review Process, Zenith will notify the Commissioner by filing a material modification and updating this Utilization Review Plan pursuant to 803 KAR 25:195. §3(4) and (5)(b).

As described herein, Zenith Insurance Management Services, Inc., dba Zenith Claims Solutions ("Zenith") performs first level review of treatment requests for utilization review. If Zenith cannot approve the treatment request, Zenith sends the treatment request to Genex Services, LLC ("Genex") for review. Zenith performs all levels of bill review internally unless a retrospective review is needed for medical necessity. Those reviews are conducted by Genex. Zenith provides utilization review, bill review and other services for affiliated and non-affiliated entities.

15. **An assurance that a medical payment obligor who contracts with an approved vendor for utilization review or medical bill audit services shall notify the Commissioner of the contract. The contractual arrangement may provide for separate utilization review and medical bill audit vendors.**

    As provided under #14 above, in the event Zenith materially changes either its Utilization Review Process or resources, including material changes in the approved plan, vendor(s) or vendor contract(s) that support the Utilization Review Process, Zenith will notify the Commissioner by filing a material modification and updating this Utilization Review Plan pursuant to 803 KAR 25:195. §3(4) and (5)(b). See next page for *Attachment B – Third Party Utilization Review Organization* on file with the Commonwealth of Kentucky, Department of Workers' Claims.

As described herein, Zenith Insurance Management Services, Inc., dba Zenith Claims Solutions ("Zenith") performs first level review of treatment requests for utilization review. If Zenith cannot approve the treatment request, Zenith sends the treatment request to Genex Services, LLC ("Genex") for review. Zenith performs all levels of bill review internally unless a retrospective review is needed for medical necessity. Those reviews are conducted by Genex. Zenith provides utilization review, bill review and other services for affiliated and non-affiliated entities.

16. Provide a copy of the Medical Director's Curriculum Vitae.

Attachment A – Curriculum Vitae and Designated Medical Director Information is on file with the Commonwealth of Kentucky, Department of Workers' Claims.

As described herein, Zenith Insurance Management Services, Inc., dba Zenith Claims Solutions ("Zenith") performs first level review of treatment requests for utilization review. If Zenith cannot approve the treatment request, Zenith sends the treatment request to Genex Services, LLC ("Genex") for review. Zenith performs all levels of bill review internally unless a retrospective review is needed for medical necessity. Those reviews are conducted by Genex. Zenith provides utilization review, bill review and other services for affiliated and non-affiliated entities.

17. Include a list of clients that contract you to perform UR/MBA services.

Contracted MBA/UR Vendors: Zenith Insurance Management Services, Inc., dba Zenith Claims Solutions ("Zenith" or "Zenith Claims Solutions") performs first level review of treatment requests for utilization review. If Zenith cannot approve the treatment request, Zenith sends the treatment request to Genex Services, LLC ("Genex") for review. Zenith performs all levels of bill review internally unless a retrospective review is needed for medical necessity. Those reviews are conducted by Genex. Zenith provides utilization review, bill review and other services for the following entities (see next page):

As described herein, Zenith Insurance Management Services, Inc., dba Zenith Claims Solutions ("Zenith") performs first level review of treatment requests for utilization review. If Zenith cannot approve the treatment request, Zenith sends the treatment request to Genex Services, LLC ("Genex") for review. Zenith performs all levels of bill review internally unless a retrospective review is needed for medical necessity. Those reviews are conducted by Genex. Zenith provides utilization review, bill review and other services for affiliated and non-affiliated 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 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

As described herein, Zenith Insurance Management Services, Inc., dba Zenith Claims Solutions ("Zenith") performs first level review of treatment requests for utilization review. If Zenith cannot approve the treatment request, Zenith sends the treatment request to Genex Services, LLC ("Genex") for review. Zenith performs all levels of bill review internally unless a retrospective review is needed for medical necessity. Those reviews are conducted by Genex. Zenith provides utilization review, bill review and other services for affiliated and non-affiliated entities.

18. Submit example letter of approval, denial, reconsideration and final reconsideration, these must be on company letterhead.

Template letters and Explanation of Benefits are on file under *Attachment E – Example Letters* with the Commonwealth of Kentucky, Department of Workers' Claims.