

**Zenith Insurance Company
21255 Califa Street
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**Mississippi
Utilization Review Plan**

7/10/2018

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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. “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.
4. “Certification” or “Certify” means a determination by a payer, private review agent or 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.
5. “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).
6. “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.
7. “Concurrent Review” means Utilization Review conducted during a patient's Hospital stay or course of treatment.
8. “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.

9. “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.
10. “Enrollee” means the individual who has elected to contract for, or participate in, a health benefit plan for their self and/or their dependents.
11. “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.
12. “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.
13. “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.
14. “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.

15. “Notification” means correspondence transmitted by mail, telephone, facsimile, email, and/or other reliable electronic means.
16. “Patient” means the intended recipient of the proposed health care, his/her representative, and/or the enrollee.
17. “Precertification” 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.
18. “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.
19. “Retrospective Review” means Utilization Review conducted after services have been provided to the worker.
20. “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)].
21. “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 or sub-specialty as the requesting provider.
22. “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.
23. “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 or sub-specialty as the requesting provider.

24. "Treatment Request" means a request for medical services or treatment for an injured employee that is subject to Utilization Review.
25. "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.
26. "Utilization Reviewer" means an entity, organization, or representative thereof, or other person performing Utilization Review activities or services on behalf of an employer, payer or third party claims administrator.
27. "Utilization Review Plan" means a description of the Utilization Review procedures of a private review agent.
28. "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.

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 twice a month 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 quality of care issues related to specific providers. The Committee includes medical directors, claims, nursing, corporate legal, claims legal and quality compliance team members. 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 Medical Management Nurse (MMN), 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:

- Zenith 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. 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 MMN for further review.
- MMNs 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 MMN can review a Treatment Request plan for approval or referral to a Clinical Peer reviewer or a Zenith Medical Director. The MMN is not permitted to deny a Treatment Request plan. The MMN refers Treatment Request plans that cannot be Certified for further review by a physician. The MMN may seek review by either an internal Medical Director or an external Clinical Peer reviewer. The MMN 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 MMN reviewer may Certify the amended Treatment Request plan.
- Zenith Medical Directors may review Treatment Request plans for approval or peer-to-peer discussion for voluntary modifications. Zenith Medical Directors are not permitted to issue denials based on medical necessity. If Zenith 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 voice-mail and/or facsimile transmission. Mail, voice-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.

Precertification

Zenith requires Precertification 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 to Zenith 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, Zenith will perform retrospective review of the services if requested to do so by the provider within one (1) year of the date the service or discharge. If Zenith determines that the services provided were Medically Necessary, then Zenith will reimburse the provider 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 Zenith determines the services are not Medically Necessary and would have been denied, the Zenith will dispute the bill 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 medical management nurse (MMN) for review. At that time, Zenith will notify the provider that it is initiating the Utilization Review Process for a medical necessity determination.

Upon receipt of Zenith's 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 MMN vendor may contact the requesting physician 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 Zenith, 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 by Zenith, upon receipt, the Treatment Request is evaluated by the MMN 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 MMN may refer the request to the Zenith Medical Director. The Zenith Medical Director may either directly contact or instruct the MMN 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 MMN may Certify the Treatment Request. If such agreement is not reached, the MMN will refer the Treatment Request to a Peer Reviewer. Proper Notifications will be provided for any actions taken by internal staff.

Pursuant to *Zenith's National Utilization Review Policy* (see attached), Treatment Requests can be modified or denied only by a physician. Zenith utilizes external Peer Reviewers for denials and either external Peer Reviewer or an internal Medical Director for modifications. No Zenith employee may override (or attempt to override by additional opinions) a decision for coverage, modification or denial made by a Zenith 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 and is not subject to the *National Utilization Review Policy*, 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. Zenith 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 Peer Reviewer may contact the requesting provider for additional appropriate information or clarification. The 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. Zenith will not 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 by Zenith 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

- 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

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 mailroom.

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.

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.

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.

Zenith conducts its telephone and on-site information gathering reviews and Hospital communications during the Hospitals' and physicians' reasonable and normal business hours, unless otherwise mutually agreed.

On-Site Review Procedures

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

1. When conducting routine prospective and concurrent Utilization Review, Zenith collects only the information necessary to Certify the admission, procedure or treatment and length of stay.
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, Zenith limits initial data requirements to the 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.

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

Zenith's 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.

Zenith reimburses healthcare providers 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, Zenith shall conduct a retrospective review of the services. If Zenith determines the services provided would have been pre-certified (in whole or in part) and if the Precertification had been timely sought by provider, then Zenith shall reimburse provider 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 Zenith finds that Precertification for services would not have been given, then Zenith 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 Zenith 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 on behalf of Zenith are performed in compliance with the URO’s filed Utilization Review Plan (MS Private Review Agent certificate# R0311).

During the First Level Clinical Review process, if Zenith cannot Certify due to lack of medical necessity requests are referred to the URO for the Second Level Clinical Review where 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 or sub-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 or sub-specialty as the requesting provider.

Contracted UR/MBA Vendors

Zenith Insurance Company reviews Treatment Requests 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 Mitchell for further review by a physician with appropriate licensing. Zenith

provides Utilization Review services for itself and several sister companies through intercompany agreements. 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.

Zenith utilizes the following procedures 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, Zenith attempts to share

the maximum information 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 its 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 confidentiality, 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

Policies and Procedures

The following attached policy describes Zenith's National Utilization Review Policy and how Zenith maintains the Utilization Review Process. This policy and procedure is incorporated in whole as part of this Utilization Review Plan.

C O M P A N Y P O L I C Y

Title: Zenith Insurance Company National Utilization Review Policy	
Application: Zenith Insurance Company, ZNAT Insurance Company and ZIMS Affiliated Entities	
Policy Number: IP01.1	Issued: January 22, 2008
Updated:	As most recently revised 12-18-2017
Approved By: Dr. Jill Rosenthal, SVP & Medical Officer; Mike Gillikin, VP-Claims; Jackie Hilston, VP - Claims	

POLICY STATEMENT

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

PURPOSE

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

DEFINITIONS

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

2. “*Medical Officer*” means physicians employed by Zenith who hold unrestricted licenses to practice medicine in any state or the District of Columbia. Zenith’s designated Medical Director is also a Medical Officer for purposes of this Plan.
3. “*Treatment Request*” is a request for Medical Services or treatment for an Injured Employee that is subject to Utilization Review.
4. “*Utilization Review Process*” means the utilization management functions that prospectively, retrospectively, or concurrently review and Certify, modify or deny based in whole or in part on Medical Necessity to cure or relieve, treatment recommendations by physicians prior to, retrospectively, or concurrent with the provision of medical treatment.

PROCEDURES FOR POLICY COMPLIANCE

Policies

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

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

2. Determinations and recommendations made by a Zenith Medical Officer or external Clinical Peer Review must be followed and implemented in a timely manner subject to the Internal Review Process set out in (3) below.
3. **Internal Review Process:** In the event a Zenith employee disagrees with or has legal process or other concerns regarding a Utilization Review determination made by a Zenith Medical Officer, or external Clinical Peer Review, the determination **must be escalated** for an interdepartmental branch staffing (with representation from claims, legal and medical management).

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

No referral for a second or third opinion may be made in lieu of this interdepartmental staffing. The Medical Officer shall have final authority in consultation with the staffing team set out above for Authorization, modification or denial of Treatment Requests subject to the Utilization Review Process.

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

5. Nothing in this policy modifies or alters non-clinical staff's ability to deny requests of care on files in which Zenith has:
 - a. officially rejected compensability of the underlying claim for workers compensation. In these situations, all denials must be for lack of compensability and not on the basis of Utilization Review Criteria; or
 - b. determined that certain body parts or medical conditions are not part of or related to the accepted compensable claim and therefore, requests for care related to those conditions or body parts should be denied.
6. There may be occasions when other medical reviews must be considered such as an Independent Medical Examination performed by either a Qualified Medical Evaluator or, Agreed Medical Evaluator. Under those circumstances, you should consult your local Medical Officer and legal staff to determine which medical decision should be followed.

EXHIBIT “A”

DESIGNATED MEDICAL DIRECTOR INFORMATION

Designated Medical Director Information on file with MS State Dept of Health, Bureau of Health Facilities, Licensure & Certification

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:

Mitchell International, Inc. dba UniMed Direct
700 E. Campbell Road, Ste. 245
Richardson, TX 75081

PO Box 852346
Richardson, TX 75085-2346

Contact: Kara Larson
Phone: (972) 931-5100

Mississippi Plan # R0305

Mitchell International, Inc. dba UniMed Direct complies with the requirements of its filed Utilization Review Plan when performing services on behalf of Zenith.

EXHIBIT “C”

ZENITH MISSISSIPPI UTILIZATION REVIEW GUIDELINES

The Mississippi Fee Schedule requires that any Fee Schedule provision that supports a determination must be specifically cited. The sole use of extraneous guidelines, including ODG, to determine appropriateness of treatment is prohibited. The Fee Schedule must be cited as a basis for denial of Interventional Pain Management (IPM) procedures and use of any outside guideline is prohibited per the Fee Schedule, Pain Management, Sect. I (3 and 4). To support the Utilization Review Process, Zenith 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:

- *Pain Management Guidelines* set forth in the Pain Management section of the Mississippi Fee Schedule (most current)
- *Official Disability Guidelines - Treatment in Workers' Comp*, excluding the return to work pathways, (ODG), published by Work Loss Data Institute
- *American College of Occupational and Environmental Medicine’s Occupational Medicine Practice Guidelines*, (ACOEM), published by Work Loss Data Institute or
- Other applicable evidence based medicine guidelines where appropriate

EXHIBIT “D”

ZENITH INSURANCE COMPANY APPLICABLE CONFIDENTIALITY AND PRIVACY POLICIES AND GUIDELINES

Zenith’s policy is to protect the confidentiality of medical health information as well as all other company documents. To accomplish this, Zenith utilizes several policies including the Zenith Code of Business Conduct, which includes the following statement:

Confidentiality / Use of Confidential Information

To protect Zenith and our clients, we are committed to preserving the right of privacy and the confidentiality and security of information. The following information is confidential:

- Business information such as financial and actuarial information and projections, computer records and programs, contracts, customer files and lists, investments, investment strategies, marketing plans, bid proposals and contract negotiations;
- Medical, financial and other information concerning injured workers, including diagnosis and treatments, personal data and billing and contact information; and
- Employee information, including personnel files, salary and bonus information (except where disclosures are required), evaluations, disciplinary matters and psychological assessments.

It is a violation of this Code for any employee, both during and after such person’s employment with the Company, to use or disclose outside the Company any confidential information to any entity or person without Authorization or in accordance with Company policies. When using or sharing confidential information, you must secure all data, electronic or otherwise. The concepts of “minimum necessary” and “need to know” always apply to the use and disclosure of confidential information. Detailed privacy and information security policies exist to help employees meet Company expectations (*refer to Zenith’s Protection of Personal Information and Business Confidential and Proprietary Information, Information and Facilities Security, and Acceptable Use of Resources policies for more detail*). Version: 6-20-2012

Other polices developed and implemented to help protect the confidentiality of information include Zenith’s:

1. Information and Facilities Security Policy
2. Acceptable Use of Resources Policy with Safeguards Attachment A; and
3. Email Security Policy

Copies of these policies will be made available to regulatory agencies upon request with the provision that the policies not be made available to the public.

EXHIBIT “E”

ZENITH INSURANCE COMPANY MISSISSIPPI PRECERTIFICATION LIST

Prior to providing treatment to the injured worker, the provider is required to submit a Treatment plan to Zenith for Precertification in compliance with Title 20, IX. Authorization for Treatment, A, Title 20, IX. Pain Management and Utilization Review Rules, I. Services Requiring Utilization Review. The following procedures require prior Certification or mandatory Utilization Review:

Prior authorization is required for the services listed below:

1. All non-emergency surgery, inpatient or outpatient (applies to facilities of any type). 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.
2. Therapeutic treatments (excludes chiropractic treatments) after 15 visits or 30 days, whichever comes first
3. Post Approved Surgery – 15 visits/30 days allowed pre-surgery and post-surgery without authorization (excludes chiropractic manipulative treatment)
4. Chiropractic manipulative treatment after 15 visits or 30 days, whichever comes first
5. Rental or purchase of supplies or equipment over \$300.00 per item
6. Rental or purchase of TENS, regardless of cost
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. Referral for massage therapy
13. Referral for orthotics or prosthetics
14. Referral for acupuncture
15. Referral for biofeedback
16. Referral for psychological testing/counseling
17. Referral for substance abuse program
18. Referral for weight reduction program
19. Referral to any non-emergency medical service outside the state of Mississippi
20. Repeat MRI (more than one per injury)
21. Repeat CT Scan (more than one per injury)
22. Repeat EMG/NCS (more than one per injury)
23. Repeat Myelograms (more than one per injury)
24. Post Approved Surgery – One repeat diagnostic procedure allowed without authorization (may be same procedure performed pre-surgery or one of the included procedures above)
25. Intraoperative neurophysiological monitoring (e.g. SSEP, VEP, DEP, BAEP, MEP)
26. Neurostimulation
27. Repeat comparison X-rays

28. Pain management diagnostic injections – more than one type in the same anatomic area on the same date of service
29. Biofeedback after 10 visits/sessions
30. Psychiatric treatment
31. Compound medications over 120 grams in one month
32. Intrathecal drug delivery
33. Intrathecal pain pumps
34. Topical Drug Delivery
35. 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 no longer covered under the Fee Schedule)

EXHIBIT “F”

Mitchell Peer and Physician Advisor Panel

Mitchell 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

Zenith’s Internal Staff Qualifications List on file with MS State Dept of Health, Bureau of Health Facilities, Licensure & Certification

EXHIBIT “H”

Companies for Which Zenith Performs Utilization Review

Zenith currently provides Utilization Review services for the following sister companies:

1. Zenith Insurance Company, 21255 Califa Street, Woodland Hills, CA 91367
2. ZNAT Insurance Company, a wholly owned subsidiary of Zenith Insurance Company;
3. The RiverStone Group (“RiverStone”), a sister company of Zenith under FairFax Financial Holdings Limited (“FairFax”) which includes administration for runoff business for the following entities which all merged into TIG Insurance Company under RiverStone:
 - TIG Insurance Company
 - i. International Insurance Company (effective December 16, 2002)
 - ii. Old Lyme Insurance Company of Rhode Island, Inc. (effective December 29, 2009)
 - iii. Fairmont Specialty Insurance Company, f/k/a Ranger Insurance Company
 - iv. (effective June 30, 2015)
 - v. Fairmont Premier Insurance Company (effective June 30, 2015)
 - vi. Fairmont Insurance Company (effective June 30, 2015)
 - vii. General Fidelity Insurance Company (effective September 30, 2015)
 - viii. American Safety Indemnity Company (effective June 30, 2016)
 - ix. American Safety Casualty Insurance Company (effective June 30, 2016)
4. Seneca Insurance Company, wholly owned subsidiary of Crum & Forster which is a sister company of Zenith under FairFax.

Zenith performs claims administration for these entities. Therefore, any communications concerning claims handled by Zenith, including unitization review services, should be directed to:

Zenith Insurance Company
21255 Califa Street
Woodland Hills, CA 91367

The following are business addresses for RiverStone and Seneca, but communications regarding claims administered by Zenith Insurance Company should not be directed to these addresses:

Seneca Insurance Company
160 Water Street, 16th floor
New York, New York, 10038

RiverStone
250 Commercial St., Suite 5000
Manchester, NH 03101