Axiom Resolve

DIAGNOSIS APPORTIONMENT ANALYSIS

Patricia Chen
Right Shoulder Rotator Cuff Tear

CLAIM NO.	WC-2023-03291
DATE OF INJURY	September 4, 2023
EMPLOYER	Northwestern Memorial Healthcare — Ancillary Services
JURISDICTION	Illinois
REPORT DATE	March 1, 2025

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Apportionment Verdict

VERDICT

Two of two diagnoses work-related (primary injury). One disputed — adhesive capsulitis causation contested. Estimated financial exposure at risk: $150,000–$220,000 PPD plus $38,000+ adhesive capsulitis treatment, contingent on IWCC ruling.

Key Findings

Rotator cuff tear (supraspinatus). Clearly work-related; causation established by both treating physician and IME examiner. Full compensability confirmed.

Adhesive capsulitis — disputed attribution. IME physician (Dr. Marsh) classifies as idiopathic / non-work-related complication; treating physician (Dr. Patel) asserts surgical complication of work-related surgery. IWCC hearing scheduled April 15, 2025 to resolve. MUA success supports surgical complication theory, weakening insurer's apportionment defense.

Pre-existing degenerative changes. IME notes mild AC joint arthrosis and glenohumeral arthrosis consistent with age-related changes; properly classified as non-compensable pre-existing conditions but have not driven treatment costs or become primary issues in claim.

Litigation impact on apportionment. The disputed adhesive capsulitis diagnosis drives $38,000+ in medical costs and extended TTD/TPD exposure. Apportionment determination will be decided by IWCC, not by claims adjuster unilaterally. Current reserves inadequate for PPD exposure.

Critical gap. No physician has explicitly separated compensable vs. non-compensable charges in medical invoicing. Medical bills do not itemize treatment by diagnosis (rotator cuff repair vs. adhesive capsulitis management).

1. Complete Diagnosis Extraction

DIAGNOSIS	ICD-10 CODE	LOCATION IN SOURCE DOCUMENTS
Rotator Cuff Tear — Full Thickness, Supraspinatus	S46.011A / S46.011D	Page 2 (Nature of Injury); Page 2 (MRI Results 09/19/2023); Page 3 (Orthopedic Consultation); Page 3 (Surgery 10/10/2023); IME Report p. 7
Partial Tear, Infraspinatus	S46.021A / S46.021D	Page 2 (MRI Results); IME Report p. 7
Subacromial Bursitis (Moderate)	M65.811	Page 2 (MRI 09/19/2023); Page 3 (Surgery report); IME Report p. 7
Glenohumeral Joint Effusion (Minimal)	M25.511	Page 2 (MRI Results 09/19/2023)
AC Joint Arthropathy (Mild)	M19.011	Page 2 (MRI Results); IME Report p. 7
Glenohumeral Arthrosis (Mild)	M19.011	IME Report p. 7
Adhesive Capsulitis (Frozen Shoulder)	M25.41	Page 3 (Jan 2024 — diagnosed 12 wks post-op); Page 4 (July 2024 MRI); IME Report p. 8
Post-Operative Status — Right Shoulder Rotator Cuff Repair	Z96.811	Ongoing post-operative management documentation
Supraspinatus / Infraspinatus Atrophy (Mild)	M62.50	IME Report p. 7

2. Apportionment Classification

DIAGNOSIS	CLASSIFICATION	BASIS FOR CLASSIFICATION
Rotator Cuff Tear (Supraspinatus, Full-Thickness)	**Work-Related**	Direct result of work mechanism (patient transfer, lateral pivot with loaded arm). Causation affirmed by both treating physician (Dr. Patel) and IME physician (Dr. Marsh): *"The September 4, 2023 patient transfer incident is a competent producing cause of the right shoulder rotator cuff tear."* (IME p. 7). Immediate onset 9/10 pain on date of injury. No pre-injury pathology documented.
Partial Tear — Infraspinatus	**Work-Related**	Co-existing pathology identified on initial MRI as part of index injury mechanism. Both physicians acknowledge as work-related injury component.
Subacromial Bursitis (Moderate)	**Work-Related**	Identified on initial MRI (09/19/2023) as sequela of acute rotator cuff tear. Resolved post-operatively; treated as component of primary work injury. No separate apportionment analysis required.
Glenohumeral Joint Effusion (Minimal)	**Work-Related**	Secondary inflammatory finding on initial post-injury MRI; attributable to traumatic mechanism. Incidental, minimal, and resolved.
AC Joint Arthropathy (Mild)	**Non-Work-Related**	IME physician explicitly classifies as pre-existing: *"These degenerative findings are consistent with age-related changes and pre-existing condition."* (IME p. 7). No evidence of acute injury to AC joint from September 4, 2023 mechanism. Degenerative changes at age 49 are age-consistent and not attributable to work injury.
Glenohumeral Arthrosis (Mild)	**Non-Work-Related**	Same basis as AC joint arthropathy. IME: pre-existing age-related degenerative changes. Not sequela of acute work trauma.

DIAGNOSIS	CLASSIFICATION	BASIS FOR CLASSIFICATION
Adhesive Capsulitis (Frozen Shoulder)	**Disputed**	**Critical apportionment dispute.** Diagnosed January 8, 2024 (12 weeks post-op). Two conflicting physician positions: Dr. Patel (treating) — surgical complication of work-related rotator cuff repair, causally connected to index injury and surgical intervention. Dr. Marsh (IME) — idiopathic condition: *"not causally related to the work injury... represents an independent medical condition rather than a direct sequela of the work-related injury."* (IME p. 7–8). IWCC hearing April 15, 2025 to resolve. MUA success (Nov 2024) and improved ROM post-MUA support surgical complication theory.
Supraspinatus / Infraspinatus Atrophy (Mild)	**Work-Related**	Secondary to rotator cuff tear and post-operative recovery. Documented on IME exam (05/14/2024). Expected post-surgical finding; not independent diagnosis.

3. Apportionment Flags

DIAGNOSIS	FLAG TYPE	DETAILS
AC Joint Arthropathy (Mild)	Pre-Existing Condition	IME explicitly classifies as age-related, pre-existing degenerative change (p. 7). Pre-employment physical (03/2019) clean for right shoulder. No treatment costs attributed to AC joint disease alone; incidental finding. **Action:** Ensure no medical bills for AC joint-specific treatment are paid as work-related.
Glenohumeral Arthrosis (Mild)	Pre-Existing Condition	Same as above. Age-consistent degenerative finding. **Action:** Monitor for unnecessary imaging or treatment targeting arthrosis.

DIAGNOSIS	FLAG TYPE	DETAILS
Adhesive Capsulitis	Attribution Concern — Critical Dispute	Treating physician attributes to surgical complication (work-related chain of causation); IME physician attributes to idiopathic condition. IME language: *"The medical literature supports both positions; however, this examiner's clinical experience supports idiopathic causation."* (p. 8). MUA success and treating physician's documented clinical reasoning supporting surgical etiology create genuine dispute. **Risk:** If IWCC rules adhesive capsulitis IS surgical complication, insurer's apportionment denial may be reversed; if IWCC agrees with IME, $38,000+ in adhesive capsulitis treatment costs could be shifted to claimant or deemed non-compensable.
Adhesive Capsulitis	Apportionment Not Addressed	Neither treating physician nor IME has prepared an itemized apportionment analysis separating treatment costs by diagnosis. Medical bills received do not itemize by diagnosis. PT bills, MUA costs, and corticosteroid injection are bundled under claim without explicit causation allocation. **Action:** Request itemized medical accounting before IWCC hearing.
Rotator Cuff Tear & Post-Op Status	Physician Separation — Clearly Documented	Both Dr. Patel and Dr. Marsh agree rotator cuff tear causation established. Separation is clear and consistent. No apportionment issue for primary injury.

4. Physician Separation Review

Has the physician explicitly separated WC findings from personal or pre-existing findings?
Partial.

Yes — for pre-existing degenerative changes

> *"MRI 09/19/2023: Full-thickness supraspinatus tear confirmed... Also noted: mild degenerative changes AC joint, mild glenohumeral arthrosis. These degenerative findings are consistent with age-related changes and pre-existing condition." — IME (Dr. Marsh), p. 7*

Separation clear: IME explicitly segregates the acute traumatic tear from incidental pre-existing arthrosis and identifies them as non-work-related age-related findings.

No — for adhesive capsulitis

Dr. Patel (treating). Does not provide a formal written apportionment analysis in the documents provided. Treatment notes document diagnosis and treatment progression but do not explicitly state whether adhesive capsulitis is (a) a direct sequela of the work injury, (b) a surgical complication, or (c) an independent condition. Clinical narrative supports surgical complication theory but lacks formal separation statement.

Dr. Marsh (IME), p. 8. Explicitly disputes causal relationship and asserts idiopathic causation. However, states: *"This examiner maintains that idiopathic etiology is more probable. The medical literature supports both positions; however, this examiner's clinical experience supports idiopathic causation."* This is a separation opinion (non-work-related), but it is contested and unresolved by the treating physician.

Documentation gap

No physician has prepared an apportionment analysis table or itemized medical cost allocation attributing specific treatment visits, imaging, injections, or PT sessions to either the rotator cuff repair (work-related) or adhesive capsulitis (disputed). This is a critical gap for claims administration and litigation.

Recommendation. Request formal written apportionment opinion from Dr. Patel addressing the IME position on adhesive capsulitis causation before IWCC hearing (due by March 15, 2025 at latest).

5. Whole-Body vs. Injury-Specific Findings

FINDING	CLASSIFICATION	JUSTIFICATION
Rotator Cuff Tear — Supraspinatus	Injury-Specific	Direct to mechanism of injury (lateral pivot, loaded arm, acute trauma). Isolated to right shoulder. Clear causal nexus. No whole-body implications.
Partial Infraspinatus Tear	Injury-Specific	Co-injury at same mechanism. Same mechanism, same body part.
Subacromial Bursitis	Injury-Specific	Localized inflammatory response to acute injury. Part of injury syndrome. Resolved post-operatively.

FINDING	CLASSIFICATION	JUSTIFICATION
Adhesive Capsulitis	Disputed: Injury-Specific (if surgical complication) or Whole-Body / Systemic (if idiopathic)	If work-related surgical complication, it is injury-specific (sequela of the work-related rotator cuff repair and surgery). If idiopathic, it is a systemic / personal condition (triggered by age, sex, metabolic factors). IME notes patient risk factors (female, age 49) supporting idiopathic etiology. However, post-operative timing (12 weeks post-op) and response to MUA support surgical complication theory.
AC Joint Arthropathy (Mild)	Whole-Body / Systemic — Pre-Existing	Age-related degenerative change. Not caused by September 4, 2023 mechanism. No acute joint injury to AC joint documented. Incidental finding. No treatment driven by AC joint disease alone.
Glenohumeral Arthrosis (Mild)	Whole-Body / Systemic — Pre-Existing	Age-related degenerative change. Not acute injury sequela. Incidental imaging finding.
Supraspinatus / Infraspinatus Atrophy	Injury-Specific	Secondary atrophy from rotator cuff tear and post-operative recovery. Expected finding. Directly related to the work injury sequelae.

Flag. No whole-body or systemic conditions (cardiac, metabolic, psychiatric, neurological) are documented in this claim. Pre-existing findings are localized to the shoulder and incidental. However, no formal physician statement separates compensable whole-body impact from injury-specific impact. Given the extended TTD period (18 months) and rehabilitation demands, IME or treating physician should address whether any systemic deconditioning or secondary health impacts (sleep disturbance, depression, weight changes) exist and whether they are apportionable to the work injury or pre-existing.

6. Plan of Action

Immediate Actions (Due by March 15, 2025)

1 Request Physician Clarification

To Dr. Patel (treating physician). Prepare written inquiry addressing Dr. Marsh's IME opinion on adhesive capsulitis causation. Request formal written response including:

- *Specific Question 1.* "In your medical opinion, is the adhesive capsulitis diagnosed January 8, 2024 a direct sequela or complication of the work-related rotator cuff tear and/or the October 10, 2023 rotator cuff repair surgery, or is it an independent idiopathic condition?"
- *Specific Question 2.* "The independent medical examiner opined that adhesive capsulitis is an idiopathic condition associated with patient risk factors (female sex, age 40–60) and is not causally related to the work injury. How do you respond to this opinion? What medical evidence supports surgical complication causation versus idiopathic causation?"
- *Specific Question 3.* "The MUA performed November 12, 2024 resulted in immediate ROM improvement to 155 degrees flexion, suggesting mechanical resolution rather than inflammatory / idiopathic resolution. Does this outcome support a surgical complication vs. idiopathic etiology? Explain your clinical reasoning."
- *Specific Question 4.* "Please provide an itemized breakdown of treatment provided for rotator cuff repair vs. adhesive capsulitis from September 4, 2023 to present. Identify which PT sessions, imaging, injections, and office visits were specifically for rotator cuff rehabilitation vs. adhesive capsulitis management."

Deadline: March 15, 2025 (before IWCC hearing April 15, 2025). Treating physician's response will strengthen or weaken insurer's apportionment position in litigation. Dr. Patel's clinical reasoning on MUA success is critical to the IWCC analysis.

2 Order Independent Medical Examination (IME #2) — Post-MMI

Scope. Post-MMI orthopedic examination focused on verifying MMI status and quantifying permanent impairment attributable solely to work-related rotator cuff repair vs. adhesive capsulitis.

Specific instructions.

- Comprehensive orthopedic exam (ROM, strength, special tests) as of anticipated MMI date (May 2025).
- Separately rate impairment for rotator cuff repair using AMA Guides 6th Edition.
- Separately rate impairment for adhesive capsulitis and identify as non-work-related (pending IWCC ruling).
- Clarify whether any impairment from pre-existing AC joint arthrosis or glenohumeral arthrosis should be separated.
- Provide clear PPD apportionment: "Work-related PPD = X%; non-work-related PPD = Y%."

Examiner selection. Different orthopedic surgeon than Dr. Marsh (IME #1) to avoid perception of bias. Select examiner familiar with adhesive capsulitis post-operative outcomes and MUA efficacy.

Timing. Schedule for late April or early May 2025 (post-IWCC hearing, approaching MMI). Allow treating physician to confirm MMI before IME #2 is scheduled.

Current IME (Dr. Marsh, May 2024) pre-dates MUA and is outdated. Post-MMI IME will provide updated impairment rating and apportionment guidance, essential for PPD reserve calculation and settlement evaluation.

3 Contact Defense Counsel

To Hartwell & Burke (defense counsel). Memo subject: Pre-Hearing Apportionment Strategy & Adhesive Capsulitis Causation.

Key items.

- *IME vulnerability.* The successful MUA outcome (ROM improvement to 155 degrees, sustained through February 2025) is problematic for insurer's position that adhesive capsulitis is idiopathic. Claimant's attorney will cite MUA success as evidence of post-surgical mechanical complication. Defense should prepare counter-argument citing medical literature on idiopathic adhesive capsulitis post-operatively, noting that MUA is standard treatment for all causes of adhesive capsulitis.
- *Treating physician position.* Dr. Patel will likely testify that adhesive capsulitis is surgical complication. His clinical notes document diagnosis as surgical complication. No formal written apportionment analysis has been prepared by Dr. Patel; this gap may benefit or harm insurer depending on hearing testimony.
- *Medical literature.* Both IME and claim documents acknowledge that *"adhesive capsulitis following rotator cuff surgery is a known complication."* This phrase cuts both ways. Defense should prepare medical literature citations distinguishing idiopathic from post-operative adhesive capsulitis.
- *Settlement authority.* Given IWCC hearing outcome uncertainty and substantial PPD exposure, recommend exploring pre-MMI settlement authority. If IWCC rules adhesive capsulitis is work-related, indemnity and medical exposure increase materially.
- *Reserve recommendation.* Current reserves grossly inadequate. Recommend increasing reserves by $150,000–$200,000 immediately.

Deliverable. Defense counsel strategy memo by March 20, 2025.

4 Request Itemized Medical Billing Reconciliation

To billing department / medical cost containment unit. Audit all medical bills received under Claim WC-2023-03291 from September 4, 2023 to present.

- Identify bills for PT, imaging, and injections performed between January 8, 2024 (adhesive capsulitis diagnosis) and November 12, 2024 (MUA).
- Separate by provider and service type: PT sessions (which visits treated rotator cuff ROM/strength vs. adhesive capsulitis ROM/flexibility); imaging (MRI 07/2024 — was this specifically for adhesive capsulitis assessment?); injections (corticosteroid injection 01/08/2024 — how much of this cost?); office visits (were separate diagnoses documented?).
- Estimate percentage of total medical costs attributable to adhesive capsulitis vs. rotator cuff repair.
- Flag amount at risk: based on $47,880 medical paid to date, estimate how much was incurred specifically for adhesive capsulitis treatment.

Deadline. March 20, 2025. Provides factual baseline for cost-shifting discussions with claimant's attorney and IWCC.

5 Update Reserves — Permanent Partial Disability

Action. Increase total reserves by $150,000–$200,000 immediately.

CATEGORY	ESTIMATE
Medical (paid + reserves)	$72,880
Indemnity (paid + anticipated TPD)	$78,268
PPD Award (if 20–30% loss of use)	$150,000–$220,000
Adhesive Capsulitis Treatment (disputed)	$0–$10,000 (depends on IWCC)
Legal / Defense Expense	$38,400
Total Estimated Ultimate Exposure	**$359,548–$429,548**
Current Total Incurred + Reserves	$275,388
Shortfall	**$84,000–$154,000**

Recommendation. Increase PPD reserve by $150,000 and legal / defense reserve by $10,000. New total reserves $228,000; new total exposure (incurred + reserves) $435,388. This aligns with claim examiner's assessment: *"Estimated ultimate exposure including PPD: $350,000–$420,000"* (Quarterly Review p. 17).

Escalation. Present reserve increase recommendation to claims management and underwriting by March 10, 2025.

6 Modified Duty Sustainability Monitoring

To Northwestern Memorial Healthcare HR. Confirm modified duty placement remains sustainable through MMI (anticipated May 2025).

- Weekly or bi-weekly confirmation that claimant is performing assigned modified duty (light duty, left-arm dominant tasks, per IME restrictions).
- Any absences, incidents, or inability to perform reported immediately.
- Documentation that accommodations remain feasible (no plan to return to full PCT duties before MMI).

If claimant returns to full duty before MMI, or if modified duty collapses, indemnity exposure increases (return to full TTD). Current TPD benefits ($510.38/week) are sustainable only if modified duty continues.

Frequency. Monthly reporting through May 2025.

7 Dr. Patel MMI Confirmation & Post-MMI Planning

To Dr. Patel.

- Confirm anticipated MMI date: May 2025 (per treating records, p. 4).
- Request written MMI opinion and permanent impairment rating (using AMA Guides 6th Edition) within 7 days of achieving MMI.
- Clarify whether impairment rating separates work-related rotator cuff sequelae from adhesive capsulitis.
- Confirm post-MMI care plan (ongoing PT, maintenance treatment, restrictions).

MMI date triggers transition from indemnity (TTD/TPD) to permanent impairment benefits. Timely MMI opinion and impairment rating are essential for claim closure planning and settlement negotiations.

8 Add to Claim File — Apportionment Documentation

Before IWCC hearing and MMI, ensure claim file includes:

- Itemized medical cost reconciliation (separating rotator cuff care from adhesive capsulitis care)
- Treating physician apportionment opinion (Dr. Patel response to IME dispute)
- Defense counsel strategy memo (adhesive capsulitis causation defenses)
- Quarterly claim review (already in file, p. 15–17) — note reserve recommendations
- Copy of IWCC hearing docket once filed/scheduled
- Post-MMI IME report once received
- Dr. Patel MMI opinion once received
- Ongoing modified duty confirmation logs — monthly documentation from employer

File status. Mark file as "Open — Litigated — Apportionment Disputed." Ensure all parties understand adhesive capsulitis causation remains unresolved pending IWCC hearing.

Summary — Apportionment Verdicts & Action Items

DIAGNOSIS	APPORTIONMENT	COMPENSABILITY	FINANCIAL IMPACT	ACTION REQUIRED
Rotator Cuff Tear (Supraspinatus)	**Work-Related**	Fully Compensable	Driving claim; PPD exposure $150–$220K	Monitor MMI; finalize impairment rating.
Infraspinatus Partial Tear	**Work-Related**	Fully Compensable	Secondary; resolved.	No additional action.
Subacromial Bursitis	**Work-Related**	Fully Compensable	Resolved post-op; no ongoing costs.	No additional action.
AC Joint Arthropathy (Mild)	**Non-Work-Related**	Not Compensable	Incidental pre-existing finding; no treatment.	Ensure no future AC joint-specific charges billed as work-related.

DIAGNOSIS	APPORTIONMENT	COMPENSABILITY	FINANCIAL IMPACT	ACTION REQUIRED
Glenohumeral Arthrosis (Mild)	**Non-Work-Related**	Not Compensable	Incidental pre-existing finding; no treatment.	Ensure no future arthrosis-specific charges billed as work-related.
Adhesive Capsulitis	**Disputed**	Contested	$38,000+ medical + unknown indemnity	Obtain Dr. Patel apportionment opinion; prepare defense counsel strategy; await IWCC ruling April 2025; audit medical bills.
Muscle Atrophy (post-op)	**Work-Related**	Fully Compensable	Secondary; resolved with PT.	No additional action.

Critical Risk Assessment

High-risk factors

1. **Adhesive capsulitis causation disputed.** IWCC hearing outcome unpredictable. Both positions (surgical complication vs. idiopathic) have medical support. MUA success favors surgical complication theory.
2. **Reserves inadequate.** Current $68,000 reserves insufficient for estimated $350–$420K ultimate exposure. PPD exposure ($150–$220K) is not reflected in current reserves.
3. **Litigation prolonged.** IWCC hearing April 2025, post-hearing briefing, potential appeal, MMI process, impairment rating dispute possible. Closure unlikely before mid-2026 absent settlement.
4. **Medical billing commingled.** No clear apportionment of charges by diagnosis. If IWCC rules adhesive capsulitis non-work-related, insurer may face difficulty recovering or offsetting those costs retroactively.

5. **Treating physician discordance with IME.** Dr. Patel and Dr. Marsh fundamentally disagree on adhesive capsulitis causation. No formal written apportionment analysis from treating physician — documentation gap.

Mitigation strategies

- **Immediate.** Obtain Dr. Patel written apportionment opinion (Action #1).
- **Short-term.** Increase reserves $150–$200K (Action #5), prepare defense strategy (Action #3), audit medical costs (Action #4).
- **Medium-term.** Monitor IWCC hearing outcome; evaluate settlement authority based on ruling.
- **Post-MMI.** Order post-MMI IME for independent impairment verification (Action #2).

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