Nationwide Insurance
Decision Point Review Plan

DECISION POINT REVIEW PLAN INCLUSIVE OF PRECERTIFICATION REQUIREMENTS

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. Genex Services, LLC (Genex) is the administrator of the Nationwide Insurance DPR Plan. The Genex DPR Plan is available in hard copy by calling Genex at 800-407-0704 or by going to the Genex website at https://www.genexservices.com/nj-dpr-plus

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 calendar 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 Nationwide Insurance 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.

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

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 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
- PENs/PNT
- Skilled Nursing/Rehabilitation Services
- Trigger Point Dry Needling
- Drug Screening
- 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;
- Schedule II, III and IV Controlled Substances, as defined by the Drug Enforcement Administration (DEA), when prescribed for more than three months;
- Compound Medications and compounded prescriptions
- 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 calendar 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 calendar days, including but not limited to:

    - Vehicles
    - Modification to vehicles
    - Durable goods
    - Furnishings
    - Improvements or modifications to real or personal property
    - Fixtures
    - Recreational activities and trips
    - Leisure activities and trips
    - 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:

- Acupuncture
- Nerve blocks
- Manipulation under anesthesia
- Anesthesia when performed in conjunction with invasive techniques
- radio frequency/rhyzotomy
- Narcotics, when prescribed for more than 3 months
- Biofeedback
- Implantation of spinal stimulators or spinal pumps
- Trigger point injections
- Tens units (transcutaneous electrical nerve stimulation)
- 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 copayment 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 durable medical equipment must be medically necessary.

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. Genex 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 Genex at Decision Points for Treatment, Diagnostic Testing or DME requiring precertification is not required.

INITIAL AND PERIODIC NOTIFICATION REQUIREMENT

Nationwide Insurance 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, Genex may impose an additional penalty copayment which shall be no greater than:

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

HOW TO SUBMIT DECISION POINT/PRECERTIFICATION REQUESTS:

Decision Point/Precertification requests must be submitted to our DPR Administrator, Genex and should be faxed 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 8:30 AM - 5:00 PM, EST/EDT. All requests for Decision Point Review and precertification received before or after business hours and on weekends and or Federal / New Jersey state holidays will be handled on the next business day.

We encourage that any questions regarding the process be addressed by calling the Genex NJ DPR+ Department at 800-407-0704 or e-mailing at NJDPRPlus@reviewstat.com.

PROPERLY SUBMITTED REQUESTS

An injured party's medical treating provider must submit all requests on the "Attending Provider Treatment Plan (APTP) form." A copy of the "Attending Provider Treatment Plan form" is available at www.nj.gov/dobi/aicrapg.htm or by contacting Genex at 800-407-0704, or at https://www.genexservices.com/nj-dpr-plus. 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 APTP 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 or ICD-10 code(s), 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 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 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, Genex 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.

Genex'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.

Genex shall respond to providers as to whether or not the medical documentation supplied by the treating provider is sufficient. If Genex 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 precertification from Genex will be provided 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")

Genex or Nationwide Insurance 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 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 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 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)

Nationwide Insurance 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 voluntary network for:

1. Magnetic Resonance Imaging (MRI)
2. Computer Assisted Tomography (CT/CAT Scans)
3. Needle Electromyography (needle EMG), H-reflex and nerve conduction velocity (NCV) tests *
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 $300.00
12. Services, equipment or accommodations provided by an ambulatory surgery facility.
13. Prescription Drugs

* except when performed together by the treating physician.

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 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, including if the treatment is denied but subsequently approved. That penalty copayment will be the responsibility of the injured party.

There is the specific voluntary Network for the below specified services:

- Prescription Drugs:
  - ScriptAdvisor at http://www.enlyte.com/tools/pharmacy-benefit-management/scriptadvisor, by calling **866-846-9279** or via email at ScriptAdvisorCS@enlyte.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 3 (d), failure to request Decision Point Review or

Precertification as required in our Decision Point Review / Precertification plan will result in a 50% copayment penalty. This co-payment penalty 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% copayment penalty.

Copayments and deductibles will first be applied to the eligible charges and then penalties will be applied for failure to precertify.

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 Genex DPR Plan, including precertification requirements,
(b) Comply with the terms and conditions of the Genex 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 appeals process means timely submission of an appeal and receipt of the response prior to filing for alternate dispute resolution. Except for emergency care as defined in N.J.A.C. 11:3-4.2, any treatment that is the subject of the appeal that is performed prior to the receipt by the provider of the appeal decision shall invalidate the assignment of benefits.
(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 Genex policy null and void. Should the provider accept direct payment of benefits, the provider is required to hold harmless the insured and Genex 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 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 email 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, 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 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.

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 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".

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 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.

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.*

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