Workers' Comp

Common and Complex Shoulder Injury Frequently Asked Questions

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6 MIN READ

According to the U.S. Bureau of Labor Statistics, shoulder injuries account for approximately 14.9% of all work-related musculoskeletal disorders (MSD) requiring days away from work, making them the second most common MSD after back injuries (37.8%). These injuries range from minor strains to complex conditions requiring surgical intervention, with significant impact on workers and employers.

In our recent webinar, Common and Complex Shoulder Injuries: Surgical Considerations and Physical Therapy Treatment, we explore the most common shoulder injuries and potential complications that can affect recovery. Here are some of the frequently asked questions from the presentation.

When is conservative care versus surgery appropriate for rotator cuff tears (including partial tears), and can tears resolve without surgery?

Conservative care is often the first treatment for rotator cuff tears, especially partial-thickness tears, degenerative tears that develop gradually with age, and patients who have manageable pain and preserved shoulder function. Treatment typically includes physical therapy, activity modification, anti-inflammatory medications and sometimes injections. Many patients experience significant pain relief and functional improvement without surgery.

Surgery is more commonly considered for large tears, traumatic tears, significant weakness or loss of function or persistent symptoms despite several months of conservative treatment. While rotator cuff tear symptoms can often improve without surgery, the tendon itself usually does not fully heal or reattach on its own—particularly in full-thickness tears. In other words, patients may feel and function much better even though the tear remains visible on imaging.

What factors can lead to a shoulder patient developing adhesive capsulitis? And what steps can be taken in surgical and non-surgical cases to avoid this complication?

Adhesive capsulitis ("frozen shoulder") develops when the glenohumeral capsule becomes inflamed, thickened and contracted, leading to progressive pain and loss of both active and passive range of motion. It can occur spontaneously or as a secondary complication after injury, surgery or prolonged immobilization.

Some patients are at higher risk and may need closer monitoring of their condition. This includes comorbidities such as diabetes and a history of injury or other issues in the affected shoulder.

Two important modifiable factors are prolonged immobilization and poorly controlled postoperative pain that limits motion. Whether the patient is managed surgically or non-surgically, the best prevention strategy is early, protected shoulder movement combined with adequate pain control and close monitoring of range of motion, especially in patients at higher risk.

How should reverse shoulder replacements be managed clinically, and why are they becoming more prevalent?

Reverse shoulder replacement differs from a standard shoulder replacement by reversing the ball-and-socket anatomy. This design allows the deltoid muscle to compensate when the rotator cuff is severely damaged or absent. Advances in implant technology and greater surgeon familiarity have improved outcomes and confidence in the procedure, contributing to wider adoption. Clinically, reverse shoulder replacements are managed through careful patient selection, structured postoperative rehabilitation and ongoing observation for complications. The procedure allows effective treatment for conditions that were previously difficult to manage, especially rotator cuff-deficient shoulders, fracture-related problems and revision cases, while benefiting from expanding indications, an aging population and improved surgical technology.

How can clinicians distinguish acute injuries from chronic or degenerative conditions, especially in workers' compensation cases?

In workers' compensation cases, the key question is often not simply "Is there an injury?" but rather "Is the condition attributable to a specific work event, an aggravation of a pre-existing condition or a chronic degenerative process?" Workers' compensation systems focus on whether work caused an injury or significantly aggravated a condition. Clinicians typically use a combination of history, timing, physical findings, imaging and prior medical records to make this distinction.

Acute injuries are typically associated with a specific work-related event, sudden symptom onset and objective findings such as swelling, bruising or tissue edema visible on imaging. In contrast, chronic or degenerative conditions usually develop gradually over time, may have a history of prior symptoms or treatment, and often show age-related changes such as arthritis or joint degeneration.

What are the most effective non-surgical treatments, including physical therapy, home exercise programs, injections, PRP and dry needling?

The most effective non-surgical treatments for shoulder injuries typically include a combination of physical therapy, home exercise program (HEP) and selected interventions such as corticosteroid injections, platelet-rich plasma (PRP) or dry needling when clinically appropriate. Physical therapy and home exercises are considered the foundation of treatment because they help improve strength, flexibility, range of motion and shoulder mechanics while reducing pain and restoring function. Corticosteroid injections may provide short-term relief of pain and inflammation for conditions such as bursitis, impingement syndrome and arthritis. PRP injections may benefit certain chronic tendon disorders and mild-to-moderate degenerative conditions, although outcomes can vary. Dry needling can be a useful adjunct for reducing myofascial pain and muscle tightness. In most cases, the best outcomes are achieved through an individualized treatment plan that emphasizes active rehabilitation and patient participation.

What services are commonly requested for workers' compensation related shoulder injuries? And what are the most likely covered services versus denials for shoulder-related care?

Most workers' compensation shoulder claims involve requests for diagnostic testing such as X-rays and magnetic resonance imaging (MRI), orthopedic evaluations, physical therapy, medications and corticosteroid injections. These services are typically approved when the injury is clearly work-related, supported by objective findings and consistent with evidence-based treatment guidelines. If conservative treatment fails, surgical procedures such as rotator cuff repair, labral repair or shoulder stabilization may also be approved.

The most common denials occur when requests exceed guideline recommendations or lack sufficient clinical support. Examples include excessive physical therapy visits after functional improvement has plateaued, repeat MRIs without a significant change in condition, repeat steroid injections, long-term opioid use and surgery for primarily degenerative or age-related shoulder conditions that cannot be clearly linked to the work injury. Also, post-surgical requests for equipment such as cold compression and continuous passive motion devices are not seen as necessary verses alternative options and are not usually supported by guidelines such as the Medical Treatment Utilization Schedule (MTUS), American College of Occupational and Environmental Medicine (ACOEM) and the Official Disability Guidelines (ODG).

What is the relationship between shoulder injuries and cervical spine involvement, and how should they be differentiated?

Shoulder disorders and cervical spine disorders are closely related and frequently overlap, making diagnosis challenging. Pain felt in the shoulder may actually originate from the neck (referred pain or cervical radiculopathy), and patients can sometimes have both conditions simultaneously. Compression or irritation of lower cervical nerve roots (C5–C7) can produce shoulder, scapular, arm pain and weakness. Alternatively, shoulder injuries can refer pain to the neck due to close proximity, muscular attachments and compensatory movements due to pain.

Special testing by a doctor or physical therapist using provocative maneuvers targeted to the suspected pain source are helpful for identifying the true pathology. When the history of condition and clinical examination are inconclusive further diagnostic studies such as MRI, Electromyography (EMG) or nerve conduction velocity (NCV) may be indicated.

What is a reasonable frequency and duration of physical or occupational therapy for shoulder conditions, and when should care be adjusted or discontinued?

For non-operative shoulder conditions (rotator cuff injury, impingement, etc.) physical or occupational therapy frequency is one to three visits per week, combined with a structured home exercise program. Treatment duration is commonly four to eight weeks, depending on diagnosis, severity, functional deficits and patient progress. Continued skilled therapy is generally reasonable when the patient demonstrates a positive response to treatment and measurable functional gains. Ongoing reassessment of progress is critical to providing appropriate therapy.

Therapy should be discontinued when treatment goals have been met, the patient can independently manage their condition with a home exercise program or there is no meaningful objective or functional improvement despite appropriate care. Discharge or referral for further medical evaluation is also appropriate when progress plateaus, noncompliance limits benefit or findings suggest an alternative diagnosis requiring a different treatment approach.

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