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**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

X

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** The reviewing physician is certified by The American Board of X

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X

**PATIENT CLINICAL HISTORY [SUMMARY]:**

Claimant is a X. The mechanism of injury X. There is an MRI report for the X. They X. There are X. There was X. The diagnosis includes X.

X: MRI X. Impression. X and X. 2. X the X. 3. X changes to the X.

X: Office Visit with Dr. X. Patient is a X. X states that X was X. X notes that at X. X is having X. Prior studies include a X. No other X. X is not medically necessary.

X: UR by X. Rationale- There are insufficient X documented to X. Additionally, as there are only X.

X: UR by Dr. X. Rationale- in this case, claimant complained of pain to X. X revealed X. X was X. There was a X. An MRI of the X. X did X. It has been X. There was X. There was also X. For these reasons, X is non-certified.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The previous X is Upheld. This claimant injured X. X has a X. X has X. X has X. X MRI demonstrated X. The patient's treating provider recommended X. This patient has X. Prior to X. Therefore, the request for X is considered not medically necessary.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)