

# NATIONAL GENERAL INSURANCE COMPANY (NGIC)'s 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.

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. The NGIC DPR Plan is available in hard copy by calling Procura Management Inc at (800) 275-9485, and is also available at [www.procura-inc.com](http://www.procura-inc.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 DME requested, payment of your bills may be subject to a penalty co-payment 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:**

For treatment, diagnostic testing or DME 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 (DME) requested, payment of bills will be subject to a penalty co-payment 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 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 DME 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.
- DME, 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 DME, 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. DME
  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/rhizotomy
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)

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).

If your provider fails to request *decision point review / precertification* where required or fails to provide clinical findings that support the treatment, testing or DME requested a co-payment penalty of 50% will apply even if the services are determined to be medically necessary. For benefits to be reimbursed in full, treatment, testing and DME 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 Procura Management Inc. 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** and for Treatment, Diagnostic Testing or DME requiring **precertification** is not required.

#### **HOW TO SUBMIT DECISION POINT and/or PRECERTIFICATION REQUESTS:**

**Decision Point / Precertification** requests **must** be submitted directly to Procura Management Inc and should be submitted by fax to Procura Management Inc at (610) 631-7011.

You may also submit your requests to Procura Management Inc at **the** following address:

Procura Management Inc.  
2435 Boulevard of the Generals, Suite 200,  
Norristown, PA, 19403  
\*[(800) 275-9485  
Fax: (610) 631-7011]\*

Procura Management Inc shall provide 24 hour, 7-day / week telephone service. Regular business hours are Monday through Friday 7:30 AM to 5:00 PM. All requests for pre-authorization received by Procura Management Inc on weekends and 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 Procura Management Inc at (800) 275-9485, or at [www.procura-inc.com](http://www.procura-inc.com).

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 code(s), each CPT code requested including frequency and duration.

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.

Within three business days following receipt of a properly submitted request, Procura Management Inc 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, Procura Management Inc 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 DME 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 DME are 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 procedures listed below, 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 co-pay of 50%, even if the services are determined to be medically necessary. In order to avoid this penalty, your treating provider must follow the appropriate procedure below:

- When medically necessary care or DME is not completed within 14 calendar days from the date in which the authorization period expires, you must request an extension, in writing, to Procura Management Inc and the extension request must include an explanation to support the request for the extension. It may either be faxed to Procura Management Inc at (610) 631-7011 or mailed to the following address: Procura Management Inc, 2435 Boulevard of the Generals, Attention AIMS Dept, Norristown, PA 19403.
- When medically necessary care or DME is not completed 30 or more calendar days from the date in which the authorization period expires, you must resubmit a request for medical review and authorization to Procura Management Inc. The request must be properly submitted to Procura Management Inc in writing and must include a properly completed APTP form. The *complete* APTP form must be accompanied with appropriate and current legible clinically supported findings. It may either be faxed to Procura Management Inc at (610) 631-7011 or mailed to the following address: Procura Management Inc, 2435 Boulevard of the Generals, Attention AIMS Dept, Norristown, PA 19403.

#### **INDEPENDENT MEDICAL EXAMINATION**

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 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. Please note that your medically necessary treatment may proceed while the Independent Medical Examination is being scheduled and until the results are available. 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 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, or three failures to attend an examination in total, 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 3 total failures to attend the exam may include 3 occurrences of any one of the following or 3 occurrences of any combination of 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 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 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 NETWORK PROGRAM (VNP) (Waiver of Penalty Co-payment):

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** co-payment 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 (NCV)
9. H reflex Study\*\*
10. Electroencephalogram (EEG)
11. DME with a cost or monthly rental in excess of \$50.00

12. Prescription Drugs
13. 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 will be supplied to both the **injured** party and the requesting provider. Those individuals who choose not to utilize the network will be assessed a penalty co-payment not to exceed 30% of the eligible charge. That **penalty** co-payment will be the responsibility of the injured party.

There are two specific Networks for the below specified services:

- A. Prescription Drugs:  
Cypress Care at (800) 419-7191 or at [www.cypresscare.com](http://www.cypresscare.com).
- B. 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.
- C. Durable Medical Equipment:  
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.
- D. 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.

## PREFERRED PROVIDER ORGANIZATION (PPO)

In addition, Procura makes available a Preferred Provider Organization (PPO) that includes all specialties, hospitals, outpatient, and urgent care facilities. The use of a provider from our PPO is strictly voluntary and is provided as a service to you. A penalty co-payment will not be applied if you choose to select a provider outside this preferred provider network. Procura's preferred providers have facilities located throughout the state. Information regarding our PPO 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 PPO Network includes Procura Management Inc. providers as well as the Magnacare Network.

## PENALTY

As outlined in N.J.A.C. 11:3-4.4 \*[3]\* (d), failure to request **Decision Point Review or Precertification** as required in our **Decision Point Review / Precertification** plan will result in a 50% penalty co-payment. This penalty co-payment 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 co-payment.

## ASSIGNMENT OF BENEFITS

Assignment of a named insured's or injured party'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 NGIC DPR Plan, including precertification requirements,
- (b) Comply with the terms and conditions of the NGIC 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.

Failure by the health care provider to comply with all the foregoing requirements will render any prior assignment of benefits under NGIC policy null and void. Should the provider accept direct payment of benefits, the provider is required to hold harmless the insured and NGIC 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 the injured party, or a health care provider disagrees with our determination related to decision point review, precertification or payment of medical expenses, the injured party, or their health care provider may submit a 1<sup>st</sup> Level Appeal for reconsideration of the decision. Consistent with the terms of the DPR 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 **1<sup>st</sup>** Level Appeals must include the basis for the appeal. All 1<sup>st</sup> Level 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 1<sup>st</sup> Level Appeals must be submitted no later than 30 calendar days from the date of the adverse determination. The injured party, and one or more health care providers, may be requested to submit additional documentation in order to complete the internal review.

Requests for 1<sup>st</sup> Level Appeal must be submitted in writing to Procura Management Inc. Your 1<sup>st</sup> Level Appeal should be faxed to Procura Management Inc at (610) 631-7011.

Your 1<sup>st</sup> Level Appeal may also be submitted by mail to Procura Management Inc at:

Procura Management Inc.  
Attention: 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 **disputing** health care provider, in writing 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 healthcare provider retains counsel to represent them during the appeal processes, they do so strictly at their own expense. No counsel fees or costs incurred during the appeal processes shall be compensable.

However, any appeal properly submitted by a health care provider whose matter has not been resolved in the first internal appeal must thereafter follow the appeal process set forth in the following section named "2<sup>nd</sup> Level Appeal."

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

All appeals regarding *decision point review*, *precertification*, or payment of medical bills must be properly submitted to Procura Management Inc for reconsideration as described above in the 1<sup>st</sup> Level Appeal process requirements. Any other disputes and any disputes not resolved through the foregoing 1<sup>st</sup> Level Appeal Process must be submitted directly to NGIC for a 2nd Level Appeal as follows:

To initiate a 2<sup>nd</sup> Level Appeal, you must submit written notice of the dispute, and request an internal review. A 2nd Level Appeal should be faxed directly to NGIC at (800) 924-0273. Proof of receipt by NGIC must be provided by the disputing party at the insurer's request.

The written notice shall set forth the basis of the 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 us at the following address:

NGIC  
Attention: 2<sup>nd</sup> Level Appeals  
P.O. Box 1623  
Winston Salem, NC 27100-1623

All properly submitted 2<sup>nd</sup> Level Appeal requests will be reviewed by NGIC within 30 calendar days from receipt of the notice and all supporting documents. A final decision will be communicated to you in writing within 30 calendar days of receipt of the properly submitted request. During this time, you shall cooperate with NGIC in the investigation of the dispute and negotiate in good faith with NGIC 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 processes may be submitted to the National Arbitration Forum (NAF). You may contact the NAF for filing information at (732) 271-6100. Forms, rules, and procedures are also available on the NAF's website at <http://www.nj.adrforum.com>.

If the injured party or healthcare provider retains counsel to represent them during the appeal processes, they do so strictly at their own expense. No counsel fees or costs incurred during the appeal processes shall be compensable.

The injured party or healthcare provider agrees to indemnify and hold NGIC 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 DPR 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