

**FARM FAMILY CASUALTY INSURANCE COMPANY  
UNITED FARM FAMILY INSURANCE COMPANY  
("FARM FAMILY")**

**DECISION POINT REVIEW PLAN INCLUSIVE OF  
PRECERTIFICATION REQUIREMENT**

This notice informs you of your rights and obligations under our Decision Point Review / Precertification (DPR) Plan and other related provisions of your automobile policy, if you experience a covered loss involving personal injury strongly recommend that you carefully read this notice. Procura Management, Inc. is the administrator of the Farm Family DPR Plan. The Farm Family DPR Plan is available in hard copy by calling Farm Family at 800-948-3276 or by going to the Procura Management Inc. website at [www.procura-inc.com](http://www.procura-inc.com).

**DECISION POINT REVIEW ("DPR")**

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.

Treatments obtained in an emergency situation and / or within ten days of the insured event are not subject to decision point review (*represented by the hexagonal symbols on the Care Paths*) / 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 Procura Management Inc 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 Procura Management Inc at 800-275-9485.

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 (DME) 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

## PRECERTIFICATION

For treatment of injuries other than an "Identified Injury" (soft tissue injury of the neck or back), an injured party or their health care provider(s) are required to obtain precertification for all of the services and/or conditions listed below. If you or your health care providers fails to precertify such services, or fail to provide clinically supported findings that support the treatment, diagnostic tests or DME 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, goods services and/or conditions, and non-medical expenses require precertification.

- 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
- 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)

**VOLUNTARY PRECERTIFICATION:**

An injured party or their health care provider is strongly encouraged to participate in a Voluntary Precertification process by providing a comprehensive treatment plan for both identified and other injuries. Procura will utilize nationally accepted criteria and the Care Paths to work with Providers to certify a mutually agreeable course of treatment to include itemized services and a defined treatment period. In addition, having an approved treatment plan means that as long as treatment is consistent with the approved plan, additional notification to Procura Management Inc. at Decision Points for Treatment, Diagnostic Testing or DME requiring precertification is not required.

**INITIAL AND PERIODIC NOTIFICATION REQUIREMENT**

Farm Family may require that you 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, Farm Family 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/PRE CERTIFICATION REQUESTS:**

Decision Point/Precertification requests must be submitted to Procura Management Inc and should be faxed to Procura at 1-610-631-7011. You may also mail your request to Procura at the following address:

Procura Management Inc.  
2435 Boulevard of the Generals, Suite 200, Norristown, PA, 19403

Procura Management Inc shall provide 24 hour, 7-day/week-telephone service. Regular business hours are Monday through Friday 7:30 AM - 5:00 PM, EST/EDT. All requests for precertification received before or after business hours and on weekends and or holidays will be handled on the next business day.

We encourage that any questions regarding the process be addressed by calling Procura's Auto Injury Management Service (AIMS) Department at 800-275-9485 or e-mailing Procura at [AIMS@procura-inc.com](mailto:AIMS@procura-inc.com).

## PROPERLY SUBMITTED REQUESTS

An injured party's medical treating provider must submit all requests on the "Attending Provider Treatment Plan (AFTP) form." A copy of the "Attending Provider Treatment Plan form" is available at [www.nj.gov/dobi/aicrapg.htm](http://www.nj.gov/dobi/aicrapg.htm) or by contacting Procura Management Inc. at 1-800-275-9485, or at [www.procura-inc.com](http://www.procura-inc.com). Failure to submit the required documentation could result in a delay in receiving a final determination of an injured party's request.

A properly submitted AFTP form must be completed in its entirety. Properly submitted requests for decision point review and precertification must include the injured person's full name and birth date, the claim number, and the date of the accident. Complete requests also must include dates of prior treatment, diagnoses and ICD-9 codes, diagnostic tests performed including the test findings, recommended tests, pre-existing conditions, CPT codes, and any additional information or documentation required to review the treatment/testing and/or DME request.

Properly submitted requests for *decision point review and precertification* must also include legible clinically supported findings that support the treatment, diagnostic test or DME requested. Clinically supported findings, supplied to Procura Management Inc, 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 DME, has:

1. Personally examined the patient to ensure that the proper medical indications exist to justify ordering the treatment, diagnostic testing or DME;
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 DME; and
4. Recorded and documented these observations, positive and negative findings and conclusions on the patient's medical records.

When an improperly submitted request is received, Procura Management Inc will inform an injured party's 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 process a review to determine medical necessity regarding the requested treatment/testing and/or DME is received.

Procura Management, Inc.'s review of decision point/precertification requests and/or extended treatment notifications will be completed within 3 business days of receipt of the necessary information.

Procura Management, Inc shall respond to providers as to whether or not the medical documentation supplied by the treating provider is sufficient. If Procura Management Inc fails to notify the provider within 3 business days, an injured party may continue with the test or treatment until the determination is communicated to the provider.

Unless otherwise indicated, all determinations regarding decision point review and precertifications from Procura Management, Inc. will be provided by phone and in writing within 3 business days of receipt of the request. If a determination is not rendered within 3 business days of receipt of the request, the treatment or testing may proceed until the injured party and / or their provider have been notified that reimbursement for the treatment or testing is not authorized.

Denials of decision point review and precertification requests on the basis of medical necessity shall be determined by a physician or dentist.

Authorized testing, treatment and/or DME are only approved for the range of dates noted in the determination letter(s).

## **EXPIRED AUTHORIZATION**

Any approved testing, treatment and/or DME completed after the authorization period (last date in the range of dates indicated in the authorization notice letter) expires will be subject to a penalty copayment of 50%, even if the services are determined to be medically necessary.

## **INDEPENDENT MEDICAL EXAMINATIONS (“IME”)**

Procura Management Inc 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 Procura Management Inc 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 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 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 Procura Management Inc at 800-275-9485 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 2 or more unexcused failures 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 DME 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 the following:

- Failure to provide the medical records and/or diagnostic films before or on the day of examination;
- Rescheduling the examination for any reason even within the required less than 3 business days prior to the examination appointment;
- 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 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 NETWORK PROGRAM (VNP)**

Procura Management Inc has a provider network that is available to you. As outlined in N.J.A.C. 11:3-4.8, the Procura Network is an approved network as part of a workers' compensation managed care organization pursuant to N.J.A.C. 11:6. The benefits of the network include ease of access, credentialed and quality providers and the fact that your penalty copayment is waived when accessing a 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 (VEP)\*\*
9. H reflex Study\*\*
10. Electroencephalogram (EEG)\*\*
11. DME with a cost or monthly rental in excess of \$300.00
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 through the *decision point review* or *precertification* process, information about accessing our voluntary network of providers is available on the websites or at the toll free numbers both of which are 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. That penalty copayment will be the responsibility of the injured party.

There is the specific Network for the below specified services:

- Diagnostic Imaging/Electrodiagnostic Testing:
  - Information regarding the Procura Management Inc provider network is available to you at [www.procura-inc.com](http://www.procura-inc.com) or by calling Procura Management Inc. at 800-275-9485.
- DME:
  - Information regarding the Procura Management Inc provider network is available to you at [www.procura-inc.com](http://www.procura-inc.com) or by calling Procura Management Inc. at 800-275-9485.
- Services, equipment or accommodations provided by an ambulatory surgery facility.
  - Information regarding the Procura Management Inc provider network is available to you at [www.procura-inc.com](http://www.procura-inc.com) or by calling Procura Management Inc. at 800-275-9485.

Information regarding our provider network is available to you at [www.procura-inc.com](http://www.procura-inc.com) or by calling Procura Management Inc. at 800-275-9485. Our provider network includes Procura Management Inc. providers as well as the Magnacare Network.

## **ASSIGNMENT OF BENEFITS**

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

- (a) Fully comply with the Farm Family DPR Plan, including precertification requirements,
- (b) Comply with the terms and conditions of the Farm Family policy
- (c) Provide complete and legible medical records or other pertinent information when requested by us,
- (d) Utilize 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,
- (e) Submit disputes to alternative dispute resolution pursuant to N.J.A.C. 11:3
- (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 Farm Family policy null and void. Should the provider accept direct payment of benefits, the provider is required to hold harmless the insured and Farm Family 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**

### **1<sup>st</sup> Level Appeal:**

If a health care provider disagrees with our determination related to decision point review, precertification or payment of medical expenses, the health care provider may submit an internal appeal for reconsideration of the decision. Consistent with the terms of the Decision Point Review Plan and the Assignment of Benefits provision a provider proceeding under an Assignment of Benefits must utilize 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. All appeals for reconsideration of a decision point review or precertification medical determination must include not only the basis for the appeal but also the medical criteria to support the dispute of a medical determination. All appeals for reconsideration must be submitted no later than 30 calendar days from the date of the adverse determination. The injured party, and /or health care providers, may be requested to submit additional documentation in order to complete the internal review.

Requests for reconsideration must be submitted in writing to Procura Management Inc via fax to Procura Management Inc at 1-610-631-7094. Your reconsideration request may also be submitted by mail to Procura Management Inc the address below. Any notice of a 1<sup>st</sup> Level Appeal not sent via the aforementioned fax must be submitted, via certified mail/return receipt requested or via courier that provides proof of delivery to Procura within 30 calendar days from the date of the adverse determination. Proof of receipt by the insurer must be provided by the disputing party at the insurer's request.

Procura Management Inc.  
Attention: 1<sup>st</sup> Level Appeals Dept  
2435 Boulevard of the Generals, Suite 200  
Norristown, PA 19403

A Procura Medical Director will be available to consult with the health care provider during the medical appeal process. A final decision will be communicated to the injured party and the health care provider within 14 business days of receipt of the properly submitted appeal and/or receipt of any supporting documentation we may request.

If the injured party or health care 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.

**2<sup>nd</sup> Level Appeal:**

Any disputes not resolved through the 1<sup>st</sup> Level Appeal Process must be submitted to Farm Family for a 2<sup>nd</sup> Level Appeal. No 2<sup>nd</sup> level appeal may be filed until the 1<sup>st</sup> Level Appeal Process has been completed. The process is as follows:

To initiate a 2<sup>nd</sup> Level Appeal, you must submit written notice of the dispute to Farm Family at least 30 days prior to filing a Demand for Arbitration. Such notice shall be submitted to Farm Family in writing via fax at 1-518-431-5980 or via e-mail to FFClaims\_MedicalClaims@FarmFamily.com. Any notice of a 2<sup>nd</sup> Level Appeal not sent via the aforementioned fax or e-mail address must be submitted, via certified mail/return receipt requested or via courier that provides proof of delivery to Farm Family 30 days prior to the filing of the arbitration. Proof of receipt by the insurer must be provided by the disputing party at the insurer's request.

The written notice shall set forth the basis of the 2<sup>nd</sup> level appeal and the facts underlying the dispute as well as include copies of all relevant supporting documents, including, but not limited to, any unpaid medical bills for medical expenses that may be in dispute and sent to Farm Family at the following fax number: 1-518-431-5980.

Below is the Farm Family mailing address used for submitting, via certified mail/return receipt requested or via courier that provides proof of delivery, to Farm Family 30 days prior to the filing of the arbitration.

Farm Family Medical Claim Unit MS# 10 PO Box 656 Albany, NY 12201	Farm Family Medical Claim Unit MS# 10 344 Route 9W Glenmont, NY 12077
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All properly submitted 2<sup>nd</sup> Level Appeal requests will be reviewed by the Farm Family within 30 calendar days from receipt of the notice and all supporting documents. A final decision will be communicated to you within 30 calendar days of receipt of the properly submitted request. During this time, you shall cooperate with Farm Family in the investigation of the dispute and negotiate in good faith with Farm Family in an effort to resolve the dispute amicably.

Pursuant to N.J.A.C. 11:3-5.1, any appeal properly submitted that has not been resolved through the internal appeal process 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.

The injured party or healthcare provider agrees to indemnify and hold the insurer and Procura Management Inc. harmless for any legal fees and/or costs incurred by us as a result of the assignee's failure to utilize the Internal Appeal Processes prior to fulfilling the Alternate Dispute Resolution requirements in this Decision Point Review Plan. To the extent permitted by law, the results of said Alternate Dispute Resolution processes shall be final and binding with no right of appeal.

## 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