

<b>Case Number:</b>	CM13-0036225		
<b>Date Assigned:</b>	12/13/2013	<b>Date of Injury:</b>	07/30/2003
<b>Decision Date:</b>	02/21/2014	<b>UR Denial Date:</b>	10/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/18/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Oklahoma and Texas. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The physician reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/She is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 46-year-old male who reported an injury on 07/30/2003, due to a fall. This resulted in injuries to include paralysis of the bilateral upper and lower extremities, closed head trauma, and a fracture of the C6-7. The patient's treatment history included epidural steroid injections, medications, and a bilateral C5-T2 posterior fusion with iliac crest graft. The patient's most recent clinical evaluation revealed no motor function in either lower extremity as well as neuropathic pain in the right upper extremity with possible chronic regional pain syndrome. The patient's diagnoses included anterior spinal artery compression syndrome, low back pain, neck pain, quadriplegia, and chronic pain. The patient's treatment plan included continuation of medications to include cyclobenzaprine, clonazepam, Lunesta, methadone, Nucynta, and Topamax.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Bisacodyl Enteric Coated Tablet 5 mg 1 Tab orally once a day #60 rx, Refills 3 (2 of 13):**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain and Opioids, Initiating Therapy Page(s): 60 and 77.

**Decision rationale:** The requested bisacodyl enteric coated tablet 5 mg 1 tablet orally once a day #60 rx, refills 3 (2 of 13) is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has been on this type of medication for an extended duration of time, and the patient's constipation is poorly managed. The California Medical Treatment Utilization Schedule recommends the continued use of medication used in the management of symptoms related to chronic pain be supported by a positive symptom response and significant functional benefit. The clinical documentation submitted for review does not provide any evidence that the patient has had any positive symptom response from this type of medication; therefore, continued use would not be indicated. As such, the requested bisacodyl enteric coated tablet 5 mg 1 tablet orally once a day #60 rx, refills 3 (2 of 13) is not medically necessary or appropriate.