Magnolia Reviews of Texas, LLC
PO Box 348
Melissa, TX 75454
972-837-1209 Phone 972-692-6837 Fax
Email: @hotmail.com

Notice of Independent

Review Decision

IRO REVIEWER REPORT

IRO CASE #: X

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 Upheld (Agree)

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]:

The claimant is a X. The claimant was X. The claimant had reported X. The claimant was treated with X. The claimant had used X. It is unclear if any X. The X detailed X. There was a X. An X was noted in an X. The X evaluation noted continuing X. The X exam noted X.

The surgical request was denied by utilization review as X.

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

The claimant presented with X. The X report was from X. This study noted a X. This study did not clearly detail a X. A more recent study was X. The current X exam did X. There was X. The X report also did X. As the X request is X. As such, it is this reviewer's opinion that medical necessity is not established for the X**.**

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