NEW JERSEY SKYLANDS INSURANCE ASSOCIATION (NJSIA)
DECISION POINT REVIEW PLAN INCLUSIVE OF
PRECERTIFICATION REQUIREMENT

DECISION POINT REVIEW:

Pursuant to N.J.A.C. 11:3-4, the New Jersey Department of Banking and Insurance has published standard courses of treatment, identified as ***Care Paths***, for soft tissue injuries of neck and back, collectively referred to as **Identified Injuries (See Exhibit A)**. N.J.A.C. 11:3-4 also establishes guidelines for the use of certain diagnostic tests.

Treatment obtained in an emergency situation and / or within ten days of the insured event, is not subject to *decision point review / precertification* requirements. This provision shall not be construed so as to require reimbursement of tests and treatment that are not medically necessary, N.J.A.C. 11:3-4.7(b).

The ***Care Paths*** provide that treatment be evaluated at certain intervals called ***Decision Points***. At ***decision points***, you or your health care provider must provide Genex Managed Care Services (Genex) information about further treatment the provider intends to pursue. This is called ***Decision Point Review***. Information regarding ***Decision Point Review***, the ***Care Paths*** and other information is available on the website of the Department of Banking and Insurance, http://www.nj.gov/dobi/aicrapg.htm, or by calling Genex at 800-407-0704. The New Jersey Skylands Insurance Association (NJSIA) Decision Point Review Plan is available at https://www.genexservices.com/nj-dpr. **The Decision Point Review Plan** is accessible by accessing URL at (www.njsi.com)

If your health care provider considers certain diagnostic testing to be medically necessary, this also requires ***Decision Point Review*** per N.J.A.C. 11:3-4, regardless of diagnosis. You or your health care provider must notify us by supplying written support establishing the need for the test before we can consider authorizing it. The list of diagnostic tests requiring prior authorization and a list of diagnostic tests which the law prohibits us from authorizing under any circumstances are shown below. If you or your health care provider fail to submit diagnostic testing requests for ***Decision Point Review*** or fail to submit clinically supported findings that support the treatment, diagnostic testing or durable medical equipment requested, payment of your bills may be subject to a penalty copayment of 50%, even if the services are later determined to be medically necessary.

The following is a list of the specific diagnostic tests subject to ***Decision Point Review***:

- Brain Mapping
- Brain Audio Evoked Potentials (BAEP)
- Brain Evoked Potentials (BEP)
- Computer Assisted Tomograms (CT, CAT Scan)
- Dynatron/cybex station/cybex studies
- Videofluoroscopy
- H-Reflex Studies
- Sonogram/Ultrasound
- Needle Electromyography (needle EMG)
- Nerve Conduction Velocity (NCV)
- Somatosensory Evoked Potential (SSEP)
- Magnetic Resonance Imaging (MRI)
- Electroencephalogram (EEG)
- Visual Evoked Potential (VEP)
- Thermogram/Thermography
- Any other diagnostic test that is subject to the requirements of ***Decision Point Review*** by New Jersey law or regulation

Personal injury protection medical expense benefits coverage shall not provide reimbursement for the following diagnostic tests, under any circumstances, pursuant to N.J.A.C. 11:3-4.5:

1. Spinal diagnostic ultrasound;
2. Iridology;
3. Reflexology;
4. Surrogate arm mentoring;
5. Surface electromyography (surface EMG);

6. Mandibular tracking and stimulation; and
7. Any other diagnostic test that is determined by New Jersey law or regulation to be ineligible for Personal Injury Protection coverage.

PRECERTIFICATION:

"Services" is defined as medical procedure, treatment, diagnostic test, prescribing of any and all prescriptions/medications, other service and/or durable medical equipment.

"Health Care Provider" or "Provider" is defined in N.J.A.C. 11:3-4. All ancillary or secondary providers must follow both internal appeals processes for reconsideration of an adverse decision.

For treatment, diagnostic testing or durable medical equipment not included in the care paths or subject to ***Decision Point Review*****,** you or your health care provider are required to obtain our precertification for the following services and/or conditions listed below. If you or your providers fail to pre-certify such services, or fail to provide clinically supported findings that support the medical necessity of the treatment, services and/or condition, diagnostic tests or Durable Medical Equipment requested, payment of bills will be subject to a penalty copayment of 50% even if the services are determined to be medically necessary. The following treatments, services and/or conditions, goods and non-medical expenses require pre-certification:

- Non-Emergency Inpatient and Outpatient Care including the facility where the services will be rendered and any provider services associated with these services and/or care.
- Non-emergency surgical procedures, performed in a hospital, freestanding surgical center, office, etc., and any provider services associated with the surgical procedure.
- Non-Emergency inpatient and outpatient Psychological/Psychiatric Services
- Outpatient care for soft tissue/disc injuries of the injured party's , neck, back and related structures not included within the diagnoses covered by the Care Path
- Extended Care and Rehabilitation Facilities
- All Home Health Care
- Computerized muscle testing
- Cat Scan w/Myelogram
- PENs/PNT
- Skilled Nursing / Rehabilitation Services
- Trigger Point Dry Needling
- Compound Drugs
- Drug Screening
- Schedule II, III and IV Controlled Substances, as defined by the Drug Enforcement Administration (DEA), when prescribed for more than three months;
- Discogram
- Infusion Therapy
- Current perceptual testing;
- Temperature gradient studies;
- Work hardening;
- Carpal Tunnel Syndrome;
- Vax-D / DRX types devices ;
- Podiatry;
- Audiology;
- Bone Scans.
- Non-Emergency Dental Restoration
- Prescriptions costing more than $50.00;
- Treatment, testing and/or durable medical goods of Temporomandibular disorders and/or any oral facial syndrome
- Transportation Services costing more than $50.00;
- Any procedure that uses an unspecified CPT; CDT; DSM IV; HCPCS codes.
- Durable Medical Goods, including orthotics and prosthetics that collectively exceed $50.00 cost and/or monthly rental greater than 30 days.
- Non-medical products, devices, services and activities and associated supplies, not exclusively used for medical purposes or as durable medical goods, with a cost of $50.00 and/or monthly rental greater than 30 days, including but not limited to:

1. vehicles
2. modification to vehicles
3. durable goods
4. furnishings
5. improvements or modifications to real or personal property
6. fixtures
7. recreational activities and trips
8. leisure activities and trips
9. spa/gym membership

- Physical, Occupational, Speech, Cognitive, or other restorative therapy or Body part manipulation, including massage therapy, except that provided for Identified Injuries in accordance with ***Decision Point Review***.
- All Pain Management services, except as provided for Identified Injuries in accordance with ***Decision Point Review,*** including but not limited to:

1. acupuncture
2. nerve blocks
3. manipulation under anesthesia
4. anesthesia when performed in conjunction with invasive techniques
5. radio frequency/rhyzotomy
6. narcotics, when prescribed for more than 3 months
7. biofeedback
8. implantation of spinal stimulators or spinal pumps
9. trigger point injections
10. tens units (transcutaneous electrical nerve stimulation)
11. PENS (Percutaneous Electrical Nerve Stimulation)

If your provider fails to request *decision point review / precertification* where required or fails to provide clinical findings that support the treatment, testing or durable medical equipment requested a penalty copayment of 50% will apply even if the services are determined to be medically necessary. For benefits to be reimbursed in full, treatment, testing and durable medical equipment must be medically necessary**.**

VOLUNTARY PRECERTIFICATION:

You and your health care provider are encouraged to participate in a Voluntary Precertification process by providing a comprehensive treatment plan for both identified and other injuries to Genex. An approved treatment plan means that as long as treatment is consistent with the approved plan, additional notification to Genex at ***Decision Points*** and for Treatment, Diagnostic Testing or Durable Medical Equipment requiring ***precertification*** is not required.

INITIAL AND PERIODIC NOTIFICATION REQUIREMENT

NJSIA requires that the insured advise and inform them about the injury and the claim as soon as possible after the accident and periodically thereafter. This may include the production of information regarding the facts of the accident, the nature and cause of the injury, the diagnosis and the anticipated course of treatment. If this information is not supplied as required, NJSIA may impose an additional penalty copayment which shall be no greater than:

(a) Twenty five percent (25%) when received 30 or more days after the accident; or
(b) Fifty percent (50%) when received 60 or more days after the accident

HOW TO SUBMIT DECISION POINT and/or PRECERTIFICATION REQUESTS:

Decision Point / Precertification requests must be submitted directly to Genex and should be submitted by fax to 866-327-9318 or

emailed to: NJDPRPlus@reviewstat.com. You may also mail your request to the following address:

Genex NJ DPR+ Department
PO Box 4379
Westlake Village, CA 91359

Genex shall provide 24 hour, 7-day / week telephone service. Regular business hours are Monday through Friday 7:30 AM to 5:00 PM EST/EDT. All requests for pre-authorization received on weekends and Federal and/or NJ State Holidays will be handled on the next business day.

Properly Submitted Requests

Pursuant to N.J.A.C. 11:3-4.7(d), all providers must use the Attending Provider Treatment Plan (APTP) form, to submit ***Decision Point Review and Precertification*** Requests. No other forms for this purpose are permitted. A copy of the APTP form is available at http://www.nj.gov/dobi/aicrapg.htm or by contacting Genex at 800-407-0704, or at https://www.genexservices.com/nj-dpr.
A properly submitted APTP form must be completed in its entirety. It must include the injured person's full name and birth date, the claim number, the date of the accident, diagnoses / ICD-9 or ICD-10 code(s), each CPT code requested including frequency, duration and signature of the requesting physician.

Properly submitted requests for ***decision point review and precertification*** must also include legible clinically supported findings that support the treatment, diagnostic test or durable medical equipment requested. Clinically supported findings, supplied to Genex, must not only be legible but also establish that a health care provider, prior to selecting, performing or ordering the administration of a treatment, diagnostic testing or durable medical equipment, has:

1. Personally examined the patient to ensure that the proper medical indications exist to justify ordering the treatment, diagnostic testing or durable medical equipment;
2. Physically examined the patient, including making an assessment of any current and/or historical subjective complaints, observations, objective findings, neurologic indications and physical tests;
3. Considered the results of any and all previously performed tests that relate to the injury and which are relevant to the proposed treatment, diagnostic testing or durable medical equipment; and
4. Recorded and documented these observations, positive and negative findings and conclusions on the patient's medical records.

Within three business days following receipt of a properly submitted request, Genex will provide its determination. Our failure to respond within three business days will allow a provider to continue treatment until we provide the required notice.

When an improperly submitted request is received, Genex will inform your treating provider what additional medical documentation or information is required. An administrative denial for failure to provide required medical documentation or information will be issued and will remain in effect until all requested information needed to properly process a review to determine medical necessity regarding the requested treatment/testing and/or durable medical equipment is received. Our determination will be provided within three business days following receipt of the additional required documentation or information. If we fail to notify the eligible injured party or provider of our determination within 3 business days following receipt of the additional required documentation or information, you may continue with the test or treatment until our final determination is communicated to your provider.

Any denial of treatment or testing based on medical necessity shall be made by a physician or dentist.

PLEASE NOTE: Authorized testing, treatment and/or durable medical equipment is only approved for the range of dates noted in the determination letter(s).

Expired Authorization:

If you or your treating Provider fails to follow the DPR plan/precertification procedures, any approved testing, treatment and/or durable medical equipment completed after the authorization period expires will be subject to a penalty copayment of 50%, even if the services are determined to be medically necessary.

INDEPENDENT MEDICAL EXAMINATION

Genex or the insurance carrier may request that you attend an Independent Medical Examination. If an Independent Medical Examination is requested, the appointment for the physical examination will be scheduled within 7 calendar days of receipt of the notice, unless the injured person agrees with Genex to extend the time period.

The Independent Medical Examination will be conducted by a provider in the same specialty of your treating provider and will be conducted in a location reasonably convenient to the eligible injured person.

Results of the Independent Medical Examination and the determination regarding your provider's request will be submitted to you in writing and to your health care provider in writing and by telephone within 3 business days after the examination. Except for non-emergent tests, surgery, procedures performed in ambulatory surgical centers, and invasive dental procedures, treatment may proceed while the examination is being scheduled and until the results become available. However only medically necessary treatment related to the motor vehicle accident will be reimbursed. If the examining provider prepares a written report concerning the examination, the eligible injured person, or his or her designee, shall be entitled to a copy of the report upon request.

Examination will be scheduled to occur within 30 calendar days of the receipt of the request. Examinations scheduled to occur beyond 30 calendar days of the receipt of the request, must be attended. Failure to attend an examination scheduled to occur more than thirty (30) calendar days after receipt of the request will be considered an unexcused failure to attend the examination.

You are required to present photo identification, or any form of identification, to the examining provider at the time of the exam. Failure to comply with this requirement will result in an unexcused failure to attend the examination.
If you are non-English speaking, then an English speaking interpreter must accompany you to the examination. No interpreter fees or costs will be compensable. Failure to comply with this requirement will result in an unexcused failure to attend the examination.

If you must reschedule your appointment, you must contact Genex at 800-407-0704 no less than three (3) business days prior to the scheduled appointment. Failure to comply with this requirement will result in an unexcused failure to attend the examination.

You must provide all medical records and diagnostic studies/tests available before or at the time of the examination. Failure to provide the required medical records and/or diagnostic studies/tests will be considered an unexcused failure to attend the IME. If the injured person has more than 1 unexcused failure to attend the scheduled exam, notification will be immediately sent to the injured person, or to his or her designee, and all providers treating the injured person for the diagnosis (and related diagnosis) contained in the Attending Provider Treatment Plan form. The notification will place the injured person on notice that all further treatment, diagnostic testing or durable medical equipment required for the diagnosis, (and related diagnosis) contained in the Attending Provider Treatment Plan form, will not be reimbursable as a consequence for failure to comply with the plan.

An example of the injured person's unexcused failures to attend the exam may include but are not limited to one of the following

- Failure to provide the medical records and/or diagnostic films before or on the day of examination;
- Rescheduling the examination with 3 or less business days notice ;
- Failure to present valid photo identification or any form of identification at the time of the examination;
- Failure to be accompanied by an English interpreter if the eligible injured party is non-English speaking;
- Failure to present for any of the examination appointments for any reason.
- Failure to attend an examination scheduled to occur beyond 30 calendar days of the receipt of the request of additional treatment/test or service in question.

VOLUNTARY UTILIZATION NETWORK (VUN) (Waiver of Penalty Copayment**):**

Genex provides access to approved voluntary Networks of affiliated entities, Mitchell International, Inc. and Coventry Health Care Workers' Compensation Services, Inc., as described below.. As outlined in N.J.A.C. 11:3-4.8, these voluntary Networks are approved as part of a workers' compensation managed care organization pursuant to N.J.A.C. 11:6. The benefits of these voluntary networks include ease of access, credentialed and quality providers and the fact that your penalty copayment is waived when accessing a voluntary network provider.

In accordance with N.J.A.C. 11:3-4.8 the plan includes a voluntary network for:

1. Magnetic Resonance Imaging (MRI)
2. Computer Assisted Tomography (CT/CAT Scans)
3. Needle Electromyography (needle EMG) *
4. Somatosensory Evoked Potential (SSEP)**
5. Visual Evoked Potential (VEP)**
6. Brain Audio Evoked Potential (BAEP)**
7. Brain Evoked Potential (BEP)**
8. Nerve Conduction Velocity *[(NCV)]* H reflex Study**
9. Electroencephalogram (EEG)**
10. Durable Medical Equipment with a cost or monthly rental in excess of $50.00
11. Prescription Drugs
12. Services, equipment or accommodations provided by an ambulatory surgery facility.

* except when performed by the treating physician.
** except when performed by the treating physician in conjunction with a Needle EMG.

When any of the services listed above is authorized at any point in the **decision point review or precertification or appeal** process, information about accessing our voluntary network of providers is available on the websites or at the toll free numbers listed below. Those individuals who choose not to utilize the network will be assessed a penalty copayment not to exceed 30% of the eligible charge, including if the treatment is denied but subsequently approved. That penalty copayment will be the responsibility of the eligible injured party.

There are two specific Networks for the below specified services:

- Prescription Drugs:
  - ScriptAdvisor at 1-855-728-7706 or at https://integratedprescriptionsolutions.com/
- Diagnostic Imaging/Electrodiagnostic Testing:
  - Information regarding the Coventry provider network is available to you at www.talispoint.com/cvty/cvtyau or by calling **800-937-6824.**
- Durable Medical Equipment (DME):
  - Information regarding the Coventry provider network is available to you at www.talispoint.com/cvty/cvtyau or by calling **800-937-6824.**
- Services, equipment or accommodations provided by an ambulatory surgery facility.
  - Information regarding the Coventry provider network is available to you at www.talispoint.com/cvty/cvtyau or by calling **800-937-6824.**

PENALTY

As outlined in N.J.A.C. 11:3-4.4 (d), failure to request ***Decision Point Review or Precertification*** as required in our ***Decision Point Review / Precertification*** plan will result in a 50% penalty copayment. This penalty copayment will be in addition to any co-payment stated in the schedule of your policy. Failure to submit clinically supported findings that support your ***decision point review or precertification*** request will result in a 50% penalty copayment

Failure to use an approved network provider for Prescription Drugs, Diagnostic Imaging/Electro diagnostic Testing, Durable Medical Equipment, and services, equipment or accommodations provided by an ambulatory surgery facility will result in a 30% penalty copayment. All penalty copayments will be applied before the application of the policy copayment and deductible.

ASSIGNMENT OF BENEFITS

Assignment of a named insured's or eligible injured person's rights to receive benefits for medically necessary treatment, durable medical equipment tests or other services is prohibited except to a licensed health care provider who agrees to:

a) Fully comply with NJSIA Decision Point Review Plan, including precertification requirements,
b) Comply with the terms and conditions of the NJSIA policy
c) Provide complete and legible medical records or other pertinent information when requested by us,
d) Complete the "internal appeals process" which shall be a condition precedent to the filing of a demand for alternative dispute resolution for any issue related to bill payment, bill processing, Decision Point Review Request or Precertification request. Completion of the internal appeal process means timely submission of an appeal and receipt of the response prior to filing for alternate dispute resolution.
e) Submit disputes to alternative dispute resolution pursuant to N.J.A.C. 11:3-5
f) Submit to statements or examinations under oath as often as deemed reasonable and necessary.

As a further condition to the Assignment of Benefits, the licensed provider agrees to consent to the consolidation of all pending arbitrations involving the same person, accident, or claim number.

Failure by the health care provider to comply with all the foregoing requirements will render any prior assignment of benefits under NJSIA policy null and void. Should the provider accept direct payment of benefits, the provider is required to hold harmless the insured and NJSIA for any reduction of payment for services caused by the provider's failure to comply with the terms of the insured's policy.

INTERNAL APPEAL PROCESS

The internal appeals process shall permit a health care provider who has been assigned benefits pursuant to N.J.A.C. 11:3-4.9, or has a power of attorney from the injured party, to participate in the internal appeals process for reconsideration of an adverse decision.

All internal appeals shall be filed using the form established by the Department by Order in accordance with N.J.A.C. 11:3-4.7(d). A properly submitted appeal form must be completed, including, but not limited to the minimum required fields as indicated by an asterisk (*). Further, an appeal rationale narrative, which must include not only the rationale for the appeal, but also any and all medical criteria to support the dispute of a medical determination, is required to be included within these forms. Failure to comply with these requirements will result in an administrative denial of the appeal. The appeal form and all supporting documentation must be submitted by the health care provider to Genex at the address, fax number or designated for appeals as follows:

Genex NJ DPR+ Department
PO Box 4379
Westlake Village, CA 91359
Fax: 866-327-9318
Email: NJDPRPlus@reviewstat.com

There are two types of internal appeals:

1. Pre-service: Appeals of decision point review and/or precertification denials or modifications prior to the performance or issuance of the requested medical procedure, treatment, diagnostic test, prescribing of any and all prescriptions/medications, other service and/or durable medical equipment (collectively known as "services")

2. Post-service: Appeals subsequent to the performance or issuance of the services

Pursuant to N.J.A.C. 11:3-4.7B(b), each issue shall only be required to receive one internal appeal review, by the insurer prior to making a request for alternate dispute resolution.

Pre-service Appeals

A pre-service appeal shall be submitted in writing/electronically to Genex no later than (30) thirty days after receipt of a written denial or modification of requested services.

A final decision will be communicated in writing to the health care provider who submitted the appeal within (14) fourteen days from the date Genex received the properly submitted appeal and all supporting documentation.

All pre-service appeals received after (30) thirty days from the date of receipt of the adverse decision notice shall be acknowledged as "Late Appeals." All pre-service appeals that are acknowledged as "Late Appeals" will not be processed. The pre-service appeal form must be completed, including, but not limited to the minimum required fields as indicated by an asterisk (*).Further, an appeal rationale narrative, which must include not only the rationale for the appeal but also any and all medical criteria to support the dispute of a medical determination, is required to be included within these forms. Failure to comply with this requirement will result in an administrative denial of the appeal.

If a pre-service appeal is not properly submitted within (30) thirty days from the date the provider has received notice of the adverse decision, the health care provider may submit another decision point review request for the services in accordance with the aforementioned section in this DPR Plan named "How to Submit Decision Point and/or Precertification Requests".

Failure to utilize the Appeals Process and submit a valid appeal as set forth above, will invalidate an assignment of benefits.

Post-Service Appeals

A post-service appeal shall be submitted in writing to Genex at least 45 days prior to initiating alternate dispute resolution pursuant to N.J.A.C. 11:3-5 or filing an action in Superior Court. The post-service appeal form must be completed, including, but not limited to the minimum required fields as indicated by an asterisk (*).Further, an appeal rationale narrative which must include not only the rationale for the appeal but also any and all medical criteria to support the dispute of a medical determination, is required to be included within these forms. Failure to comply with this requirement will result in an administrative denial of the appeal.

A final decision will be communicated in writing to the health care provider who submitted the appeal within (30) thirty days from the date Genex received the properly submitted appeal and all supporting documentation.

Pursuant to N.J.A.C. 11:3-5.1, any completed appeal may be submitted to Alternate Dispute Resolution. If the injured party or healthcare provider retains counsel to represent them during the appeal process, they do so strictly at their own expense. No counsel fees or costs incurred during the appeal process shall be compensable. To the extent permitted by law, the results of said Alternate Dispute Resolution processes shall be final and binding.

DISPUTE RESOLUTION PROCESS

Any disputes not resolved in the Appeals Process must be submitted through the Personal Injury Protection Dispute Resolution process governed by regulations promulgated by the New Jersey Department of Banking and Insurance (N.J.A.C. 11:3-5) and can be initiated by contacting Forthright at 732-271-6100 or toll-free at 1-888-881-6231. Information is also available on Forthright's Web site, http://www.nj-nofault.com. We retain the right to file a Motion to remove any Superior Court action to the Personal Injury Protection Dispute Resolution Process pursuant to N.J.S.A. 39:6A-5.1 as indicated above.

Failure to utilize the Appeals Process and submit a valid appeal at set forth above, will invalidate an assignment of benefits.

EXHIBIT A

Identified Injuries

The following **International Classification of Diseases, 9th** Revision Clinical Modification - fifth edition **ICD-9-CM** diagnostic codes are associated with Care Path 1 through Care Path 6 for treatment of Accidental Injury to the Spine and Back and are included on each appropriate Care Path. The ICD9 codes referenced do not include codes for multiple diagnoses or co-morbidity.

Care Path 1
728.0 Disorders of muscle, ligament and fascia
728.85 Spasm of muscle
739.0 Non allopathic lesions - not elsewhere classified
739.1 Somatic dysfunction of cervical region
847.0 Sprains and strains of neck
847.9 Sprains and strains of back, unspecified site
922.3 Contusion of back
922.31 Contusion of back, excludes interscapular region
953.0 Injury to cervical root

Care Path 2
722.0 Displacement of cervical intervertebral disc without myelopathy
722.2 Displacement of intervertebral disc, site unspecified, without myelopathy
722.70 Intervertebral disc disorder with myelopathy, unspecified region
722.71 Intervertebral disc disorder with myelopathy, cervical region
728.0 Disorders of muscle, ligament and fascia
739.0 Non allopathic lesions - not elsewhere classified
953.0 Injury to cervical root

Care Path 3
728.0 Disorders of muscle, ligament and fascia
728.85 Spasm of muscle
739.0 Non allopathic lesions - not elsewhere classified
739.2 Somatic dysfunction of thoracic region
739.8 Somatic dysfunction of rib cage
847.1 Sprains and strains, thoracic
847.9 Sprains and strains of back, unspecified site
922.3 Contusion of back
922.33 Contusion of back, interscapular region

Care Path 4
722.0 Displacement of cervical intervertebral disc without myelopathy
722.1 Displacement of thoracic or lumbar intervertebral disc without myelopathy
722.11 Displacement of thoracic intervertebral disc without myelopathy
722.2 Displacement of intervertebral disc, site unspecified, without myelopathy
722.70 Intervertebral disc disorder with myelopathy, unspecified region
722.72 Intervertebral disc disorder with myelopathy, thoracic region
728.0 Disorders of muscle, ligament and fascia
739.0 Non allopathic lesions - not elsewhere classified

Care Path 5
728.0 Disorders of muscle, ligament and fascia
728.85 Spasm of muscle
739.0 Non allopathic lesions - not elsewhere classified
739.3 Somatic dysfunction of lumbar region
739.4 Somatic dysfunction of sacral region
846 Sprains and strains of sacroiliac region
846.0 Sprains and strains of lumbosacral (joint) (ligament)
846.1 Sprains and strains of sacroiliac ligament
846.2 Sprains and strains of sacrospinatus (ligament)
846.3 Sprains and strains of sacrotuberous (ligament)
846.8 Sprains and strains of other specified sites of sacroiliac region

846.9 Sprains and strains, unspecified site of sacroiliac region
847.2 Sprains and strains, lumbar
847.3 Sprains and strains, sacrum
847.4 Sprains and strains, coccyx
847.9 Sprains and strains, unspecified site of back
922.3 Contusion of back
922.31 Contusion of back, excludes interscapular region
953.2 Injury to lumbar root
953.3 Injury to sacral root

Care Path 6
722.1 Displacement of thoracic or lumbar intervertebral disc without myelopathy
722.10 Displacement of lumbar intervertebral disc without myelopathy
722.2 Displacement of intervertebral disc, site unspecified, without myelopathy
722.70 Intervertebral disc disorder with myelopathy, unspecified region
722.73 Intervertebral disc disorder with myelopathy, lumbar region
728.0 Disorders of muscle, ligament and fascia
739.0 Non allopathic lesions - not elsewhere classified
953.3 Injury to sacral root