

*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:**

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.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a X who reported an injury X when X was X. The claimant was X. The claimant reported X. The claimant was X. X were X. It appears that the claimant had X. There was a clinical report dated X which noted complaints of X. The X noted X. There was also X noted in the X. X was X. The requested X noted to X given the clinical finding X.

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

The claimant had been followed for complaints of X. The X did note X. The

claimant had X completed which was stated to X. The claimant did report X; however, there were X. Therefore, it is this reviewer's opinion that medical necessity for the requests is not medically necessary and the previous denials are upheld.

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

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

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