BestInjury™ Practice Standards
Relating to the Proper Management of Injury Cases
From a Medico-Legal Perspective

Best Injury Practices, Inc.

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WORKING DRAFT

1. 48-HOUR AVAILABILITY. When a PROVIDER receives a call relating to the scheduling of an initial appointment for any patient injured in an accident ("Patient"), the PROVIDER will agree to see the Patient within 48 hours of the call.

2. MISSED APPOINTMENTS. PROVIDER will be responsible for immediately contacting any applicable case manager ("CASE MANAGER") of any missed appointments by the Patient.

3. POLICY ON COLLECTING AT TIME OF SERVICE. PROVIDER will be responsible for clearly delineating and communicating PROVIDER'S policy on collecting from the Patient at the time of service. Such policy will be in writing and include any circumstances which might justify a modification to such policy.

    a. Such circumstances will not include the fact that Patient has received, or has become a candidate for receiving, surgical care.

4. CHIEF COMPLAINT(S). PROVIDER will be responsible for formulating and communicating the chief complaint(s) relating to the Patient to the CASE MANAGER no later than the earlier of the following: (i) one (1) week of a request by the CASE MANAGER, and (ii) Week 4 from date of the initial examination by the PROVIDER.

5. TIMELY REFERRAL FOR DIAGNOSTIC PROCEDURES. Following the determination of the chief complaint(s), PROVIDER will be responsible for making timely referrals for any additional objective diagnostic procedures which have not been previously performed subject to the following:

    a. Diagnostic procedures must be medically indicated,

b. Referrals must be made, if at all, by means of industry-standard prescription forms pre-approved by the CASE MANAGER,

c. Referrals must be made, if at all, no later than Week 6 from the date of the initial examination, and

d. Referrals must be communicated to the CASE MANAGER concurrently at the time of the referral.

6. MODIFICATION OF CARE / TIMELY REFERRAL TO ANY ADDITIONAL NECESSARY PROVIDERS. Upon completion of any additional diagnostic procedures, PROVIDER will promptly evaluate the resulting reports in determining whether to (i) continue, modify or discontinue the PROVIDER'S course of care and (ii) refer the Patient to any other necessary providers, subject to the following:

   a. Procedures must be medically indicated,

   b. Referrals must be made, if at all, by means of industry-standard prescription forms pre-approved by the CASE MANAGER,

   c. Referrals must be made, if at all, no later than Week 7 from the date of initial examination,

   d. Referrals must be communicated to the CASE MANAGER concurrently at the time of the referral, and

   e. Any determinations relating to ongoing care by the PROVIDER must be communicated to the CASE MANAGER no later than one (1) week of the evaluation of the diagnostic reports.

7. REFERRALS MUST BE MADE TO APPROPRIATE PROVIDERS AND DIAGNOSTIC FACILITIES. PROVIDER will refer to other providers and diagnostic facilities based, in part, on the adoption of written standards acceptable to the CASE MANAGER not inconsistent with these standards.

8. PROCESS FOR RELEASING PATIENTS FROM CARE; TIMELY PRODUCTION OF FINAL REPORTS. PROVIDERS will be responsible on a monthly basis for (i) assessing all outstanding injury cases, performing any necessary re-evaluations, and otherwise determining whether a Patient needs to be released from care, and (ii) promptly

communicating with CASE MANAGER regarding such cases. PROVIDER will be responsible for compiling a narrative and transmitting such report, along with supporting medical documentation and ledger of charges, to the CASE MANAGER or as directed by the CASE MANAGER no later than one (1) week of the earlier of the following: (i) a request by the CASE MANAGER for such information, and (ii) a decision to release the Patient from care.