

Life in the Fast Lane: Quick Techniques for Office-Based OMT

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Learning Objectives

At the conclusion of this presentation, the physician will be able to:

- Review OMT techniques
- Identify OMT techniques that can be performed quickly
- Develop a plan to utilize time efficient OMT techniques
- Review areas of treatment
- Review billing for OMT

4 Keys to Successful OMT

- ① Accurate Diagnosis
- ② Appropriate Choice of Force
- ③ Accurate Localization of Force
- ④ Appropriately Placed Fulcrum



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Classification of Manipulative Procedures

- Direct
 - Toward the restrictive barrier and increased tissue tension and restriction
- Indirect
 - Away from the restrictive barrier and toward a sense of ease and increasing tissue compliance
- Combined
 - Combination of direct and indirect methods applied concomitantly or sequentially—but in general we categorize a technique for its starting position



INDIRECT

DIRECT

Counterstrain

Facilitated Positional Release

Osteopathic Cranial Manipulation

Myofascial Release

Balanced Ligamentous Tension

Ligamentous Articular Strain

Still Technique

Inhibitory

Articulatory

Muscle Energy

Soft Tissue

High Velocity Low Amplitude (HVLA)

Muscle Energy

Muscle Energy

- Engage barrier
- Isometric contraction in opposite direction with 3-5 lbs. (general guideline) of force for 3-5 seconds
- Relax for a few moments (1-2 seconds)
- Engage new barrier
- Repeat until finished...
- Recheck



Keys to Making Muscle Energy Most Effective

- ① Patient & Physician positioning – to eliminate bobble head & physician in a relaxed position
- ② Use translational motion for localization in Sidebending & Flexion/Extension
 - Use lateral translation first (for sidebending)
 - Use A-P translation second (for flexion / extension)
 - Introduce rotation last – very little should be needed (remember 3rd law)
- ③ Have a true isometric contraction ...
 - Ask patient to gently or lightly move in a single plane direction that you can specifically control ... this will result in the best true isometric contraction & no loss of isometrics
- ④ Physician waiting for ALL tissues to fully relax

Contraindications

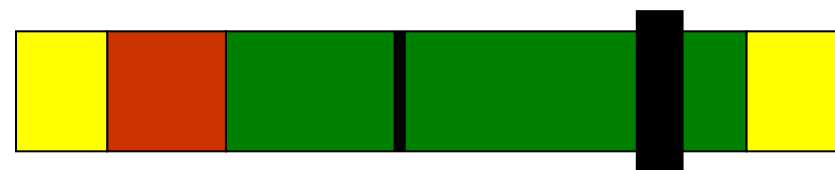
- Moderate to severe muscle strains
- Severe osteoporosis
 - May increase risk of tendinous avulsion
- Acutely injured, spastic, or painful muscles
- Fracture, dislocation, or severe joint instability
- Post-surgical
- Low vitality patients
 - Acutely post-MI, acute COPD exacerbation, ICU patient, etc
- Lack of cooperation of patient



Counterstrain

Counterstrain

- **Indirect** manipulative treatment model
 - Passive technique (Patient doesn't do any work.)
- Based on initial positioning of patient relative to restrictive barrier
- Unique advantage: patient can provide feedback to physician to indicate when they are in correct position for treatment
- Paying attention to tissue changes under monitoring hand
 - Enables one to learn to palpate more subtle tissue changes needed to be effective in applying other treatment models
- Patient is passively positioned **away from** the restrictive barrier to point of comfort
 - Often toward the point of original injury



Direct

Indirect

Indications for Counterstrain Technique

- Acute or chronic somatic dysfunctions with an associated tender point
- When to use Counterstrain
 - Acute injury (where direct techniques may exacerbate the injury)
 - Somatic dysfunction with a neural component (hyper-shortened muscle)
 - Severely ill/hospitalized patient
 - Frail patients or those hesitant about forces used in other forms of OMT

Contraindications to Counterstrain

- Absolute
 - Lack of patient consent
 - Inability to tolerate treatment position
 - Manifestation of neurological symptoms in treatment position
 - Exacerbation of potentially life-threatening symptomatology by treatment position
- Contraindications (May want to think twice!)
 - Fracture in area used to treat somatic dysfunction
 - Torn ligament in area where positioning would risk further tearing



Relative Contraindications to Counterstrain

- Patients who cannot voluntarily relax
- Severely ill patient, who may not tolerate treatment reaction
- Apprehension while approaching treatment position
- Inability of patient to effectively communicate
- Inability to tolerate classic treatment position (in a non-modifiable treatment position)
- Upper cervical hyper-rotation and hyperextension in patients with known vertebral artery disease
 - Also, upper cervical ligamentous instability, dens malformation, severe osteoporosis
- Patient with severe acute rheumatological flare

Facilitated Positional Release (FPR)

Elements of FPR

- Developed by Stanley Schiowitz, DO
 - Similar theorized MOA to strain counterstrain (SCS)
 - Based on the principle that the α -afferent sensory fibers (stretch receptors) cause the γ -efferent motor fibers to relax when the stretch load is reduced.
1. Flatten anterior-posterior curves
 2. Set in position of ease
 3. Apply activating force (compression or distraction usually)
 4. Hold for 3-5 seconds
 5. Return to neutral

Balanced Ligamentous Tension (BLT)



Balanced Ligamentous Tension (BLT)

General Considerations & Rules:

- Primarily indirect technique affecting the connective tissues of body: fascia, ligaments, tendons, and indirectly, lymphatics, and blood flow
- BLT and ligamentous articular strain (LAS), are terms that both come from the phrase William Garner Sutherland stated ... “Ligamentous articular strains are treated by using balanced ligamentous tension.”
- The reason why both names have persisted is that various osteopathic physicians call their methods of treatment by either term

Balanced Ligamentous Tension (BLT)

General Considerations & Rules:

- BLT techniques are usually associated with very light touch & often use respiratory cooperation
 - approximately 1 to 3 pounds
- BLT techniques have three common components:
 - Disengagement
 - Exaggeration
 - Balance

Balanced Ligamentous Tension (BLT)

Disengagement

- To disengage the physician must use either compression or decompression of a joint and its tissues, most commonly compression
- Once disengaged the joint or tissue will move
- The osteopathic physician uses palpation to bring the tissue to a neutral point

Exaggeration

- The joint or tissue is taken into the direction of injury, exaggerating the position of the diagnosis of relative freedom
- Close to the point of injury is the most likely location to find the dysfunction
- By approaching the dysfunction with exaggeration of its relative freedom, a balance point is determined

Balance point

- Establishing the balance point leads to the resolution of the somatic dysfunction
- The first points are determined by palpation and diagnosis ... this is where treatment begins
- All of the parameters of pull are brought to a state of balance
- Balance consists of not taking the tissues beyond the elastic limits, and yet it is not light touch
- The key to successful treatment is this delicate balance of all the ligaments, all the strains, and all the other tissues, fascia, etc



High Velocity Low Amplitude (HVLA)

Important Concepts for HVLA

- Accurate **diagnosis** is the key to performance of HVLA (thrust) techniques
- HVLA (thrust) approach is characterized by **positioning** to engage the restrictive barrier, followed by a corrective maneuver to move through the barrier
- Positioning against the restrictive barrier in **all planes** is followed by a rapid and brief corrective thrust
- HVLA (thrust) techniques can be taught and learned easily. The necessary motor coordination for effective use requires extensive practice and experience

Steps to HVLA thrust:

- Gently position patient against restrictive barrier
- Apply constant gentle pressure against barrier
- Encourage patient to breathe and relax
- Apply a gentle high velocity, low amplitude thrust through restrictive barrier
- Reposition patient to neutral position and **reassess**

Contraindications to HVLA

Absolute (regionally or segmentally specific):

1. Upper Cervical (OA, AA)

Rheumatoid Arthritis

Down Syndrome

Achondroplastic dwarfism

Chiari malformation

Vertebrobasilar insufficiency

2. Fracture / Dislocation / spinal or joint instability

3. Ankylosis / Spondylosis with fusion

4. Surgical fusion

5. Klippel – Feil Syndrome

6. Inflammatory Joint Disease

7. Joint Infection

8. Bony Malignancy

9. Patient Refusal



Relative Contraindications (regionally or segmentally specific)

1. Acute HNP (herniated nucleus pulposus)
2. Acute Radiculopathy
3. Acute whiplash / severe mm spasm / sprain / strain
4. Osteopenia / Osteoporosis
5. Spondylolisthesis
6. Metabolic Bone Disease
7. Hypermobility





Demonstration

Billing and Coding

Regions

- Somatic dysfunction
 - Head M99.00
 - Cervical Spine M99.01
 - Thoracic Spine M99.02
 - Lumbar Spine M99.03
 - Sacrum M99.04
 - Pelvis M99.05
 - Lower Extremities M99.06
 - Upper Extremities M99.07
 - Ribs M99.08
 - Diaphragm/Abdomen M99.09

Osteopathic Manipulative Treatment

- 1-2 regions 98925
- 3-4 regions 98926
- 5-6 regions 98927
- 7-8 regions 98928
- 9-10 regions 98929

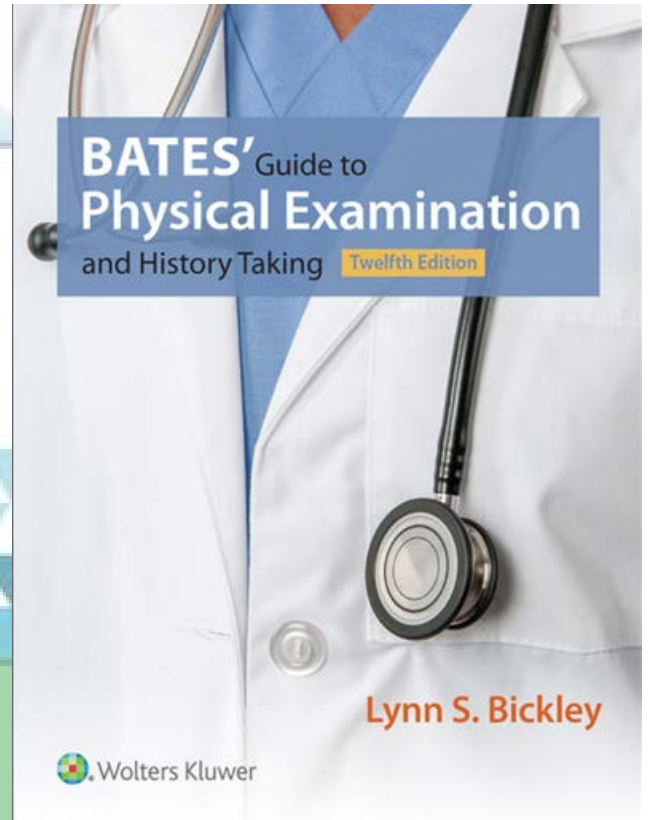
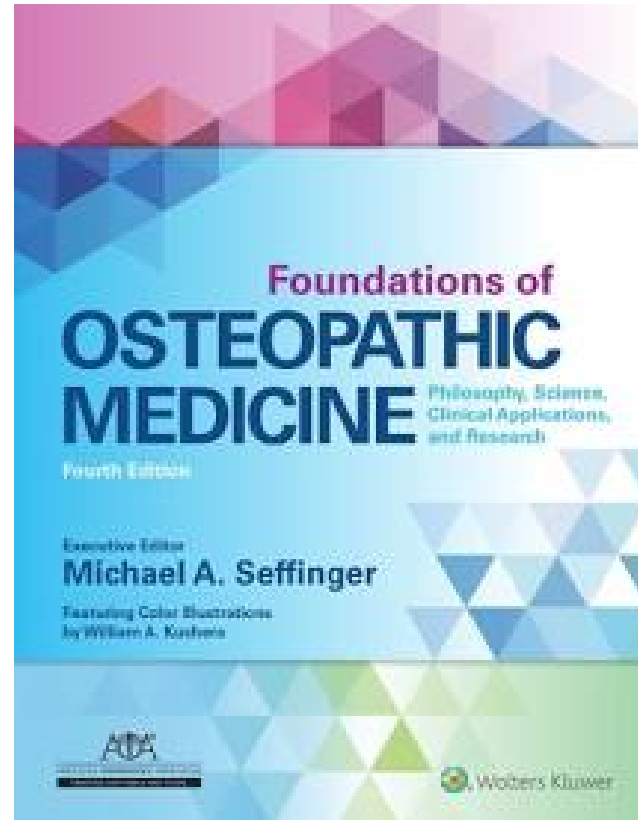
Office Visit

Modifiers



References

- David Harden, DO
- Al Kozar, DO
- Jason Sneed, DO



Questions?

