

*Magnolia Reviews of Texas, LLC*  
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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:**

Board Certified X

**REVIEW OUTCOME:**

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

X

Provide a description of the review outcome that clearly states whether **medical necessity exists** for **each** of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

X

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This claimant was X. The X that have been provided for X. X had X. An X. Dr. X took X to X and X. The X that X had X and a X. Dr. X performed a X at X on that X. The X all X and had X. The X a X. A new X reported X. There was X.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION: ODG documentation**

ODG X and X. While the X was X and to X, a X is X. On X, the X. X had X and X had X. The claimant has X and X and X has X. The X showed X. X is not recommended. There are no indications for X.

**Therefore, X with ODG recommendations, the request for X is not certified or medically necessary**

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

**CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

**X MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**