TREATMENT OF THE OFFICE BASED PATIENT WITH OMT
“Soup to Nuts, Head to Toe, The Whole Enchilada”

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Disclosures

We have no Commercial, Financial or Legal disclosures.

But we sure would like some...
Objectives

1) Discuss perceived barriers to using OMT in your practice
2) Review OMT nomenclature and definitions
3) Discuss high yield OMT techniques for each region
4) Discuss the basics of proper way to bill for OMT
5) Hands on sessions
Barriers to Full Body OMT

1) “I’m not good enough”
2) “Osteopathic Manipulative Treatment is too time consuming”
3) “Won’t get paid for the work”
Fryette’s Laws (Principles/guidelines)

- Laws apply to Thoracic and lumbar spine Only.

- Law #1
  - In a Neural position Sidebending precedes Rotation in the OPPOSITE direction.
  - Group Curves.

- Law #2
  - In a NON-Neutral position Rotation precedes Sidebending in the SAME direction.
  - Single vertebral Segment.

- Law #3
  - Motion in any one plane will modify the mobility of that segment in the other two planes of motion.
Soft Tissue Techniques

- Defined by the Educational Council of Osteopathic Principles (ECOP) as “a direct technique, which usually involves lateral stretching, linear stretching, deep pressure, traction, and/or separation of muscle origin and insertion while monitoring tissue response and motion changes by palpation”

- Direct and Active or Passive.
Soft Tissue Techniques

- **Parallel Traction**
  - Myofascial structure contacted at *origin* and *insertion* and treatment force is directed *parallel* to the musculotendinous axis.

- **Perpendicular Traction**
  - Myofascial structure is contacted at its *midpoint* between origin and insertion and treatment force is directed *perpendicular* to longitudinal axis. (90’<)

- **Direct inhibitory Pressure.**
  - Myofascial structure being treated is contacted over *musculotendinous* portion of hypertonic muscle and force is directed *into* tissue.
Muscle Energy

- Defined by the Education Council of Osteopathic Principles (ECOP) as “a form of osteopathic manipulative diagnosis and treatment in which the patient’s muscle are actively used on request, from a precisely controlled position, in a specific direction, and against an distinctly executed physician conterforce.”

- Active and Direct or Active and Indirect technique.
Muscle Energy

1) Doc places bone or joint so that the muscle group engages the restrictive barrier (opposite the Diagnosis) in all planes of motion.
2) Pat. then contracts muscles to reverse direction in all planes of motion.
3) Doc maintains counterforce for 3-5 seconds.
4) Pat. relaxes completely.
5) During post-isometric relaxation phase, Doc takes up the slack.
6) Repeat above for 3-5 times.
Counterstrain

- Defined by the **Educational Council of Osteopathic Principles (ECOP)** as “a system of diagnosis and treatment that considers the dysfunction to be a continuing, inappropriate strain reflex, which is inhibited by applying a position of mild strain in the direction exactly opposite to that of the reflex; this is accompanied by specific directed positioning about the point of tenderness to achieve the desired therapeutic response.”
- **Indirect** and **Passive** Technique.
- “Find it, Fold it, Hold it”
Counterstrain

1) Find the tender point associated with the dysfunction
2) Tell the patient the tender point is a 10/10 on the pain scale
3) Place the patient in the position that reduces the pain of the tender point by 70-100% (from a 10 to a 3)
4) Hold this position for 90 seconds. 120 seconds for Ribs
5) Passively return the relaxed patient to neutral
6) Recheck the tender point
Myofascial Release Techniques

- Defined by the Educational Council of Osteopathic Principles (ECOP) as a “system of diagnosis and treatment first described by Andrew Taylor still and his early students, which engages continual palpatory feedback to achieve release of myofascial tissue.”

- Direct or Indirect and Active or Passive.
Myofascial Release Techniques

1) Doc palpates a restriction; muscle tension, tenderness or decreased movement.
2) Once a restriction is found the Doc decides direct or indirect.
   a) Direct Treatment - myofascial tissue is moved toward restrictive barrier.
      i) Can use limb as a lever while monitoring tissue tension or direct traction along the long axis of the muscle.
   b) Indirect Treatment - myofascial tissue is moved away from restrictive barrier.
      i) Can use limb as a lever while monitoring tissue tension or direct compression along the long axis of the muscle.
3) Doc “Fine Tunes” with twisting the myofascia or applying a transverse forces perpendicular to the long axis of the muscle in a direct or indirect fashion.
4) Doc and use enhancers to help induce a release; respiration, eye movements or muscle contractions.
5) Doc then whats for a release. Tissues may “melt” or “give way”
Articulatory Techniques

- Defined by the Educational council of Osteopathic Principles (ECOP) as “a low velocity/moderate-to-high amplitude technique where a joint is carried through its full motion with the therapeutic goal of increased freedom range of movement. The activating force is either a springing motion or repetitive concentric movement of the joint through the restrictive barrier.”

- Direct and Active or Passive.
Articulatory Techniques

1) Doc moves affected joint to the limit of all ranges of motion.
2) Once a restrictive barrier is reached, slowly and firmly, continue to apply gentle force against it.
3) Doc may use respiratory cooperation or Muscle Energy to increase myofascial stretch of tight tissue.
4) Return the articulation to its neutral position.
5) Repeat the process several times.
6) Stop when no further response is achieved.
High Velocity Low Amplitude

- Defined by the Educational Council on Osteopathic Principles (ECOP) as "an osteopathic technique employing a rapid, therapeutic force of brief duration that travels a short distance within the anatomic range of motion of a joint, and that engages the restrictive barrier in one or more planes of motion to elicit release of restriction."

- Passive, Direct technique.
High Velocity Low Amplitude

1) Doc diagnosis the somatic dysfunction.
2) Doc moves dysfunctional segment to the **restrictive barrier**.
3) Pat is asked to relax.
4) Final force is often applied during exhalation.
5) Docs force is a **short, quick thrust** to move segment **through restrictive barrier**.
6) Re-evaluate range of motion.
Cranial OMT

- Osteopathy in the cranial field is too in depth to be covered in this lecture.

- We will cover a few head techniques that can help your patients and can be easily incorporated into an outpatient office.
OMT Head

- Suboccipital release
  - Patient Supine.
  - Doc at end of table.
  - Doc finger pads in suboccipital region,
  - Contacting Trapezius and underlying tissue.
  - Patient tucks chin to chest.
  - Doc applies upward pressure into the tissue.
  - Pat Then relaxes completely.
  - Doc may add distraction and/or lateral traction.
  - Hold until a release is felt.
OMT Head

- **TMJ Dysfuction**
  - Pat. *Supine.*
  - Doc at head of table.
  - TP on posterior surface of ramus of the mandible above the angle at attachment of *Medial Pterygoid.*
  - Doc glides slightly open jaw laterally toward the TP.
  - Hold until tenderness is gone.
OMT Head

- **TMJ Dysfunction**
  - Pat. Supine.
  - Doc at head of table.
  - TP just inferior to the zygoma, in belly of **Masseter** muscle.
  - Doc glides slightly open jaw laterally toward the TP.
  - Hold until tenderness is gone.
Cervical Spine
Diagnosis of the Cervical Spine

- **OA motion testing**
  - Right translation = Left Sidebending
  - Right deep sulcus = Left sidebending = Right rotation
  - SB and Rot. are **Opposite** (OA=Opposite Always)

- **AA motion testing**
  - Flex neck to 45 Degrees and **rotate** head from left to right.

- **C2-C7 motion testing**
  - Right Translation = Left Sidebending
  - Palpate posterior articular pillars to determine rotation.
  - SB and Rot are the **Same**.
Cervical Muscle Energy

- Muscle Energy of the Cervical spine
  - Pat. Supine.
  - Doc at end of table.
  - Sidebend Pat. C-spine to the left/right.
  - First stretch, then ME.
  - Patient pushes Opposite, then relaxes completely.
  - Doc find new restrictive barrier and repeats 3-5 times.
Cervical Muscle Energy

- AA
  - Doc Flex C-spine to 45 degrees.
  - Rotate pat. to the left/right.
  - Patient pushes opposite then relaxes completely.
  - Doc finds new restrictive barrier and repeats 3-5 times.
Thoracic OMT
Thoracic Soft Tissue Techniques

- Pat. Prone.
- Doc on side of table opposite the treatment.
- Doc hand over medical aspect of paravertebral muscles.
- Doc adds a downward force + lateral/medial/cecalad/caudad pressure to engage tissue.
- Hold for several seconds then slowly release.
Thoracic Myofascial Release

- Pat. Prone.
- Doc places both hand palms down and adds a downward force to engage the tissue.
- Doc monitors inferior/superior, rotational and twisting motion availability.
- Doc moves tissues Direct or Indirect to meet the barrier.
- Force is held until release is felt.
- Doc can further engage barrier.
Thoracic Spine HVLA

- Patient **Prone**.
- Doc at side of table.
- Doc places right thenar eminence on transverse process at the level of dysfunction and left hypothenar eminence on opposite transverse process.
- Pat. Inhales and Exhales.
- Doc follows exhalation to end point.
- Thrust is downward with a twisting in direction fingers are pointing.
Upper Extremities
Upper Extremity Spencer Technique

1) Shoulder extension with elbow flexed
2) Shoulder flexion with elbow extended
3) Circumduction with slight compression with elbow Flexed
4) Circumduction and traction with elbow extended
5) Abduction with elbow flexed
6) Adduction and external rotation with elbow flexed
7) Internal rotation with arm abducted, hand behind back
8) Distraction, Stretching Tissues, and Enhancing Fluid Drainage with Arm Extended
Spencer Technique

- Shoulder **Extension** with Elbow flexed.

- Shoulder **Flexion** with Elbow Extended.
Spencer Technique

- **Circumbution** with Slight **Compression** with elbow Flexed.

- **Circumduction** and **Traction** with Elbow Extended.
Spencer Technique

- Abduction with Elbow Flexed.
- Adduction and External Rotation with Elbow Flexed.
Spencer Technique

- **Internal Rotation** with arm **Abducted**, Hand behind Back.

- Distraction, Stretching Tissues, and Enhancing Fluid Drainage with Arm Extended.
Rib Region
Rib Motion

- **Pump-handle motion.**
  - Primarily Ribs 1-5.
  - Increase AP diameter on inhalation.
  - Around Transverse Axis.

- **Bucket-handle motion.**
  - Primarily Ribs 6-10.
  - Increase Transverse diameter on inhalation.
  - Around AP Axis.

- **Caliper Motion.**
  - Primarily 11-12.
  - Around Vertical Axis.
Diagnosing Rib Dysfunctions

- Pump-handle motion.
- Bucket-Handle motion.
- Caliper motion.
Inhalation Rib Muscle Energy

- **Pat. Supine**
- Doc places hand on key rib
- **Flex** Pat. forward for ribs 1-5
- **Sidebend** Pat. for ribs 6-10
  - Pat. reaches for knee on affected side
- Pat. Inhales then Exhales deeply and holds breath for 3-5 sec
- Doc **follow** rib down on **exhale** and **resists** motion on **inhalation**
- Doc finds new restrictive barrier
- Repeat 3-5 times
Exhalation Rib Muscle Energy

- Muscle Energy with Respiratory Assist
  - Rib 1: Anterior and middle scalene
  - Rib 2: Posterior scalene
  - Ribs 3-5: Pectoralis Minor
  - Ribs 6-9: Serratus Anterior
  - Ribs 10-11: Latissimus Dorsi
  - Rib 12: Quadratus Lumborum

“Rib Dance”
Lumbar Spine
Lumbar Spine Muscle Energy/HVLA

- Pat. lateral recumbent.
- Doc faces Pat. at side of table.
- Doc monitors dysfunctional segment.
- Doc flex/ext. Pat. legs and hips until dysfunctional segment is in neutral position.
- Pat. straightens bottom leg with top leg bent.
- Doc changes monitoring hand and Pat. grabs elbow of Doc.
- Doc stands up and induces rotation moving Pat. shoulder posteriorly.
- Doc pushes Pat. hip anteriorly.
- Pat. instructed to straighten the spine by pushing shoulder anteriorly and hip posteriorly.
- Pat. relaxes completely.
- Doc engages new restrictive barrier and repeats 3-5 time.
Lumbar Spine Muscle Energy
Lumbar Spine HVLA

- **HVLA of Type 1 Dysfunction.**
  - Pat. set up same as above.
  - Pat. completely relaxed.
  - Thrust directed into table while:
    - Shoulder moved superior and
    - Pelvis/sacrum moved inferior.

- **HVLA of Type 2 Dysfunction.**
  - Pat. set up same as above.
  - Pat. completely relaxed.
  - Thrust directed into table while:
    - Shoulder moved inferiorly and
    - Pelvis/sacrum moved superiorly
Pelvis
Diagnosing the Pelvis

- **Standing Flexion Test**
  - Iliosacral motion.
  - Doc eye level same as PSIS.
  - Doc thumbs on inferior notch of PSIS while Pat. bends forward.
  - Somatic Dysfunction on side of superior PSIS at the end of motion.
Diagnosing the Pelvis

- Patient **Supine**.
- Pat. **hip-flops** to reset pelvis.
- Doc palpates **ASIS** to evaluate levelness and distance from the umbilicus.
  - Sup/Inf and In/Outflare
- Doc palpate Level of **PSIS**.
- Doc palpated **medial malleolus** for leg length discrepancies.
Anterior Pelvis / Innominate ME

- Anterior Innominate Rotation
  - Patient (Pat.) **Supine** or **Prone**.
  - Doctor (Doc) flex patient's hip and knee to restrictive barrier.
  - Patient pushes knee into doctor.
  - Doctor provides an equal counterforce for 3-5 sec.
  - Doctor can pull hip posterior as well.
  - Patient **relaxes completely**.
  - Doctor adjusts to find new restrictive barrier.
  - Repeat 3-5 times.
Posterior Innominate ME

- **Posterior Innominate Rotation**
  - Pat. *Supine* with affected leg off the table.
  - Doc controls opposite ASIS and places other hand above the knee.
  - Doc extends patients hip until restrictive barrier is reached.
  - Pat. then lifts leg up to ceiling while Doc resists for 3-5 secs.
  - Pat. *completely relaxes.*
  - Doc engages new restrictive barrier
  - Repeat 3-5 times.
Psoas Counterstrain

- **Psoas Major**
  - Pat. Supine.
  - TP ⅔ the distance from ASIS to midline.
  - Doc flexes hips and knees and rotates toward TP.
  - Fin tune and hold until a release is felt.
Iliacus Counterstrain

- Iliacus
  - Pat. Supine
  - TP ⅓ the distance from ASIS to midline.
  - Doc flexes hips and knees and places Pat. feet on Doc thigh.
  - Doc crosses patients ankles and externally rotates hips.
  - “Frog leg”
  - Fine tune and hole until release is felt.
Pubic Muscle Energy

- **Gaping of the Pubic Symphysis**
  - Pat. **Supine**.
  - Pat. hips flexed to 45° and knee flexed to 90°.
  - Doc **hugs** Pat. knees.
  - Pat. move both knee laterally while Doc. resists.
  - Pat. relaxes completely
  - Doc then places **forearm** or closed **fist** between patients knees.
  - Pat. moves both knee medially while Doc resists.
  - Alternate above 3-5 times.
Sacrum
Seated Flexion Test
- Sacroiliac Motion.
- Pat. seated with both feet flat on floor.
- Doc places thumbs on inferior notch of PSIS.
- Pat. leans forward.
- Positive test if at end of flexion PSIS are not level.
- Somatic dysfunction on side of superior PSIS.
Diagnosing the Sacrum

- Palpate the **sacral sulci**
  - Which one is Deep/Shallow?
- Palpate **ILA’s**
  - Which is Posterior/Inferior?
Diagnosis the Sacrum

- **Sacral base Anterior/Posterior, Spring Test**
  - Doc pushes on sacral base to assess for spring.
  - Positive test = steel-like resistance.
  - Indicates backward Torsion or extension.

- **Sphinx Test**
  - Doc monitors sacral sulci.
  - Pat. raises upper body onto their elbows.
  - Asymmetry of the sulci that remain or worsen indicates backward sacral torsion.
Piriformis Counterstrain

- TP found at midpoint between ILA and greater trochanter.

- Pat. Supine.
  - Pat. hip flexed to 45’ and knee to 90’.
  - Doc finds the tender point.
  - Doc abducts and externally rotates the hip.
- Fine tune.
- Holds until a release is felt.
Piriformis Counterstrain

- **Pat. Prone**
  - Doc finds Tender point.
  - Pat. drops his leg off the side of the table.
  - Pat. leg rest on Doc thigh/knee.
  - Doc. Abducts and Externally rotates the hip.
  - **Fine tune** to reduce TP.
  - Hold until a release is felt.
Lower Extremities
Lower Extremity Counterstrain

- Iliotibial Band.
  - Pat. **Supine**.
  - Tender point along lateral hip on IT band.
  - Doc finds TP.
  - Pat. hip is abducted and flexed.
  - Hold until release is felt.

- Pat. **Prone**.
  - Doc finds TP.
  - Then brings Pat. leg of the table.
  - Pat. hip is abducted and flexed.
  - Hold until release is felt.
Lower Extremity Counterstrain

- **Plantar Fasciitis**
  - Pat. **Prone**.
  - **TP** is found on anterior aspect of calcaneus at attachment of **Quadratus Plantae**.
  - Doc. finds **TP**.
  - Doc. flexes forefoot.
  - Holds until a release is felt
Visceral Techniques

- Defined by the Educational Council of Osteopathic Principles (ECOP) as “a system of diagnosis and treatment directed to the viscera to improve physiological function; typically the viscera are moved toward their fascial attachments to a point of fascial balance; also called ventral techniques.”

- **Direct, Indirect or Combined**
Visceral Techniques
Mesenteric Lift Technique

- Pat. Supine.
- Doc on left side of Pat.
- Doc places fingers on RLQ medial to ASIS.
- Doc pushed finger into abdomen until resistance is felt.
- Doc adds *traction toward umbilicus* until release is felt.
- Doc repositions hands between iliac crest and lower ribs.
- Doc pushes finger into abdomen and adds traction toward umbilicus until release is felt.
- This is repeated at RUQ, epigastric, LUQ, descending colon, LLQ.
- Doc. then reposition hands on line between the Right ASIS and RUQ.
- Gentle pressure is gradually increased toward RUQ.
Mesenteric Lift
Colonic Stimulation

- Pat. **Supine.**
- Doc places hands over **splenic flexure** (LUQ).
- Doc rolls fingers down descending colon.
- Doc repositions hands on transverse colon.
- Doc rolls fingers to follow path of the colon.
- Doc continues to reposition until hands are on the cecum.
- Doc rolls fingers along ascending, transverse, and descending colon.
Colonic Stimulation
Pearls of Billing Defined

- **Somatic Dysfunction:**
  - Defined as “The impaired or altered function of related components of the somatic (bodywork) system including: the skeletal, arthrodial, and myofascial structures, and their related vascular, lymphatic, and neural elements.”
  - The **ONLY diagnosis** that supports **MEDICAL NECESSITY** for OMT
    - You **CANNOT** do OMT under the diagnosis of Low Back Pain or Cervicalgia.
 Pearls of Billing Cont.

- Somatic Dysfunction diagnosis has to be one of the ten regions.
  - **Head** region: M99.00
  - **Cervical** region: M99.01
  - **Thoracic** region: M99.02
  - **Lumbar** region: M99.03
  - **Sacral** region: M99.04
  - **Pelvic** region: M99.05
  - **Lower Extremity** region: M99.06
  - **Upper Extremity** region: M99.07
  - **Rib** region: M99.08
  - **Abdomen and other** region: M99.09
Pearls of Billing Cont.

- Billing Codes
  - Osteopathic Manipulation, 9-10 Body Regions (98929)
  - Osteopathic Manipulation, 7-8 Body Regions (98928)
  - Osteopathic Manipulation, 5-6 Body Regions (98927)
  - Osteopathic Manipulation, 3-4 Body Regions (98926)
  - Osteopathic Manipulation, 1-2 Body Regions (98925)
Pearls of Billing Cont.

- Low Back Pain example A/P:
  1) Low Back Pain \( (CC) \)
  2) Muscle spasm \( (Tissue \, DX) \)
  3) Degenerative Disc Disease of the Lumbar Spine \( (Imaging \, Dx) \)
  4) Somatic Dysfunction of the Pelvic Region \( (Anything \, beside \, Lumbar) \)
Pearls of Billing Cont.

- Upper Respiratory Infection example A/P:

  1. Shortness of Breath/Cough/Chest Congestion *(CC)*
  2. Myalgia/Myositis *(Tissue Dx)*
  3. Lower Lobe Pneumonia *(Imaging DX)*
  4. Somatic Dysfunction of the Pelvis *(Avoid the lungs)*
Pearls of Billing Cont.

- Any procedure must have a procedure note associated with it.
- This includes OMT and all surgical procedures including injections.
- Procedure notes should include pre and post pain levels documented, OMT techniques used during treatment.
References
